World Vision®

Timed and Targeted Counselling for Health and Nutrition

Facilitator's Manual for Training in ttC

Module 2: Childbirth and Newborn Care

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

Facilitator's Manual for Training in ttC 2nd Edition.
Facilitator's Manual for Training in ttC 1st Edition published 2011.

Published by Sustainable Health on behalf of World Vision International

For further information about this publication or World Vision International publications, or for additional copies of this publication, please contact wvi_publishing@wvi.org.

World Vision International would appreciate receiving details of any use made of this material in training, research or programme design, implementation or evaluation.

Authors: Michele Gaudrault and Polly Walker
Contributors: Sue England, Danielle Chekaraou, Annette Ghee, Fe Garcia, Tina Monique James, Alison Schafer, Carmen Tse.
Updates to the 2nd edition: Polly Walker 2014.

Publishing Coordination: Katie Fike. Senior Editor: Marina Mafani. Copyeditor: Nancy Warren. Interior Layout: Alice Contreras.

Cover photo © World Vision

Contents

Abbreviations

ADP	Area development programme
ARI	Acute respiratory infection
ARV	Antiretroviral
ART	Antiretroviral therapy
ANC	Antenatal care
CHW/V	Community health worker/volunteer
CHX	Chlorhexidine
COH	Channels of Hope
COMM	Community health committee
CVA	Citizens Voice and Action
DPA	Development Programme Approach
ECD	Early child development
EBF	Exclusive breastfeeding
EMOC	Emergency obstetric care
EMONC	Emergency obstetric and newborn care
FP	Family planning
GBV	Gender-based violence
HIV	Human Immunodeficiency Virus
HTSP	Healthy timing and spacing of pregnancy
HVs	Home visitors
IMCI	Integrated management of childhood illness
KMC	Kangaroo Mother Care
LBW	Low birth weight (baby)
LLIN	Long-lasting insecticidal net
MHPSS	Mental health and psychosocial support
MNCH	Maternal, newborn and child health
MoH	Ministry of Health
NGO	Non-governmental organisation
NO	National office
PHC	Primary health care
PLW	Pregnant and lactating women
PMTCT	Prevention of mother-to-child transmission of HIV
PNC	Postnatal care
PPH	Postpartum haemorrhage
PPI	Postpartum infection
PSS	Psychosocial support
RH	Reproductive health
SAM	Severe acute malnutrition
SBA	Skilled birth attendant
SC	Stabilisation centre
SGA	Small for gestational age
SO	Support office
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TA	Technical approach
TB	Tuberculosis
TBA	Traditional birth attendant
ttC	Timed and targeted counselling
ttC-HVs	ttC home visitors
U5MR	Under-5 mortality rate
VCT	Voluntary counselling and testing
WASH	Water, sanitation and hygiene
WFP	World Food Programme
WHO	World Health Organization
WV	World Vision

PREFACE TO TTC MODULE 2: CHILDBIRTH AND NEWBORN CARE

How to use this document

This is part 2 of the ttC technical content curriculum, which follows ttC Methodology and Module 1: Healthy Pregnancy. It has been completed in those countries that have elected to use the World Vision technical content rather than a local Ministry of Health (MoH) curriculum. We do not recommend that this training be done in combination with previous modules, as this is too much information for a single training event.
It can also be used in a hybrid approach, selecting sessions that are gaps in the national curriculum. All such choices must be made in collaboration with the Ministry of Health of the respective country you are working.
This document can be used for the following purposes:

1. **Curriculum selection:** Use this document to compare side by side with the MoH curriculum during the ttC adaptation phase.
2. **Curriculum adaptation and module selection:** If you are using an MoH curriculum, you may wish to review this document and select elements or modules of interest that do not have equivalents in your MoH-led training, such as:
    - Sessions 5, 12 and 15. Conducting the visits – these can be used as practical/revision sessions
    - Session 18: Completing the *ttC Register*
    - Session 19: Referral and follow-up of the sick newborn or postpartum mother.

3. **Refresher training for existing ttC-HVs:** If you have already undergone training with ttC core curriculum version 1 and your ttC home visitors (ttC-HVs) are due to undergo refresher training, you may wish to include the sessions on *new content.* All new content in ttC second edition has been included as *additional sessions* and therefore these modules can be used independently during refreshers, specifically:
    - Session 7: Caring for the mother after birth, including psychosocial support (PSS)
    - Session 9: Early child development
    - Session 11: Special care of the small baby in the first month
    - Session 16: Children born to HIV-positive mothers
    - Session 17: Additional support for high-risk newborns and mothers
    - Special session on chlorhexidine cleaning of the umbilical cord stump (optional)
    - Additional material has been added to strengthen Visits 4 and 5 to include cleaning of the umbilical cord stump, hygiene, warmth for the newborn and maternal PSS.

Use disclaimer

Icons

Ask the group

Technical information

Summarise

Recap the key messages and objective

Use job aids (materials)

Activity

Discussion topic

INTRODUCTION

Welcome to the facilitator's manual for training in timed and targeted counselling (ttC). This is the second module of the technical training component of ttC, which focuses on late pregnancy care, preparation for childbirth and the immediate and essential care of the newborn up to the first month of life. This corresponds to the last visit in pregnancy (Visit 4), the first week of life postpartum visits (Visits 5a, b, and c) and the first month of life visit (Visit 6).

Key resources used in the development of the ttC project model include:

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

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

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

Training Materials needed for ttC Module 1

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

ttC published resources	Trainers Guide and DVD Facilitator's Manual (one per facilitator) ttC Participant's Manual (one per literate participant) ttC Storybooks 4-6 (1 set per ttC-HV) ttC Household Handbook (one per participant) Food cards (one set per facilitator) ttC Newborn register Sample referral / counter referral forms (or use local version) - three per participant
Additional training materials	Flipchart and paper, and markers Sample of maternal health card Sample of child health card Breastfeeding photocards Umbilical cord photocards WHO counselling card (Care for Child Development) printed, or projected on screen *Demonstration materials:* 2-3 dolls for demonstration Clean delivery kit 2 towels, baby hat and socks "Fake breasts" prop for role play (optional) Homemade rag doll with cord attached to placenta, for role play (optional) Red cloth to represent blood, for role play (optional) Water, soap, a large basin, mug or pitcher (4 sets) Weighing scales (for baby weight) Vegetable oil (optional) Ground pepper or cinnamon (optional) Chlorhexidine solution samples (one per group) Beans An LLIN, most commonly found in the area Hanging supplies (hooks, nails, poles – whatever is needed) Photocopies of the instructions that come with the bed net, one for each ttC-HV Tables to use as beds during the demonstration *For watching videos:* Projector and screen Laptop or DVD player DVD: Early Initiation of Breastfeeding DVD: Immediate Newborn Care video clips DVD: "Immediate care after birth" DVD: Breast-crawl DVD or video clips: observing breastfeeding, correct positioning and attachment

VISIT 4: LATE PREGNANCY

Session 1: Danger Signs during Labour and Birth

Session plan	Activity 1: Determine what they already know Activity 2: Danger signs in labour and delivery Activity 3: Role play danger signs in delivery Activity 4: Barriers and enablers to prompt referral	 Time: 2h00
Learning objectives	At the end of this session participants will be able to: • recall the key preparation steps that will enable families to act quickly if labour starts early or there are danger signs in labour • recognise the danger signs during labour and delivery • explain the danger signs to households and counsel them appropriately on actions to take and how to overcome barriers to rapid care seeking.	
Key messages	• As part of the birth plan, families should have all materials for birth, a plan for transport and money for emergencies ready before labour starts. If labour comes early or a danger sign occurs, the woman can be quickly taken to the facility. • Take woman to a health facility if a danger sign is present (if home birth). During labour, go immediately if the mother has one of these signs: o feels no movement or reduced movement of the baby o water breaks without labour commencing after 6 hours o bleeding o any bleeding during labour but before birth o too much bleeding immediately after birth o fever and chills o prolonged labour/birth delay (12 hours or more) o fits or loss of consciousness.	
Preparation and materials	*Materials* • Flipchart, paper and markers • Storybook for Visit 4 • Household handbooks *Preparation* • Gather all training materials in advance.	

VISIT 4

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- recall the key preparation steps that will enable families to act quickly if labour starts early or there are danger signs in labour
- recognise the danger signs during labour and delivery

- explain the danger signs to households and counsel them appropriately on the actions to take and how to overcome barriers to rapid care seeking.

Activity 1: Determine what they already know

Ask: Do you know of any women in your communities who have experienced complications during labour or birth? What happened? What was the outcome?

Ask: What are the danger signs during labour and birth? What should you do if these are present?

Activity 2: Give relevant information: Danger signs in labour and delivery

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

Explain or read aloud:

DANGER SIGNS IN LABOUR AND DELIVERY

It is not possible to predict if a woman will experience complications in labour, even if she has had uncomplicated births in the past. For that reason, it is always best to give birth in a health facility with skilled birth attendants (SBAs) who can respond to any complications that may arise. Nevertheless, if a facility birth is not possible, or if labour starts early, families must be able to recognise danger signs in labour and delivery and be prepared to immediately take the woman to the facility should any complications arise.

VISIT 4

Have the ttC-HVs look at the page in the household handbook that refers to danger signs in labour and delivery. Refer to the relevant page in the ttC Participant's Manual where the above information is found, and answer any questions they may have.

DANGER SIGNS DURING LABOUR AND DELIVERY (SEE HOUSEHOLD HANDBOOK)

- Woman feels no movement or reduced movement of the baby
- Water breaks without labour commencing within 6 hours
- Bleeding
- any bleeding during labour but before birth
- too much bleeding immediately after birth
- Fever and chills
- Prolonged labour/birth delay (12 hours or more)
- Severe headache, fits or loss of consciousness

There are danger signs not in the household handbook which might be difficult for the family to detect but if the mother delivers at home should be aware are serious danger signs and need urgent referral:

- placenta not delivered or incomplete after birth
- dark green liquid expelled from womb during labour.

Necessary actions

- Tell someone immediately – don't hide it or wait to see what might happen.
- Call for help and take the woman to the health facility immediately.
- Go to the front of the line and explain the situation to the health staff.
- Give liquids to the woman while in transit to the health facility (unless she is having a seizure, in which case liquids should not be given).

Remind the group about the four delays discussed in Module 1, which may be the main reasons for the death of the mother or baby during delivery:

THE FOUR DELAYS

Danger: Delay in recognising the danger sign

Decision: Delay in deciding to seek care

Distance: Delay in reaching care (distance to the health clinic and/or lack of transport)

Service: Delay in receiving effective care.

Discuss these delays with the participants. Explain that they will work with families so that they **recognise the danger signs** and make the **decision to immediately seek care** (within the first 24 hours) if a danger sign is present. **Ask** the participants to discuss the situation in their area with regard to Delays 3 and 4. Is it difficult for families to reach the health clinic? Once they arrive at the health clinic, are there often delays in receiving service? How can these delays be overcome?

Ask: What could cause delay in a family immediately departing for the facility? What preparations should the families have completed to prepare them for emergencies?

EMERGENCY PREPARATIONS

In advance of the onset of labour, the family should have prepared an emergency plan and gathered materials for the birth so they are ready to leave urgently at any time:

- Identify emergency transport to the health facility.
- Save money for transport and other expenses at the health facility.
- Gather supplies for home or facility birth: clean delivery kit, including clean blade and chlorhexidine (CHX) solution, soap, gloves, cord ties, a plastic sheet, sanitary napkins/pads and clean clothes for the mother and the baby.

Activity 3: Reinforcing the information: Role play

Working in groups: Ask two groups to role play in plenary a situation of a woman experiencing one of the listed complications during labour in the middle of the night. The role play should demonstrate all of the necessary actions that should be taken to help the woman.

- Group 1: Labour starts earlier than expected and the woman experiences complications, but the family does not have emergency plans in place or materials for delivery.
- Group 2: The same situation, but the family has emergency plans and materials ready.

Discussion questions: How did the situations differ? How did this affect the outcome? How did the mother feel in the Group 1 scenario? How might this affect the woman's labour and the baby? When should ttC-HVs ensure that the family has emergency plans and materials in place for the birth?

Activity 4: Discussion: Barriers and enablers for prompt referral of danger signs

Working in groups: Considering these key actions for Visit 4 – recognition of danger signs and prompt referral, ask the group to consider the barriers and enablers:

- What causes delays in the recognition of danger signs? Remind them about the three delays from Module 1.
- What causes delays in referral during labour?
- What would make it easier for families to respond quickly?
- What can the ttC-HVs do to help families overcome barriers and find solutions? (Such as counselling families, checking emergency plan and materials.)

Ask each group to report back to the ttC-HVs and then make notes in their *ttC Participant's Manual*.

Visit 4. Quick referral for danger signs in labour and delivery

Key messages and additional information	Barriers *What makes it difficult to do?*	Enablers *What would make it easier to do?*	Counselling response or solution
Take the woman to a health facility if a danger sign is present (if home birth). During labour, evacuate immediately if the mother has one of these signs: - bleeding during labour but before the birth - too much bleeding immediately after birth - fever and chills - prolonged labour/birth delay (12 hours or more) - severe headache, fits or loss of consciousness - Water breaks without labour commencing after 6 hours. - Woman feels no movement or reduced movement of the baby. *Remember:* As part of the birth plan, families should have all materials ready for birth, transport plan and	Lack of awareness, no transport Poor birth preparation Financial constraints pertaining to access to transport	Knowledge of the danger signs Having emergency plans and birth materials ready in advance	

VISIT 4

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.			

Session 2: Immediate Essential Care of the Newborn after birth

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: Immediate essential newborn care after birth Activity 3: Reinforce the information: Immediate care sequence demonstration Activity 4: Reinforce learning: DVD demonstration Activity 5: Give relevant information: Postnatal follow-up and immunisations Activity 6: Give relevant information: Immediate danger signs in the newborn Activity 7: Barriers and enablers to immediate essential newborn care	 Time: 2h30
Learning objectives	At the end of this session participants will be able to: • understand why the first hours after birth are critical to the baby's survival, and know the immediate essential care actions given to the baby after birth • understand the immediate actions taken by the SBA when the baby is born to ensure warmth, hygiene, breathing, cord care and breastfeeding • counsel families who have given birth at home to practice immediate essential newborn care too and to take the baby to the health facility as soon as possible for a check-up.	
Key messages	• The SBA should give immediate essential care of the newborn during the first hour of life, including the following actions: o Dry the baby immediately after birth using clean warm cloths to remove blood and fluid from the body, face and head. o Begin rubbing and stimulation to help breathing. o Clean the baby's airway if needed: nose and mouth to assist breathing. o Keep the baby warm by providing a warm room, hat and socks. • Place the baby in skin-to-skin contact with mother during the first hour of life. o Cut the cord with a clean blade from the clean birthing kit. o Do not bathe baby for first 24 hours. o Help the baby to breastfeed within 30 to 60 minutes after birth; give colostrum. o Observe the baby's colour and breathing – lips, tongue and mouth should be pink, not grey or blue, and check breathing regularly for several hours after birth. • If a birth occurs at home , the family should give immediate essential newborn care and encourage the mother and baby to attend postnatal care at a health clinic as soon as possible after the home birth. As soon as possible after delivery, take the infant for immunisations and a check-up at the clinic.	
Preparation and materials	*Materials* • Storybook for Visit 4 and household handbooks • Doll • Clean delivery kit • Two towels for drying • Baby hat and socks • DVD: "Immediate care after birth" • Laptop or DVD player	

VISIT 4

Preparation
Set up the DVD player and TV/computer and projector.
Check the DVD and make sure you are on the correct clip.

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- understand why the first hours after birth are critical to the baby's survival, and know the immediate essential care action to be given to every baby after birth
- understand the immediate actions taken by the SBA when the baby is born to ensure warmth, hygiene, breathing, cord care and breastfeeding
- counsel families who give birth at home to practice immediate essential care of the newborn too and to take the baby to a health facility as soon as possible for a check up.

Activity 1: Determine what they already know

Ask: What happens to babies right after they are born in your communities? When are they dried? What else is done?

Ask: What happens if you stand wet without clothes after bathing in cold weather?

The response will be that you get cold. The same thing happens to a newborn baby who is left wet with birth fluids after birth, but newborns become cold much faster than adults. If babies get cold they can become sick.

Ask: How can a newborn pick up an infection during the first hour after birth?

The baby can pick up infections from unclean hands touching the baby, unclean baby wraps or clothes, unclean surfaces, or if a dirty unsterile blade is used to cut the umbilical cord.

Activity 2: Give relevant information: Early essential newborn care

Explain or read aloud from the *ttC Participant's Manual,* and answer any questions participants may have.

THE FIRST HOURS OF LIFE

The first hours of life are a critical period for a baby's survival, and special care must be given. Four key things should be remembered during this period:

WARMTH: It is essential that **newborns be kept warm** during this time. Newborns get cold easily immediately after birth when they are exposed to temperatures that are colder than inside the womb, because they cannot adjust their body temperature like adults.

BREATHING: If the newborn has suffered prolonged or complicated labour he or she may have *breathing*

difficulties or birth asphyxia, so it is important to **help the baby breathe** and to regularly check the breathing to prevent deaths due to asphyxia.

HYGIENE/CLEAN BIRTH: Throughout the first hours of life, mother and baby can become infected in various ways. There are *five essential cleans to remember during delivery,* which must be followed to prevent infection in the newborn:

- Clean hands – Birth attendants and supporters must wash their hands with soap before touching the mother or baby, and wear protective gloves.
- Clean surface – Use a clean plastic sheet to ensure that the baby is delivered on a clean surface.
- Clean cord tie – Take from the clean birth kit.
- Clean blade – The umbilical cord must be cut with a clean/new blade from the delivery kit.
- Clean cord care – Keep the umbilical cord clean and dry and do not bandage. (Or apply chlorhexidine (CHX)*) .

BREASTFEEDING: Both mother and baby both benefit from beginning **breastfeeding in the first hour of life** as this helps to expel the placenta and to protect and give the baby energy after the ordeal of labour.

**It is not recommended any other product be used on the umbilical cord.*

Contextualisation: If the policy supports the distribution and use of CHX for the cleaning of the umbilical cord, for babies born at home , then adjust hygiene guidance accordingly.

Activity 3: Reinforcing the information: Immediate care sequence demonstration

Refer to the list below in the *ttC Participant's Manual*. Read through the sequence and ask which theme the actions refer to (warmth, hygiene, breathing, breastfeeding).

IMMEDIATE ESSENTIAL NEWBORN CARE

The SBA and/or birth companion present during labour should ensure that the following actions are taken immediately after the birth, regardless of where the delivery took place (home, health facility, in transit).

1. **Warm** the room where the birth takes place and where the baby will stay. *(Warmth)*
2. Ensure that all attendants and supporters have **clean hands** and that the mother is on a clean surface. (*Hygiene*)
3. **Dry** the baby as soon as it is born (comes out of birth canal). Remove the wet cloth or towel and replace with a dry cloth. *(Warmth)*
4. Clear the baby's **nose and mouth** right away to make sure that there are no obstructions to the baby's breathing. (*Breathing)*
5. Keep the baby in **skin-to-skin** contact with the mother (on her abdomen) and cover the baby with a dry sheet or blanket. *(Warmth)*
6. Put a **hat/cap and socks** on the baby. *(Warmth)*
7. The cord should not be cut immediately, but rather wait a few minutes until the cord stops pulsating so that the baby can start life with all the blood it requires. The cord should then be tied with **clean cord ties** cut with a **clean blade**. (*Hygiene)*
8. Put the baby to the **breast** soon after the cord is cut. (*Breastfeeding*)
9. When the baby is not feeding, the mother can rub the baby's back and legs to keep the baby warm and **promote good circulation** of blood. (*Breathing and warmth)*
10. Do not give the baby a bath on the day of birth. *(Warmth)*

VISIT 4

The facilitator can then **show** these steps in a demonstration using the doll, clean delivery kit and cloths and volunteers to play the role of the mother and birth companions. The other facilitator should read the sequence, as the actors role play. During the actions, the participants can point out any errors, then ask other volunteers to come to the front of the room and repeat the demonstration.

Activity 4: Reinforce learning: DVD demonstration

Contextualisation: The following video is available from the Global Health Media Website to download. Additional languages can also be used: http://globalhealthmedia.org/immediate-care-after-birth. It may be useful to also recap key messages about hand washing at this time, or do a demonstration.

Immediate essential newborn care (drying, skin-to-skin contact, early initiation of breastfeeding)

Gather the trainees so that all of them can see the video, played on either a laptop or a DVD player. Introduce the video explaining that it demonstrates what happens during and after a birth in a health facility. Show the DVD clip and explain what is happening at each step. The video is 9 minutes, but facilitators may stop and restart the video in order to emphasise the key points as they happen. Ask if there are any questions.

Immediate care after birth

Activity 5: Give relevant information: Postnatal follow-up and early immunisations

Explain or read aloud:

POSTNATAL CHECK UP AND IMMUNISATIONS

A newborn requires two important immunisations at birth or in the immediate days following birth. **Explain** to participants that they will counsel caregivers to ensure that they understand that the newborn needs to receive two immunisations:

- BCG vaccine protects against serious forms of tuberculosis in children.
- Oral polio (OPV). Early OPV dose is called OPV-0 (zero).

Key message: For home deliveries, encourage the mother and baby to attend postnatal care at the health clinic as soon as possible after a home birth. As soon as possible after delivery, take the infant for immunisations and a check-up at the clinic.

Show vaccine cards to participants, showing where early vaccines are marked when completed.

Activity 6: Give relevant information: Immediate danger signs in the newborn

Ask: What signs during the first day of life suggest that a newborn is in danger? What happened?

Explain or read aloud:

Families should be aware of any sign that the newborn is unwell, including reduced activity/lethargy, breastfeeding problems, difficulty breathing or changes in temperature. If a home birth, go immediately to a facility. For facility deliveries call the doctor/midwife right away.

Key message: Refer newborn urgently if a danger sign is present:

- unconscious, lethargy
- chest indrawing
- unable to breastfeed
- fits/convulsions
- fast or difficult breathing
- fever.

Activity 7: Barriers and enablers to early essential newborn care

Working in groups: Consider the barriers and enablers to newborn care practices in the table below, grouping by 1) breathing, 2) warmth, 3) hygiene and 4) recognition of and referral for danger signs (breastfeeding will be covered in the next session). Ask them to consider beliefs about newborn care in their communities. For example, the family may believe that the baby needs bathing to remove the whitish film (called vernix) from the body. After this, ask the groups to report how they could help families overcome any practical or cultural barriers.

Visit 4. Immediate essential and newborn care

Topics	Key messages and additional information	Barriers What makes it difficult to do?	Enablers *What would make it easier to do?*	Counselling response or solution
Immediate Essential newborn care	Encourage *hand washing* with soap before touching the newborn baby or mother during delivery. Use a clean blade to cut the umbilical cord.			
	Help the baby breathe: Clear baby's airway (nose and mouth) and ensure that baby is breathing clearly during first hour of life. Dry the baby immediately after birth. Use rubbing and stimulation.			
	Keep the baby warm: • Put baby skin-to-skin with mother. • Warm room, hat, socks, blanket. • Do not bathe baby for first 24 hours.			
	Postnatal care at health clinic for mother and baby. As soon as possible after delivery take the mother and infant for a check-up at the clinic and immunisations			
Danger signs in newborns	Refer newborn urgently if danger sign is present: • Unconscious, lethargy • Chest indrawing • Unable to breastfeed • Fits/convulsions • Fast or difficult breathing • Fever			

Summarise the main points of the session

- Newborns must be kept warm after delivery because if they get cold, they can become ill. We can keep newborn babies warm by:
  - drying them as soon as they are born and removing the wet cloth
  - putting them in skin-to-skin contact with the mother and covering the baby and mother with a dry cloth
  - helping them breastfeed very soon after birth (usually within 30 minutes)
  - avoiding bathing them on the first day after birth.
- Other important actions that must be taken immediately when a baby is born include cleaning the nose and mouth to ensure that there are no obstructions to the baby's breathing, and rubbing the baby's back and legs to stimulate breathing.
- It is important to take the baby to the health facility as soon as possible for his or her first immunisations, and for a general post-delivery check-up.

Session 3: Promote Early Initiation of Exclusive Breastfeeding

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: Initiation of breastfeeding Activity 3: Show DVD clip: Breast-crawl Activity 4: Barriers and enablers to early and exclusive breastfeeding Activity 5: Provide relevant information: Expressing breast milk	 Time: 1h30
Learning objectives	At the end of this session participants will be able to: • explain to families why early initiation of exclusive breastfeeding is important • effectively counsel families to help overcome barriers to initiating breastfeeding immediately after birth • teach households how to express breast milk, and in which situations this might be necessary.	
Key messages 	• Put baby to the breast within 30 to 60 minutes after birth. • Do not discard first milk (colostrum) and do not give any other substance to eat or drink. • Exclusively breastfeed: Babies should be given only breast milk to eat and drink during the first 6 months of life. Most healthy mothers have sufficient milk, and additional fluids or foods, including water, are not needed, provided you breastfeed the baby regularly and on demand (8 to12 times per day). • Help a mother to express breast milk if she is unconscious or ill following delivery.	
Preparation and materials 	*Materials* • Flipchart, paper and markers • Storybook and household handbooks • 'fake breasts' props for role play (optional) • Homemade rag doll with cord attached to placenta, for role play (optional) • Red cloth to represent blood, for role play (optional) • DVD: Breast-crawl • DVD player or laptop *Preparation* • Gather all training materials in advance. • Set up the DVD and TV/computer and projector. • Check the DVD and make sure you are on the correct clip.	

VISIT 4

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- explain to families why early initiation of exclusive breastfeeding is important
- counsel families to overcome barriers to initiating breastfeeding immediately after birth
- teach households how to express breast milk, and in which situations this might be necessary.

Activity 1: Determine what they already know

Ask: How long after delivery is breastfeeding started in your community? Why?

Ask: What are the most common beliefs about colostrum (the first milk) in your community?

Ask: What is usually given to the babies in your community after birth?

Write each question on the blackboard/flipchart, and list responses beneath the question. Do not make any judgments on what is said.

Activity 2: Give relevant information: Initiation of breastfeeding

Read aloud:

EARLY BREASTFEEDING

Breastfeeding should begin within the first 30 minutes after birth. Babies are ready for breastfeeding when they open their mouth, turn their head as if searching for the nipple or suck on their fingers or hand. No other food or liquid, even traditional teas or water, should be given before or after the baby breastfeeds. Starting to breastfeed early and exclusively is one of the best ways to ensure that a baby stays healthy, and has many advantages for both the newborn and the mother.

Ask: What are the advantages of starting breastfeeding early?

Emphasise the points in the box below during the discussion.

ADVANTAGES OF EARLY INITIATION OF EXCLUSIVE BREASTFEEDING

For the baby

- The baby gets all of the benefits of the first milk (colostrum or yellow milk), which is like the baby's first vaccination and protects the baby from illness.
- Providing milk only (no supplements, teas or water before or after the first feed) protects from illness and makes sure the baby gets all the nutrition from the mother's milk.
- Early suckling helps make more milk.
- Breastfeeding helps keep the baby warm.

For the mother

- Breastfeeding helps expel the placenta.
- It reduces the mother's bleeding.
- It can prevent breast engorgement.
- It promotes bonding between mother and baby.

Activity 3: Show DVD clip: Breast-crawl

Show the DVD clip 'Breast-crawl'. You can download it from http://www.breastcrawl.org/video.shtml or if you have Internet access show directly from http://www.youtube.com/watch?v=b3oPb4WdycE

This DVD takes 7.14 minutes and shows how a newborn instinctively seeks the breast shortly after birth. **Discuss** the DVD with the participants when you have finished watching it.

Activity 4: Barriers and enablers to early initiation of exclusive breastfeeding

Ask: Why do some women not practise early and exclusive breastfeeding?

From their answers, identify which of these are *beliefs* and *knowledge/skills.*

Explain: Many places have cultural *beliefs* about early breastfeeding and giving colostrum that may present a barrier to this practice. **Refer** to the answers in Activity 1, and **summarise** local practices that are barriers/enablers to good breastfeeding. The family or birth attendant might not have the knowledge or skills to ensure that early breastfeeding occurs. Examples are given in the table below. Ask the ttC-HV to think about possible solutions.

Perceived barrier	Type of barrier	Possible counselling response
Family feels the first milk is dirty and should be removed	Beliefs	Counsel on the benefits of colostrum: the first milk is very beneficial for the baby as it acts like a first immunisation. All babies should be fed the first milk.
Mother feels that the milk has not 'come-in' yet/she doesn't have enough milk	Beliefs	Mother may believe she cannot breastfeed until her breasts are full, which can occur as late as three days after birth. Counsel mothers that the baby only needs a tiny amount of milk (show marble-sized stomach of newborn baby), so what the mother has is enough.
Baby doesn't cry for milk	Beliefs	Not all babies show they are hungry by crying, but they may show hunger by opening their mouths, 'rooting' – turning the head searching for the nipple, or sucking their fingers or hand. The baby should be put to the breast, even if he/she does not cry for milk.
It is tradition to give the baby water, ritual teas, or animal milks prior to the first feeding	Culture/beliefs	Counsel the mother and her supporters (especially mother in law, traditional birth attendant [TBA] or older woman who might influence this decision). Explain that the baby only needs breast milk and other liquids or foods may actually make the baby very sick or make the baby too full to breastfeed properly and get all of the nutrition and protection benefits from the colostrum.

Baby does not 'latch on' or is unable to feed	Knowledge/skills	Some babies may struggle with the first feeding, for many reasons, especially after a difficult birth or if the baby is small. In other cases the nipple is too big, or the first time mother needs support to get started. An SBA can help counsel the mother on proper attachment and positioning for breastfeeding. If the baby cannot latch, then the milk should be expressed into a clean cup and given via the cup or a spoon. A baby unable to breastfeed is a danger sign and requires urgent referral. The facility should not discharge a mother and baby until they are breastfeeding comfortably.
Performing other activities after birth	Knowledge/skills	Families or TBAs may think that the mother or the baby needs to be bathed before they start breastfeeding, or may not know the importance of starting immediately. Even if the mother is tired, she should be encouraged to give the first feed before resting or eating, and other activities should be delayed until the baby has been fed.

Activity 5: Provide relevant information: Expressing breast milk

Ask: Why might a mother be unable to immediately breastfeed her baby?

Ask: How can mothers ensure that the baby receives the first milk even if the mother herself is unable to breastfeed? Have you experienced this yourself?

Explain that the nurse or TBA can help the mother to express milk from the mother and feed it to the baby from a clean cup. Ask if any of them have done this, and if so, ask them to explain the process to the other participants. Review the storybook pages: 'Expressing breast milk', and the following information in the *ttC Participant's Manual*.

Explain or read aloud:

EXPRESSING BREAST MILK

- It is important to learn how to express breast milk, in case the infant has trouble latching on, or if the mother experiences any difficulties feeding due to painful nipples or breasts. To express breast milk, follow these steps:
  a. Wash your hands with soap.
  b. Massage the breast to help the milk come down.
  c. Place thumb and index finger on either side of the nipple, about three to five centimetres (one to two inches) back from the nipple.
  d. Press gently inward towards the rib cage.
  e. Roll fingers together in a slight downward motion.
  f. Repeat all around the nipple if desired.
- Expressed breast milk kept covered in a clean container will remain fresh for about 8 hours.

Summarise the main points of the session

- Breastfeeding immediately after birth has many advantages for both the baby and the mother. The first milk given to the baby just after birth is like a vaccine because it protects the baby from disease.
- A mother can breastfeed immediately after she gives birth even if she does not feel that her breasts are full. Breastfeeding will frequently help her to produce more milk.
- If a mother cannot breastfeed immediately after giving birth because of complications in delivery such that the mother is ill or unconscious, the nurse or TBA should express the milk from her breasts and feed it to the baby from a clean cup.
- The mother should breastfeed her baby **exclusively**. This means that no other food or liquids should be given to the baby – breast milk provides everything the baby needs.

Session 4: Hand washing

Session plan	Activity 1: Give relevant information: Hand washing Activity 2: Demonstrate skill and practise hand washing Activity 3: Barrier to hand washing and hygiene	 Time: 1h00
Learning objectives	At the end of this session participants will be able to: • explain the importance of washing hands before and after handling the newborn • know how to correctly wash hands • counsel families on hygiene for the newborn.	
Key messages 	• Family members must always wash their hands before they touch a newborn, as this will prevent bringing germs or infection to the baby. • Family members should wash their hands more carefully than usual, as they have practised, before touching a baby. • Everyone in the home should wash their hands after using the toilet/latrine, before cooking, before eating and before handling a newborn.	
Preparation and materials 	*Materials* • Flipchart, paper and markers • Storybook for Visit 3 • Household handbooks • Water, soap, a large basin, mug or pitcher (four sets) • Vegetable oil (optional) • Ground pepper or cinnamon (optional) • Training DVD • DVD player and TV/computer and projector *Preparation* • Have materials ready for hand washing demonstration. • Set up the DVD and TV/computer and projector. • Check the DVD and make sure you are on the correct clip.	

VISIT 4

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session participants will be able to:
- explain the importance of washing hands before and after handling a newborn
- demonstrate to families how to wash their hands correctly using soap
- counsel families on hygiene for the newborn.

Activity 1: Give relevant information: Teaching the family hand washing

Ask: Why it is important to wash your hands before touching a newborn?

Discuss, making sure the following points are covered.

NEWBORN HYGIENE

Newborns can get an infection more easily than an adult or an older child. Infection in a newborn can be dangerous and newborn babies can get sick and die very quickly. Frequent and correct hand washing is one of the most effective ways to prevent infections. As a ttC-HV, it is very important that you **always wash your hands** before touching the baby, so that you don't bring germs or infection to the baby, and that you encourage and show family members how to do the same.

Have the trainees *read aloud* the steps of correct hand washing from the box below. **Explain** that this method of hand washing is only for them before they touch a newborn, and how they should teach family members. When they wash their hands after going to the toilet or before eating, they can continue to use their usual way of hand washing.

STEPS OF CORRECT HAND WASHING

- Remove any bracelets or watches and roll up sleeves.
- Wet your hands and forearms up to the elbow.
- Apply soap and thoroughly scrub your hands and forearms up to the elbows. Give special attention to scrubbing your nails and the space between your fingers.
- Rinse with clean water flowing from a tap or poured by someone using a mug or pitcher.
- Air-dry with your hands up and elbows facing the ground, so water drips away from hands and fingers.
- Do not wipe your hands with a cloth or towel, because even a clean-looking towel may have germs on it.

Note: if there is no soap available, hands may also be washed with **ash** or with **lemon juice**. It is important to make sure that the ash has not become contaminated by sitting around for a long time. These alternatives are a **second choice**, only if soap is not available. The best option is always soap.

Now explain to the ttC-HVs that, while the above method of washing hands is important before handling a newborn, hand washing should be a regular practice in all of the following situations:

Note: You may introduce the following information in the form of a competition, asking the ttC-HVs to list the situations when hands should be washed.

WHEN TO WASH HANDS

- After using the toilet/latrine
- Before cooking
- Before eating
- Before and after handling a newborn

Activity 2: Demonstrate and practise hand washing

Show a video clip on hand washing, (use UNICEF, community IMCI or WASH training resources), if available. If not available, proceed directly to demonstration.

- **Demonstrate** correct hand washing technique while the participants observe.

Working in groups:

- **Divide** participants into groups of three to five.
- **Have** the groups practise hand washing using the steps in the box above.
- **Observe** if they are following the steps in the box above.

Activity 3: Barrier to hand washing and hygiene

Ask: What prevents people from hand washing at important times?

Write down all responses, then consider how to counsel the family to ensure that hand washing is done in their household at all of the key times. Elicit suggestions from them as these will show the key ways families can overcome barriers to hand washing in their communities.

Barrier	Possible response
No soap/cannot afford soap	Support the family to use ash or lemon juice or locally made soaps instead of soap. Or counsel the family to ensure that some soap is purchased and used especially during the newborn phase.
Household hand washing facilities are not conveniently located	Find a convenient way to place hand washing facilities (e.g. basin and plastic kettle) close to where the baby is being nursed and sleeping.
People forget to wash their hands	Put a sign up near toilets and above food-preparation areas. Place hand washing materials in an obvious location where people will be reminded when they see them.
People don't believe it is important	Counsel the family on the dangers of passing on infections to the newborn baby: that almost half of child deaths occur in the newborn phase, many of these due to preventable infections.

Summarise the main points of the session

- ttC-HVs must always wash their hands before they touch a newborn, as this will prevent bringing germs or infection to the baby, especially the umbilical cord.
- ttC-HVs should wash their hands more carefully than usual, as they have practised, before touching a baby.
- Everyone should wash their hands after using the toilet/latrine, before cooking, before eating and before handling a newborn.

Session 5: Conducting Visit 4: Late Pregnancy

Session plan	Activity 1: Understanding the story Activity 2: Give relevant information: Fourth visit during pregnancy Activity 3: Practise the fourth visit during pregnancy Activity 4: Debrief in plenary	 Time: 1h30
Learning objectives	At the end of this session participants will be able to: • demonstrate how to conduct a fourth visit to a pregnant woman and her family • demonstrate how to use the visuals appropriately during the counselling visit • be prepared to conduct a fourth household visit and engage effectively and appropriately with household members.	
Key messages 	• During the fourth visit during pregnancy, dialogue, negotiate and encourage families to take action in the case of delivery complications, and to be prepared to carry out the appropriate actions immediately after the birth of the baby. • There are two sets of stories for the last visit including 'Complication in Labour' (positive and negative) and 'Essential Newborn and Maternal Care' (positive and negative). • Other recommended actions during the home visit include: o Check that the birth materials are all ready and the emergency plan is in place. o Demonstrate proper hand washing and practise with the family. o Check hygiene practices and the availability of hand washing facilities and soap in the home.	
Preparation and materials 	*Materials* • Flipchart, paper and markers • Storybook for Visit 4 and household handbook *Preparation* • Gather all training materials in advance.	

VISIT 4

Introduce the session

OBJECTIVES OF THE SESSION

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

- demonstrate how to conduct a fourth visit to a pregnant woman and her family
- demonstrate how to use the visuals appropriately during the counselling visit
- conduct a fourth household visit and engage effectively and appropriately with household members.

Activity 1: Understanding the story and identifying positive and negative practices

Distribute copies of Storybook 4. Working in groups with one facilitator/helper per table, ask the facilitator to read the story to the group, applying good techniques of storytelling.

Good techniques of storytelling:

- Know the story very well and refer to pictures as you go.
- Don't just read the story, tell it.
- Make sure everyone can see the pictures as you are telling the story.
- Engage the audience in the story (ask questions, encourage comment).
- Use a good tone in your voice.

At the end of the story, the group should go around in a circle and identify positive and negative practices. Use the table below as a checklist, and keep them guessing until they have all of them.

Storybook 4: Key messages

Storybook #	Positive story messages	Negative story messages
4	Monica understands the signs of danger during labour and delivery. Monica tells her mother when she is not feeling well. They go to the clinic as soon as they realise that she is in danger. The nurse takes Monica to the maternity ward, without delay. Both Monica and the baby survive, even though Monica was in danger. *Essential newborn and maternal care:* • Be prepared in advance and buy supplies. • Delay cord clamping. • Hygiene: SBA and companion must wash hands. • Hygiene: Provide a clean surface for mother. • Hygiene: Use clean delivery kit and razor. • Keep baby dry and warm, don't wash, lie skin-to-skin with mother. • Encourage immediate breastfeeding. • Have mother rub and stimulate baby's skin. • Wash hands before touching baby. • Encourage exclusive breastfeeding. • Encourage early immunisation. • Encourage postpartum consultation and check.	Grace and Emmanuel did not understand that labour longer than 12 hours is dangerous. They did not understand that a fever during delivery is dangerous. They did not take Grace to the health facility immediately when she had these problems.

Activity 2: Give relevant information: Fourth visit during pregnancy

Review the sequence of the Home Visit 4 with the participants, in the *ttC Participant's Manual* (brief recap). If they are not literate proceed directly to conduct a demonstration.

SEQUENCE FOR FOURTH HOME VISIT DURING PREGNANCY

Before starting: Greet the family. Explain the purpose of the visit. Ensure that the identified supporters are all present.

Identify and respond to any difficulties: Ask the mother if she has any danger signs, including any emotional distress. Conduct referral if needed. Apply psychological first aid principles if needed.

ttC counselling process:

Step 1: Review the previous meeting Review household handbook pages from the previous visit (Visit 3). Review any negotiated behaviours that she agreed to try and praise any progress. Renegotiate if the family is still struggling.

Step 2: Present and reflect on the problem story: 'Complications in labour' – tell the story and ask the guiding questions.

Step 3: Present information: positive story: 'Complications in labour' – tell the story and ask guiding questions.

Step 2 (Second story): Present and reflect on the problem story: 'Essential newborn and maternal care' – tell the story and ask the guiding questions.

Step 3: Present information: positive story: 'Essential newborn and maternal care' – tell the story and ask guiding questions.

There is no step 3b (technical information)

Step 4: Negotiate new actions using the household handbook:

- Remember 'getting to the root cause' questions (what makes it difficult; why is that the case?)
- Remember getting to solution questions (what would make that easier, how can we help to ensure that happens?)

Step 5: ttC-HV additional actions:

- Check that the birth materials are all ready and the emergency plan is in place.
- Demonstrate proper hand washing and practise with the family.
- Check hygiene practices and the availability of hand washing facilities and soap in the home.

Record the results of the meeting: Fill in the *ttC Register* for this visit. *(We will do this at the end.)*

End the visit: Decide with the family when you will visit again (ensure that they inform you as soon as possible when the woman is in labour or when they return from the facility after the birth). Thank the family.

Activity 3: Practise the fourth visit during pregnancy

- **Ask** for 10 volunteers to role play the household visit counselling in plenary for this session.
- **Explain** to the volunteers that they should divide the steps of the counselling sequence among themselves. The first will role play the first step, the second will role play the second step, and so on, until the complete sequence of the first home visit has been completed.
- **Advise** the observers to take note of what the ttC-HVs do well in the role plays and what needs improvement, using the **counselling skills guide** for reference, found on the last page of the ttC-HV manual.

Activity 4: Debrief in plenary

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

Summarise the main points of the session

- During the fourth visit during pregnancy, dialogue, negotiate and encourage families to take action in the case of delivery complications, and to be prepared to carry out the appropriate actions immediately after the baby is born.
- There are two sets of stories for the last visit, including 'Complications in labour' (positive and negative) and 'Essential newborn and maternal care' (positive and negative).
- Other recommended actions during the home visit include:
  - Check that the birth materials are all ready and the emergency plan is in place.
  - Demonstrate proper hand washing and practise with the family.
  - Check hygiene practices and the availability of hand washing facilities and soap in the home.

Special Session on Chlorhexidine (CHX) Cleaning of the Umbilical Cord Stump

Contextualisation: Applying CHX digluconate 7.1 per cent to the umbilical cord stump in the first week of life

If the MoH policy in your country supports CHX digluconate 7.1 per cent aqueous solution for the care of the umbilical cord stump for babies born at home, and the distribution, education, application and postnatal follow-up by CHWs, then this session should be included when you contextualise ttC.

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: Chlorhexidine cleaning of the umbilical cord stump Activity 3: Video sources Activity 4: Class demonstration and practice	 Time: 1h30
Learning objectives	At the end of this session participants will be able to: • counsel families on the role of CHX in the care of umbilical cord and its importance in preventing infections during a home visit in the first week of life • demonstrate the correct application procedure, or teach the family to apply CHX to the cord during the home visit • complete any forms for the control of CHX stock distribution and use by the families.	
Key messages	• Prepare for the birth by having the MoH approved CHX for umbilical cord care available and ready with your clean birth kit. (This is provided by health staff, CHW/ttC-HV or purchased by the family). • Apply the CHX solution or gel as soon as possible after the cord is cut and within the first 24 hours. • Apply CHX daily to the cord and skin around it for 7 days • Any family member or a CHW can apply the CHX after training. • Do not put anything else on the umbilical cord after applying the CHX.	
Preparation and materials	*Material* • Flipchart, paper and markers • Storybook for Visit 4 and household handbook • Doll and cloths • CHX solution samples (one per group) *Preparation* • Gather all training materials in advance.	

VISIT 4

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

At the end of this session, ttC-HV will be able to:

- counsel families on the role of CHX in the care of umbilical cords and its importance in preventing infections during a home visit in the first week of life
- demonstrate the correct application procedure, or teach the family to apply CHX to the cord during the home visit
- complete any forms for the control of CHX stock distribution and use by the families.

Activity 1: Determine what they already know

Ask: What are the current practices for cord care in your communities? Are any traditional practices still used?

Lead a discussion about current beliefs or practices regarding cord care both in the home and at facilities.

Activity 2: Give relevant information: Chlorhexidine cleaning of the cord stump

Explain or read aloud:

TECHNICAL INFORMATION: APPLICATION OF CHLORHEXIDINE TO THE CORD STUMP

- One application of CHX 7.1 per cent (aqueous solution or gel, delivering 4 per cent CHX) to the umbilical cord stump as soon as possible after the cord is cut and within the first 24 hours is recommended for all newborns born at home.
- Continuing with a daily application during the first week of life is recommended for all newborns born at home. (Some countries may have a policy for only one application.)
- Application of CHX to the umbilical cord should be done immediately after the cord is cut or as soon as possible on the first day of life
- CHX applied as per these recommendations could prevent a quarter of all newborn deaths due to sepsis/infection.
- CHWs and/or ttC-HVs who have received MoH-approved training on CHX for cord care can assist in the distribution, education, application and reporting as per country policy.

Key messages for families planning a home birth

- Prepare for the birth by having the MoH-approved CHX for cord care available and ready within your clean birth kit. (This is available from health staff, CHW/ttC-HV or a private pharmacy.)
- Gloves are not required but hands must be washed with soap and water before applying the CHX.
- Apply the CHX solution or gel as soon as possible after the cord is cut and within the first 24 hours
- Apply the CHX once daily to the stump and skin around it for 7 days .
- Any family member or a CHW can apply the CHX once they are trained.
- Do not put anything else on the umbilical cord after applying the CHX.

Activity 3: Video sources

Use local video or training materials if available. If you have Internet access, show video on experiences of CHX for umbilical cord care in Nepal: http://www.youtube.com/watch?v=TChDiEBXWGM

If local guides have not yet been produced by UNICEF / WHO in country, use resources from the Healthy newborn Network Chlorhexidine cord cleaning resource page: http://www.healthynewbornnetwork.org/topic/chlorhexidine-umbilical-cord-care

You can fast forward this video to the places where the CHX is being applied to the cord of a new baby. You do not need to show the whole video.

Activity 4: Class demonstration and practice

Demonstration by facilitators: Use the doll to demonstrate applying the solutions, and then demonstrate how to counsel the family on key issues related to the use of the solution. If there are locally produced materials with the CHX, ensure that they are used here.

HOW TO APPLY THE CHLORHEXIDINE:

- Wash hands well with soap and water before touching the baby and the skin or cord.
- Apply the gel by squeezing the tube and/or placing drops of lotion and put it directly on the cord and on the skin around the cord.
- Spread the gel or liquid with your finger so that the stump and the skin around the area are well covered

COUNSEL THE FAMILY:

Before the birth:

- Ensure that the family has CHX solution ready with the birth kit.
- Advise them how they can access this: Health staff, CHW or pharmacy.
- Apply the CHX solution or gel as soon as possible after the cord is cut and within the first 24 hours.

After the birth:

- Any family member or a CHW can apply the CHX once they have been trained, after the first 24 hours. The solution can be applied daily in the home in the first week of life.
- Do not put anything else on the umbilical cord after applying the CHX, and do not bandage the cord.

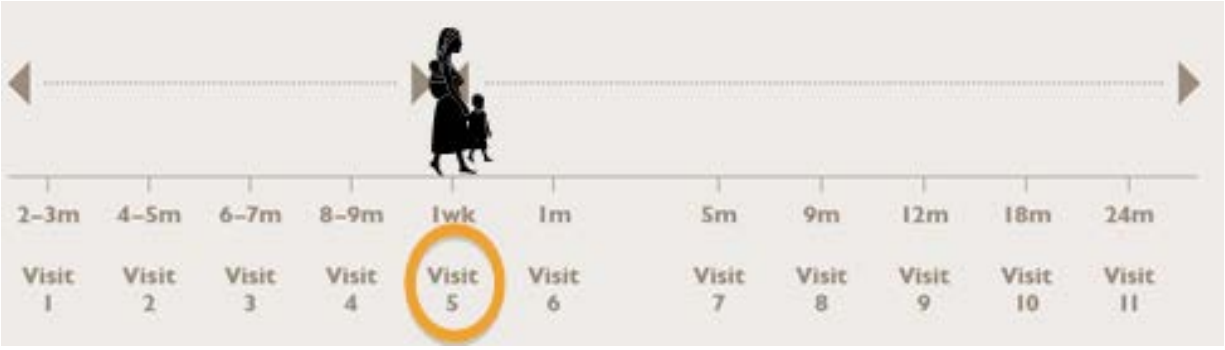
Contextualisation: Record CHX distribution on register/tracker

The MoH will provide registers for recording the distribution and use of CHX solution within the programme. During this session, you should distribute these forms and explain how to use them. CHW usage is included in the household handbook, but can also be added to *ttC Registers* for the newborn phase.

Summarise the main points of the session

- **Who should distribute?** CHX solution may be distributed though facility-based antenatal care, CHW or via private pharmacies, depending on country policies. The ttC-HV should ensure the family has CHX solution ready within the birth kit.
- **Why is it important?** Chlorhexidine applied as per these recommendations could prevent a quarter of all newborn deaths due to sepsis/infection.
- **When is it applied?** Apply the CHX solution or gel as soon as possible after the cord is cut and within the first 24 hours. Do not put anything else on the umbilical cord after applying the CHX, and do not bandage the cord. **After the birth:** Any family member or a CHW can apply the chlorhexidine after they have been trained.. The solution can be applied daily in the home in the first week of life.
- **How is it applied?** To apply the CHX solution, first wash your hands well with soap and water before touching the baby and the skin or cord. Apply by squeezing the gel/drops directly on the cord and surrounding skin. Spread the gel or liquid with your finger so that the stump and the skin around the area are well covered.

VISITS 5A, 5B, 5C: FIRST WEEK OF LIFE



Session 6: Essential Newborn Care in the First Week of Life

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: Keep the newborn warm Activity 3: Reinforce the information: Route of infections Activity 4: Watch DVD/clips on essential newborn care Activity 5: Give relevant information: Routine care of the newborn Activity 6: Give relevant information: Counsel the family on early childhood development for the newborn	 Time: 2h00
Learning objectives	At the end of this session participants will be able to: • understand why the first week of life is so critical to a baby's survival • counsel and demonstrate to families the essential care that will **protect** the newborn and help it survive the first week of life • counsel families on the importance of bed nets for malaria prevention in areas where malaria is common • understand the importance of immunisations and counsel families to ensure that newborns receive essential immunisations • counsel families on the importance of play and communication with the newborn from birth.	
Key messages 	Essential newborn care in the first week of life • Keep the baby **warm** • Do not bathe the baby until after the first 24 hours. • Bathe the baby in **warm** water only. • Keep a hat on the baby's head. • Wrap the baby in two extra layers than adults OR keep close to mother in skin-to-skin contact. • Protect from infections through **hygiene** – *eyes, cord, skin* • Wash your hands with soap before touching the baby. • Keep the cord area clean and dry, and do not cover with a bandage. • Do not put anything on the cord. • Keep the baby's eyes clean. • Wash the baby daily and change soiled clothes regularly. Routine newborn care • To protect against malaria, mother and newborn should both sleep under a long-lasting insecticidal net (LLIN). • If a home delivery, mother and baby should be taken to a health clinic for postnatal care as soon as possible for birth immunisations and a check-up. • Talk, sing, smile and interact with your baby especially when breastfeeding.	
Preparation and materials 	*Materials* • Flipchart, flipchart paper, markers, adhesive • Storybook 5 and household handbooks	

VISIT 5

Preparation

- Gather all training materials in advance.
- Prepare slips of paper as per instructions in activity 13.

Contextualisation: Chlorhexidine cleaning of the umbilical cord stump

If the country policy allows the distribution of CHX solution for the umbilical cord stump through ttC-HVs then they should ensure that mothers have this material prior to delivery. During follow-up in the first week of life, they will check to see if the mother has been applying it correctly, or they will apply it with her. Adjust this session accordingly.

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- understand why the first week of life is so critical to the baby's survival
- counsel and demonstrate to families the essential care that will protect the newborn and help it survive the first week of life
- counsel families on the importance of bed nets for malaria prevention in areas where malaria is common
- understand the importance of immunisations and counsel families to ensure that newborns receive the essential birth immunisations
- counsel families on the importance of play and communication with the newborn from birth.

Activity 1: Determine what they already know

Ask: What actions are important for the baby's well-being during the first week after birth?

Participants can share stories from their own lives about the ways they cared for their own babies. Write their ideas on the flipchart.

Activity 2: Give relevant information: Keep the newborn warm

Explain: One extremely important action in the day following the baby's birth is to make sure that the baby is kept warm *at all times*. The baby has just emerged from the warm and consistent environment of the womb and needs protection from becoming too cold.

Read aloud:

ACTION #1: KEEP THE NEWBORN WARM

- Keep the room where the mother and baby are warm and free from draughts.
- Keep the baby in skin-to-skin contact with the mother.
- When the baby is not skin-to-skin, dress the baby in several layers of clothes, and keep him/her in the same bed as the mother.
- Keep the baby's head covered with a hat.
- The baby should not be bathed during the first day, just wiped dry and wrapped.
- Avoid bathing the baby in cold weather.
- When necessary to bathe the baby, use warm water and bathe quickly. Dry the baby immediately after the bath and put in skin-to-skin contact with the mother, or dress warmly and place next to the mother.

Activity 3: Reinforcing the information: Route of infections

Ask: How can infections be prevented?

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

Working in groups: Distribute a picture of a baby and coloured stickers or Post-it notes. Explain that an infection is when germs get into the body and cause illness. During the first week of life, the baby is vulnerable to infections, which can be life threatening. Where can germs get in? Ask the groups to use the stickers to **find five points of entry** for infections, how they might be infected and mark them on the baby. During plenary, groups should report a point of entry for infections and how they can be *prevented.* Discuss the ideas below in plenary.

Where on the body?	How can they become infected?	How to prevent it?
Eyes	Dirty hands, dirty cloths used for cleaning Also through infection during delivery	Clean the eyes, checking for infections and treat with tetracycline ointment if infected. Bathe regularly. Wash hands before handling the baby.
Ears	Germs in the air, and hands, not washing	Check for infection. Bathe regularly.
Mouth	Eating or drinking any food and water other than breast milk Using bottles or cups that aren't clean Putting dirty hands in the	Encourage exclusive breastfeeding – no bottles. Change the baby when it soils itself. Keep the baby away from animals.

	mouth	Wash hands before handling the baby.
Nose and throat	Breathing in germs in the air, such as from people with colds and coughs	Keep the baby away from ill people who are coughing or sneezing.
Umbilicus	Germs on the blade, on your hands Germs in substances like palm or mustard oil, cow dung, mud or ash	Clean it daily with soap and water and dry well. Do not put anything on the cord (other than CHX). Wash hands before handling the baby and cord. Do not touch or pick or pull the cord stump, do not cover with bandage.

Refer to the *ttC Participant's Manual* information below.

ACTION #2: PREVENT INFECTION IN THE NEWBORN, HYGIENE

- Care-givers and visitors wash hands before handling the baby, using soap if available or ash or lemon juice if there is no soap.
- Keep the baby's eyes clean.
- Clean the baby's skin by washing in warm water daily and every time he/she passes stools or urine.
- Put clean clothes or wraps on the baby every day.
- Care of the cord stump
  - Keep the cord clean and dry, and do not apply anything to the cord (other than CHX solution).
  - Do not touch or pick or pull the cord stump, do not bandage, let the cord fall of naturally after three to four days.

Activity 4: Watch DVD/clips on essential newborn care

The cold baby

The cold baby:

Watch the DVD clip, and note what actions are being taken to protect the baby from cold.

- Keep the head covered.
- Encourage skin-to-skin contact.
- Wrap the baby.

VISIT 5

Warning signs in newborns
for mothers and caregivers

Warning signs in newborns:

Skip to immediate postpartum care section.

Comment on the wrapping and drying of the baby and how the mother keeps the baby warm.

Comment on hygienic practices and care.

Activity 5: Give relevant information: Routine care of the newborn

Contextualisation: Skip action # 3 if you are working in an area where malaria is uncommon.

Now explain to the participants that a way to prevent the serious illness of malaria in areas where malaria is common is for the baby to sleep under a mosquito bed net together with his/her mother.

Read aloud:

ACTION #3: MALARIA PREVENTION FOR THE NEWBORN

A newborn baby is vulnerable to infection by malaria just as other children are. Therefore, families should ensure that the newborn and mother always sleep under an LLIN-treated bed net.

- The newborn sleeps under a bed net together with his/her mother.
- ttC-HVs should check to ensure that the mother and baby sleep under a net.

ACTION #4: INFANT IMMUNISATIONS

Explain to the ttC-HVs that a newborn requires two important immunisations at birth or in the days immediately following birth. Explain to the participants that they will counsel caregivers to ensure that they understand that the newborn needs to receive two immunisations:

- BCG vaccine to protect against serious forms of tuberculosis in children
- Oral polio.

ttC-HVs should check if the baby has received the first vaccines and counsel the families to go to the health facility for these immunisations if they have not yet done so (in cases where the baby was born at home).

ACTION #5: JAUNDICE (YELLOW SKIN AND EYES)

Ask the ttC-HVs if they have ever seen a yellow-skinned or jaundiced baby. Explain that jaundice in the first week of life is very common and usually not something to be concerned about if the baby is otherwise well and breastfeeding regularly. ttC-HVs should ask the mother about jaundice. If the baby has very yellow soles of the feet and is not feeding well, this is a danger sign and the baby must be taken to a health facility.

Activity 6: Give relevant information: Counsel the family on early childhood development (ECD) for the newborn

Action #6: Promote early development through love, play and communication

Ask: How can the baby's development be promoted?

Ask: When does a baby start to learn?

It is important for the family to know that the baby learns from birth. The following are important for development during the early newborn stages:

ACTION #6: PROMOTE THE BABY'S DEVELOPMENT

1. Touch and movement: Providing ways for a baby to see, hear, and move its arms and legs freely helps in its development, as do touching, gently stroking and holding the infant. The mother and father may rub the baby's legs and back when the baby is not feeding.

2. Communicate: If the mother and other family members look into the baby's eyes and talk to the baby, it also helps in the baby's development. When the mother is breastfeeding is a good time. Even a newborn baby sees the mother's face and hears her voice.

Discuss these points with the participants. Ask the ttC-HVs if it is common in their communities for mothers and other family members to touch, stroke and talk to babies at this newborn stage. Listen to their responses and facilitate a discussion as to how these practices can be promoted and/or improved among families in the community, if necessary.

Summarise the main points of the session

- Keep the baby warm during the first week of life.
- Prevent infections by ensuring good hygiene through frequent hand washing.
- Ensure that the baby sleeps under a bed net with the mother in areas where malaria is common, and teach mothers and family members to watch the baby for danger signs.
- Take the baby and mother for a postnatal check-up and first vaccinations as soon as possible after the birth.
- A baby learns from birth. It is important to play with and communicate with the baby, by talking, singing, and gently touching.

Session 7: Caring for the Mother after She Has Given Birth

Session plan	Activity 1: Determine what they already know Activity 2: Care of the postpartum mother Activity 3: Danger signs in the postpartum mother Activity 4: Reinforce the information: Postpartum risks Activity 5: Care of the mother who has suffered birth complications Activity 6: Demonstration: Checking the mother postpartum Activity 7: Barriers and enablers to postpartum care	 Time: 1h30
Learning objectives	At the end of this session participants will be able to: • define the postpartum period and its importance to maternal health • describe the key self-care actions that mothers and families should take during the postpartum phase • describe the danger signs that indicate that postpartum mothers need urgent referral and how to approach these during household visits.	
Key messages	Essential maternal postpartum care • Attend postnatal care at a health facility as soon as possible after a home birth and within 4 to 5 days after delivery. • Maternal hygiene: Mothers should wash all over using soap twice a day for 5 days, especially the perineum and any wound or tear. • Mothers should continue to eat nutritious food and take iron and folic acid for three months after giving birth. • A postpartum mother should rest well, and have the support of her family. • Danger signs in postpartum mother: Take the mother to the health facility urgently if she experiences: o heavy bleeding o severe abdominal pain o fever or chills o mastitis – swelling or redness of the breast.	
Preparation and materials	*Materials* • Storybook 5 and household handbooks	

VISIT 5

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- define the postpartum period and its importance to maternal health
- describe the self-care actions that mothers and families should take during the postpartum phase
- describe the danger signs that indicate that postpartum mothers need urgent referral, and how to approach these during household visits.

Activity 1: Determine what they already know

Ask: What and when is the postpartum phase? Why is it important for the mother?

Explain:

THE POSTPARTUM PHASE

The postpartum phase lasts from 0 to 45 days after delivery when the mother is at high risk of suffering infection or complications related to delivery. During this time, the woman should take extra care of herself to prevent infections and keep up her strength for breastfeeding and caring for her new baby, and has special self-care and support needs.

Ask: Does anyone have experience in caring for a mother in the first days and weeks after she has given birth? How did she feel? Do you know of any cases where a woman experience difficulties? What happened?

Ask: What advice is given to a woman after she has delivered? Are there any taboos, such as food she should eat, when she should have sex, start working, etc?

Note their answers on the flipchart and circle the most important. Now ask them to look at the flipcharts and take turns answering questions:

Ask: What important advice should you give to postpartum mothers?

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

Refer participants to the appropriate page in their manuals.

Explain or read aloud:

IMMEDIATELY AFTER THE BIRTH

During a facility or a home birth, someone should be with the mother for the first hour to ensure that she is feeling well – and perhaps longer if she has had a difficult delivery. The three greatest concerns for the mother in this time are:

- bleeding too much
- fever and chills, which might indicate an infection
- loss of consciousness/fainting.

During the first hours and day after the birth, encourage the woman to:

- breastfeed the baby and keep it in skin-to-skin contact
- eat a light meal and drink fluids
- encourage the woman to pass urine
- rest well.

Essential maternal care

Action #1: Postpartum follow-up care:

- The postpartum mother must be checked at home by a community nurse or home visitor at least twice in the first week after giving birth.
- She must be seen at a clinic for a postpartum check-up as soon as possible after a home delivery and within 45 days after a facility delivery.

Action #2: Maternal hygiene:

- The mother should keep her body clean, especially to prevent infection in her womb and her breasts. Keeping her breasts clean reduces the risk of passing on an infection to the baby. She should wash all over with soap twice a day for 5 days after giving birth, especially the perineum and any wound or tear.

Action #3: Good nutrition and iron intake:

- After the birth the mother will need to continue to have good nutrition, especially whilst she is breastfeeding. She should continue to eat a balanced diet containing three food groups and continue to have three meals and a healthy snack every day. The mother may be weaker after delivery and eating healthily will help her to recover. Her body needs extra nutrients and water for breastfeeding her growing baby. She should also continue to take iron folic acid tablets until at least 45 days postpartum.

Action #4: Rest and psychosocial support from the family:

- After the birth, mothers will need to rest well to recover from the birth, especially if they have experienced any complications. The family should try to offer support to ensure that the mother gets the rest she needs and that she takes light exercise, and is given emotional support and care. Light exercise will help her to recover quickly, but she should not push herself too hard. The woman should not do heavy work during this phase, walk long distances or lift heavy objects.

Activity 3: Give relevant information: Danger signs in the postpartum mother

Ask: Does anyone know of a case where a woman suffered from problems after delivery? What happened? What were the danger signs? What are the most important danger signs postpartum?

DANGER SIGNS IN THE POSTPARTUM MOTHER

Action #5: Understanding danger signs and the need for prompt referral:

- The postpartum phase refers to the 45 days after a woman has given birth. It is the phase in which she is most vulnerable to becoming ill due to complications linked to childbirth. Some of these complications are dangerous and are major contributors to maternal deaths. The first week is the most dangerous.

Take the mother to the health facility straight away if she experiences:

- heavy bleeding
- fever or chills
- abdominal pain
- mastitis – swelling or redness of the breast.

Activity 4: Reinforce the information: Postpartum risks

1. Postpartum haemorrhage (PPH)

What is PPH and how does it occur?	PPH is defined as excessive bleeding from the vagina or rectum after the birth and occurs most frequently within the first 24 hours. A small amount of bleeding postpartum is normal, especially in the first two days and after breastfeeding. If the bleeding contains clots and is more than one to two soaked pads or other cloth in one to two hours, it is considered PPH. Blood loss can occur due to a relaxed womb or because of damage to the womb, birth canal or anus during delivery. The placenta or parts of it may be retained in the womb and this can cause bleeding.
How can we help a woman who is suffering from bleeding?	Immediately after the birth the uterus may be relaxed and needs to be rubbed. Get the woman or family members to rub the belly below the umbilicus. Make sure the bladder is empty – ask her to pass urine. Check the bleeding by placing a cloth or pad and keep all soiled pads. Apply a firm pad, and make sure the woman is lying down with her legs elevated while you organise transport for her to the clinic. Arrange transport – Do not move her or expect her to walk around or stand up as this can make the bleeding worse. She should be lying down throughout. Give her plenty to drink and small things to eat to keep her blood sugar (energy) up, and prevent shock. Try to keep her conscious during referral.

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

PPI is one of the biggest postpartum killers, and occurs when a woman catches an infection during or after birth. She may become very ill and even die if treatment is not received quickly.

Lead a discussion around the following questions:

How can a woman catch a postpartum infection?	Dirty hands/not using gloves during delivery or other poor hygiene Dirty birth location or birth materials Any tears or sores in the vaginal opening, perineum or abdomen can become infected if they are not cleaned carefully and regularly after delivery.
How can a postpartum infection be prevented?	Good hygiene practices – hand washing and gloves used in delivery. Correct use of the hygienic delivery kit and clean birth location Good hygiene, especially bathing genitals using soap in the postpartum phase Regularly changing sanitary cloths, washing them carefully with hot water Washing after each time she passes faeces.
How can we detect a postpartum infection?	**Fever** – this is usually the first sign of a womb infection. **Abdominal pain** – normally women experience some abdominal discomfort, as the womb contracts back to its normal size. This should feel like mild cramps and pass after three days. If she continues to have pain, or the pain is sharp and constant, this is a danger sign. **Vaginal discharge/foul-smelling blood** – for several days after delivery the mother may experience some coloured discharge but this should not be foul-smelling or abundant. If the discharge is foul-smelling unusual or abundant, this can mean an infection.

3. Breast problems or painful breastfeeding

Ask: What problems can occur when a woman starts breastfeeding, and why?

Ask: What could we advise the mother if she experiences any problems in breastfeeding?

NB: NEVER advise a woman to stop trying to breastfeed if she experiences problems.

Problem	Why might this happen?	Counselling solutions
Engorgement of the breast	Poor position and attachment Baby is not feeding enough	Continue breastfeeding. Increase feeds. Make sure she is breastfeeding on both breasts equally. Use warm compresses (cloth soaked in warm water) on the breast, or gently massage around the nipples.
Sore or cracked nipples	Poor position and attachment	Continue breastfeeding.

	Poor hygiene Use of substances on breast that irritates or infects the nipples	Check position and attachment. Wash breasts with soap and water before feeding and dry carefully after feeds. Wear loose clothing, do not wear a bra, and don't put any substance on the breast.
Breast infection Mastitis: red, swollen, painful and hot area on the breast, fever	Infection in the breast due to too much milk or the breast not being emptied well due to poor attachment or any of the above problems	Continue breastfeeding. All the above messages apply, plus: See a health care worker immediately. The mother may need to take medicine.

Remind the ttC-HVs to show mothers how to express milk into a cup and continue breastfeeding throughout any feeding difficulty.

4. Postpartum depression: Baby blues and anxiety

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

MATERNAL DEPRESSION AFTER THE BIRTH

Maternal mental health problems after giving birth are very common in all parts of the world, and one in five women may experience difficulties. There is no single cause of maternal mental health problems, but women at increased risk are those who:

- are in poverty
- have an unintended pregnancy
- suffer intimate partner violence or abuse in the home
- have previously experienced mental health problems.

Postpartum depression symptoms may include:

- feeling sad or crying for no reason
- loss of appetite
- unable to sleep or feeling very tired all the time
- intense irritability and anger
- lack of joy in life
- feelings of shame, guilt or inadequacy
- severe mood swings
- frightening thoughts or extreme worry.

What are the risks?

Women experiencing maternal mental health problems may not get adequate support, or be able to care for themselves by eating well, practising good hygiene, seeking care or taking medicines when needed. Mental health

problems can affect the child too as the mother is less able to responsively breastfeed, stimulate and play with the child and respond to its needs. The children of depressed mothers MAY experience more disease, malnutrition, and development problems.

Activity 5: Give relevant information: Care of the mother who has experienced birth complications

Ask: What should we do to help women who have experienced difficult births?

Ask: What extra care might they need?

CARE OF THE MOTHER WHO HAS EXPERIENCED BIRTH COMPLICATIONS

- Women who experienced complications in pregnancy may also be more vulnerable in the postpartum phase.
- They may have had a tear or been cut during delivery, suffered prolonged labour or high blood pressure leading to fits/convulsions
- They may be a young age or have experienced their first birth and may need more emotional support.

Women recovering from Caesarean delivery

- What happens in a Caesarean?
- The doctor will make an incision (cut).
- The baby is pulled from the uterus via the belly (abdomen) rather than via the vagina
- The placenta is removed, and the cut is repaired using stitches.
- The wound is then cleaned and dressed.

What happens after a Caesarean?

- Mothers and babies tend to stay in the hospital for several days, are given medicine to reduce pain and prevent infections, until the wound starts to heal.
- The dressings need to be changed regularly and the nurse or midwife or doctors will advise on wound cleaning and care.
- Recovery takes 4 to 6 weeks. The mother is likely to have some pain and tiredness. She should rest well, not do any heavy lifting at all, drink extra water and eat nutritious food.
- The mother should be extra careful of the wound as it is healing, checking and changing dressings regularly and cleaning with antiseptic if it becomes dirty after she goes home.
- Refer immediately if the wound becomes inflamed, red or oozes pus, or if she is experiencing severe pain.
- Increase the visit schedule if possible to check for danger signs and recovery, until the mother is well and the wound is healed.

Activity 6: Reinforce the information: Demonstration: Checking the mother postpartum

Select volunteers to participate in the demonstration, including as mother and family members. The trainer will play the ttC-HV, demonstrating the questions and observing.

ASSESSING THE MOTHER

Ask and observe the mother:

Tell me about the birth, what happened? (Where, who was there, were there any complications, tears or bleeding?)
How are you feeling now?
Are you experiencing **bleeding?**

- How much blood?
- For how long?

Have you experienced any **fever?**

- Check for fever

Have you experienced any **abdominal pain?**

- Where is it (upper or lower abdomen – check if it is in the womb)
- Is it severe, consistent?
- Has it lasted more than three days after delivery?

Are you feeling weak, tired or dizzy?

- Check her eyes and hands for pallor – she may have anaemia.

Have you had any difficulties breastfeeding?

- Are you experiencing painful, swollen breasts, cracked or sore nipples?

Activity 7: Barriers and enablers for postpartum care

Key messages and additional information	Barriers What makes it difficult to do?	Enablers What would make it easier to do?	Counselling response or solution
Mothers should receive postnatal care at a health facility as soon as possible after a home birth and within 45 days after delivery.			
Maternal hygiene – mothers should be washed all over with soap twice a day for 5 days, especially the perineum and any wound or tear.			
Mothers should continue to eat well and take iron and folic acid as recommended.			
Mothers should rest well, have support of the family and not return to heavy work too soon.			

Danger signs in postpartum mother: Mothers are to be taken to a health facility urgently if any danger signs are present.			

Session 8: Infant Feeding: Establishing Exclusive Breastfeeding

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: Establishing breastfeeding Activity 3: Give relevant information: Feeding during Illness Activity 4: Technical session: Assisting the mother with difficulty breastfeeding Activity 5: DVD demonstration Activity 6: Reinforcing the information: Positioning and attachment Activity 7: Common beliefs and problems with breastfeeding Activity 8: Barriers and enablers to exclusive breastfeeding	 Time: 2h10
Learning objectives	At the end of this session participants will be able to: • explain optimal feeding of the newborn in the first week and month of life • counsel on benefits of exclusive breastfeeding until 6 months • identify barriers that families may have in practising the feeding recommendations, and understand how to respond to these concerns • assist mothers with any difficulties they have with establishing breastfeeding.	
Key messages	• Put baby to breast within 30 to 60 minutes after birth. • Do not discard first milk (colostrum) and do not give any other substance to eat or drink. Do not use bottles. • Babies should be given only breast milk to eat and drink during the first 6 months of life. Most healthy mothers have sufficient milk, and additional fluids or foods (including water) are not needed provided you breastfeed the baby regularly and on demand (8 to 12 times per day). • If baby cannot breastfeed, express the colostrum and feed it with a cup. • Correct positioning and attachment to the breast will help to prevent breastfeeding problems. • An HIV-positive mother can protect her baby from HIV by following the practices described above.	
Preparation and materials	*Materials* • Flipchart, paper and markers • Beans • Storybook 5 and household handbooks • DVD or video clips: observing breastfeeding, correct positioning and attachment • Laptop or DVD player *Preparation* • Gather all training materials in advance. • Set up the DVD and TV/computer and projector. • Check the DVD and make sure you are on the correct clip.	

VISIT 5

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- explain optimal feeding of the newborn in the first week and month of life
- counsel on the benefits of exclusive breastfeeding until 6 months
- identify barriers that families may have in practising the feeding recommendations, and understand how to respond to these concerns
- assist mothers with any difficulties they have with establishing breastfeeding.

Activity 1: Determine what they already know

For this activity, **explain** that the participants on one side of the room will represent 'true' and the other side 'false'. **Read** a series of statements and, as you do, the participants will walk to the side of the room according to their answer or opinion with regard to the statement. For each statement, **facilitate** a discussion around the reasons for their choice, revealing common beliefs around child feeding among the participants and, possibly, in the wider community.

Statement	Answer
1. Throw away the mother's first milk before putting a newborn to the breast because the first milk, which has been waiting in the warm breast, can be sour.	False
2. Putting a baby to the breast too soon could risk the life of a mother who is weak and bleeding after giving birth.	False
3. If the baby cannot latch on right away, you should squeeze the breast milk into a clean cup and give it to the baby.	True
4. The first milk contains substances that protect the baby from infections.	True
5. Infants should be given fewer feedings during illness.	False
6. Breastfeeding on a three-hour schedule helps an infant learn the self-discipline to wait for attention.	False
7. A mother should not talk to her infant while breastfeeding because talking distracts the infant from getting enough breast milk.	False
8. A 5-month-old infant should be breastfed as often as he/she wants, day and night.	True
9. A mother living with HIV should never breastfeed her infant.	False
10. Cooked and mashed squash is a good, nutritious food for most 4-month-old infants.	False
11. In very hot weather, an infant may need water, in addition to breast milk.	False
12. At age 3 months, give food to an infant who begins to show an interest in family food.	False
13. Put the newborn to the breast as soon as the cord is cut, without waiting to clean the newborn or waiting for the mother's milk to come.	True

Activity 2: Give relevant information: Establishing breastfeeding

Explain to the ttC-HVs that this session focuses on feeding for babies from birth to 1 month. ttC-HVs should be helping mothers to establish good breastfeeding, encouraging exclusive demand breastfeeding, good positing and attachment. Review the following in the *ttC Participant's Manual:*

FEEDING RECOMMENDATIONS FOR THE NEWBORN

1. First milk (colostrum)

The very first milk that comes from the mother's breast (the colostrum) contains many infection-fighting properties. It helps the baby be strong and healthy. It should not be thrown away. Instead, advise the mother to put her baby as soon as possible (within 30 minutes) to her breast. Colostrum is yellow and thick and gradually changes to become white watery milk by the time the baby is 4 to 7 days old.

2. Exclusive breastfeeding

Breast milk **alone** is the only food and drink an infant needs for the first 6 months. No other food or drink, not even water, is needed during this period. The only exception is if there is medicine to give the baby, following the instructions of a health worker. Exclusive breastfeeding protects the baby from diarrhoea, pneumonia and other infections.

3. Breastfeed frequently and on demand

Feeding frequently in the first days and weeks will help the milk come in and the breasts become full. Mothers should feed 'on demand' – that is, every time the baby is hungry (shown by lip smacking, sucking its hands or crying), whenever they want to be fed and for as long as they want to feed, day or night. Typically this will be every 2 to 3 hours or at least 8 times in 24 hours if the baby is emptying the breast during a feed. If the baby does not wake him/herself at night, the mother should wake the baby for feeding after 3 hours.

4. Express milk into a cup if newborn cannot attach or is too weak to suckle

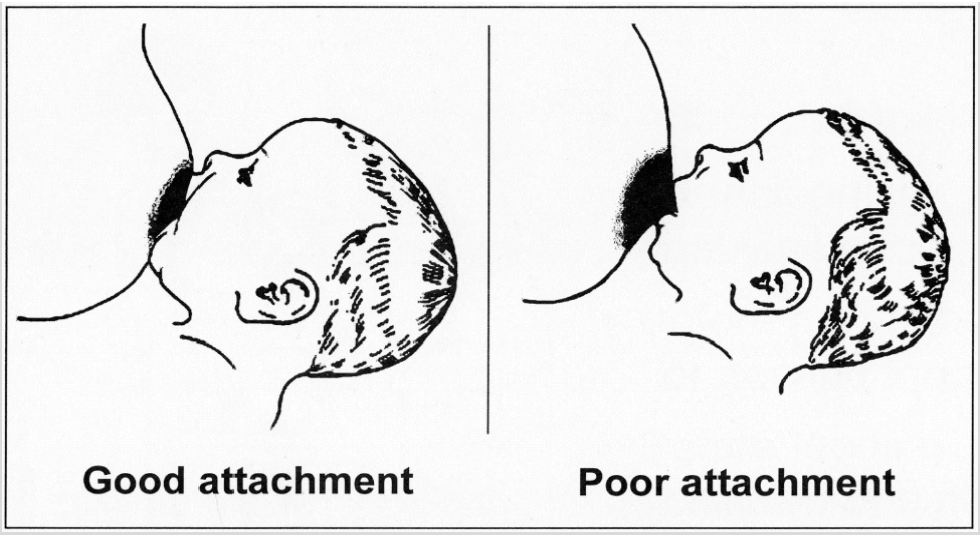
Most newborns are strong enough to begin suckling right away. However, a baby may be too small or weak. It may be necessary to express milk from the breast, and give it to the newborn in small sips using a spoon or a small cup. The ttC-HV will need to provide step-by-step instructions on hand expression.

5. Hand expression

- Wash your hands.
- Place thumb and index finger on either side of the nipple, about 3 to 5 centimetres (1 to 2 inches) back from the nipple.
- Press gently inward towards the rib cage.
- Roll fingers together in a slight downward motion.
- Repeat all around the nipple if desired.

6. Good attachment

Make sure that the baby is well attached to the breast and is suckling well. A well-attached baby sucks with the mouth wide open. Almost all of the dark area surrounding the nipple (the areola) is in the baby's mouth, and the baby will take strong sucks and swallow. If the breasts become very hard and full it might be difficult for the baby to attach properly. If this happens, massage and express some milk out to help soften the nipple so that the baby can attach properly.



7. No bottles

Discourage the use feeding bottles as the teat can interfere with the newborn's suckling on the breast making establishing breastfeeding more difficult. Also, a bottle and teat are hard to clean and could cause infections.

8. Reassure the mother

Reassure mothers that, with frequent feeding, their infant will stimulate the breasts to produce more milk. Almost every mother can exclusively breastfeed successfully. If the mother encounters difficulties, prompt attention and simple advice can usually resolve the problem. Reassure the mother if the baby is passing urine regularly(3 to 6 times a day) he/she is getting enough milk.

Activity 3: Give relevant information: Feeding during illness

Ask: How do you feel when you go for a full day without eating? Ask participants to describe how the lack of sufficient food affects their physical energy and their ability to think clearly.

Explain how correct feeding is needed for the growth of an infant's **body** and **mind**.

VISIT 5

NUTRITION FOR THE HEALTHY CHILD

Good nutrition before birth, through the mother's good health, and in the first years of life improves the child's growth and ability to learn. If infants are not properly fed, they will suffer the following effects:

1. Poor growth

Poorly nourished children do not grow well. They are shorter than other children the same age. They are less active when they play and have less interest in exploring.

2. Increased illness

Poorly nourished children are often sick. Over half of the children who die from common childhood illness – diarrhoea, pneumonia, malaria and measles – are poorly nourished. By helping young children get better nutrition, you will help to prevent them from dying of disease.

3. Reduced energy

Poorly nourished children who survive do not have enough energy or nutrients (vitamins and minerals) to meet their need for normal activity.

4. Difficulty learning and long-term effects

Poorly nourished children may have difficulty learning new skills, such as walking, talking, counting or reading. They may not do as well in school when they grow up. As adults, they may not earn as much income as others, and may be more likely to get other diseases like diabetes and heart disease. The effects of poor nutrition in young children are largely irreversible, which shows the critical importance of good feeding practices in the early years of life.

Facilitator aide: Additional information on breastfeeding

Note: This information may help you to answer any questions the ttC-HVs may have.

REASONS FOR EXCLUSIVE BREASTFEEDING

- Exclusive breastfeeding means that the child receives **only** breast milk. The child takes no additional food, water or other fluids. If needed, the exclusively breastfed child can take medicine and vitamins. Exclusive breastfeeding gives an infant the best chance to grow and stay healthy.
- Giving other food or fluids **reduces** the amount of breast milk the child takes and the amount of breast milk the mother produces. Frequent feeding produces more milk.
- Water, feeding bottles and utensils can pass **germs** to the young infant, even when they appear clean. The germs can make the infant can sick.
- Other food or fluid may be too **diluted** or thin. This happens when the caregiver cannot afford enough breast-milk substitutes for the child, or the substitute is prepared incorrectly.
- Other milk may not contain enough **vitamin a**.
- **Iron** from cows or goat milk is poorly absorbed.
- Newborns have **difficulty digesting animal milk**. Animal milk may cause **diarrhoea**, rashes, or other symptoms of allergies. Diarrhoea may continue and become persistent, leading to malnutrition.
- The very first milk from the mother's breast (the colostrum) is yellow and rich with **vitamins and nutrients, including vitamin A and natural sugar.** This is a 'liquid gold' for the newborn baby.
- A mother should feed her child whenever the child is hungry, '**on demand**', day and night, at least eight times every 24 hours. Feeding on demand is not 'spoiling' the child. Responding to the child helps the child learn to trust others, builds the child's self confidence, which will help him/her throughout life.

- The reason for a baby crying is not always **hunger**. A mother will learn to recognise the signs of hunger, such as making sucking motions with the mouth, sucking on the mother's fingers and seeking the breast.

Activity 4: Technical session: Assisting the mother with difficulty breastfeeding

Distribute the storybook for the technical session on breastfeeding. **Review** the actions that a woman can take if she is having difficulty breastfeeding. These are described below.

ASSISTING THE MOTHER WITH BREASTFEEDING

- Ensure that the mother is drinking enough water – she should always drink enough to satisfy her thirst.
- The breasts may be gently massaged from back to front to help the milk come down and to soften the nipple so the baby can attach well.
- Ensure that the mother is in a comfortable position for breastfeeding.
- The mother should let the baby finish on one breast before switching to the other, to help the baby get the nutritious fat-rich milk at the end of the feed. To remember, she should begin each breastfeeding session on a different breast.
- A mother can express her breast milk to be given to the baby in a cup, if she is away for an extended period of time. Expressed breast milk remains fresh for up to 8 hours when covered.
- It is important that the baby is correctly attached to the breast. A well-attached baby sucks with the mouth wide open, and sucks from the areola, not the nipple.

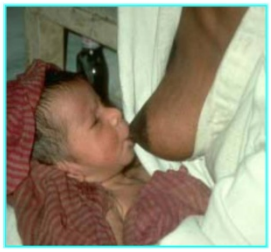
Activity 5: DVD demonstration: Observing a breastfeed

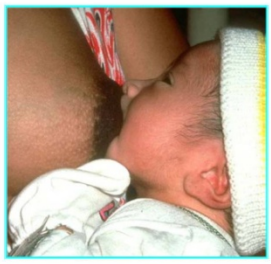
Show the Integrated Management of Childhood Illness (IMCI) DVD on attachment and positioning. http://www.youtube.com/watch?v=7aKt2IV0a68.

Check the participants' understanding of the DVD clip by asking if attachment is good or poor using the pictures below, and ask participants to demonstrate why the attachment and position is good or poor. **Answer** any questions they may have.

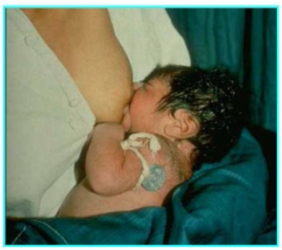
Activity 6: Reinforcing the information: Positioning and attachment

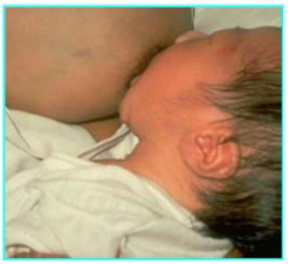
1


2


3


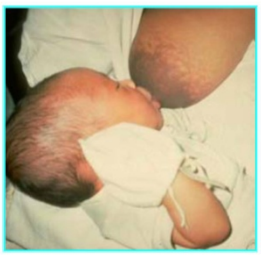
4


5


6


7

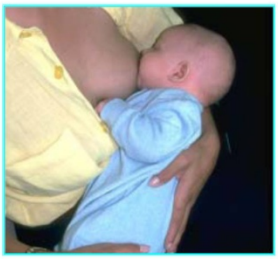

8

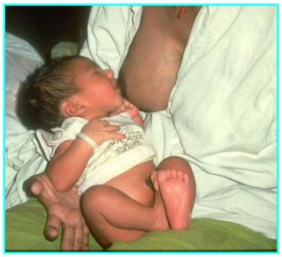

9


Breastfeeding Attachment – Trainer Guide

No.	Good / Poor sorting	Cheeks touching breast	Mouth wide open	Lower lip turned outwards	Areola more visible above than below mouth
1	Good attachment	Yes	Yes	Yes	Yes
2	Poor attachment	No	No	Yes	No
3	Poor attachment	Yes	No	No	Yes
4	Poor attachment	No	No	No	No
5	Good attachment	Yes	Yes	Yes	Unclear
6	Good attachment	Yes	Yes	Yes	Unclear
7	Poor attachment	Yes	No	No	No
8	Good attachment	Yes	Yes	Yes	Unclear
9	Poor attachment	No	No	Yes	Yes

10


11


12


13


14


15


Breastfeeding Positioning – Trainer Guide

No.	Good / Poor positioning	Body and head are aligned	Head and body both turned towards breast	Body of infant is touching mother's body	Attachment?
10	Good positioning	Yes	Yes	Yes	Unclear
11	Good positioning	Yes	Yes	Yes	Good
12	Poor positioning	No (head turned to side)	No	No	Poor
13	Poor positioning	No (body twisted slightly)	Yes	Not fully	Unclear
14	Good positioning	Yes	Yes	Yes	Unclear
15	Poor positioning	No	No	Yes	Yes

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

Contextualisation: Ensure that the box below is aligned with the common beliefs and problems in your communities.

Working in groups: Use the table below to discuss some of the common reasons that women don't breastfeed exclusively. Write each problem on a piece of paper and distribute them among the groups. After discussion, ask them to share responses to the problem during plenary.

Possible problem	Possible counselling response or possible solution
Colostrum: It is the custom not to breastfeed the infant until it is 2 or 3 days old (cultural barrier).	By delaying breastfeeding, the child is not getting the benefits of the colostrum. Colostrum helps with better eyesight, protection from illness and the development of the infant's brain. A delay in breastfeeding also reduces the flow of breast milk. Counsel the mother and female companions in the home.
Exclusive breastfeeding: The mother says the baby is crying all the time and her milk is not sufficient (belief).	Crying doesn't always indicate hunger, but can also mean the baby needs attention, love or warmth, needs to pass wind or has stomach discomfort. If the infant urinates at 6–8 times a day and is gaining weight according to growth-monitoring charts, then the infant is getting enough milk. The mother may not be keeping the baby at the breast long enough. Milk at the front of the breast is mostly water and is important for hydration. The milk that the baby gets after that is rich, thick and high in fats and protein for growth and brain development (hind milk), which satisfies hunger. It is good to empty the breast to make sure the baby gets both the front and back milk.
Exclusive breastfeeding: The mother says that during the summer it is very hot and the baby will need a lot of water.	Breast milk is almost all water, but it also contains essential vitamins and nutrients. As long as the mother drinks enough water, there will be enough water in the breast milk for the baby. The breast milk is a clean source of water!
Family wants to give formula or animal feed so that the baby gets used to it, because the mother has to return to work soon.	Explain the advantages of breastfeeding and risks of giving other fluids or foods. Advise that the mother can learn to express breast milk, which can be kept at room temperature for eight hours, and be fed to the baby in a clean cup by the caregiver in the mother's absence.
Mother has sore nipples and says that breastfeeding is painful.	Work with the mother to correct the baby's attachment. Teach the mother to express the milk by hand so that the baby can be fed while solving the attachment problem. Note: If the mother has deep, shooting breast pain, this is a sign of infection and should be referred.
The breast is very sore and hot to the touch, or inflamed. The mother	The mother should go to the health clinic. She might need medicine. The mother should continue feeding the infant from the normal breast, and

may also have a fever.	she should express and discard milk from the infected breast.
The mother has cracked or bleeding nipples.	The mother should continue breastfeeding from the normal breast, and express the milk from the problem breast. She should rub breast milk on the nipples and let them dry and stay uncovered. She should not wash the nipples more than she normally would during bathing. The ttC-HV should make sure the baby is attached to the breast correctly.

Activity 8: Barriers and enablers to exclusive breastfeeding

Working in groups: As per the above exercise, except this time use the household handbook to review the negotiated practices for exclusive breastfeeding. Think through all the possible barriers and enablers for the mother adopting and maintaining the practice to 6 months, and write notes in the *ttC Participant's Manual* in the table and present their ideas back to the plenary.

Key messages and additional information	Barriers *What makes it difficult to do?*	Enablers *What would make it easier to do?*	Counselling response or solution
Exclusive breastfeeding to 6 months* No other foods or water No bottles or utensils	Beliefs Cultural norms and family influence Problems with breastfeeding	Skills and knowledge Expressing milk Family support	
Breastfeeding on demand at least 8 times in 24 hours	Work or time Problems with breastfeeding		

Summarise the main points of the session

- Ensuring good nutrition in the early years of life is critical for children's long-term physical growth and mental development.
- The first milk (the colostrum) should be given to the baby within 30 to 60 minutes of birth. This milk provides important vitamins and minerals for the baby and protects him/her from illness.
- Breast milk alone is the only food and drink that a baby needs from birth to 6 months of age. No other food or liquid is required – not even water.
- In most cases, an HIV-positive woman will breastfeed until her baby is 6 months of age. It is very important that she gives no additional food or water to the baby during this time.
- Almost every mother can breastfeed successfully. A woman who is having difficulty breastfeeding may be helped in various ways.

Session 9: Early Child Development

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: Early development Activity 3: Give relevant information: Counsel the family on ECD from birth Activity 4: Play and communicate with the young infant (WHO counselling cards)	 Time: 1h30
Learning objectives	At the end of this session participants will be able to: • explain the importance of registering a baby's birth and advise families where and how to register • explain the importance of play and communication in a child's development • counsel families on how to adopt healthy, positive infant interactions that promote the baby's development.	
Key messages 	• To fully develop, babies need love, attention and to interact with their caregivers • Mothers and family members should look, hug, talk, sing and play with their baby everyday right from birth. • Change and growth of the brain occurs most rapidly in the first years of a baby's life with good nutrition, good health and strong parent-infant connection. • Exclusive breastfeeding, bathing, changing diapers, soothing/calming babies when they cry are all opportunities for the mother/caregiver to interact/connect with the baby.	
Preparation and materials 	*Materials* • WHO counselling card (Care for Child Development) printed, or projected on screen • Household handbook • Projector and screen	

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- explain the importance of registering a baby's birth and advise families where and how to register
- explain the importance of play and communication in a child's development
- counsel families on how to adopt healthy, positive infant interactions that promote the baby's development.

VISIT 5

Activity 1: Determine what they already know

Ask: How did you play and talk with your children when they were 1 month old? Did you smile, talk, sing, cuddle? Share as many examples as possible that they did or have seen.

Ask: What were the babies able to do in response by 1 month? Did they smile and make sounds? Were they able to communicate with people?

Ask: Do you think it is important that the family play and talk to babies when they are so young? Why/why not? What beliefs and norms exist about this in your area?

Lead the discussion and write the key themes on the flipchart – especially around social norms – and return to these during the session.

Activity 2: Give relevant information: Early development

NEWBORN, BIRTH AND UP TO 1 WEEK – YOUR BABY LEARNS FROM BIRTH.

Early childhood period is a time of significant growth – especially of the brain, which will affect the whole of their adult life. The newborn brain grows very rapidly as the baby hears, sees, tastes or is touched, and is very receptive to learning. If newborns and young children receive love, attention and stimulation, good nutrition and health care, they attain better education, get better jobs and become more productive adults.

Ask participants to describe the following behaviours on interacting with a newborn baby:

- How do you show love to a baby?
- How do you talk to a baby?
- Should you sing to a newborn baby?
- How do you play with a baby?
- How can you make a baby smile?

List responses on a flipchart.

NEWBORN BABIES NEED LOVE AND COMMUNICATION TO DEVELOP FULLY.

- Family members can show the baby love by cuddling, touching, stroking, smiling, and soothing the baby.
- They can talk and sing to the baby in a soft, gentle manner. Babies love singsong voices and lullabies.
- The can communicate with the baby by looking into the baby's eyes, talking, singing, soothing, stroking and holding the baby. Breastfeeding is a good time to do this. It is during this interaction between mother and baby that the baby begins to feel close to the mother – a relationship that promotes emotional well-being of both mother and baby.

Discussion questions

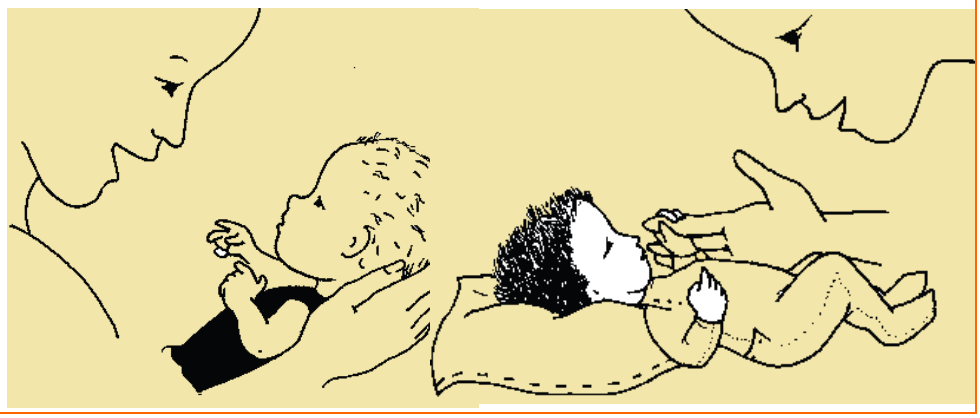
- Can a newborn baby hear you?
- Can a newborn baby see you?
- Can a newborn baby hear music or other noises?
- Can a newborn baby smell you?

NEWBORN SENSES

Newborn babies can see and hear and smell quite well. Their vision is only developed to see clearly from the distance of the breast to the face of the mother, but they can see colours and shadows, light and dark. Newborn babies are attracted to the human face and they will follow a face. Newborn babies can smell their mother and her breast milk. It is believed that newborn can recognise the voice of the mother and close family members they heard in the womb!

Activity 3: Give relevant information: Counsel the family on play and communication

Refer to the following in the *ttC Participant's Manual,* and discuss the key actions the family can take for this age group. Whilst the pictures show only a mother, it's important to remind them that all family members, especially the father and older children, can also help play and talk with the baby. Use the box below to explain what the mother and family can do from birth to play and communicate with the newborn.

Age of young infant	Recommendations for family
Newborn, birth up to 1 week  newborn	Your baby learns from birth. Play • Provide ways for your baby to see, hear, move arms and legs freely, and touch you. • Gently soothe, stroke, and hold your child. • Skin-to-skin contact is good. Communicate • Look into your baby's eyes, and talk to your baby. • When you are breastfeeding is a good time. Even a newborn baby can see your face and hear your voice. 

VISIT 5

Activity 4: Reinforcing the information: Play and communicate with the young infant (WHO counselling cards)

Show or project the picture from the WHO Early Child Development Counselling Card.

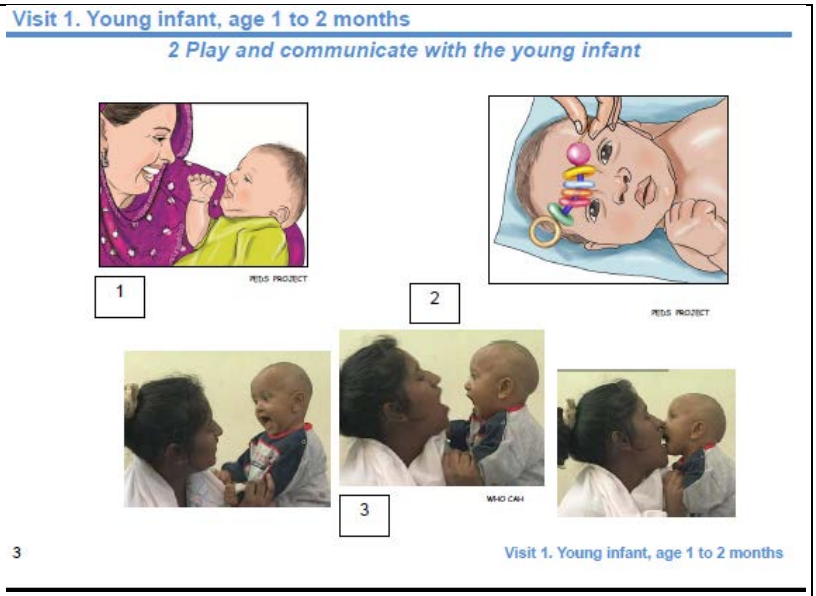
Discuss the pictures on the cards

What activities do you see in these pictures? Listen to the answers. Tell the story about how Nandi and her family play and communicate with the baby to help him learn.

DISCUSS THE FOLLOWING:

The whole family enjoys playing with the baby. It helps him grow strong. They allow the baby to move freely so he can kick and move and discover his hands and toes. He reaches to touch familiar faces (Picture 1).

Nandi slowly moves colourful objects in front of the baby's eyes to help the baby learn to follow and reach for things (Picture 2). At first it is difficult for the baby to control the movement of his eyes and hands. He becomes stronger and his muscles learn control by playing with older family members.



Nandi enjoys getting her baby to smile and laugh with her (Picture 3). She gets a conversation going by copying her baby's sounds and gestures. This is a fun game for the baby and prepares him for talking later. And Nandi is learning to watch closely what her son does and respond to him.

Summarise the main points of the session

- To fully develop, babies need love, attention and interactions with caregivers. Newborn babies beginning learning and communicating from birth.
- Mothers and family members should look, hug, talk, sing and play with their baby everyday, right from birth.
- Change and growth of the brain occurs most rapidly in the first years of a baby's life with good nutrition, good health and strong parent-infant connection.
- Exclusive breastfeeding, bathing, changing diapers, soothing/calming babies when they cry are all opportunities for the mother/caregiver to interact/connect with the baby.

Session 10: Danger Signs in the Newborn

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: Danger signs in the newborn Activity 3: Watch DVD: Warning signs in newborns Activity 4: Spot the difference: Umbilical cord infections Activity 5: Demonstration: Assessing a newborn baby Activity 6: Barriers and enablers to care seeking	 Time: 1h20
Learning objectives	At the end of this session participants will be able to: • recognise the danger signs in newborns and counsel families to seek care immediately when danger signs are present • develop skills in conducting an inspection of the newborn during the home visit to look for signs of infection or illness, or feeding difficulties • describe jaundice in the newborn and the home care required.	
Key messages	If the mother or father (or any other family member) suspects any danger sign in the newborn, they should go urgently to a health facility. Danger signs in the newborn include: • lethargic or unusually sleepy • unable to breastfeed • fits/convulsions • chest indrawing and difficult or fast breathing • fever or skin unusually cold • skin pustules • redness of the umbilical cord stump • jaundice – dangerous especially if accompanied by lethargy/poor feeding • small baby (below 2 kg).	
Preparation and materials	*Materials* • Storybook 5 and household handbooks • Downloaded newborns videos (trainer's DVD or Internet links) • Laptop and projector • Umbilical cord pictures (printed in colour), or project on screen *Preparation* • Download video links or files in advance and check that they work. • Print the umbilical cord pictures for Activity 4. • Set up projector with sound.	

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- recognise the danger signs in newborns and counsel families to seek care immediately when danger signs are present
- develop skills in conducting an inspection of the newborn during the home visit to look for signs of infection or illness, or feeding difficulties
- describe jaundice in the newborn and the home care required.

Activity 1: Determine what they already know

Ask: What are the danger signs in a newborn that indicate that the baby needs urgent care?

Ask: Does anyone know of a case where a newborn in your community became ill? Did you see the infant? What happened?

Ask: Why, even though newborn deaths are the most common child deaths, are they often not referred to the hospital or reported?

Write the answers on the flipchart and then return later to mark them in the handbook.

Explain:

- Danger signs in a newborn are hard to determine.
- Death can occur very quickly (in a matter of hours).
- Many people believe that a newborn life cannot be saved.

It is often difficult to recognise that a newborn baby is unwell, as they don't show the same signs that older infants do when they are sick. The mother must be aware of the baby's normal feeding and waking activity so that she can report if the baby is feeding less or sleeping more than usual, which may be signs the child is unwell.

Activity 2: Give relevant information: Danger signs in a newborn

Distribute the storybook with the technical session on danger signs in newborns. Review the illustrations and the information in the box below.

TAKE THE BABY TO THE HEALTH FACILITY URGENTLY WHEN:

General signs

- Convulsions – The baby is rigid or is having fits.
- Lethargic/unconscious/reduced activity – Changes in the baby's normal activity, such as weak crying, not responding to touch, reduced movement, or unusual sleepiness.

- Unable to breastfeed – The baby is sucking weakly, or for less time than usual, or is unable to feed at all.

Breathing difficulties

- Noisy or fast breathing – The baby makes a noise like grunting, is breathing very fast or with difficulty.
- Chest indrawing – The part under the ribcage sucks inwards when the baby breathes in.

Body heat and colour

- Fever – A fever in a newborn baby is a sign of serious disease, but is not likely to be due to malaria. The body may feel warm to the touch or the mother may report the baby feeling warmer than usual.
- Body cold to touch – Cold body temperature in a newborn is also a danger sign.
- Yellow colour/jaundice – The baby's skin and eyes appear yellowish especially on the soles of the feet and palms of hands. This is especially dangerous if the baby is not feeding well or is lethargic.

Umbilical cord infection

- Umbilical redness – Extends to the skin, oozing pus, wetness or foul smelling.
- Extensive skin pustules

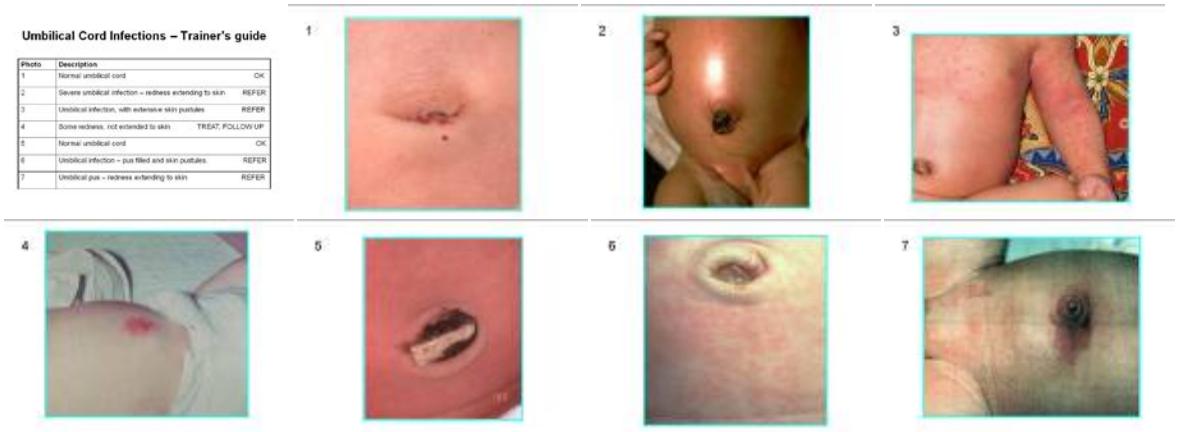
Activity 3: Watch DVD: Warning signs in newborns

Watch the following video clips and discuss with the participants.

Warning signs in newborns, *for mothers and caregivers* 	Breathing problems 	Umbilical infections 
Sepsis 	Jaundice 	Skin infection 

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

Working in groups: Distribute the colour pictures of umbilical cord stumps and ask them to sort into two groups, those they should refer, and those that are normal. Alternatively, project them on the screen and ask participants to vote.



Activity 5: Demonstration: Assessing the newborn baby

The top-to-toe inspection: Use a doll and group work to go over the baby from top to toe – use a poster on the wall or draw on the wall to assist. Demonstrate on the doll, where appropriate, how to check the baby. Remind the group that before handling the baby they should **always wash their hands** (see hand washing session). Whilst observing, they can make notes against this section in the *ttC Participant's Manual*. After the demonstration, ask volunteers to come and demonstrate as well.

Check	Healthy baby	What might be wrong	Why?
Movement and crying	Arms and legs move strongly and the baby cries loudly when awake	Baby seems very sleepy most of the time Arms and legs are floppy with no movement If the child is crying very weakly, this can be a sign of a problem	Birth complication or infection or too small baby
Breathing	Breathing seems easy and not too fast and not very noisy No chest indrawing	Chest indrawing Irregular breathing, fast breathing/gasping Noisy breathing (rasping, grunting sound)	Birth complication or infection or too small baby
Colour	Tongue, lips, palms of hands or soles of feet are pink	Tongue, lips, palms of hands or soles of feet are dark/bluish in colour	Birth complication or infection or too small baby
Warmth	Back or belly should feel warm but not too hot or cold	Fever or too cold	Infection or birth complication or too small baby

Skin	Skin around the cord and creases (underarms, neck and legs) is dry and free from pustules Skin is not yellow	Skin pustules Jaundice	Infection or too small baby
Eyes	No discharge, not sticky	Sticky, discharge, pus	Eye infection caused by infection in the mother
Umbilical cord	Clean, not bleeding	Bleeding, redness or swelling, oozing pus Redness extending to the skin	Infection in umbilical cord from unclean cord cutting or poor hygiene
Weight	Greater than 2.5 kg is normal	Less than 2.5 kg should be referred to a health facility	Small baby is also called low birth weight (LBW) or premature baby (born too soon)

ASSESSING THE BABY

During all home visits in the first week, check the baby. Make sure that the mother knows the danger signs, and tell her to inform you immediately or go directly to hospital if she notices any of these signs.

Ask the mother:

- How is the baby today?
- How is the baby feeding? How often?
- Have you noticed any changes in the baby's activity (such as becoming too sleepy)?
- Has the baby has shown any danger signs (see household handbook)?

Check the baby:

- Watch for movement and crying when baby is awake.
- Listen to the breathing and observe the baby's chest movements.
- Check skin temperature with your hand and look at skin colour.
- Look for skin pustules, especially near the cord stump and in the creases of skin.
- Check the eyes for pus.
- Check skin colour – look at soles of feet and palms of hands for yellow jaundice (use outside light).
- Check the umbilical cord to ensure that it is clean and dry.
- Weigh the baby (if you have scales) and have been trained.

Activity 6: Barriers and enablers to care seeking

Explain that families may have problems taking sick newborns or sick mothers to a health facility even if they identify signs of illness. Consider the four delays for referral (discussed previously).

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

Ask the participants what problems families in their communities might have in taking mothers and newborns to a health facility.

Use the example barriers below to guide your discussion. **Instruct** the ttC-HVs to fill in the table in their manuals with these and any other ideas. Also, ask them to give examples of beliefs and practices from their own experience.

Barrier	Possible counselling advice
Family thinks they should take a sick baby to a faith healer first. (beliefs > delay in decision)	Explain that a baby with danger signs needs urgent treatment at a health facility, and could die quickly if he/she does not get this treatment.
Family has fear of the health facility. (beliefs > delay in decision)	Explain that treatment using injections is necessary for a baby with severe illness. This can be done only at a health facility.
Family thinks it would cost them too much to get treatment. (finances > delay in decision)	Explain the cost of treatment at a health facility, and if it would be covered by their savings for an emergency; or if the family could begin to save for such an emergency.
Family does not have any transport to take the baby to the health facility. (access > delay in reaching care)	Help the family to explore options for arranging transport or identifying transport possibilities in advance.
Mother thinks that the baby's symptoms are not due to a medical problem (beliefs > delay in danger)	Ensure that the mother and all family members know the signs that indicate that a child has a medical problem. Resolve any cultural beliefs about illness in the newborn through discussion.

Summarise the main points of the session

- Danger signs in the newborn are difficult to detect and it's important that the family be aware of the signs and observe the baby carefully at all times. They should inform the ttC-HV or go directly to the health facility if they suspect that the baby has a danger sign.
- During each home visit in the first week of life they should assess the baby and give the top to toe check to ensure that the baby is well.
- Families can overcome the barriers to care seeking by being aware of danger signs and ready to leave quickly if the baby shows any signs. Mother and baby should be accompanied to the nearest hospital.

Session 11: Special Care of the Small Baby in the First Month

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: Preterm and low birth weight babies Activity 3: Caring for the small baby Activity 4: Demonstration: carrying the baby skin to skin Activity 5: DVD demonstration	 Time: 1h15
Learning objectives	At the end of this session participants will be able to: • recognise and describe the characteristics of a small baby (includes both preterm (born too soon) and small for gestational age (SGA) • explain why small babies need extra care and protection to survive • demonstrate how to keep a small baby warm in the first month using kangaroo mother care (KMC) (facility and home) • describe how to help a mother breastfeed a small baby • conduct extra home visits and checks to ensure that the small baby stays well.	
Key messages	• Small babies need special care to keep them warm using skin-to-skin KMC. • Small babies may need extra help breastfeeding or be fed expressed breast milk. • Small babies can become very sick and die quickly compared to healthy sized babies, so know the danger signs and have a plan to get help quickly. • Small babies need extra home visits by ttC-HVs and extra visits to the clinic for check-ups in the first month of life. • Small **babies need extra care for development such as interacting or communicating with them, softly singing, talking, when the baby is awake or during feeding.**	
Preparation and materials	*Materials* • DVD player and projector • Doll and cloths, hat and sock *Preparation* • Download the appropriate video clips and set up the video and projector ready.	

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- recognise and describe the characteristics of a small baby (includes both preterm and SGA)
- explain why small babies need extra care and protection to survive
- demonstrate how to keep a small baby warm in the first month using KMC (facility and home)
- describe how to assist a mother to breastfeed a small baby
- conduct extra home visits and check needed to ensure the small baby stays well.

VISIT 5

Activity 1: Listen to the story

In the village of Bedanda there lived a young boy whose name was 'Miracle'. He was bright and cheerful and everyone said he was a lucky child. His mother, Grace, explained why she gave him the name Miracle. She was only 16 when she became pregnant and she suffered a difficult pregnancy and had malaria. At only 7 months, she went into labour. The labour was long, and her family took her to the hospital. Eventually she gave birth, but he was tiny and weak, his skin seemed thin and papery, and he was covered in light hairs. She tried to breastfeed but he was not able to latch on. The doctor explained the baby had been born too soon and may not survive, and her family advised her not to name him yet as he would not stay long in the world. But Grace told them she would do anything to save his life, and stayed in the hospital whilst they gave him medicine and care for several weeks. When she left, the health staff advised her to:

- continue to keep the baby skin-to-skin on her chest and wrapped with a hat on to keep him warm
- use extra clothing for the baby
- express breast milk into a cup to feed him until he was able to breastfeed normally, as often as she could, day and night
- take extra care with hygiene: hand washing with soap before touching the baby
- take baby for a check-up at the clinic regularly until he is normal weight.

When she came home, the family said it was a miracle that the baby had lived. She took special care of him at home and had extra support from the ttC-HV and her family. By the time two months had passed he was growing well, so Grace decided to call him 'Miracle' so people would know what a special child he was.

Discussion points

- Why did the doctor think the baby may not survive?
- What signs were there that the baby was premature?
- What did Grace do that helped the baby to survive?
- Skin-to-skin, keeping the baby wrapped on her chest, and used extra clothing (warmth)
- Breastfeeding, or giving the baby expressed milk (nutrition)
- Extra hygiene and routine checkups.

What might have been the impact if Grace had experienced depression after the birth?

Ask the group to share any similar experiences from their own communities. What happened?

Activity 2: Give relevant information: Preterm and low birth weight babies

Ask: How can you recognise a small baby?

The mother may know if the baby was premature, or this may be indicated by the birth weight. But some characteristics are typical of premature babies, which you might observe of a baby who was born too soon.

SIGNS THAT A BABY WAS BORN TOO SOON

Skin – may appear thin and with visible blood vessels

Feet and hands – no creases on the palms of hands or soles of feet

Arms and legs – thin and floppy, do not resist pressure

Hair – may have a light coating of fine hair on face, back

Genitals – in boys, the testes have not descended; in girls, the genitals appear larger/exposed.

Low birth weight – All newborn babies should be weighed as soon as possible after delivery. All home births should be referred to the health facility as soon as possible.

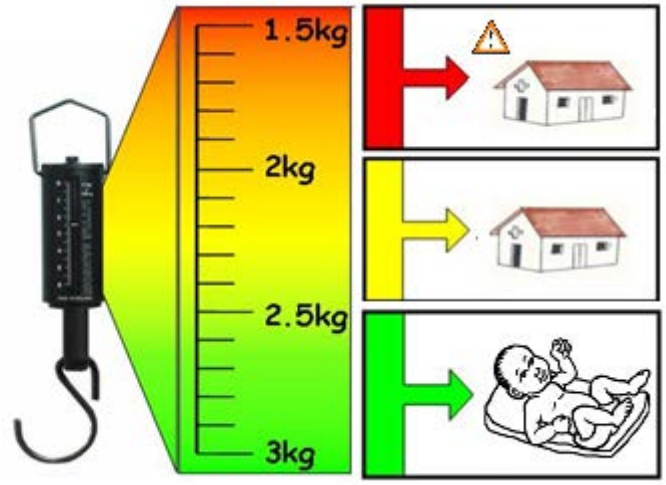
Healthy baby – Weighs more than 2.5 kg at birth

Small baby needing special care – Weighs between 2 and 2.5 kg

Small baby needing urgent referral (and likely hospital care) – Weighs less than 2 kg

What causes babies to be small:

- being born too soon
- small gestational age.



Activity 3: Give relevant information: Caring for the small baby

Ask: Why do small babies get sicker than babies of normal weight?

Explain or read aloud this section from the ttC Participant's Manual.

SPECIAL CARE OF THE SMALL BABY

A small baby is weaker and smaller than normal-weight babies, and has less protection from infections. Being smaller, they have less fat and get cold much more quickly too. They can get ill very quickly and may die, so it is important to be alert at all times.

FACILITY-BASED CARE OF THE SMALL BABY

If the small baby was born at home, he/she requires urgent referral to a health facility. A small baby should not be cared for in the community unless mother and baby have been discharged by the facility. The ttC-HV can support the mother by initiating feeding and introducing skin-to-skin contact, then should transport the mother and baby to the facility whilst carrying the baby 'kangaroo style'.

In the facility, the staff will provide any treatment the baby might need and help the mother to care for the baby, teaching the importance of feeding, warmth and hygiene. When the baby is stabilised, mother and baby may be discharged, but will need regular follow-up care in the home that the ttC-HV can support.

COMMUNITY-BASED CARE OF THE SMALL BABY

EXTRA HYGIENE

- Keep the baby indoors, in a clean, smoke-free environment.
- All members of the family must always wash their hands carefully before handling the baby.
- Clean the cord carefully and dry, or use chlorhexidine.
- Keep the baby away from sick people.

EXTRA FEEDING

- If the baby is able to suck and feed successfully, allow it to feed as often and as long as it wants. It should feed at least every two hours, day and night, which may mean waking the baby to feed.
- Small babies may need to be fed with expressed milk in addition to suckling, as they may tire easily. Mothers should be supported to start expressing breast milk within the first 6 hours after the birth of the small baby. In the first few weeks when the baby is learning to breastfeed but cannot complete the feed, the mother can put the baby to the breast, and after the baby tires, the mother can give additional expressed milk using a cup or spoon or express milk directly into the baby's mouth. The mother can express breast milk into a sterile/clean container just before the baby sucks. In health facilities, tube feeding may occasionally be required.

EXTRA WARMTH

- The mother (and other family members) should carry the small baby skin-to-skin for the first month, on her front or chest (also referred to as kangaroo style), which you can support her and the family to do correctly.
- The small baby should always have an additional layer of clothing than normal, should be bathed in warm water, very carefully and quickly, and should wear a hat and socks at all times.

EXTRA MONITORING

- Keep extra vigilant for danger signs.
- Make home visits for a small baby more frequently and maintain until they are growing and well.
- Take the baby to the clinic for a check-up regularly – every 1 to 2 weeks in the first month.

EXTRA PLAY AND LOVING INTERACTIONS WITH CAREGIVER

- Small babies need extra care for development such as interacting or communicating with them, softly singing, talking, when the baby is awake or during feeding.

Activity 4: Demonstration: Carrying the baby skin-to-skin

Explain that for small babies, the mother should carry the baby on her front instead of on her back. Two facilitators should conduct this demonstration, ideally wearing loose clothing, and with a woman playing the role of the mother. Conduct the demonstration as follows:

- The doll should be naked and held upright. Place the doll inside the clothes (skin-to-skin contact), between the breasts (this can be done over clothing for the demo, but explain that to participants). The legs and hands should be spread apart against the mother's chest (like a frog) and the head to one side, not flat against the chest.
- Wrap the cloth around the baby as normal to hold it in place, ensuring that the cloth does not restrict the baby's breathing and that the head and neck are supported. Cover the head with a small hat or cloth.
- The mother may dress in normal clothing (ideally loose), allowing for the baby's head to be revealed.
- Demonstrate that the mother can sleep in this position – tilted rather than lying down, to keep the baby's head upright. This can be tricky, and the family can also take turns carrying the baby skin-to-skin when the mother is bathing and resting.
- Check the temperature and breathing of the baby frequently (use a thermometer or breath-counter if provided). If you have scale for weighing, monitor the baby's weight regularly.

Activity 5: DVD demonstration

- Kangaroo mother care: Show KMC video. http://www.healthynewbornnetwork.org/topic/kangaroo-mother-care-kmc. Ask participants if they have any questions about KMC after the video.
- Breastfeeding the small baby – expressing and spoon/cup feeding

Summarise the main points of the session

- Small babies are especially vulnerable to infections, cold and feeding problems.
- We can increase the survival of such babies by providing special care in the home and facility.
- Refer all small babies urgently for facility-based care. Once the baby's condition is stabilised, it can be cared for in the community by supporting the family to ensure that the baby gets extra care:
    - extra warmth (skin-to-skin and extra clothing)
    - extra hygiene
    - extra feeding (breastfeeding and cup feeding)
    - extra visiting and checking for danger signs.
    - Extra play and loving interaction caregiver

Session 12: Conducting the First Visit after Birth (Visit 5a, b, c)

Session plan	Activity 1: Understanding the story Activity 2: Give relevant information: Conducting visit 5a Activity 3: Practise Visit 5 Activity 4: Debrief in plenary	 Time: 1h00
Learning objectives	At the end of this session participants will be able to: • demonstrate how to conduct the first home visit after birth (Visit 5a) and engage effectively and appropriately with household members • demonstrate how to use the visuals appropriately during the counselling visit • understand the importance of three home visits in the first week of life and demonstrate how to conduct the additional follow-up visits to review key messages, to check mother and baby for danger signs, and to help mother to resolve any problems she might be experiencing.	
Key messages	Essential newborn care • Breastfeeding • Danger signs in newborn • Conduct Visit 5a - first week of life as soon as possible after the baby has been born, within 24 hours of a home birth and as soon as they return home after a facility delivery. In this extended visit, learn about the birth, assess the mother and baby for danger signs, apply cord care, assess and support establishing breastfeeding and check vaccinations as well as the basic visit story and handbook counselling activities. Refer all home births. • Conduct, if possible, two more visits in the first week of life, according to the schedule given by the health authorities (Visits 5b and 5c). During this shorter visit, assess the mother and newborn for danger signs, apply cord care, and assess breastfeeding if problem has been reported.	
Preparation and materials	*Materials* • Flipchart, paper and markers • Storybook for Visit 5, and household handbooks • Doll, cloths, hat and socks *Preparation* • Gather all training materials in advance. • Arrange the room for group practice as well as plenary demonstration.	

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- demonstrate how to conduct the first home visit after birth (Visit 5a) and engage effectively and appropriately with household members
- demonstrate how to use the visuals appropriately during the counselling visit
- understand the importance of three home visits during the first week of life and demonstrate how to conduct the additional follow-up visits to review key messages, to check mother and baby for danger signs, and to help mother to resolve any problems she might be experiencing.

Activity 1: Understanding the story

Working in groups: With one facilitator/helper per table, distribute copies of Storybook 5. **Read** the story to the group, then have participants identify the positive and negative practices. Use the table below as a checklist.

Module 2. Storybook 5 messages

Positive story messages	Negative story messages
Essential newborn care and breastfeeding • Lesedi receives advice on how to breastfeed her baby. • Lesedi breastfeeds her baby exclusively and the baby is healthy. • Massage breasts from back to front to encourage milk forward. • Make sure baby is correctly attached to the breast. • Do not continuously switch breasts while feeding; empty one before changing; begin with the other breast on the next feed. • Breastfeed the baby exclusively and don't give any other fluids. • Don't give bottles to the baby. • Feed every 2–3 hours. • Keep the baby awake while feeding. • Talk and sing to the baby. • Massage the baby's back and legs. **Postnatal care** • Monitor the growth of the baby. • Ensure that the baby is immunised. • Give iron and folate to Lesedi. • Ensure that the baby sleeps under a bed net with mother.	• Madupe doesn't have confidence about her breastfeeding. • She doesn't know how to stimulate her breasts so that the milk will come. • She gives goat's milk to the baby. • She doesn't wash her hands. • She feeds the baby using a bottle. The nipples of the bottle are not sterile (they are not clean enough, even if Madupe washes the bottle). • She doesn't notice that the baby has a fever and that the baby has difficulty breathing. • The baby is in unclean surroundings. • She gives water to the baby. • Madupe and her mother wait too long to get help for the baby. • The baby is kept naked: the baby is not warm.

Activity 1: Give relevant information: Visit 5a – The first visit after birth

Review the visit, in the *ttC Participant's Manual* (brief recap). If not literate, proceed to demonstration.

SEQUENCE FOR VISIT 5A (FIRST HOME VISIT AFTER DELIVERY)

Before starting:

Greet the family. Explain the purpose of the visit. Ensure that all identified supporters are present.

Identify and respond to any difficulties:

Ask the mother if she has any danger signs, including any emotional distress. Apply psychological first-aid principles if needed. (*Proceed directly to the checks if mother doesn't raise issues immediately.)*

Assessment steps:

- Assessing the mother (revision from Session 7):
  - Understand the birth story: where, who present, what happened (any complications, tears, bleeding).
  - How are you feeling now?
  - Ask about bleeding, fever, abdominal pain, tiredness, breast problems.
- Assessing the newborn (revision from Session 8):
  - **Ask the mother:** How the baby is, feeding progress, movements and crying, any danger signs.
  - **Check the baby:** Movement and crying, breathing, skin temperature and colour, look for pustules, check the eyes, check the umbilical cord.
  - **Weigh the baby (optional)**
- Clean the umbilical cord with chlorhexidine solution (if approved)

ttC counselling process:

Step 1: Review the previous meeting Review household handbook pages from the previous visit (Visit 4). Review any negotiated behaviours around the birth and determine if those were met.

Step 2: Present and reflect on the problem: Problem story: 'Essential newborn care and breastfeeding' Tell the story and ask the guiding questions.

Step 3: Present information: positive story: 'Essential newborn care and breastfeeding' Tell the story and ask the guiding questions. Present and reflect on the positive story: 'Postnatal care' – tell the story and ask the guiding questions.

Step 3b: Present technical information **'Breastfeeding problems' and 'Danger signs birth to 1 month'**

Step 4: Negotiate new actions using the household handbook

Remember 'getting to the root cause' questions (what makes it difficult; why is that the case?)
Remember 'getting to solution' questions (what would make it easier, how can we help ensure that happens?)

Step 5: ttC-HV actions

Observe the mother breastfeeding her baby if possible and provide any assistance as necessary.
Encourage exclusive breastfeeding.
Ensure that the baby has been taken for his/her first immunisations.
Refer all home births.

Record the results of the meeting: Fill in the *ttC Register* for this visit *(we will do this at the end).*

End the visit: Decide with the family when you will visit again in the next few days (Visits 5b and 5c). Thank the family.

If the participants have read through this, then the facilitator should proceed to conduct the full visit sequence in plenary with volunteers playing the role of the mother, father, birth companion (TBA or other). A second facilitator should narrate the actions as they happen, and participants can ask questions or stop the demonstration as required.

Activity 2: Practise home visit 5a in groups

Working in groups: Participants should split off and practise the sequence of the visit, with one helper or facilitator per group to narrate the steps. This visit is more complex, so it will be better to get into smaller groups rather than practising in plenary.

Activity 3: Give relevant information: Conducting Visits 5b and 5c

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

Review the information with the ttC-HVs.

THE IMPORTANCE OF NEWBORN VISITS

The first month of life, called the newborn period, is the most risky period in the life of an individual. Of every 100 children born alive, about 10 die before reaching the age of 5 years. Of these 10, about three die in the first month of life itself, the newborn period. **Most of these newborn deaths occur in the first week of life.**

Many newborns fall sick in the first days of life due to complications of childbirth, or infections. After birth, newborns have to adapt to a different way of feeding, breathing and staying warm. The first day of life is particularly important, as they can get sick easily. It is important to pay closer attention than usual during this critical period, and three visits are needed to check for danger signs, apply chlorhexidine solution to the cord stump, and help the mother to establish breastfeeding.

The ttC-HV should make two more visits during the first week of life, not to introduce any new messages, but to check on the mother and baby, to help to resolve any problems that they might be experiencing, or to refer the mother and baby to the health facility if any danger signs are present.

REVIEW THE VISIT 5B AND 5C SEQUENCE IN THE *TTC PARTICIPANT'S MANUAL* (BRIEF RECAP), OR READ ALOUD. SEQUENCE FOR VISIT 5B AND 5C (FOLLOW-UP VISITS)

Before starting:
Greet the family. Explain the purpose of the visit. Ensure that the identified supporters are all present.

Assessment steps

- Assessing the mother (revision from Session 7)
  - How are you feeling now?

- Ask about bleeding, fever, abdominal pain, tiredness, breast problems as before.

- Assessing the newborn (revision from Session 8)
  - Ask the mother: How the baby is, feeding progress, movement and crying, any danger signs.
  - Check the baby: Movement and crying, breathing, skin temperature and colour, look for pustules, check the eyes, check the umbilical cord.
  - Weigh the baby (optional)
- Clean the umbilical cord with chlorhexidine solution (if country policy).
- Step 5: ttC-HV actions:
  - Only observe a feed again if the mother reports any difficulties, or previously had problems.
  - Ensure that the baby has been taken for his/her first immunisations.
  - Ensure that home births were taken to be checked at the facility.
- Record the results of the meeting – Fill in the ttC Register for this visit (we will do this at the end).
- End the visit.

Activity 4: Role play the return visits

Working in groups: Have small groups role play visits 5b and 5c, using the steps in the box above, checking the mother and the baby. After practice ask one group to present their role play in plenary.

Summarise the main points of the session

- During the fifth home visit, dialogue, negotiate and encourage mothers and families to exclusively breastfeed the baby, keep the baby warm, prevent infection in the baby through good hygiene practices, take the baby to the health facility for immunisations and growth monitoring, check the mother and baby for danger signs and take the baby to the health facility immediately if any of the signs are present, and register the baby's birth.
- During the fifth home visit, tell three stories and ask the corresponding guiding questions:
  1. problem story: essential newborn care and breastfeeding
  2. positive story: essential newborn care and breastfeeding
  3. positive story: postnatal care.
- Reinforce the messages with two technical sessions:
  1. breastfeeding
  2. danger signs: birth to 1 month (newborn and mother).

VISIT 6: FIRST MONTH

Session 13: Care Seeking for Fever and Acute Respiratory Illness

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: Malaria Activity 3: Give relevant information: Acute respiratory illness Activity 4: Give relevant information: General danger signs Activity 5: Show DVD clip: IMCI – General danger signs Activity 6: Role play demonstration: Assessing the sick child Activity 7: Give relevant information: Feeding during illness Activity 8: Demonstration: Correct hanging of a bed net (optional)	 Time: 2h00
Learning objectives	At the end of this session participants will be able to: • understand how malaria is transmitted, and prevented by sleeping under a long-lasting insecticide-treated bed net, and advise on how to correctly hang a bed net • assess any child with fever for danger signs and counsel on care seeking • understand the risk of pneumonia and other respiratory infections, recognise the danger signs, and counsel on care of the sick child and care seeking • counsel mothers to continue breastfeeding during and after the child's illness	
Key messages 	• If the baby has fever, go urgently to the nearest health facility within 24 hours. Look out for general danger signs with fever: o unable to breastfeed or drink o vomiting everything o convulsions o lethargic or unconscious. • Take the child with cough to the clinic urgently if they have any of these signs: o fast or difficult breathing o noisy breathing or grunting o chest draws inwards when infant breathes in. o unable to feed or breastfeed o vomiting everything o lethargic or unconscious o convulsions. • When an infant has a cough or cold, to prevent pneumonia: wrap the baby warmly, clean mucus from the nose frequently, wash hands with soap every time you handle the baby, and allow plenty of rest. • Ensure that you breastfeed more frequently and for more time during illness to make sure the baby recovers well, both during and after the illness. Give more to eat and drink than usual for infants over 6 months. • All infants must sleep under an LLIN-treated bed net every night to protect from mosquito bites, from birth until 6 years old, in all seasons.	
Preparation and materials	*Materials* • Flipchart, paper and markers • Storybook for Visit 6 and household handbooks In areas where malaria is common	

VISIT 6

- An LLIN, most commonly found in the area
- Hanging supplies (hooks, nails, poles – whatever is needed)
- Photocopies of the instructions that come with the bed net, one for each ttC-HV
- Tables to use as beds during the demonstration

Preparation

- Gather all training materials in advance.
- Prepare for the demonstration of the hanging of bed nets, as above (in areas where malaria is common).

Contextualisation: Do not carry out the activities related to malaria if you are not working in a malarial area. In such cases, remove the malaria-related objectives.

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- understand how malaria is transmitted, and prevented by sleeping under a long-lasting insecticide-treated bed net, and advise on how to correctly hang a bed net
- assess any child with fever for danger signs and counsel on care seeking
- understand the risk of pneumonia and other respiratory infections, recognise the danger signs, and counsel on care of the sick child and care seeking
- counsel mothers to continue breastfeeding during and after the child's illness

Activity 1: Determine what they already know

Ask: Has anyone ever had malaria? Have your children had it?

Ask: How do you describe the symptoms? How was the malaria treated?

Ask: Does anyone know how malaria is transmitted (how do you catch malaria)?

Activity 2: Give relevant information: Malaria

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

INFORMATION ABOUT MALARIA

- Malaria is transmitted through mosquito bites. Sleeping under an LLIN-treated mosquito net is the best way to prevent mosquito bites.
- Even younger babies are vulnerable to malaria as there is no vaccine, and breastfeeding does not fully protect them. Wherever malaria is common, children are in danger. Young children lack immunity from malaria and are at risk of severe malaria and death within 24 hours.
- A child with a fever should be examined immediately by a trained health worker and if malaria is diagnosed, the child should receive anti-malarial treatment as soon as possible – normally within one day.
- A child under 6 months of age suffering from malaria needs plenty of breast milk. Children older than 6 months need plenty of liquids and food.

Activity 3: Give relevant information: Acute respiratory illness

Ask: What is pneumonia/ARI? Why is it dangerous?

ACUTE RESPIRATORY ILLNESSES

- Typically a cough or cold is not a sign of a serious problem. Children catch them frequently and if they are cared for well in the home, it will not develop into something more serious.
- A cough can sometimes develop into a serious chest infection. An infant or child who is breathing rapidly or with difficulty might have pneumonia, a chest infection whereby the lungs fill with fluid and the baby cannot breathe. Pneumonia is a life-threatening illness needing immediate treatment at a health facility.
- Many children die of pneumonia at home because their caregivers do not realise the seriousness of the illness and the need for immediate medical care.
- Families can help prevent pneumonia by making sure that babies are exclusively breastfed for the first 6 months and that all children are well nourished and fully immunised.
- TB risk: A child with a harsh cough also needs immediate medical attention. The child may have tuberculosis, another type of infection in the lungs. Any child who has been living in the home with an adult who has tuberculosis, or who suffers a persistent cough lasting over 2 weeks should be referred.
- Risk of indoor woodstoves: Children and pregnant women are particularly at risk of pneumonia when exposed to smoke from tobacco or cooking fires.
- Care of a child with cough to prevent pneumonia:
    - Wrap the baby warmly.
    - Clear mucus from the nose frequently.
    - Wash hands with soap every time you handle the baby.
    - Breastfeed frequently and more than usual.
    - Give more to eat and drink than usual.
    - Allow plenty of rest.

Activity 4: Give relevant information: General danger signs

Ask: What are the most serious danger signs in children?

Ask: Have any of your children had these danger signs? What did you do? What happened?

Write the danger signs they identify on a flipchart and return to this after the discussions and highlight/circle those that have the most serious consequences (general danger signs and signs of severe pneumonia).

Distribute the technical session in Storybook 6 on danger signs in children. Ask them to follow this information in the *ttC Participant's Manual* and identify the signs in the storybook.

GENERAL DANGER SIGNS

The most common symptoms of illness in children aged 2 to 59 months are:

- diarrhoea – runny stool three or more time in one day
- fever – body temperature higher than usual
- cough – sign of a throat or chest infection or a cold.

Not all of these cases require *urgent treatment.* But there are certain danger signs that, when observed in a child age 2 to 59 months, either without any other symptoms, or in combination with diarrhoea, fever or cough, indicate that a child is ***seriously ill and needs urgent medical care.*** If the child has one of these signs they would be unable to take any medicines at home, and may die if not seen quickly.

General danger signs (urgent medical care)

- The child is unable to suck, or eat or drink anything.
- The child has persistent vomiting, vomits everything.
- The child has seizures (fits).
- The child is unusually sleepy or unconscious.

Danger signs (needs to be referred)

- The child has a fever.
- The child has fast or difficult breathing and/or an indrawn chest.
- The child has a cough together with an indrawn chest.
- The child has three or more watery stools in a day.
- The child has blood in the stools.
- The child has pus in the eyes.
- The child has pus in the ears.
- The child has swelling in both feet.
- The child has body blisters/rash.

Activity 5: Show DVD clip: IMCI: General Danger Signs – UNICEF/WHO

If available in your country, show video clips including the following:

- general danger signs in children age 2 to 59 months
- chest indrawing
- fast and noisy breathing.

Activity 6: Role play demonstration: Assessing the sick child

Demonstrate with volunteers whilst a second facilitator narrates the process as the role play progresses.

ASSESSING THE SICK CHILD AGED 2 TO 59 MONTHS

Ask: IS THE CHILD ABLE TO DRINK OR BREASTFEED?

The child is not able to suck or swallow when offered a drink (clean water) or breast milk. If the mother says the child is unable to drink or breastfeed, ask her to describe what happens when the child is given something to drink. If you are unsure of the answer, ask her to offer a drink or breast milk. Look to see if the child is swallowing the water or breast milk.

Ask: DOES THE CHILD VOMIT EVERYTHING?

The child is not able to retain what he/she has eaten or drunk. For this sign, what goes into the child's mouth must come back out of the child's mouth every time; if the child is able to retain something, then this sign is absent. If in doubt, offer the child a drink and observe what happens. If the child vomits everything immediately, then this sign is present. If the child doesn't vomit immediately, then this sign is absent.

Ask: HAS THE CHILD HAD FITS OR CONVULSIONS?

During a convulsion, the child has trembling movements of the entire body. The child's arms and legs stiffen as the muscles are contracting, and may lose consciousness or not be able to respond to her voice. When asking the mother, use words the mother understands, such as 'fits' or 'spasms.'

Look: TO SEE IF THE CHILD IS VERY SLEEPY OR UNCONSCIOUS?

The child is not awake and alert when he/she should be, is drowsy and does not show interest in what is happening around him/her. The child may stare blankly or without any facial expression appearing to not notice what is going on around him/her. An unconscious child cannot be wakened. He/she does not respond when touched, shaken or spoken to.

Ask the mother if the child seems unusually sleepy or if she cannot wake the child. Look to see if the child wakens when talked to. Gently shake the child or clap hands near the child.

If the child has any of these signs – then refer them immediately. See Session 19 on referral.

Activity 7: Give relevant information: Feeding during illness

Ask: How does illness affect a young child's breastfeeding? Do they feed more or less than usual? What should they be doing? What are the communities' beliefs about children breastfeeding during illness?

Ask one or two volunteers to share examples from their own experience of caring for their sick child. How did the child eat, how did they encourage the child to eat and drink more than usual?

BREASTFEEDING DURING ILLNESS

A child under 6 months of age suffering or recovering from any illness, especially with fever, needs plenty of breast milk. Children older than 6 months need plenty of liquids and food.

Children under 6 months

The sick child may not breastfeed for as long as usual, or show the usual signs of hunger. Therefore, it is important you breastfeed them as much as possible. If they breastfeed for only a short period of time, offer them more frequently than usual.

Children over 6 months

At 6 months infants will have started on solid foods and other drinks. But when sick, they may be less inclined to eat solids. Mothers should breastfeed as much as possible, and after feeds encourage the child to eat small snacks, or soft liquid foods. Give small quantities frequently rather than a large meal if this is easier.

Activity 8: Demonstration: Correct hanging of a bed net (optional)

1. Demonstrate the correct hanging of a bed net, using a local example of an approved LLIN, string, hooks or nails to attach the net to walls or ceiling. Arrange tables for beds. Make sure you have the training venue's permission to put up the nets, or demonstrate without screwing in the hooks.
2. Distribute the photocopied instructions to the ttC-HVs. Proceed through the steps of the demonstration to show correct hanging of the bed net. Emphasise that correct hanging is important to ensure that there are no spaces, holes or tears where mosquitoes can enter.
3. Give the ttC-HVs an opportunity to practise hanging the net.

Summarise the main points of the session

- Young children are at risk of severe malaria and death within 24 hours. The best way to prevent malaria is by sleeping under a long-lasting insecticide-treated bed net. Nets must be hung correctly and checked for tears to prevent mosquitoes from entering through any spaces.
- A child with a fever must be taken to a health facility or trained health worker within 24 hours.
- Coughs and colds are common in children and are not usually a problem. Sometimes a cough can lead to a serious problem, called pneumonia. This is a life-threatening illness requiring immediate treatment at a health facility, or tuberculosis, which also requires immediate care.
- The mother should continue breastfeeding the child during the illness and increase breastfeeding after the illness.

Session 14: Routine Care of the 1-month-old Child: Services, Birth Registration and Play

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: Growth monitoring Activity 3: Reinforce the Information: Growth monitoring Activity 4: Immunisation and vaccine-preventable diseases Activity 5: Common misconceptions about immunisations Activity 6: Reinforcing the information: Immunisation schedules Activity 7: Give relevant information: Family planning Activity 8: Play and communication from 1 to 6 months Activity 9: Give relevant information: Birth registration Activity 10: Barriers and enablers: GMP, vaccines and family planning	 Time: 2h30
Learning objectives	At the end of this session participants will be able to: • understand the reasons for regular growth monitoring of young children, and correctly interpret a growth-monitoring card • counsel families to take children for the full schedule of immunisations and check on Child Health Cards to check which have been completed (literate ttC-HVs) • have a basic knowledge of the diseases that immunisations prevent and the immunisation schedule.	
Key messages 	• Children must complete five rounds of vaccinations, at birth; 6 weeks; 10 weeks; 14 weeks and 9 months. • Ensure that all children have complete vaccination records, that you attend clinics at the time needed, and that you keep vaccination cards in a safe and dry place. • Children's growth should be monitored on a regular basis. Weight and growth should be measured monthly at your local health facility. • Mothers should use family-planning methods to prevent unwanted pregnancies and practise healthy timing and spacing of pregnancies.	
Preparation and materials 	*Materials* • Flipchart, paper and markers • Storybook for Visit 6 and household handbooks • Sample growth-monitoring cards *Preparation* • Gather all training materials in advance. • Ask participants to bring their child's/children's growth-monitoring cards.	

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- understand the reasons for regular growth monitoring of young children, and correctly interpret a growth-monitoring card

VISIT 6

- counsel families to take children for the full schedule of immunisations and check on Child Health Cards to check which have been completed (literate ttC-HVs)
- have a basic knowledge of the diseases that immunisations prevent and the immunisation schedule.

Activity 1: Determine what they already know

Ask: How many times have you taken your children to be immunised? Which immunisation did they have and for what diseases? Why is it important to immunise? What would happen if you did not immunise your child? Did you take your own children for regular weighing and measuring? Why do you think it's important to weigh the child regularly? What happens if a child is not growing well?

Activity 2: Give relevant information: Growth monitoring

Explain or read aloud:

GROWTH MONITORING

- A young child should grow well and gain weight rapidly. From birth to age 2, children should be weighed every month. If a child has not gained weight for about two months, something is wrong.
- If a child does not gain weight for 2 months, he or she may need larger or more frequent servings or more nutritious food, may be sick, or may need more attention and care. Parents and health workers need to act quickly to discover the cause of the problem.
- Each young child should have a growth chart. The child's weight is marked with a dot on the growth chart each time he or she is weighed, and the dots should be connected after each weighing. This will produce a line that shows how well the child is growing. If the line goes up, the child is doing well. A line that stays flat or goes down indicates cause for concern.

Activity 3: Reinforce the information: Growth monitoring

Draw a growth-monitoring graph on the flipchart or a blackboard with examples of the different sorts of lines that will result if a child is gaining, maintaining or losing weight over a period of time.

- Emphasise that a normal graph should show the child's weight in the middle to high range. If the weight is below the lowest line, then this is cause for immediate concern.
- Emphasise that if a line stays flat or goes down, something is wrong and the health staff will recommend immediate action so that the child can gain weight.

Participants with their own children's growth charts can be invited to show the group, or draw their child's growth line on the flipchart. The participants discuss if the line shows healthy growth or not. If any line is flat or decreasing ttC-HV should ask what happened and what was done to improve the child's growth.

Activity 4: Give relevant information: Immunisation and vaccine-preventable diseases

Read or explain the information in the box. **Answer** any questions that the ttC-HVs have.

INFORMATION ON IMMUNISATIONS

- Immunisation is urgent. Every child needs a series of immunisations during the first year of life.
- Immunisation protects against several dangerous diseases, including tuberculosis, polio, diphtheria, tetanus, pertussis and measles. A child who is not immunised is more likely to suffer illness, become permanently disabled, or become undernourished and possibly die.
- It is safe to immunise a child who has a minor illness, a disability or who is malnourished.

Contextualisation: Adapt the table below to the country's vaccine schedule.

Working in pairs: Distribute Storybook 6 and review the technical session on vaccine-preventable diseases, review the pictures of the diseases that immunisations prevent. **Instruct** them to practise explaining the information as if they were counselling families.

Refer to the *ttC Participant's Manual* and **review** the immunisation table, below. **Explain** it is not necessary to remember what vaccines are given at which times, but that it is important to know **when** the immunisations should be given, so that they can remind the mothers to attend at the right time.

- Which vaccines have already been given at birth? (Answer BCG and OPV-0).
- When the next round of immunisations is scheduled? (Answer: at 6 weeks).
- What actions should you take during Visit 6? (Counsel the families to take their children to be vaccinated at 6 weeks – either at the facility or mobile/outreach programme.

Immunisations	All countries	Some countries
At birth	BCG Polio (OPV)	Hepatitis b
6 weeks	DTP/Penta Polio	Hepatitis b Hib PCV rotavirus
10 weeks	DTP/Penta Polio	Hepatitis b Hib PCV rotavirus
14 weeks	DTP/Penta Polio	Hepatitis b Hib PCV rotavirus
9 months	Measles	Yellow fever

Activity 5: Common misconceptions about immunisations

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

Discuss the ways the ttC-HVs might help families to overcome these problems. Some examples of beliefs about immunisations are given below; also include other ideas that the ttC-HVs may provide.

Inaccurate belief	Counselling response
Infants should not be given any injection during the first month.	Giving BCG and polio vaccine to an infant does not have any ill effect. Even premature babies can be immunised. Delaying immunisation is not beneficial for the infants. Delay in immunisation can be fatal.
Infants with fevers and colds should not be immunised.	Immunise as per the health worker's advice. It is usually safe to immunise a child who has a minor illness.
The infant will have a fever after being vaccinated.	It is true that the infant will have a fever and restlessness for a day after being vaccinated but there is no need to fear. The infant's body needs to be wiped with a cloth dipped in lukewarm water and the mother should continue to breastfeed. If the child has a high fever then he/she should be taken to the health centre.
Only one vaccine can be given at a time.	BCG, DTP, polio and measles vaccines can all be given at the same time through injections in different parts of the body. This is especially useful for families living in remote villages, and for older children who were not given BCG or DTP in the first year.

Activity 6: Reinforcing the information: Immunisation schedules

Divide the participants into small groups. **Instruct** them to look at the three cases below and determine what vaccines should be given, based on the schedule provided. Show each cases using an example using the local health cards so they can learn to identify gaps in the vaccine schedule. After, **review** their responses.

Case 1:	An 8-month-old infant has been given only BCG. **Answer:** Polio and DTP, and in some countries hepatitis b and Hib.
Case 2:	A 10-month-old infant has been given BCG, DTP 1 and polio 1. **Answer:** Polio, DTP and measles, and in some countries hepatitis b and Hib.
Case 3:	A 3-week-old baby has received no immunisations at all. **Answer:** BCG and polio.

Activity 7: Give relevant information: Family planning

Ask the participants to stand in two lines either side of the facilitator. One line is false and the other is true. **Explain** that there are many ideas and beliefs about family planning after pregnancy that may not be correct. **Explain** that you will read a statement and they should switch their positions according to their answers. Before giving the correct answer **ask** a volunteer to explain his/her opinion.

True or false statements

Is it not possible for a woman to become pregnant in the first week after she has given birth if she resumes sexual activity.	False
After delivery, a woman should not resume sexual activity with her husband until the baby is 6 months old.	False
If a woman is exclusively breastfeeding the baby until 6 months of age, she cannot get pregnant.	False
A woman cannot use the contraceptive pill when breastfeeding as this is harmful for the baby.	False

If you want to have a large family, it is better to have pregnancies close together as this is better for the mother's health than waiting.	False
If a woman has not resumed menstruation then she cannot get pregnant.	False

Explain the answers to the participants and answer any questions they may have.

POSTPARTUM FAMILY PLANNING

- Normally it is advised that women resume normal sexual activity after 6 weeks postpartum, particularly if she has suffered a tear and the wound is still healing. All women should attend a postnatal check up, to check if the wound has healed well (this is typically done before 45 days after delivery).
- It might be unlikely, but it is possible that a woman can become pregnant *straight after* the birth, if not using contraception. She can become pregnant before her normal menstrual cycle returns. For this reason she will be offered family planning immediately or at the second postnatal consultation.
- ttC-HVs should counsel mothers to take up family planning *as soon as possible after delivery* to prevent new pregnancies until the baby is at least 2 years of age. This prevents health problems for both mother and child, caused by close birth spacing.

Activity 8: Give relevant information: Counsel the family on play and communication

Explain: Visit 6 happens at 1 month, and the next visit is not until 5 months. This is a crucial time in the *development of the baby's brain*. The more the caregivers play and talk to the child, the better the brain development. In this phase the child begins to coordinate movements of hands and feet, roll and crawl, and begin to interact and communicate with caregivers. Refer to the following in the *ttC Participant's Manual,* and explain what family members can do from one to six months to play and talk to the baby.

Age of young infant	Recommendations for family
1 to 6 months 	*Play* • Provide ways for your child to see, hear, feel, move freely and touch you. • Slowly move colourful things for your child to see and reach for. • Sample toys: shaker rattle, ring on a string. *Communicate* • Smile and laugh with your child. • Talk to your child. • Get a conversation going by copying your child's sounds or gestures.  

VISIT 6

Activity 9: Give relevant information: Birth registration

Ask: Why is it important to register the birth?

Facilitate a discussion with the participants around birth registration. **Ask** the CHWs to describe the process of registering the birth of babies in their communities. **Ask** them if their own children are registered. **Ask** them why birth registration is important. You may **make** a list of the advantages of birth registration on the flipchart.

BIRTH REGISTRATION

Registering the birth of a newborn baby will ensure that the child receives the social services to which he/she is entitled. Birth registration shows that the child's life is valued and that the child deserves to be counted.

ttC-HVs should encourage families to register their newborn baby's birth, so that their infant will benefit from all of the civil services that birth registration makes possible.

Discussion: Accessing birth registration

- Where can we register babies in our communities?
- Which ministry/department is in charge of birth registration, and what are the extensions of that in your area?
- What does a birth certificate look like?
- What are the benefits that a child may be entitled to in your communities if they have a birth certificate? Examples are social welfare support, health insurance, and school registration requirements.
- Present the group with an example of a birth certificate from the country, or project a sample on the screen. Show them where to find the key information.

Activity 10: Barriers and enablers to the recommended practices

Working in groups: Refer to this table in their manuals, and divide participants into five groups, each with one negotiated practice from the table below. Ask them to debate their ideas about barriers, enablers and counselling responses and then ask them to provide feedback in plenary. Some ideas/examples are given around birth registration to help start the discussion.

Key messages and additional information	Barriers What makes it difficult to do?	Enablers What would make it easier to do?	Counselling response or solution
Attend clinic to update immunisations. The importance of immunisations; DPT and OPV at 6 weeks – risk of vaccine-preventable diseases: polio, measles, diphtheria, pertussis, and pneumonia.			
Attend clinic to complete growth monitoring of the child.			
Family planning	*Knowledge and beliefs* *Culture/social norms*		
Stimulation and play for the 1- to 6-month-old baby			
Birth registration	*Knowledge: where to register* *Access: registration centre far away* *Culture: Parents afraid to register the baby for social/cultural reasons, e.g. single mothers, or child born outside of marriage* *Financial: if it costs to register the baby*	*Knowing where and how Understanding what the importance is to the family and child* *Entitlements – knowing the benefits of registration: social welfare support, school registration, etc*	*Counsel on access and benefits*

Summarise the main points of the session

- A young child should grow well and gain weight rapidly. From birth to age 2, children should be weighed every month. If a child has not gained weight for about 2 months, something is wrong.
- Immunisation is urgent. Every child needs a series of immunisations during the first year of life. Immunisations protect against several dangerous diseases. Children who are not immunised are likely to suffer serious illness and to perhaps die from these illnesses.
- The ttC-HVs should counsel families to take their children for routine growth monitoring and immunisations, either at the health facility or with mobile brigades that come to the community, and to register the child's birth as soon as they can.
- All women should be using family-planning methods to prevent unwanted pregnancy and ensure healthy timing and spacing of pregnancies.

Session 15: Conducting Visit 6: First Month

Session plan	Activity 1: Understanding the story Activity 2: Give relevant information: Visit 6 - the first month Activity 3: Practise Visit 6	 Time: 1h20
Learning objectives	At the end of this session participants will be able to: • demonstrate how to conduct the one-month home visit (Visit 6) • demonstrate how to use the visuals appropriately during the counselling visit • be prepared to conduct the household visit and engage effectively and appropriately with household members.	
Key messages 	• During the sixth home visit you will dialogue, negotiate and encourage mothers and families to recognise the danger signs in children and seek immediate care as needed, and to take the child to the health facility for routine growth monitoring and immunisations. • During the sixth home visit, tell two stories and ask the corresponding guiding questions: o problem story: Care seeking for fever, ARI, birth spacing and routine health services o positive story: Routine clinical visits, care seeking for fever, ARI, birth spacing, and essential newborn and maternal care. • Reinforce the messages with two technical sessions: danger signs in children, and vaccine-preventable diseases.	
Preparation and materials 	*Materials* Flipchart, paper and markers Storybook for Visit 6 and household handbooks *Preparation* Gather all training materials in advance.	

Introduce the session

Explain that the purpose of this session is to help the ttC-HVs master the process of carrying out Visit 6: the first month.

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- demonstrate how to conduct the one-month visit (Visit 6)
- demonstrate how to use the visuals appropriately during the counselling visit
- conduct the household visit and engage effectively and appropriately with household members.

Activity 1: Understanding the story

Working in groups: Review Storybook 6 and identify positive and negative practices using the checklist.

Module 2. Storybook 6 messages

Positive story messages	Negative story messages
• Exclusive breastfeeding. • Sleeping under bed net. • They understand the danger signs in a child (difficult breathing). • They take the baby to the clinic immediately. • Mariana continues to breastfeed when the child is ill.	• Meena and Peter don't sleep under a bed net. • Daniel and Meena don't understanding that a fever in a baby requires immediate medical care. • They wait too long to take him to the clinic.

Activity 2: Give relevant information: Visit 6: The first month

Review the sequence of the sixth home visit with the participants in the *ttC Participant's Manual* (brief recap). If they are not literate, proceed directly to conduct a demonstration.

SEQUENCE FOR VISIT 6

Before starting: Greet the family. Explain the purpose of the visit. Ensure that all of the identified supporters are present.

Identify and respond to any difficulties: Ask the mother if she has any danger signs, including any emotional distress. Conduct referral if needed. Apply psychological first-aid principles if needed.

Assess the child: Check the baby for danger signs, refer if any danger signs are present.

ttC counselling process:

Step 1: Review the previous meeting Review household handbook pages from the previous visit (Visit 5). Review negotiated behaviours and praise any progress. Renegotiate if the family is still struggling.
Step 2: Present and reflect on the problem: Problem story: 'Care seeking for fever ARI' – tell the story and ask the guiding questions.
Step 3a: Present information: positive story: 'Routine clinical visits, care seeking for fever, ARI, birth spacing' and 'Essential newborn and maternal care' – tell the story and ask the guiding questions.
Step 3b: Conduct technical session: Danger signs in children and vaccine-preventable diseases
Step 4: Negotiate new actions using the household handbook
Step 5: ttC-HV additional actions:

Observe the mother breastfeeding the baby and provide any assistance as necessary.
Ask about choice of family planning.
Remind about 6-week clinic visit for growth monitoring and immunisations.
Remind about clinic visits 10 and 14 weeks for growth monitoring and immunisations.
If the mother is HIV-positive, remind about HIV testing and co-trimoxazole treatment.

Record the results of the meeting: Fill in the *ttC Register* for this visit *(we will do this at the end)*

End the visit: Decide with the family when you will visit again (at 6 months). Thank the family.

Activity 3: Practise Visit 6

Ask for 10 participants to role play the household visit counselling in plenary for this session.

Explain that they should divide the steps of the counselling sequence among themselves. The first will role play the first step, the second will role play the second step, and so on, until the complete sequence of the first home visit has been completed.

Advise the observers to take note of what is done well in the role plays and what needs improvement, using the **counselling skills guide** for reference, found on the last page of the ttC-HV manual.

Summarise the main points of the session

- During the sixth home visit, you will dialogue, negotiate and encourage mothers and families to recognise the danger signs in children and seek immediate care as needed, and to take the child to the health facility for routine growth monitoring and immunisations.
- During the sixth home visit, tell two stories and ask the corresponding guiding questions:
  - problem story: care seeking for fever, ARI, birth spacing and routine health services
  - positive story: care seeking for fever, ARI, birth spacing and routine health services
  - positive story: postnatal care.
- Reinforce the messages with two technical sessions:
  - danger signs in children
  - vaccine-preventable diseases.
- Remember that how you interact with a pregnant woman and her family will affect how relaxed and confident she feels and whether she decides to follow your advice.

MONITORING AND REFERRAL FOR NEWBORNS AND POSTPARTUM MOTHER

Session 16: Infants Born to HIV-Positive Mothers

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: HIV testing for the HIV-exposed infant Activity 3: Give relevant information: Breastfeeding for the HIV-positive mother Activity 4: ART treatment of the HIV-positive infant and breastfeeding mother Activity 5: Demonstration and practice: Counselling for the HIV-positive mother Activity 6: Barriers to recommended practices	 Time: 1h00
Learning objectives	At the end of this session participants will be able to: • understand and counsel families on the importance of immediate HIV testing for the HIV-exposed infant • counsel the family of the HIV-positive infant on breastfeeding, routine care and monitoring for danger signs • counsel the family on uptake of co-trimoxazole preventive therapy for prevention of infections in the HIV-exposed infant.	
Key messages 	• It is very important to know as soon as possible whether or not the baby is HIV positive so that they can receive correct medicines and care. • HIV-positive infants should begin lifelong treatment for HIV (ART) as soon as they are diagnosed, and be supported to continue to take the medicines to protect them from becoming ill. • HIV-exposed infants should be given co-trimoxazole preventive therapy as soon as possible after birth whilst waiting for HIV test results. • When a mother is HIV-positive it is **even more important that she exclusively breastfeed** her baby until 6 months of age. • Newborns and young infants who have been exposed to HIV or become HIV positive after birth respond very well to treatment and if they are given their ARVs correctly they will go on to live productive, healthy and potentially long lives.	

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- understand and counsel families on the importance of immediate HIV testing for the HIV-exposed infant
- counsel the family of the HIV-positive infant on breastfeeding, routine care and monitoring for danger signs
- counsel the family on uptake of co-trimoxazole preventive therapy for prevention of infections in the HIV-positive infant.

Activity 1: Determine what they already know

Ask: How soon after the delivery should the HIV-positive mother arrange to have the baby tested for HIV?

Ask: How soon do families in your community usually arrange HIV testing of the child?

Activity 2: Give relevant information: HIV testing for the HIV-exposed infant

Read aloud or discuss the following points, and answer any questions they may have.

BABIES BORN TO HIV-POSITIVE MOTHERS

- It is recommended to test the HIV-exposed baby for HIV as soon as possible after delivery and at least before he/she reaches 6 weeks of age. If this test is available, it is very important to know as soon as possible whether or not the baby is HIV positive so that they can receive medicines and care.
- If the baby's HIV status is positive, or still unknown, the HIV-exposed baby should start a medication called co-trimoxazole when he/she reaches 6 weeks of age. This will help prevent infections.
- HIV-positive mothers should be receiving special medications known as ART and continue to take them.
- Mothers who are HIV positive may also be at risk of having active tuberculosis (TB), which can expose the young infant (from birth to 6 months) to TB. TB can be passed on to the infant whilst breastfeeding and by direct close contact with the mother. If the mother has TB-like symptoms such as night sweats, persistent cough and weight loss, then both mother and baby need to be checked at the clinic.

Activity 3: Give relevant information: Breastfeeding for the HIV-positive mother

Contextualisation: if working in an area where it is feasible for HIV-positive mothers to prepare commercial infant formula correctly and with purified water (AFASS), that can be the recommendation given to these mothers, in lieu of breastfeeding. In most contexts, the consistent, correct and clean preparation of formula cannot be guaranteed, as such, exclusive breastfeeding is the accepted recommendation.

Explain that HIV-positive mothers need to make the best decisions for feeding their babies. In most cases, the HIV-positive mother will breastfeed her baby, unless she has reliable access to a milk substitute and conditions to prepare it correctly, with clean water. Breastfeeding is the best option for mother and baby. Review the recommendations for the HIV-positive mother below and answer any questions.

BREASTFEEDING FOR THE HIV-POSITIVE MOTHER

- When a mother is HIV-positive it is even more important that she exclusively breastfeed her baby until 6 months of age. If the mother gives the baby any additional food or drink, the risk of the baby contracting HIV from the breast milk actually increases instead of decreases.
- The mother should also continue with the medicines (ARVs) that they are given for either themselves or their infant for at least one week after they stop breastfeeding. If the mother is taking ART then she can continue to breastfeed the baby until age 2.

Activity 4: ART treatment of the HIV-positive infant and breastfeeding mother

Ask: When should an HIV-positive baby begin being given HIV medicines (ART)? Does this usually happen in your communities? Why/why not?

HIV TREATMENT FOR THE HIV-POSITIVE CHILD

- A child identified as HIV positive should begin ART medicines as soon as possible. ART treatment for HIV-positive children tends to respond very well to treatment and has limited side effects.
- Starting ART treatment as soon as possible is important, as this will slow damage to the immune system and helps kids to stay healthy longer, while fighting off opportunistic infections that can cause illness in untreated babies.
- As ART treatment for infants is initiated at a young age and will likely be lifelong, concerns about adherence and toxicity or side effects are particularly important. Parents should immediately refer an infant who shows any danger signs.
- A HIV-positive infant may also be given co-trimoxazole treatment at home, which helps to prevent infections and helps to keep the baby healthy.
- Breastfeeding mothers should continue to take ART throughout the breastfeeding period and ideally, consider it as lifelong treatment.

Activity 5: Demonstration and practice: Counselling for the HIV-positive mother

Lead two demonstrations in which you counsel a family on the care of the HIV-positive mother, and a family who has an HIV-positive infant, using information in the box below.

COUNSELLING POINTS FOR THE HIV-POSITIVE MOTHER

- HIV testing: All children born to an HIV-positive parent should be tested for HIV. This should be done as soon as possible after birth. Ensure that testing has been completed in Visit 6.
- Co-trimoxazole treatment: Ensure that the child takes preventive co-trimoxazole treatment.

COUNSELLING FOR THE HIV-POSITIVE CHILD

- Identify additional community support: Family members should seek guidance on adherence and specialised counselling for caring for HIV-positive children through the facility or community-based programmes, ensuring the family is aware of any activities in your communities that can support them.
- Attend routine follow-up care for the mother and child: The mother and HIV-positive baby will need to attend clinics more regularly for care, growth monitoring and checkups.
- Prevention and awareness of illness: HIV-positive babies may suffer infections more frequently and more severely than uninfected children, including colds, fever, diarrhoea, pneumonia, fungal infections (shown by persistent nappy rash), so families should be even more careful to prevent infections and refer quickly when they see a danger sign.
- Exclusive breastfeeding to 6 months: It is even more important for the HIV-positive mother to exclusively breastfeed the baby until he/she is 6 months of age.
- Play and communication: Children with HIV need extra love, play and communication, which will improve the baby's nutrition, attachment to the mother and brain development.

Activity 6: Barriers to recommended practices

Working in groups: Refer to this table in their manuals, and divide participants into five groups, each with one negotiated practice from the table below. Ask them to debate their ideas about barriers, enablers and counselling responses and then ask them to provide feedback in plenary. Some ideas/examples are given around birth registration to help start the discussion.

Key messages and additional information	Barriers What makes it difficult to do?	Enablers What would make it easier to do?	Counselling response or solution
HIV-positive mother – have the HIV-exposed baby tested for HIV as soon as possible.			
HIV-positive mother – ensure that the child takes preventive co-trimoxazole treatment.			
Care for the HIV-positive infant			
ART treatment for the HIV-positive baby is started early and continued every day.			
Enable access to community and facility support, attendance at clinic appointments for follow-up care.			
Engage in exclusive breastfeeding until baby is 6 months old.			

Summarise the main points of the session

- Which babies need HIV tests and when? All babies born to an HIV-positive parent should be taken for HIV testing as soon as possible.
- Which babies should be given co-trimoxazole treatment from birth? All babies born to HIV-positive mothers, even if the HIV status of the baby is unknown.
- How should an HIV-positive mother breastfeed the baby? HIV-positive mother should exclusively breastfed to 6 months. If they are taking ARV they can continue to breastfeed the baby normally to 2 years of age.
- What care guidance should we give for the mother of the HIV-positive baby? Give ART treatment for the HIV-positive baby as soon as possible and every day; access community and facility support, attend of clinic appointments for follow-up care regularly; exclusive breastfeeding until 6 months of age; play and communicate with the baby.

Session 17: Additional Support for High-Risk Newborns and Mothers

Session plan	Activity 1: Discussion of risk factors for newborns and mothers Activity 2: High-risk case studies	 Time: 1h15
Learning objectives	At the end of this session participants will be able to: • describe two possible risk factors for newborns and two for mothers • describe three ways that they might be able to provide additional care and support to high-risk cases.	
Key messages 	• A high-risk postpartum mother is more likely to experience complications or danger signs postpartum, one who may have difficulties caring for her infant, or who needs additional medical care • Risk factors common in postpartum mothers include: HIV-positive mothers, women who have undergone Caesarean or other delivery complication, adolescent mothers and mother's experiencing mental health and psychosocial difficulties, or who have lost a pregnancy due to miscarriage or still birth. • A 'high-risk' newborn is one that is more likely to experience complications, danger signs, or difficulty feeding, or who may require additional medical care. • Risk factors common in the newborn period include small babies (LBW, prematurity) or those who experienced difficulties during delivery, HIV-exposed, maternal orphan, congenital malformation or disability, and twins. • High-risk newborns and high-risk postpartum mothers can receive additional support: o additional home visits, counselling support or breastfeeding support. o monitoring and supporting medicine adherence and clinic attendance o increased vigilance for danger signs and hygiene promotion o referral if required.	

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- describe two possible risk factors for newborns and two for mothers
- describe three ways that they might be able to provide additional care and support to high-risk cases.

Activity 1: Discussion of risk factors for newborns and mothers

Ask: Are some women MORE LIKELY to suffer complications following delivery? How do we know which mothers might have difficulties? What are risks that they might face? What might be the additional needs of these women compared to others?

Write their answers on the board, then invite the health staff to circle or identify those which are the highest risk, and to explain what this risk is, or use the table below to discuss specific risks.

High-risk postpartum case	What is the risk?	Additional home-based care needs	Additional medical care needs
HIV-positive mother	Transmission of HIV to child, risk of illness and infections in mother, side effects of medicines	ARV treatment support, PMTCT support, increased vigilance for danger signs, improved diet and self-care Exclusive breastfeeding	Attend ARV support clinic
Caesarean delivery	Increased risk of infection, rupture of wound	Wound care and hygiene Support to complete medicines if taking antibiotics or iron; Increased vigilance for danger signs Increased rest and family support with the baby	Attend follow-up clinic to check wound repair
Complication in labour such as haemorrhage, tearing.	Increased risk of infection, obstetric fistula, rupture of wound, haemorrhage	Wound care and hygiene Increased vigilance for danger signs Support to complete medicines if taking antibiotics or iron	Attend follow-up clinic more regularly
Adolescent mother or single unsupported mother	Potential difficulties caring for herself, the child or breastfeeding May be more likely to have had a difficult delivery	Increased family or community support Breastfeeding support	Ensure access to medical care
Mother with postpartum mental health and/or psychosocial difficulties	Difficulties caring for herself and/or her child May stop breastfeeding Poor caregiver-infant attachmentand child development risk of GBV / IPV	Supportive counselling, including Psychological First Aid for response to distress Support to implement stress management techniques Increased social support	Access medical care May require a mental health referral or access support services
Woman who has experienced pregnancy loss due to miscarriage or still birth	May not attend postpartum care May become pregnant again too soon May be vulnerable to	Supportive counselling, including Psychological First Aid for response to distress Support to implement stress management techniques	Access to services May require a mental health referral or access

	perinatal mental health problems	Increased social support	support services

Recap the key messages

- A high-risk postpartum mother is more likely to experience complications or danger signs postpartum, one who may have difficulties caring for her infant, or who needs additional medical care. This might also include women who experienced mental illness prior to childbirth or those that have a new onset of mental health challenges postpartum.
- Risk factors common in postpartum mothers include: HIV-positive mothers, women who have undergone Caesarean or other delivery complication, single or adolescent mothers, mothers with mental health and psychosocial difficulties.

Now explain to the group that we want to think about which newborns are the most vulnerable. Ask the group about their own experiences with newborns:

Ask: Have they found some newborns to be more vulnerable than others? Which ones? What are risks that they might face? What might be the additional need of these newborns?

Write their answers on the board, then invite the health staff to circle or identify those which are the highest risk, and to explain what this risk is, or use the table below to discuss specific risks.

High-risk postpartum case	What is the risk?	Additional home-based care needs	Additional medical care needs
Small baby (LBW and born too soon Premature baby) or twins/multiples	Increased risk of infection Risk of hypothermia (cold) Increased likelihood of breastfeeding problems Increased risk of danger signs	May need breastfeeding support, or expression of breast milk Promote hygiene Promote skin-to-skin contact and warmth Monitor regularly for danger signs	Hospitalisation likely if under 2 kilos Regular check-ups May need kangaroo care May need special feeding or incubation
Complications in labour (prolonged labour, asphyxia or resuscitation, other)	Increased risk of complications in the first week of life	Increased vigilance for danger signs, especially breathing (cyanosis)	Only if referral
HIV-exposed infant (any born to HIV-positive mother)	Transmission of HIV to child if breastfed incorrectly, or if mother stops taking ARV Risk of developing illness	Support to exclusively breastfeed; ARV adherence for the mother	Attend HIV clinic for testing for the baby. ensure regular ARV clinic attendance for mother
Congenital malformation or disability	May have difficulties feeding e.g. cleft palate Parents may struggle to care for the baby as per their needs	Increased family support Breastfeeding support	Only if referral

Maternal orphan	Increased risk of child death (15 times higher!)	Support with feeding, identify adoptive parent/mother Support father to care for baby	Only if referral

Recap the key messages

- A 'high-risk' newborn is one that is more likely to experience complications, danger signs, or difficulty feeding, or who may require additional medical care.
- Risk factors common in the newborn period include small babies and twins/multiples (low birth weight or born too soon, premature babies), those who experienced difficulties during delivery, HIV-exposed, maternal orphan, congenital malformation or disability

Activity 2: High-risk case studies

Working in groups: Give each group a case study, and ask each group to discuss what the woman's needs are, what additional actions they might take from the list below, and how they can counsel her and her family. The four groups should then provide feedback to other participants.

HIGH-RISK NEWBORNS AND HIGH-RISK POSTPARTUM MOTHERS MAY NEED ADDITIONAL SUPPORT:

- additional home visits and counselling or breastfeeding support
- monitoring and supporting medicine adherence and clinic attendance
- increased vigilance for danger signs and hygiene promotion.

Case study	Possible answers
Ashtu is looking after her sister's baby, as her sister died in childbirth. Ashtu took the baby to the clinic to get advice about feeding the baby, and on return you visit her at home.	High-risk baby Additional home visits and counselling or feeding support
Augusta had a difficult labour, she experienced a lot of blood loss following a large vaginal tear and needed a blood transfusion. Her baby needed resuscitation after delivery. At the time of the home visit Augusta reports that the baby is not able to latch onto the breast.	High-risk mother and baby Refer to facility for feeding problems. Additional home visiting and supportive counselling Increased vigilance for danger signs and hygiene promotion
Carmen is HIV positive and is taking ARV treatment. She delivered in the facility and is exclusively breastfeeding her baby.	Monitor and support medicine adherence and clinic attendance Refer baby for HIV testing

Clezia gave birth to twins by Caesarean section. One of the twins feeds well and gains weight in the first week. The other twin weighs only 2 kilos, and is not feeding well and doesn't gain weight after 2 weeks. Clezia is struggling to feed the twins, and says she cannot care for them well as her Caesarean wound is very painful.	High-risk mother and babies Breastfeeding support Monitor and support medicine adherence and clinic attendance Increased vigilance for danger signs and hygiene promotion
Esther enjoyed her pregnancy, felt excited about the birth and the family were eager to meet the new baby. After a month, Esther started feeling very tired. She was short-tempered and quickly became frustrated with the demands of the baby. She felt she was a bad mother and was embarrassed about not knowing what her baby needed. Esther spent a lot of time at home alone and the family said she was eating poorly and the baby cried all the time.	Possible postpartum depression Additional home visits and supportive counselling Counsel Esther and the family to play and engage with the baby Encouragement to link more closely with family members for help Monitoring to ensure situation does not worsen

Session 18: Completing the Newborn ttC Register

Session plan	Activity 1: Review of the forms Activity 2: Sample cases and completing the forms Activity 3: Validating the birth information on the health record Activity 4: Discussion and practice	 Time: 2h00
Learning objectives	At the end of this session participants will be able to: • complete the newborn register correctly • explain how to validate the birth information using health records/card.	
Key messages	• The newborn register serves as a record of important information relating to the birth, and additional visits and observations of the newborn in the 1st week of life. • For all practices the ttC-HVs should mark a tick for a positive answer and a cross for a negative answer, aligned to the timing of the home visit.	
Preparation and materials	*Materials* • Newborn registers (3 per participant) • Sample registers – printed or projected on screen • Child health record / facility birth record (local example) *Preparation* • Distribute the newborn registers and project sample cases on screen.	

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- complete the newborn register correctly
- explain how to validate the birth information using health records/card.

Activity 1: Review of the forms

Distribute a copy of the '*ttC Register* – Newborn' to each participant.

Note: it is intended that a single register be used for both literate and non-literate ttC-HVs. Non-literate participants may require help completing written portions of registers, but should be able to complete the pictorial portion of the register with training and support.

- The newborn register serves as a record of important information relating to the birth, and the additional visits and observations of the newborn in the first week of life.
- For all practices, the ttC-HVs should mark a tick ✓ for a positive answer and a cross ✗ for a negative answer, aligned to the timing of the home visit.

Explain the structure of the forms:

Universal register information:

Contextual change: Registration information can be transferred from the pregnancy register, or deleted if printing of forms is back-to-back.

Column structure and timing: The register has a column structure – fill in each visit in a vertical column aligned to time of the visit. Use the first column for visits 5a, b and c completed in the first week of life, and the second column for the one-month visit.

How to mark planned and completed visits: In the row 'visits planned,' write the date of the next planned visit. In the row below, literate ttC-HVs can write the date the visit was completed. If they are not literate, they could mark the visit with a tick ✓ to show they have done the visit.

Indicators: Each row corresponds to health practices around the delivery and first week of life the ttC-HVs will have promoted using the stories and household handbook. Write a tick ✓ for practices done and a cross ✗ for not done/not yet done.

Danger signs and referral: In each visit you will check for danger signs. If you recommend referral, write the date of referral (or tick ✓ if the ttC-HVs are not literate). If there is no danger sign, write a cross ✗. Wait until confirming that she *went to the health facility* before marking referral as completed.

Activity 2: Sample cases and completing the forms

Explain that two examples/storylines will be used to help us learn how to fill out the registers: Lara and Sheila. Clarify that these are **not** stories that will be used during home visits (and so are not found in the household handbook or the ttC job aids) but will be used only during the training.

Contextualisation: You will need to cross-check the story examples below with the final versions of the *ttC Register* you are using.

EXAMPLE 1: LARA

Lara delivered on 18 October at a health facility, and you conduct the first week of life visits on days 1, 3 and 5 after the delivery. Her husband, Hussein, participates only in the first visit.

Lara reports that after delivery, the baby's weight was 3.7 kilos and had no complications or risk factors. She managed to breastfeed in the first hour after delivery and the baby was wrapped and dried in the facility delivery room. The baby received the first vaccines before being discharged from the facility.

During all three home visits you observe that both Lara and the baby are well and have no complications, however Lara reports that she is not sleeping under a mosquito net at this time.

Mark on the form an appropriate date to complete the one-month visit.

EXAMPLE 2: SHEILA

Sheila gave birth to twins on 22 November, and she delivered at home with a traditional birth attendant. During the first hour after delivery the TBA washed the twins and wrapped them, but Sheila did not breastfeed them until several hours later. Very sadly, although both the twins were born alive, one of them died on the first day of life.

FIRST WEEK OF LIFE (VISITS 5A, B AND C)

You visit Sheila on days 1, 3 and 6. Sheila's husband participates in all three visits.

On day 3 you recommend that Sheila travel to the health facility with the baby that survived.

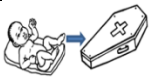
When you return on day 6, you find that Sheila has been to the facility and the baby was weighed at 2.6 kilos and given the first vaccines. Both mother and baby are now using a mosquito net, which they hadn't been doing previously.

FIRST MONTH (VISIT 6)

You visit Sheila when her baby, Matthew is a month old, and her husband is not there. She is still using the mosquito net and the baby is breastfeeding well.

Note: When the participants have finished filling in the registers, ask them to talk in pairs about how they would counsel each family based on the information they have been given.

Worked example: Lara

Instructions: Record information EVERY VISIT		Newborn			PX completed by the supervisor when case is complete
		 Week 1	 week 2 3 4		
Date of birth		*18/10/2014*			
Visits planned (*write data planned*)		V1 V2 V3 *19th 21st 23rd*	V4 *16th Nov*	Data code	
Maternal death 0-45d *(date of death)*		✗ ✗ ✗		D2	*Number of*
Stillbirth *(No. of babies stillborn)*		✗		D3	*Number of stillborns*
Live births *(No. of babies born alive)*		*1*		ND2	*Number of babies born alive*
Newborn death *(date of death)*		✗ ✗ ✗		D4	*Number of newborn deaths*
ttC home visits postpartum *(date of visit)*		*19/10 21/10 23/10*		N1	*Woman received at least four visits?*
Husband/partner participation in ttC visit		✓ ✗ ✗		N2	*Husband/partner present for most of visits?*
High-risk newborn		✗		N3	*Number of high-risk newborns?*

Enter in this column for visits in the first week of

This column to be completed by supervisor during tallying

Skilled birth attendance in a facility		✓		N4	*Number of women who delivered in facility with skilled attendant?*
Birth weight Baby 1		*3.7 kilos*		N5	*Number of babies that are LBW = <2.5kg?*
Birth weight Baby 2					
Birth weight Baby 3					
Baby is receiving kangaroo mother care		✗		N6	*Number of babies receiving KMC?*
Baby was breastfed in first hour of life		✓		N7	*Was the baby breastfed in the first hour?*
Baby was wiped and wrapped in the first hour of life		✓		N8	*Was the baby wrapped and wiped, not bathed in first hour?*
Baby sleeps under a mosquito net at all times		✗ ✗ ✗		N9	*Baby slept under net at all visits?*
Babies who received early vaccines (BCG and OPV-0)		✓		N10	*Baby received both BCG and OPV-0?*
Postpartum danger sign identified		✗ ✗ ✗		E2	*Total number of events?*
Newborn danger sign identified		✗ ✗ ✗		E3	*Total number of events?*
Referral completed				E4A	*Total number of events?*
Post-referral home visit completed				E4B	*Total number of events?*

Under each indicator the ttC-HV should mark tick ✓yes (the woman reported that she has or is doing this practice.

Or ✗= no, she has not done or is not doing at this time.

Activity 3: Validating the birth information on the health record (literate ttC-HVs)

Contextualisation: Provide local samples of maternal health or child health records.

The information the mother or family reports during the home visit needs to be validated against the existing records that were made at the health facility. Using the examples provided from your area, show where on the records to find the following information:

- date of birth
- location of delivery
- vaccinations given
- birth weight recorded
- newborn death/date of death
- any complication in delivery.

Activity 4: Discussion and practice

Have participants pair off and practise filling the register with one of them role playing as the home visitor and the other as the mother. The one playing the role of the ttC-HV will ask all the needed open-ended questions to fill out the register section pertaining to this visit, and the other will respond to the questions. Once this is completed, switch roles and repeat the process. You may carry out this activity in the same way regardless of whether you are working with literate or non-literate ttC-HVs.

Summarise the main points of the session

- Universal register information: What details are required here?
- Planned and completed dates: Were they able to calculate the date for the next visit? What challenges did they face in doing this?
- Health practices around birth: What details are required here?
- Twin birth and stillbirth or death: Did you have any challenges completing these?
- For non-literate ttC-HVs: Ask how they felt filling in the *'ttC Register* - Newborn'. Were they able to get the information they needed? What challenges did they face?
- What challenges do they think may find when they actually fill this record during a home visit?

Session 19: Referral and Follow-up of the Sick Newborn and Postpartum Mother

Session plan	Activity 1: Review of danger signs in newborn and postpartum mother Activity 1: Care of the newborn and postpartum mother during referral Activity 2: Completing the referral forms Activity 3: Practising filling in the forms Activity 4: Discussion: Home-based follow-up Activity 5: Interpreting counter-referral forms	 Time: 1h30
Learning objectives	At the end of this session participants will be able to: • describe some considerations when transporting a newborn baby with a complication • describe how to conduct a follow-up home visit for a referred newborn with a complication • complete a written referral form to the best of their ability and interpret counter-referrals received from the health facility (literate HVs).	
Key messages 	• When conducting emergency referral of a newborn baby, ensure that baby is accompanied by mother and a family member or ttC-HV, well wrapped and regularly monitored for breathing, continuing breastfeeding as much as possible, and that the mother is carrying all medical records or cards, money and materials needed for a hospital stay. • During a follow-up home visit after referral, the ttC-HV should ensure that the newborn/mother received the medical care and medicines they needed, are fully recovered following the treatment, and that self-care guidance has been given to them. Provide additional support to the breastfeeding mother.	
Preparation and materials 	*Materials* • Sample referral / counter referral forms or local version: Three per participant *Preparation* • Distribute referral forms.	

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- describe some considerations when transporting a newborn baby with a complication
- describe how to conduct a follow-up home visit for a referred newborn with a complication
- complete a written referral form to the best of their ability and interpret counter-referrals received from the health facility (literate HVs).

Activity 1: Review of danger signs in newborns and postpartum mother

Start this session by quickly reviewing the danger signs in the mother and newborn that they should be vigilant of in the first month of life, using the storybooks for Visit 5.

Activity 1: Care of the newborn and postpartum mother during referral

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

FOR THE SICK NEWBORN:

- Wrap the newborn well, carry the baby close to your chest to keep warm, and monitor the baby's breathing regularly.
- Continue breastfeeding as much as possible throughout the journey, do not give anything else unless recommended by a health professional.
- Take medical records, cards, money to pay for services and transport, food and water, clothes and materials prepared for an overnight hospital stay.

FOR THE SICK MOTHER:

- She should travel with the newborn baby and accompanying family member who can help.
- Encourage her to continue to breastfeed the baby if possible.
- If she is experiencing bleeding:
- Apply a sanitary pad or clean cloths; keep her lying down during transport.
- Arrange suitable transport for her and do not allow her to walk or stand up as this can make the bleeding worse.
- Encourage her to drink and eat to keep her blood sugar (energy) up during the journey, and to prevent shock. Try to keep her conscious, and reassure her.
- When conducting emergency referral of a newborn baby, ensure that the baby is accompanied by mother and a family member or ttC-HV, is well wrapped and regularly monitored for breathing, continuing breastfeeding as much as possible, and that the mother is carrying all medical records or cards, materials needed for a hospital stay.

Activity 2: Completing the referral form

Contextualisation: Use MOH referral/counter-referral forms as necessary.

Ask the group about their experience using the referral form and discuss any concerns. Remind them on how to use the form:

- Complete only one side of the form and send it with the mother.
- Copy the ID information from the ttC Register or from the woman's health card.
- Describe all relevant symptoms and conditions of the birth, location of delivery, and tick the indicated state of the patient at the time.
- Clearly list any medicine or treatment given (including traditional medicines).

Activity 3: Practising filling in the form

Have participants work in teams using the case studies provided to complete the forms. When they have finished, discuss the results in groups. If you have facility staff present, ask them to confirm that the information is communicated correctly, clearly and completely. Complete the form as if they were referring from their communities to the nearest health facility.

- Isobel Nyala # 0042 is at 5 days postpartum. She had a home delivery, which was assisted by a traditional birth attendant. She experienced a lot of bleeding during delivery and the TBA said she suffered a tear. She reports pain and stinging, some discharge and continued bleeding. Counsel her and the TBA who will travel with her, and complete the form. \
- Aisha Konte #0162 is concerned about her newborn baby Maimuna who is 6 days old. She had a facility birth, and although the labour was long the newborn fed well in the first 3 days and Aisha was discharged. Since then, the baby has fed less and has spent most of the time asleep. You assess the baby and notice her hands and feet are cold, she is difficult to rouse, but has no other symptoms. Counsel the mother and complete the form.

Activity 4: Discussion: Home-based follow-up

Ask the group: What is the purpose of conducting a home visit after you have sent a patient to the clinic? Discuss their answers and stress:

- Ensure that the patient was seen and accessed treatment and medicines they needed.
- Discourage purchasing of medicines from unofficial suppliers.
- Ensure that medicines and care guidance are completed by the mother/patient.
- Ensure that the patient is now better and if not send them back to the clinic.

Explain the purpose of home visiting after an emergency referral:

- During a follow-up visit, a ttC-HV should ensure that the patient received the medical care and medicines needed, are fully recovered, and is following the treatment and self-care required.

For a newborn or postpartum mother who has suffered a complication, it may be necessary to do additional home visits until she and the baby are fully recovered, and to ensure that she has the family support she needs to care for the baby.

Activity 5: Interpreting counter-referral forms

Recap the purpose of counter-referral from the facility:

- A written counter-referral (facility discharge note), may be written by facilities, with the patient's consent and can communicate important information about the care of the patient, which might be important for the ttC-HV or family, such as:
- conditions identified that need extra care
- when the patient should return for follow-up at the facility
- medicines the patient should be taking
- danger signs to look out for and care guidance to follow
- when the ttC-HV should follow-up in the home.

The trainer should complete copies of the counter-referral with the following cases and distribute to the groups.

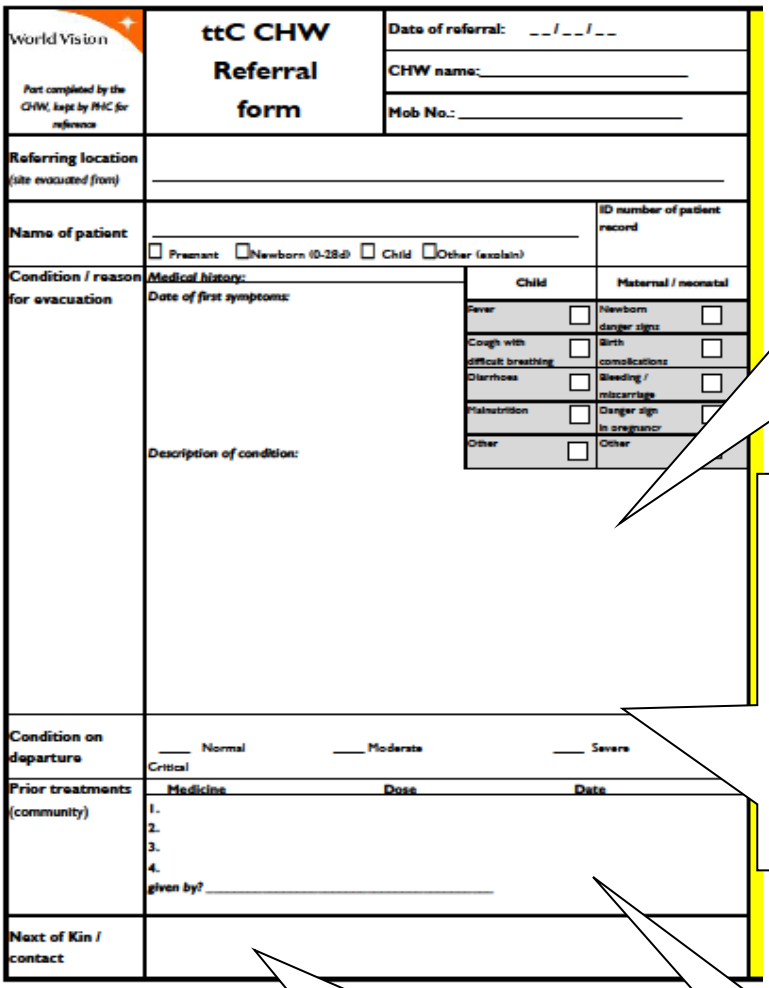
Ask the ttC-HVs to read and interpret the forms. Then read the italics and discuss (with health staff if possible) how to handle the case.

- Isobel Nyala # 0042 was discharged on 18 August and was treated for postpartum infection and second-degree tear. She was given stitches and treated with **antibiotics**, which she must take three times daily for 10 days, and two iron/folate tablets once a day for a month. She should return for follow-up in two weeks, and immediately if she experiences any further discomfort or fever. The form suggests you should visit twice a week for two weeks.

  During the home visit, Isobel reports that she is feeling better. She is taking the iron tablets. However, the pharmacy told her they didn't have the antibiotics she needed in stock and to come back again in two days. Counsel Isobel and her family on what to do. **Possible answers:** Return to the clinic to get another prescription, follow-up as guided.

- Aisha Konte #0162 and her baby Djenna were discharged on 27 August. Djenna was treated for sepsis and given treatment in the hospital, but was given no medicines to be taken at home. The report said she should come back for follow-up in a week's time, and return immediately if there are any signs of illness. They recommend one follow-up visit a week for two weeks.

  During the home visit, the ttC-HVs find Djenna is recovering well, and is now breastfeeding without difficulty. She seems much more awake and alert than before. Aisha confirms that she does not have other concerns. **Possible answers:** Follow-up as guided, and ensure that she attends the clinic when instructed.


World Vision

Part completed by the CHW, kept by PHC for reference

ttC CHW Referral form

Date of referral: __/__/__

CHW name:_____

Mob No.: _____

Referring location (site evacuated from) _____

Name of patient _____ ID number of patient record

☐ Pregnant ☐ Newborn (0-28d) ☐ Child ☐ Other (explain)

Condition / reason for evacuation

Medical history:

Date of first symptoms:

Child		Maternal / neonatal	
Fever	☐	Newborn danger signs	☐
Cough with difficult breathing	☐	Birth complications	☐
Diarrhoea	☐	Bleeding / miscarriage	☐
Malnutrition	☐	Danger sign in pregnancy	☐
Other	☐	Other	

Description of condition:

Condition on departure ____ Normal ____ Moderate ____ Severe Critical

Prior treatments (community)

Medicine	Dose	Date
1.		
2.		
3.		
4.		

given by? _____

Next of Kin / contact

Write what danger signs they have experienced, and since when. You may need to report if they delivered at home or hospital and any complications experienced during delivery.

At the time they left the location, were they:

Normal - able to walk, comfortable?

Moderate – able to walk with difficulty?

Severe – conscious, unable to walk?

Critical – unconscious or very

In the event of further complication, whom should the health facility contact? Write a mobile number if possible.

Ask the family for all treatments the woman or child might have taken before leaving the village. Ask if they can take the medicines with them to the facility, or list them here.

Health staff will write what the condition was, and what was treated here (if the mother gives consent to share this information.

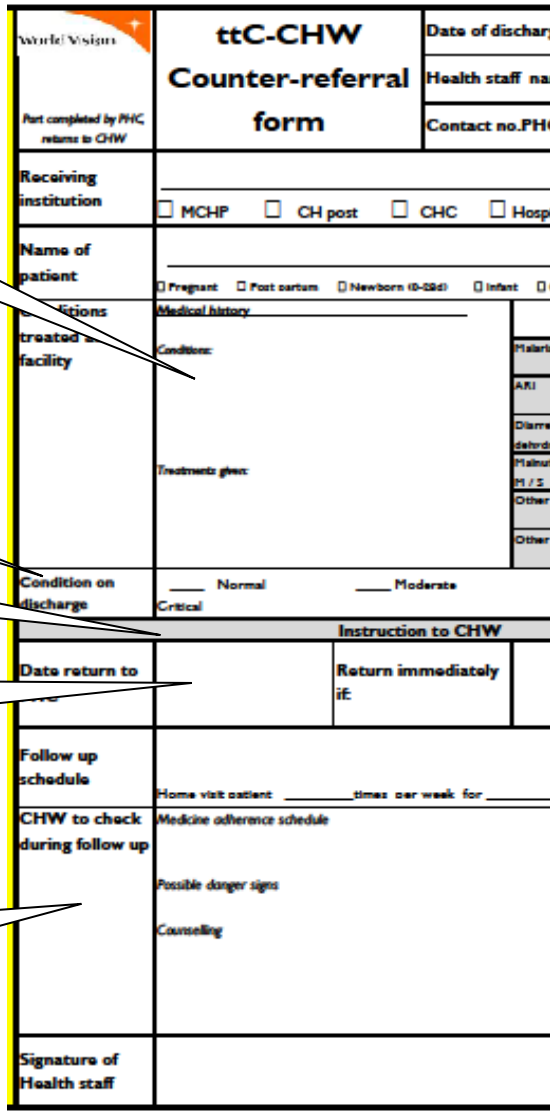
Health staff to declare the condition of patient on departure – sometimes the family may opt to remove a sick patient from the facility to care for them at home.

Health staff to list date required for follow-up – ttC-HV can ensure that this follow-up clinic appointment is attended.

Health staff to list danger signs indicating patient should return immediately, such as fever, headache, no improvement.

Message to the ttC-HV to check (if needed):

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



World Vision

Part completed by PHC returns to CHW

ttC-CHW Counter-referral form

Date of discharg

Health staff na

Contact no.PH

Receiving institution

☐ MCHP ☐ CH post ☐ CHC ☐ Hosp

Name of patient

☐ Pregnant ☐ Post partum ☐ Newborn (0-28d) ☐ Infant

Medical history

Conditions treated at facility

Conditions:

Malari

ARI

Diarrh dehydr

Malnu M / S

Other

Other

Treatments given:

Condition on discharge

____ Normal ____ Moderate Critical

Instruction to CHW

Date return to

Return immediately if:

Follow up schedule

Home visit patient _____times per week for _____

CHW to check during follow up

Medicine adherence schedule

Possible danger signs

Counselling

Signature of Health staff

World Vision

FOR FURTHER INFORMATION

PLEASE CONTACT:

WVI Offices

World Vision International Executive Office
Waterview House
1 Roundwood Avenue
Stockley Park
Uxbridge, Middlesex
UB11 1FG, UK

World Vision Brussels & EU Representation ivzw
18, Square de Meeûs
1st floor, Box 2
B- 1050 Brussels, Belgium
+32.2.230.1621

World Vision International Liaison Office
7-9 Chemin de Balexert
Case Postale 545
CH-1219 Châtelaine
Switzerland
+41.22.798.4183

World Vision International United Nations Liaison Office
919, 2nd Avenue, 2nd Floor
New York, NY 10017, USA
+1.212.355.1779

WVI Regional Offices

East Africa Office
Karen Road, Off Ngong Road
P.O. Box 133 - 00502 Karen
Nairobi
Kenya

Southern Africa Office
P.O. Box 5903
Weltevredenpark, 1715
South Africa

West Africa Office
Hann Maristes
Scat Urbam n° R21
BP: 25857 - Dakar Fann
Dakar
Senegal

East Asia Office
Bangkok Business Centre
13th Floor, 29 Sukhumvit 63 (Soi Ekamai)
Klongton Nua, Wattana, Bangkok 10110
Thailand

South Asia & Pacific Office
750B Chai Chee Road #03-02
Technopark @ Chai Chee
Singapore 469002

Latin America and Caribbean Regional Office
P.O. Box:133-2300
Edificio Torres Del Campo, Torre 1, piso 1
Frente al Centro Comercial El Pueblo
Barrio Tournón
San José
Costa Rica

Middle East and Eastern Europe Regional Office
P.O Box 28979
2084 Nicosia
Cyprus

World Vision is a Christian relief, development and advocacy organisation dedicated to working with children, families and communities to overcome poverty and injustice. Inspired by our Christian values, World Vision is dedicated to working with the world's most vulnerable people. World Vision serves all people regardless of religion, race, ethnicity or gender.