Republic of Ghana,
Ministry of Health

Ghana Health Service
Your Health Our Concern

World Vision

Ghana National Community Health Worker Training Manual

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

Participant's Manual

FOREWORD BY THE MINISTER OF HEALTH, GHANA

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

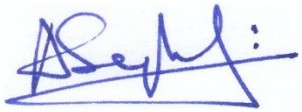
The Ministry of Health (MoH) focuses on strengthening Community-based Health Systems. In view of this, the Community-based Health Planning and Services (CHPS) Policy has been formulated to guide interventions that will facilitate the achievement of good health and wellbeing of the people living in Ghana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

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

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

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

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



Alexander Segbefia Minister of Health

STATEMENT BY WORLD VISION INTERNATIONAL IN GHANA

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

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

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

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

Mr. Hubert Charles
National Director

CONTENTS

ABBREVIATIONS

ARI	Acute respiratory infection
ARV	Antiretroviral
ART	Antiretroviral therapy
ANC	Antenatal care
CHW/V	Community health worker/volunteer
CHMC	Community health management committee
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
KMC	Kangaroo Mother Care
LBW	Low birth weight (baby)
LLIN	Long-lasting insecticide treated net
MHPSS	Mental health and psychosocial support
MNCH	Maternal, newborn and child health
MoH	Ministry of Health
NGO	Non-governmental organisation
PFA	Psychological First Aid
PHC	Primary health care
PLW	Pregnant and lactating women
PMTCT	Prevention of mother-to-child transmission of HIV
PNC	Postnatal care
PSS	Psychosocial support
RH	Reproductive health
SAM	Severe acute malnutrition
SBA	Skilled birth attendant
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TTC	Timed and Targeted Counselling
U5MR	Under-5 mortality rate
VCT	Voluntary counselling and testing
WASH	Water, sanitation and hygiene

KEY RESOURCES

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- Caring for the Newborn at Home: A training course for community health workers. (2012). World Health Organisation and UNICEF.
- The Community Infant and Young Child Feeding Package: A facilitator's guide (2013). UNICEF.
- Caring for Newborns and Children in the Community: Caring for the Sick Child (2011). World Health Organisation. ISBN: 978 92 4 154804 5
- Facts for Life, Fourth Edition, UNICEF, 2010
- Home-Based Life Saving Skills (HBLSS) First edition. (2004) American College of Nurse-Midwives.
- CHW AIM: A Toolkit for Improving Community Health Worker Programs and Services (CHW AIM) (2010). Crigler L and K Hill. Published by the USAID Health Care Improvement Project. Bethesda, MD: University Research Co., LLC (URC).
- Taking Care of a Baby at Home After Birth: What Families Need to Do (2011). Core Group, Save the Children, the American College of Nurse-Midwives, and MCHIP.
- WHO Recommendations on Postnatal Care of the Mother and Newborn (2014). World Health Organisation. ISBN: 9789241506649 *(Key resource for chlorhexidine cleaning of the umbilical cord)*
- Psychological first aid: Guide for field workers (2011). World Health Organisation, War Trauma Foundation and World Vision International. ISBN: 978 92 4 154820 5
- Care for child development: improving the care for young children. (2012) World Health Organisation, UNICEF. ISBN: 9789241548403
- Model IMCI handbook: Integrated management of childhood illness (2005). World Health Organisation; UNICEF. ISBN: 9241546441. WHO reference number: WHO/FCH/CAH/00.12
- Caring for newborns and children in the community, adaptation for high HIV or TB settings. Community health worker manual, Facilitator notes, Chart booklet, Referral form (2014). World Health Organisation. ISBN: 9789241548045
- Ghana Family Health Divison: Maternal and Newborn Care Manual for Community Health Volunteers.

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MODULE DESCRIPTION

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

Module objectives:

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

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

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

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

Terminal Performance Objectives	By the end of this unit, participants will be able to: • Provide TTC visits per schedule and with participation from family • Dialogue and negotiate new behaviors with families • Provide psychological first aid for women in distress and refer when needed

SESSION 1.1: INTRODUCTION TO TIMED AND TARGETED COUNSELLING

Session Objectives	*At the end of this session participants will be able to:* • Explain the importance of special care for a woman during pregnancy • Explain why birth and the first days of life are particularly vulnerable for the mother and baby, and explain the importance of maternal and newborn care • Explain why it is important for the CHW to counsel the family in the home, using timed and targeted visits • Describe the materials that are used in this training, to help in the CHW's work.

The pregnancy and newborn period

EXTRA CARE FOR THE PREGNANT WOMAN

Pregnancy is a time of great change for a woman. Her body must make many adjustments because of the new life she is carrying inside of her. Unfortunately, about 800 women die **every day** from problems related to pregnancy and childbirth.19F[1] Tens of thousands more experience complications during pregnancy, many of which are life-threatening for the women and their children – or leave them with severe disabilities.

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

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

THE NEONATAL PERIOD

'The first month of life, called the newborn or neonatal period, is the most risky period in the life of an individual. Out of every 100 children born alive, about 10 die before reaching the age of 5 years. Of these 10, about three die in the first month of life itself, the newborn period. Most of these newborn deaths occur in the first week of life. Most of these early deaths are due to infections, being unable to breathe, or being born too early'.[3]

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

- Having difficulty breathing at birth (we call this asphyxia)

[1] WHO, *Maternal mortality: Fact sheet No. 348*, updated May 2014 (see who.int)
[2] WHO *Facts for Life: Safe Motherhood*, 4th Edition. http://www.factsforlifeglobal.org/02/messages.html
[3] World Health Organization and UNICEF (2012), *Caring for the Newborn at Home: A training course for community health workers*.

- Baby born too small / too early (we call this prematurity)
- Infection

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

TIMED AND TARGETED COUNSELLING (TTC)

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

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

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

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

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

The CHW also targets the most vulnerable households for the visits. Counselling is an essential part of each visit, and the CHW uses dialogue and negotiation, which we learnt about in Module 1.

OVERVIEW OF TTC HOME VISITS

1. **Identify pregnant women in the community through house to house visits.**
2. **Make three home visits to pregnant women in the community:**
   - **Visit 1:** as early in pregnancy as possible – as soon as the mother misses a period – in order to encourage the pregnant women to go for ANC early, and to review the home care that the pregnant woman needs
   - **Visit 2:** toward the middle of the pregnancy so that the CHW can advise the family with regard to HIV and AIDS, other STIs and tuberculosis.
   - **Visit 3:** about one month before delivery so that the CHW can promote birth at a health facility, help the family to come up with a birth plan, or to prepare for home birth if a facility birth is not possible, and to discuss the family planning options that will be available to the family after birth and optimal newborn care practices immediately after birth.

3. Make seven visits after birth during the first year of the baby's life.

- **Visits 4 a, b, c: Three visits during the first week after birth**
- **Visit 5: When the baby is one month old**
- **Visit 6: When the baby is five months old**
- **Visit 7: When the baby is nine months old**
- **Visit 8: When the baby is 12 months or 1 year old**

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

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

The timeline of visits

TTC MATERIALS

- **The Participants' Manual Module 3** provides information they need to carry out their work related to TTC. If they forget some of the information, they can refer to their manual.
- **Storybooks:** The CHWs will learn how to tell the stories during home visits. There are eight sets of stories – one problem story and one positive story in each set.
- **Family Health Card:** CHWs will distribute the Family Health Card to each household that they counsel. These cards contain drawings with the key health practices. These serve as reminder tools for households, so that they will not forget the important messages.
- **TTC Register:** This is a record kept by the CHWs of the details of each pregnant woman (and later her child) and of the home visits they make. It is used to track health practice uptake

- **The CHW diary:** It is recommended to provide CHWs with a blank journal in which to keep track of home visits planned and note any issue that arose.
- **Referral and Counter referral forms:** These are used in transferring a patient to a health facility and in providing follow-up care in the home

Key messages

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

Notes:

SESSION 1.2: DIALOGUE COUNSELLING AND NEGOTIATION

Session Objectives	*At the end of this session participants will be able to:* • Explain key communication skills, barriers and enablers • Identify root causes that prevent behaviour change, and solutions to address them • Use the family health card to negotiate new health practices

COMMUNICATION SKILLS – RECAP FROM MODULE 1

1. **Two-way communication**: working with people in which you try to understand how they feel and help them to decide what to do. Counselling is two-way communication between the CHW and the family. *Counselling is NOT simply giving information or messages*
2. **Showing respect** in culturally appropriate ways.
3. **Appropriate body language**, such as where and how we sit in the household, smiling in appropriate ways, using appropriate hand gestures, and appropriate male-female interaction.
4. **Asking questions**, especially open-ended and non-judgmental questions
5. **Communicating listening** through appropriate body language and responses
6. **Praising** as appropriate
7. **Responding appropriately**: Accept what the mother (or family member) thinks and feels without agreeing or disagreeing; praising the mother/family member for what they are doing right and giving relevant information to correct a mistaken idea or reinforce an appropriate idea or behaviour
8. **Checking understanding** by asking questions, asking household members to repeat what they just learnt and by asking them to demonstrate what they learnt, as appropriate.

DIALOGUE

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

KNOWLEDGE VS. ACTION

We learnt in Module 1 that information or knowledge alone is not always enough to lead to changes in behaviours or actions. There is often a gap between knowledge, beliefs and actions. Simply giving a person new information does not guarantee that they will *or can* put the action or behaviour into practice. In this training, the CHWs will learn better ways of communicating. CHWs will *not* simply present information to families and stop there.

BARRIERS TO BEHAVIOUR CHANGE AND ENABLERS

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

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

TYPES OF BARRIERS

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

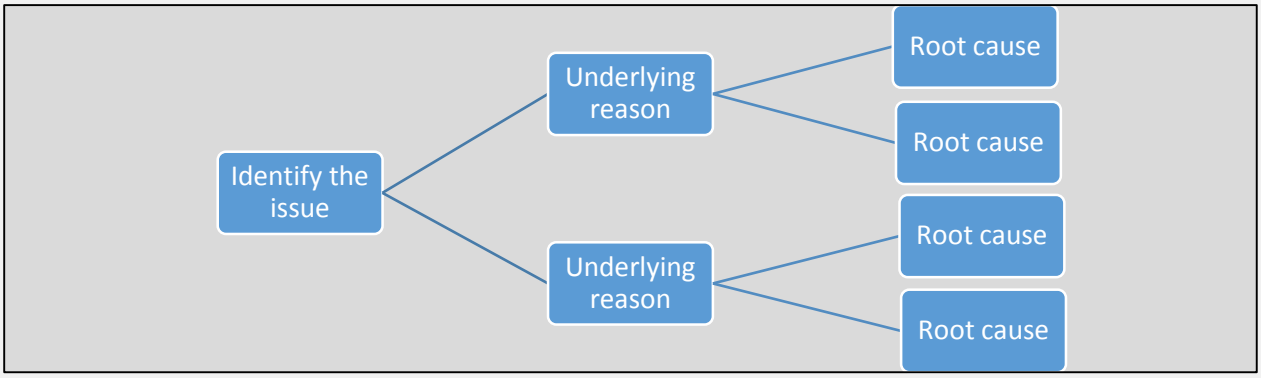
Sometimes a person may not carry out a recommendation because he/she **does not have** what he/she needs to do so. They will need to respond differently in such cases, as compared to a case when the barrier involves beliefs, or likes and dislikes.

GETTING TO THE ROOT CAUSE

When you speak to household members about health practices you need to aim to get to the barrier - the *real* reason the family cannot currently do that behaviour. In the previous session we learnt about the various types of barriers. These are also called **root causes** – because they lie at the "root" of why families do not practice the health behaviours they know.

We will now look at how to identify those root causes

When we have identified a health practice that is not being done, it often takes at least two steps to get to the root cause of the problem. A common way to do this in conversation would be to follow a WHY-WHY route of questioning.



EXAMPLE 1: GETTING TO THE ROOT CAUSES

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

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

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

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

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

FINDING SOLUTIONS TO ROOT CAUSES

The CHW works with the family to identify possible solutions to the root causes.
Using open-ended questions such as:

"What do you think would make it easier to do this?"
"How can we help that to happen?"

Can help in exploring deeper in to the issues and find possible solutions.
Remember at this point you can share any suggestions you may have, or you can ask other family members for suggestions. But it's always important to ask for solutions from the person themselves *before providing advice*. Explain after the role play – it's not always this easy, and you might need extensive negotiation to find solutions to all the barriers,

EXAMPLE 2: FINDING SOLUTIONS TO ROOT CAUSES

CHW: So, you have no one to help care for the children whilst you go to ANC
Woman: That's right.
CHW: What would make it easier for you to go to ANC?
Woman: (*thinks…*): If someone can help with the children, I could go
CHW: How can we help that to happen?
Woman: (thinks….) We could ask my mother-in-law to help whilst I go to the clinic
CHW: So shall we agree to try and do that?
Woman: Yes. I can ask her

It is important that the CHW does not "prescribe" solution, but use open-ended questions to explore possible solutions
Reaching solutions in this manner and encouraging the family to try the new behaviour is also called "negotiation" or "negotiating for behaviour change"

NEGOTIATION

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

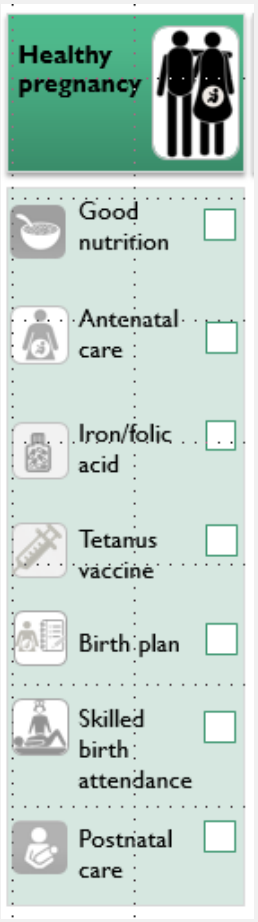
USING THE FAMILY HEALTH CARD FOR NEGOTIATION

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

a) Helping the family **identify the barriers and root causes** to improving their family health practices (what *prevents* them doing the preferred practice)
b) **Counselling the family**, using techniques such as dialogue, discussion, probing and open ended questions, to try to **find their own solutions** to overcome the barriers they identified (i.e. what would *enable them* to do the preferred practice).

c) **Negotiating** with them to try the solution/s identified between now and the next visit

HOW TO USE THE FAMILY HEALTH CARD



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

"What makes this difficult for you to do this practice?"
or "What usually happens when.... e.g. a child get sick, or when you make food for the family?"
and *"Why do you think it is?"*

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

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

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

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

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

"How can we help that to happen?"

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

When you have finished the counselling discussion, if the family could not come up with a solution and does not think that they can overcome the barrier, then circle the × underneath the drawing. Explain to the family that this × is to help the CHW remember the difficulties they face when they visit next time. Explain to the family that this does not mean the family has done anything wrong.

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

7. **At the end of all the negotiated practices review** with the family all of the actions that they are agreeing to try between now and the time when you come to visit again. Praise them on their decision to try to do something new!
8. **Next Visit**: Next time, Step 1 is to review what happened in the last visit. Review the Family Health Card with the family and go over the barriers recorded and any solutions they agreed to try, and ask them if they were successful. If they were **not** successful, continue to discuss the reasons with them, and try again to find solutions to the barriers, if they are now doing this key behaviour, now put a circle around the ✓mark and cross out the previous information. **Praise the family for their success.**

Key Messages

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

Notes:

SESSION 1.3: AN OVERVIEW OF THE HOUSEHOLD VISIT

Session Objectives	*At the end of this session participants will be able to:* • Understand the process they will follow during all TTC visits to the household • Engage family members in dialogue and negotiation for health behaviors • Explain why this counselling process is more likely to lead to behaviour change than a simple presentation of new information.

Steps of a TTC Visit

HOUSEHOLD COUNSELLING PROCESS: OVERVIEW

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

HOUSEHOLD COUNSELLING PROCESS: DETAILS OF EACH STEP

Before Starting

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

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

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

Step 1: Review the previous meeting

The CHW will review the section in the Family Health Card from the previous visit with the family members. The CHW will review any actions they were not previously practising but had agreed to try and discuss with the family their experiences. How did it go? Were they successful? Why or why not? This is a very important first step in any household visit (this step is not needed for Visit 1).

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

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

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

Step 3: Present positive actions using the Positive Story

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

Step 3+: Technical information (some visits)

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

Step 4: Negotiate new actions using the Family Health Card

In this step, the CHW will look at the **Family Health Card** together with the family, turning to the pages that go with the visit.

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

GOOD TECHNIQUES OF STORYTELLING:

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

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

Key Messages

The steps to follow in a TTC home visit are:

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

Notes:

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

Session Objectives	By the end of this session the participants will be able to: • Understand the link between maternal mental health problems and poor infant/child health outcomes • Recognise at least three signs that a mother may be experiencing maternal mental health or psychosocial problems • Respond to mothers showing signs of emotional distress using the action principles of PFA • Describe positive and negative coping strategies for mental health and wellbeing • Teach mothers about simple calming and stress-reduction techniques.

MENTAL HEALTH IN WOMEN

One in four people will experience a mental illness at some point in their lives[4];

People with mental illness are not "crazy" or "mad" – often they are simply struggling to cope with their everyday problems;

Women are twice as likely to experience depression as men with a significantly higher risk following childbirth[12].

We know that mothers experiencing depression can often struggle to care for and meet the needs of their infants and children.

Maternal mental health and psychosocial problems do not mean somebody is "mad" or needs psychiatric care. Often, they just need additional support in practical and emotional ways.

Research shows maternal mental health and psychosocial problems are linked to stunting, stopping breastfeeding too soon, weak bond between mother and baby and infant/child development delays. Therefore, it is important that we also look out for the mental health and psychosocial well-being of mothers.

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

Explain how a mother with maternal mental health and psychosocial support problems will often face a cycle where they feel depressed or too anxious to bond with, to talk and play with their child, while the child then becomes lethargic and apathetic and does not seek out attention, while the mother can then lessen her attention to the child – and the cycle continues.

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

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

Introduction to the PFA action principles

PSYCHOLOGIC FIRST AID – ACTION PRINCIPLES

IN EVERY VISIT TO THE HOME:

LOOK:

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

LISTEN:

- **Approach people who may need support**. If a mother is showing signs of distress, you can ask her about this and whether she would like more support to cope with these challenges. Or, you can indicate your own concern about these signs of distress and why it might be important to talk about this more. Ensure she is aware that the CHW will respect her privacy and confidentiality
- **Listen to peoples' needs and concerns.** Try not to interrupt them or to immediately solve all their problems. Simply encourage them to share what they are finding difficult and how this is affecting them and their child. Use your good communications skills and active listening. After

listening for a time, you might like to ask about what challenges are the most urgent for her to address. Explore ways with the mother for how she might be able to improve her situation or resolve important problems. Try not to give direct advice, but ask what her own ideas are for reducing her stress and difficulties. She may have used strategies previously that could help her now.

- **Help them to feel calm.** Distress is often the result of people feeling overwhelmed and unable to cope with what's happening in their life. This might be a good opportunity to teach the mother some simple ways of reducing her stress, which we'll review later.

LINK:

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

END ASSISTANCE WELL & FOLLOW UP:

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

Responding to Distress

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

Intimate Partner Violence

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

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

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

How common is the problem?

Up to 61% of women report that an intimate partner has physically abused them at least once in their lifetime

Up to 59% of women report forced intercourse, or an attempt at it, by an intimate partner in their lifetime

Up to 28% of women report they were physically abused during pregnancy, by an intimate partner

Increased risk in pregnancy

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

Responding to IPV

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

Being non-judgemental and supportive and validating what the woman is saying (believe her and take her concerns seriously)

Providing practical care and support that responds to her concerns, but allow her to make her own choices

Listening without but not pressuring her to talk about her experiences (care should be taken when discussing sensitive topics when family are involved)

Helping her access information, and helping her to connect to services and social supports

Assisting her to increase safety for herself and her children, where needed

Providing or helping her to connect with support in her community or elsewhere.

Responding to a recent SV incident

As above

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

Providers should ensure:

That the consultation is conducted in private

Confidentiality, i.e. not sharing this information with anyone without the permission of the woman.

Sources:

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

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

Identifying positive and negative coping strategies

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

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

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

Self-care and rest – During pregnancy and childbirth positive coping methods can be supported, for example: ensuring women look after themselves well, eat and sleep well, rest regularly and take time for relaxation, connect with family and friends, looks for community support groups.

Accessing family and community support – as well as recognising when she is becoming overwhelmed / exhausted or experiencing mental distress and responding accordingly, will help to prevent the negative impact on herself or her child / family.

Calming techniques

YOU CAN TEACH THE MOTHER THE FOLLOWING TECHNIQUES TO HELP HER DEAL WITH STRESS

Tapping

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

Mindful awareness

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

Mindful breathing

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

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

Key messages

- Mental health and psychosocial problems are common, especially among women who have recently given birth.

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

Notes:

UNIT 2: VISIT 1 – EARLY PREGNANCY

Terminal Performance Objectives	By the end of this unit, participants will be able to: • Identify all pregnant women early in their communities, early in pregnancy • Counsel pregnant women and their familes on appropriate nutrition and general home care for the pregnant woman • Promote four antenatal care visits for the pregnant woman • Identify vulnerable pregnancies and facilitate additional support and birth plan • Carry out all the steps of TTC visit 1 (after practicum)

SESSION 2.1: IDENTIFYING EARLY PREGNANCIES AND REACHING VULNERABLE HOUSEHOLDS

Session Objectives	*At the end of this session participants will be able to:* • Describe at least three household risks or vulnerability factors that make families less likely to seek care • Explain why it is important to identify pregnant women early in pregnancy • Explain how visiting all households at project start helps identify pregnancies • Describe at least two ways to identify pregnant women in the community.

IDENTIFYING ALL PREGNANT WOMEN

Why is it important to identify all pregnant women in the community?

All mothers and newborns are vulnerable and need care. Often, the ones who are missed are the most vulnerable and at risk of illness and death, due to physiological and physical changes that occur during pregnancy, or of experiencing perinatal depression, domestic violence

How can we identify all women in the community?

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

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

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

IDENTIFYING PREGNANT WOMEN *EARLY* IN THEIR PREGNANCIES

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

ACCESSING THE MOST VULNERABLE

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

- Adolescent, disabled, single and working mothers
- Women who may suffering depression or victims of domestic violence
- Large families or women caring for many children
- Households with financial difficulties
- Houses which are isolated or difficult to reach
- Women with chronic illness
- Women / Household with no educational background

HOW TO CONDUCT AN INTRODUCTION VISIT

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

Key messages

- It is important to identify all pregnant women in your community and to do so as early in pregnancy as possible. Pregnant women need to attend ANC at a health facility. The sooner a woman goes for ANC, the sooner she will receive important services and information, and the healthier she and her baby will be.
- The CHW should visit a pregnant woman four times during pregnancy, to ensure ANC attendance, to help the family plan for a facility birth if possible, and to provide important information on care during pregnancy and danger signs.
- CHWs can use house to house sensitisation visits, community groups, midwife referrals and key informants to identify early pregnancies.
- The CHW should spend extra time with individuals and/or families you identify as more vulnerable because they are least likely to access health care and are at greater risk of complications. TTC home visitors should make sure they include families least likely to access health services such as:
    - Adolescent, disabled, single and working mothers
    - Women who may suffering depression or victims of domestic violence
    - Large families or women caring for many children
    - Households with financial difficulties
    - Houses which are isolated or difficult to reach.

SESSION 2.2: NUTRITION IN PREGNANCY

Session Objectives	*At the end of this session participants will be able to:* • Recall key messages related to nutrition • Identify foods containing iron, vitamin A, vitamin C and oil • Understand and explain the importance of good nutrition for pregnant women • Know how to counsel family members on good nutrition for pregnant women.

FOOD GROUPS

Foods can be grouped into three: energy giving foods, body building foods, and protective foods. **Energy giving foods** burn in the body and provide us with energy for moving, sleeping, working, etc. **Body building foods** provide nutrients for building the muscle, bone, skin, brain and hair. **Protective foods** are vitamins and minerals: they protect our eye, skin etc. from infection and disease.
A balanced diet means that a pregnant woman eats foods from all three groups every day

FOODS CONTAINING MICRONUTRIENTS

Foods containing iron

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

- Liver, lean meats, fish and insects (animals)
- Dark green leafy vegetables (plants).

Foods containing vitamin C

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

- Oranges, grapefruit, tomatoes, citrus fruits

Foods containing vitamin A

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

Foods containing an oil source

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

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

VITAMIN A + OIL **IRON + VITAMIN**




Activity 3: Importance of iron

THE IMPORTANCE OF IRON

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

Nutrition for the pregnant woman

NUTRITION FOR THE PREGNANT WOMAN

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

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

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

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

KEY MESSAGES AND ADDITIONAL INFORMATION	ROOT CAUSES *What makes it difficult to do this behaviour?*	SOLUTIONS: *What would make it easier to do this behaviour?*
Handwashing at appropriate times*		

Iodized salt		
Increased quantity and variety of foods for pregnant woman		
Three food groups (discuss locally available foods) – eat a balanced diet. Include micronutrients (iron-rich foods, vitamin A-rich foods)		

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

Key messages

- Pregnant women need to eat a healthy balanced diet with food from all three food groups every day:
  - Energy foods (rice, bread, maize)
  - Growth foods (fish, meat, eggs, beans)
  - Protective Foods (fruit, vegetables)
- They should also ensure they eat vitamin A rich foods such as liver, eggs, dairy products, fatty fish, ripe mangoes, papaya, sweet potatoes, green leafy vegetables, carrots and palm oil; vitamin C rich foods such as oranges tomatoes and citrus and iron-rich foods such as liver, eggs and dark green leafy vegetables.
- Iodized salt should be used instead of ordinary salt during pregnancy to help prevent illness; salt should be used in small amounts.
- Take extra care with hygiene: always wash hands with soap or ash after using latrine, before preparing or eating food, or feeding children

Notes:

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

HOME CARE FOR THE PREGNANT WOMAN

- Why should pregnant women get more rest?

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

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

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

centre. When all is done the woman would have enough blood to prevent anaemia during and after pregnancy.

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

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

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

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

DANGER SIGNS DURING PREGNANCY

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

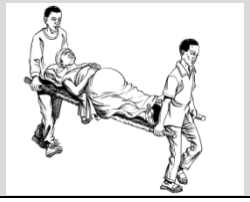
REFERRAL - GOING TO A HEALTH WORKER WITH A PROBLEM	
WHAT?	**WHY?**
Call for help	Others can help to get transport, money and decide what to do.
Have the woman lie down	The woman needs rest
Cover the woman with a cloth	Covering the woman keeps her warm to prevent more sickness.
Give the woman small sips of liquid – about one cup liquid to drink about every hour.	Liquids prevent dryness and weakness
Write referral note	So that the health worker knows why the woman referred
Go directly to the Health Worker at the health facility.	The woman is very sick and may die. The Health Worker will know how to help.

Tell the Health Worker what happened and what was done. Listen to the Health Worker's instructions.	When the Health Worker hears the problem she can help very quickly. The health worker may need the family to get supplies, food, drink, or people to give blood.

THE FOUR DELAYS

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

Barriers and enablers to home care in pregnancy

KEY MESSAGES AND ADDITIONAL INFORMATION	ROOT CAUSES: *What makes it difficult to do?*	SOLUTIONS: *What would make it easier to do?*
Sleep under LLIN in high malaria prevalent areas. 	*Family/culture* *Attitude/ Ignorance*	*More support in work*
Do not smoke or drink alcohol during pregnancy 	*Access to IFA, belief in effect, constipation, forgetting*	*Reminder to take, knowing to take with food, treat constipation*
Adequate rest & assistance from family members 		
Take iron and folic acid tablets daily*		
Refer woman to health facility immediately if danger sign is 	*Knowledge/ Finances/ Means of transport*	

present (see list of signs)		

Key messages

A pregnant woman should:

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

Notes:

SESSION 2.4: PROMOTING ANTENATAL CARE

Importance of antenatal care

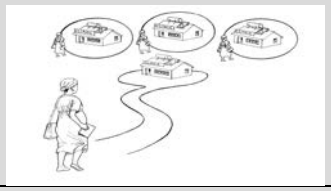
OVERVIEW OF CARE GIVEN DURING ANTENATAL VISITS

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

- Examination of the pregnant woman; blood pressure, eyes, weight, urine, if possible blood tests
- Monitor the uptake but not initiate treatment IFA tablets to prevent anaemia and strengthen blood
- Educate the women on this but not to immunise. At least two TT immunisations to prevent tetanus
- Educate and encourage the woman to go for Testing for infections such as HIV, TB and STIs, and treatment and care if needed – treatment of STIs can help prevent miscarriages and stillbirths; testing can be for both the woman and her partner
- Advice on home care for the pregnant woman and to ensure that the baby grows well
- Preparing for birth including preparing for a health facility delivery and informing the family about danger signs and the importance of early care seeking for them
- De-worming tablets at four months in areas where intestinal worms are common
- Long-lasting insecticide-treated bed nets and intermittent preventive treatment (IPTp) to prevent malaria in areas where malaria is very common.

The minimum number of ANC visits recommended is five.

Barriers (root causes) and enablers to promoting ANC

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

TB testing / screening		Knowledge	Counselling and support

Key messages

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

Notes:

SESSION 2.5: SUPPORTIVE CARE FOR HIGH RISK PREGNANCIES

HIGH RISK PREGNANCY

- A high risk pregnancy is one in which a pregnant woman has one or more factors known to increase her chance of complications or psychosocial problems in pregnancy or childbirth.

Vulnerability factors in pregnancy may include: being HIV-positive, diabetes, sickle cell disease, previous pregnancy loss, previous haemorrhage (or other serious complication), previous hypertensive disease in pregnancy, being under 18 years or over 35 years of age, previous surgery such as caesarean section or repair of fistula, complications in the current pregnancy identified by the antenatal clinic staff including twins or multiple pregnancy, or hypertensive disease of pregnancy.

HIGH RISK FACTORS IN PREGNANCY		
High risk factors in pregnancy – examples	**What is the risk?**	**Additional support needs?**
All cases of high risk pregnancy should deliver in a health facility or hospital.		
Positive HIV test	Transmission of HIV to child, risk of illness and infections in mother, side effects of medicines	ARV treatment support, PMTCT support, increased vigilance for danger signs, improved diet and self-care, planned hospital birth and community based support
Current or previous hypertensive disease in pregnancy (explain: problems with high blood pressure)	Chance of convulsions is higher and need for surgery like caesarean section increased (and increased chance of losing the baby before birth or after birth	Medicine treatment and support for compliance, Increased vigilance for danger signs, Improved diet and self-care, planned hospital birth
Adolescent (under 18 years)	Increased chance of not attending ANC, or delivery at a facility, increased chance of miscarriage or loss of the baby before birth, increased chance of complications during in birth such as haemorrhage, obstructed labour or infection, and of psychosocial issues in the home such as GBV/ IPV.	Increase vigilance for danger signs, improved self-care, planned hospital birth
Woman experiencing perinatal mental health problems, psychosocial difficulties such as domestic violence or abuse	Reduced access to services, mental health problems such as depression and anxiety, reduced capacity for care of self and child	PFA if needed, access to appropriate support services, emotional support and counselling
Existing medical conditions	Disability – such as cerebral palsy or polio TB in pregnancy	

Social risks and vulnerabilities: Social vulnerabilities of households can also be highlighted, as covered in session 3, insofar as that they must *also* take these into consideration when considering a high risk pregnancy.

BIRTH PLAN – AN INTRODUCTION

A birth plan means that the woman and her family have considered the various needs including money and essential items required for the birth of a baby and have clear and viable ideas about how they can meet these needs in advance.
Many tragedies occur during labour and birth because the woman or family did not consider before the event what might be needed and the possible complications of giving birth
Midwife or nurse – may conduct an assessment and approve the plan;
CHW or CHW – be aware of the birth plan, and support the woman and her family;
Birth companion – chosen accompanying person during the birth, such as the husband, sister, mother-in-law, or a friend.
All women should have developed a birth plan *at least two months* prior to birth, and this should be revised in any subsequent visits.
All women should develop a birth plan including birth location, chosen assistant, birth companion, clean delivery kit, emergency transport and money saved to cover any potential costs of procedures, medicines or hospital stay.

ADDITIONAL BIRTH PLAN SUPPORT FOR HIGH RISK PREGNANCIES

- All women can develop complications or psychosocial problems during pregnancy or childbirth and need to be prepared in case danger signs or issues arise.
- All women should develop a birth plan including birth location, chosen assistant, birth companion, clean delivery kit, emergency transport and money saved to cover any potential costs of procedures, medicines or hospital stay.
- Vulnerable pregnant women should consider moving closer to the hospital in late pregnancy and before the start of labour. The facility should have emergency care availably day and night
- Vulnerable mothers should travel with a chosen birth companion so they have someone to take care of them.
- Family members should be made aware of any health or risk factors and danger signs to look out for, and what to do in the event of a danger sign.
- Most vulnerable pregnant women need additional support:
- Additional home visiting and supportive counselling
- Monitoring and supporting medicine adherence
- Psychosocial support from family or services
- Ensure regular access to ANC and maternity service

Key Messages

- A vulnerable pregnancy is one in which a pregnant woman has one or more factors known to increase her chance of complications or psychosocial problems in pregnancy or childbirth.
- Vulnerability factors in pregnancy may include: being HIV-positive, previous pregnancy loss, previous haemorrhage (or other serious complication), previous hypertensive disease in pregnancy, being under 18 years or over 35 years of age, previous surgery such as caesarean section or repair of fistula, complications in the current pregnancy identified by the antenatal clinic staff including twins or multiple pregnancy, or hypertensive disease of pregnancy.

- All women can develop complications or psychosocial problems during pregnancy or childbirth and need to be prepared in case danger signs or issues arise.
- All women should develop a birth plan including birth location, chosen assistant, birth companion, clean delivery kit, emergency transport and money saved to cover any potential costs of procedures, medicines or hospital stay.
- Vulnerable pregnant women should consider staying close to a facility close to the due date
- Most vulnerable pregnant women need additional support:
    - Additional home visiting and supportive counselling
    - Monitoring and supporting medicine adherence
    - Psychosocial support from family or services
    - Ensure regular access to ANC and maternity services

Notes:

UNIT 3: VISIT 2 – MID-PREGNANCY

SESSION 3.1: HIV AND AIDS, TB, AND PMTCT

HIV and AIDS during pregnancy and childbirth

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

- HIV, the virus that causes AIDS, spreads through unprotected vaginal and anal sex (intercourse without a condom), transfusions of contaminated blood, contaminated needles and syringes, and from an infected woman to her child during pregnancy, labour and delivery, or breastfeeding.
- TB and HIV can be treated using medicines given at the clinic. AIDS can be effectively treated with antiretroviral therapy (ART).
- All pregnant women should be tested for HIV and syphilis, and screened for TB and other STIs as part of ANC. It is very important that their sexual partners/husbands should be tested too, at the same time. If either parent tests positive for HIV or TB, it is important to test ALL children living in the Household.
- Symptoms of TB include: persistent cough, night sweats, weight loss (or stagnant weight in children) malaise, fever. Refer any person or child with these symptoms to a health centre.
    - HIV infection can be passed from a mother to her child during pregnancy, labour and delivery or through breastfeeding. This can be prevented if the mother takes ART medicines during and after her pregnancy as guided by the health facility. The baby is also given ARV prophylaxis from birth to six weeks of age.
- Once she has started taking ART, a mother should not miss her treatments but make sure she takes her tablets as prescribed (treatment-adherence). If she stops treatment at any time, the baby can be at risk of infection or she could suffer health problems. If she experiences any side effects from the medicines she should seek medical help immediately.
- Infants born to HIV-positive mothers should be taken for HIV test 6weeks (*as early as possible)* after birth, for early detection and treatment using ART and co-trimoxazole preventive treatment to keep them from becoming ill.
- Child feeding for HIV-positive mother: all women, but especially those HIV positive women, should exclusively breastfeed the child to six months of age and add complementary feeds from six months. If they are taking ART therapy they may continue to breastfeed until the child is one year.
- All women, but especially HIV-positive pregnant women, should always deliver in a health facility, as mother and baby will need special care during and after the birth (such as PMTCT, or Prevention of Mother-to-Child Transmission), and to ensure a safe and clean delivery.
- Condoms should always be used during every sexual encounter while the HIV-positive woman is pregnant and breastfeeding, to avoid the risk of re-infection and to keep virus levels low.
- An HIV-positive or TB-positive pregnant woman needs to take special care during pregnancy. They should make sure they attend four or more antenatal visits, adhere completely to their medicines, eat a well-balanced diet rich in a variety of nutrients, and rest often to ensure the best health for her and her baby.

The discovery that one is HIV-positive during pregnancy can lead to emotional distress for many women, the increased risk of intimate partner violence, or abuse. CHWs will need to be particularly sensitive and aware of this when addressing the issue of HIV in the home.

HIV AND AIDS: AFTER BIRTH

- A baby born to an HIV positive mother should be given ARV prophylaxis from birth to six weeks and tested at 6 weeks of age. It is important to find out as soon as possible if the baby is HIV infected, so that treatment may be given.
- If the baby is found to be HIV-positive then he/she will need to be given medicines as soon as possible, which will control the infection and prevent them from becoming sick.
- If the baby is HIV-positive, or if the baby's HIV status is not known, the baby would also receive ART medication (HIV medicines) to prevent other infections such as pneumonia. This medication is known as co-trimoxazole, and will be given to the baby from 6 weeks of age. The CHW should counsel HIV-positive mothers to take the baby to the health clinic when the baby reaches 6 weeks of age, in order to receive this medication.
- An HIV-positive mother who is taking ART consistently throughout and after pregnancy, can breastfeed her child normally until they are 24 months of age. It is especially important that they should give the baby *only* breastmilk for the first six months, just like all other mothers. At six months of age the mother will introduce complementary foods to her baby, and continue to breastfeed, just like all other mothers.

KEY ACTIONS FOR COUNSELLING HIV-POSITIVE WOMEN AND THEIR FAMILIES:

- Explain that HIV infection can be controlled with the right medicines and that you will help her to access the medicines and care that she needs.
- Use positive language, listen and empathise with her worries.
- Explain to her family about ART treatment access and availability in the area

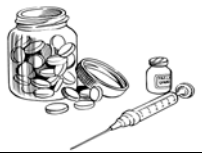
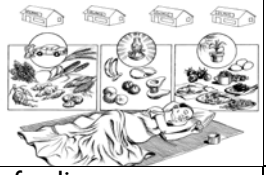
Recommend: the key counselling messages

- Partners of HIV-positive women should go for testing.
- HIV infection of the baby can be prevented by taking ART medicines (antiretroviral therapy) during and after pregnancy as guided by the health care worker, and by giving birth in a health facility.
- Once she has started taking ART make sure she takes her tablets every day to prevent possible infection of the baby and health problems. If she experiences any side effects from the medicines seek medical help immediately.
- Condoms should always be used throughout pregnancy and breastfeeding.
- It is especially important for an HIV-positive woman to have good nutrition during pregnancy, to rest well, prevent infections (hygiene and handwashing) and attend four or more antenatal visits.

Refer: for further support services

- In the community (HIV support workers if they exist) and only with the client's consent
- HIV clinics/health facilities for follow up services.

Key Messages and additional information	**Root causes**: *What makes it difficult to do?*	**Potential Solutions:** *What would make it easier to do?*

Testing during pregnancy for HIV and Syphilis, and screening for TB and other STIs for women, and if positive,their partners (Household Handbook Visit 1) 	Partner testing, culture, stigma, fear	Family support
Accessing HIV and TB treatment and taking medicines every day (ART adherence for HIV-positive mothers) 	Stigma, access to medicines, family influencers, side effects	Reminders, support for side effects, connecting to existing HIV support groups
Early infant diagnopreventive treatment for HIV exposed infants 	Access, beliefs	Partner participation, knowledge
Condoms during sexual intercourse while pregnant and breastfeeding to prevent re-infection	Gender power dynamics, myths and inappropriate beliefs, knowledge, attitudes concerning condoms	Partner participation, increased knowledge, increased self-efficacy in negotiating and using condoms consistently
All women, but especially HIV-positive women deliver in a health facility for special care and PMTCT 	Access to care, distance from health centre, costs ,lack of funds for facility delivery kit	Increased facilitated alliance with TBAs, modified social norms that demand facility delivery
Nutrition, rest and antenatal care for the for HIV-positive mother 	Family attitudes, work, poverty	Family support
Early and exclusive breastfeeding 	Beliefs, fear, familypressure to supplement feeding	Knowledge, support from family community

Key messages

- All women and their partners should undergo testing during pregnancy for HIV, TB and other STIs. Children not previously tested for HIV should be tested if either parent is HIV positive.
- It is important to screen children for TB if child or anyone in the home has been diagnosed with TB. Refer any person experiencing TB symptoms: persistent cough, night sweats, weight loss (or stagnant weight gain in children) malaise, fever.

- TB and HIV can be treated using medicines given at the clinic. You must take all the medicines as prescribed, without break (treatment-adherence) otherwise you can become ill.
- All women, but especially HIV-positive women deliver in a health facility.
- Infants born to HIV positive mother should be taken for HIV test 6 weeks after the birth for early detection and treatment.
- All women, but especially HIV positive women, should exclusively breastfeed the child to six months of age, and continue until one year if they are taking ART treatment.

Notes:

UNIT 4: VISIT 3 – LATE PREGNANCY

SESSION 4.1: BIRTH PREPARATION

Preparing for birth and its importance

PREPARING FOR BIRTH

During the 3rd visit in pregnancy the CHW will help the family prepare for the birth. Having a birth plan can reduce confusion at the start of labour and the unpredictable time of birth. It can increase the chance that the woman and her baby will receive appropriate, timely care. Birth-planning helps families think ahead to what is needed for a safe birth and decide how to overcome any difficulty they may have.

Helping the family prepare their own birth plan involves an ongoing discussion with the woman and her family, and should include decisions about: location of birth, transport, savings, birth supplies for mother and baby, emergency plans, birth companion support, travel plans and household care or care of other children.

While it is always best to give birth in a facility, sometimes this decision does not happen immediately. If the family is undecided, go through the elements of preparing for birth in a health facility and have them think it over. Talk to them again about facility birth at the next visit. It may not be possible for all women to give birth in a health facility. If a family decides not to birth in a health facility even after discussions, it is important that you help them make the home birth as safe and clean as possible. Do not judge or scold them for their choice.

REASONS TO INCLUDE HUSBANDS AND FAMILY MEMBERS IN DISCUSSION

- Giving birth in a facility may involve money, so this decision should be made along with the husband and any others involved.
- If everyone agrees beforehand, when labour starts there will be no problem in making the decision to go to the health facility.
- In some societies the husband and/or the father-in-law has to give permission for the woman to leave the house, so if he agrees beforehand that will allow her to go even if he isn't at home at the time.
- Leaving home means that there needs to be money for transport and someone to look after the house and other children; this may involve other family members.

BIRTH PLANNING

1. Prepare for birth, in a health facility or at home. It is safest to deliver in a health facility. Many problems can be prevented and any that do arise can be treated promptly with the required skill and medications. If the family chooses not to give birth in the facility, the following steps are still important for a home birth in case of emergency.

2. Decide how the family will ensure a skilled birth attendant is present during labour and birth. If the woman gives birth in the health facility, skilled birth attendants will be there to help the woman through her labour and birth, and with any complications that she might develop. If the family cannot deliver in a health facility, they should make every effort to find the mostly highly trained person possible to assist with the birth at home.

3. Identify transport to get to the health facility. Labour can start at a time during the day or night, and it may be difficult to find transport at the last moment. Transport is important for a home birth as well, in case there are complications during the labour and birth and the woman needs to be referred.

4. Save money for transport and other expenses at the health facility. It is important to save small amounts of money throughout pregnancy in order to have enough money to cover all the costs of transport and other expenses for birth at the health facility.

5. Gather the supplies needed for home or facility birth. . Women need to bring: a clean delivery kit including clean blade and chlorhexidine solution, soap, gloves, cord ties, a plastic sheet, sanitary napkins/ pads and clean clothes for the mother and the baby. It is important to keep the items clean, and ready in a bag during late pregnancy so they can easily found when needed. These supplies are also needed for a home birth. Also have ready the MOH approved CHX for umbilical cord care (when it becomes available) with clean birth kit. (provided by health staff, CHW or purchased by the family).

6. Decide to go to the health facility early in labour or stay close to the facility before labour begins. It is important to go to the facility early in labour so that there is enough time to arrive before the baby comes, especially if the mother has had a baby before. Ideally, if the family live far from the nearest clinic the woman could stay close to the facility in the last weeks of pregnancy to avoid long and difficult travel during labour or a birth along the way.

7. Identify a supportive birth companion who will accompany the mother to the facility. Early on in the pregnancy, identify the person who is suitable to accompany the woman to the health facility for labour and birth. This person should be aware of the transportation plan and of the importance of going to the facility early in labour. Try to include this person in your discussions during the home visits.

8. Plan who will care for the household while the pregnant woman and other family members are in the facility. It is important that arrangements are made beforehand for someone to take care of the household, including caring for older children, other family members, animals, etc.

THE IMPORTANCE OF DELIVERING IN A FACILITY

It is safest for all women to deliver with a **skilled birth attendant** and in a **health facility** because health workers have the skills, equipment and medication needed to help ensure a safe birth and a healthy baby.

Sometimes problems arise during labour and birth, like bleeding or fits, which require skilled health It is not possible to predict if a woman will experience complications in labour, even if she has had uncomplicated births in the past. Workers, medications and equipment to treat, without which the mother and/or baby could die.

Therefore, it is safest to deliver in a facility that can manage these and other problems. It is especially important that HIV-positive women deliver in a facility to reduce the risk of transmitting the HIV virus from the mother to the baby during labour and birth.

Nevertheless, if a facility birth is not possible, or if labour starts early, families must be able to recognise danger signs in labour and delivery and be prepared to immediately take the woman to the facility should any complications arise.

The CHW should strongly encourage HIV-positive women, and any woman identified as high risk to find a way to labour and birth at a facility, and if they live far from the clinic, to plan to stay nearby the clinic before their due date.

DANGER SIGNS DURING LABOUR AND DELIVERY

Woman feels no movement or reduced movement of the baby
Water breaks without labour commencing within 6 hours
Bleeding: any bleeding during labour but before birth or too much bleeding immediately after birth
Fever and chills
Prolonged labour/birth delay (12 hours or more)
Severe headache, fits or loss of consciousness
Placenta not delivered upto 30 minutes after childbirth or incompletely expelled
Dark green liquid expelled from womb during labour.

NECESSARY ACTIONS

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

THE FOUR DELAYS

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

PREPARING FOR UNEXPECTED DELIVERY AT HOME	
WHAT ACTIONS	**WHY?**
Clean and warm place for birth.	A clean place for the birth helps prevent infection. A warm place helps keep the baby warm (prevents heat loss).
Clean birth things New or clean cord ties and new razor blade For mother and baby: Clean clothes, clean cloths, mats, pads.	To prevent unclean things getting in cord and prevent bleeding from cord. To keep the mother and baby warm, clean, and dry. To soak up fluids and blood.
Clean helpers: clean hands, clean apron and clean gloves • Wash hands with soap and water. • Use gloves or other hand coverings. • Use an apron	Wash hands to remove dirt/germs from hands. Gloves and apron keep blood/fluids off hands and clothing to prevent infection
Identify a birth attendant and another person to care for the baby	All women need someone to attend to them during delivery. It is important that this person is experienced, and preferable trained. The birth attendant often concentrates on the mother**. It is important that there is some other person to assist the baby**. This person will need to make sure the baby is kept warm, clean and safe immediately after delivery. This person is

	usually the mother, mother in law, sister or a close friend of the pregnant woman

Barriers to health facility delivery

REASONS WHY MOTHERS DO NOT DELIVER IN HEALTH FACILITY

- Cost of medical items need for the birth, transport and the health facility fee
- They believe that home births are just as safe
- Feeling more comfortable delivering with TBA at home
- Lack of knowledge of the importance of a facility delivery
- Lack of transport
- Fear of the procedures at a health facility or of the attitudes and disrespectful treatment of some health facility staff
- Rapid labour resulting in the birth occurring suddenly at home or on the way to the facility
- Influence of family members –e.g. mother in law or mother.

REASONS WHY FAMILIES ARE UNABLE TO TRANSFER MOTHER IN AN EMERGENCY

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

PROBLEM	POSSIBLE ADVICE/SOLUTION
Cost of birth	• Let families know how much a health facility delivery costs; include 'hidden costs' even if the delivery itself is free. • Help them see how saving a very small amount of money each week adds up to a significant amount over the pregnancy, especially if the entire family is involved. • Stress that delivering in a health facility helps ensure a safer birth and a healthy baby. If complications occur during home birth, it will cost much more to get emergency treatment than the cost of a facility birth. • Ensure that the pregnant woman enrols for health insurance early in pregnancy
Perception of home births as safe	• Explain to the family that the health facility is the best place to prevent and treat birth complications. • Explain that complications such as prolonged labour, delayed placenta and bleeding after birth can happen to any woman, even those who have had safe deliveries.
Feeling comfortable with delivering with TBA at home	• Acknowledge the importance to the woman of having a TBA who she feels comfortable with at the birth, but if complications occur the mother or the baby could pay with their lives. • Suggest that possibly the TBA could go with you to the health facility and be a support (or birth companion) during labour and childbirth.
Lack of transport	• Toward the end of pregnancy, encourage the woman to try to find a place to stay (with a relative or friend) close to the facility. • Help families identify a means of getting to the facility for the birth day or night and in bad weather. • Encourage families to make advance arrangements with a vehicle owner, including taking his or her phone number.

	• Encourage community planning to provide transport for birth and emergencies.
Fear of health facility procedures and health worker attitudes	• Explain to the family that if medical procedures are not conducted when they are required, the woman or her baby can be severely injured or die. • Encourage the family to identify a birth companion who could accompany the pregnant woman and help communicate with health facility staff, ensuring she is treated with respect. This could be the CHW if appropriate.
Birth sometimes occurs very quickly	• Explain that it is important to go to health facility for the birth as soon as labour starts. That is why it is important to plan for the birth during pregnancy. • Help families ensure that they have everything they need for a safe home birth in case the labour is very quick. • Toward the end of pregnancy, encourage the woman to try to find a place to stay (with a relative or friend) close to the facility.
Influence of family members	• Engage with those family members who make household decisions in your discussions. If they are not in the house, arrange for them to come, or to attend next time and conduct the barriers analysis with them.

Key messages

- It is safest for a mother and her baby to deliver in a health facility with a skilled birth attendant. Even if the mother is healthy, she can have problems during birth that require medicines, equipment and/or skilled health professionals to save her and her baby.
- HIV-positive women should always give birth in a health facility because they will receive special care to help prevent the HIV virus from being passed from the mother to the baby.
- Families should have a clear birth plan in place, to include saving money, arranging transport and collecting supplies. As part of the birth plan, families should have all materials for birth, a plan for transport and money for emergencies ready before labour starts. If labour comes early or a danger sign occurs, the woman can be quickly taken to the facility.
- The CHW can play a very important role in helping the family to overcome difficulties in having the birth in a facility, and to help them prepare for the birth.
- Take woman to a health facility if a danger sign is present (if home birth).

Notes:

SESSION 4.2: HEALTHY TIMING AND SPACING OF PREGNANCIES

BIRTH SPACING

1. **Couples are advised to wait and plan another pregnancy after the last child has reached 2 years of age, to ensure optimal health for mother and young children.**

   One of the greatest threats to the health and growth of a young child under the age of two is a pregnancy and birth of a new baby. Breastfeeding for the older child stops too soon, and the mother has less energy and time to prepare the special foods a young child needs. As a result, children born less than two years apart usually do not develop or grow as well, physically or mentally, as children born two years apart or more. Two years will give enough time for a woman's body to fully recover fully from pregnancy and childbirth. This is also called Healthy Timing and Spacing of Pregnancies (HTSP)
2. **To allow the woman's body to recover, a couple should also wait for six months after a miscarriage before trying for a new pregnancy.**

   A woman's body needs about six months to recover fully from a miscarriage.
3. **Family planning services provide people with the knowledge and the means to plan when to begin having children, how many to have and how far apart to have them, and when to stop. There are many safe and acceptable ways of avoiding pregnancy.**

   Health facilities should offer advice to help people choose a family planning method that is acceptable, safe, convenient, effective and affordable. Of the various contraceptive methods, only condoms protect against both pregnancy and STIs, including HIV and AIDS.
4. **Family planning is the responsibility of both men and women; everyone needs to know about the health benefits.**

   Men as well as women must take responsibility for preventing unplanned pregnancies. They should have access to information and advice from a health worker so that they are aware of the various methods of family planning that are available. Encourage men to go with their wives to discuss family planning with the clinic staff. (Additional info if the CHW is also an FP depot holder)
5. **Methods of family planning available** are – condoms, oral contraceptive pills [e.g. name], depo provera injections implants [norplant, Jadel), IUD [Copper-T], female and male sterilization. The health worker at the local health centre will provide the detailed information about these methods to help the family make a choice.

KEY MESSAGES AND ADDITIONAL INFORMATION	ROOT CAUSES *What makes it difficult to do?*	SOLUTIONS *What would make it easier to do?*
Postpartum family planning (as soon as possible after birth and before the baby is 6 months old)	*Beliefs, perceived risks (that they cannot get pregnant)*	
Limit pregnancy to the healthy childbearing years of 18–35	*Early marriage preference in some cultures* *Adolescent peer pressure* *Sexual coercion to start early* Marrying late	*Education* *Family support* Men as partners

Wait at least two years after a birth before trying to get pregnant again	*Knowledge, beliefs, wish to have large families,*	
Wait at least six months after a miscarriage before trying to get pregnant again		
Using family planning modern methods available at health facility (provide list)	Knowledge, beliefs, skills, preference for traditional methods, family / partner opinion	

Key messages

- It is important for the health of the mother and the children to space pregnancies, and to limit childbirth to the healthy childbearing years of 18–35.
- Young girls should delay their sexual debut until after the age of 18, and if not possible, then use birth control to prevent adolescent pregnancy.
- There should be a space of at least three years between births. A couple may begin to think of another pregnancy when the last child has reached two years of age.
- To allow the woman's body to recover, a couple should wait for six months after a miscarriage before trying for a new pregnancy.
- There are many simple and acceptable ways to prevent an unwanted pregnancy. Some or all of these services are available in health facilities.

Notes:

SESSION 4.3: IMMEDIATE ESSENTIAL CARE OF THE NEWBORN AFTER BIRTH

THE FIRST HOURS OF LIFE

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

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

BREATHING: If the newborn has suffered prolonged or complicated labour he or she may have *breathing difficulties or birth asphyxia*, so it is important to **help the baby breathe** and to regularly check the breathing to prevent deaths due to asphyxia.

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

Clean hands – Birth attendants and supporters must wash their hands with soap before touching the mother or baby, and wear protective gloves.
Clean surface – Use a clean plastic sheet to ensure that the baby is delivered on a clean surface.
Clean cord tie – Take from the clean birth kit.
Clean blade – The umbilical cord must be cut with a clean/new blade from the delivery kit.
Clean cord care – Apply the CHX solution or gel as soon as possible after the cord is cut and within the first 24 hours (when the gel becomes available). Do not apply anything else on the cord stump.

IMMEDIATE ESSENTIAL NEWBORN CARE STEPS

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

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

EARLY 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.

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.

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:

- Wash your hands with soap.
- Massage the breast to help the milk come down.
- Place thumb and index finger the areola on either side of the nipple, about three to five centimetres (one to two 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.

Expressed breast milk kept covered in a clean container will remain fresh for about 8 hours.

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.

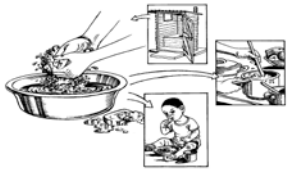
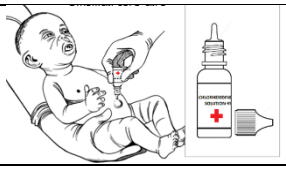
DANGER SIGNS IN THE NEWBORN

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

- Yellow colouration (or jaundice)
- unconsciousness, lethargy
- chest indrawing
- unable to breastfeed
- fits/convulsions

- fast or difficult breathing
- fever.

Barriers and enablers to early essential newborn care

KEY MESSAGES AND ADDITIONAL INFORMATION	ROOT CAUSES What makes it difficult to do?	SOLUTIONS *What would make it easier to do?*
Handwashing with soap before touching the newborn baby or mother in delivery. 		
Help the baby breathe: clear baby's airway (nose and mouth) and ensure baby is breathing clearly during first hour of life: - Dry baby immediately after birth - Rubbing and stimulation. 		
Early initiation of breastfeeding: - Put baby to breast within 30-60 minutes after birth - do not discard first milk (colostrum) - exclusive breastfeeding; give no other foods or liquids to the baby. 		
Keep the baby warm: - Put baby skin-to-skin with mother - Warm room, hat, socks, blanket - Dry baby immediately after birth - Do not bathe baby for first 24 hours 		
Clean umbilical cord with chlorhexidine solution, and put nothing else on the cord. 		
Postnatal care at health clinic; mother and baby. As soon as possible after delivery, take the mother and infant for a check-up at the clinic and immunizations 		

Refer newborn urgently if danger sign is present: - Unconscious, lethargy - Unable to breastfeed - Fits/convulsions - Fever - Fast or difficult breathing - Chest indrawing - Jaundice - Skin pustules - Eye infection - Redness pus or swelling of cord stump 		

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

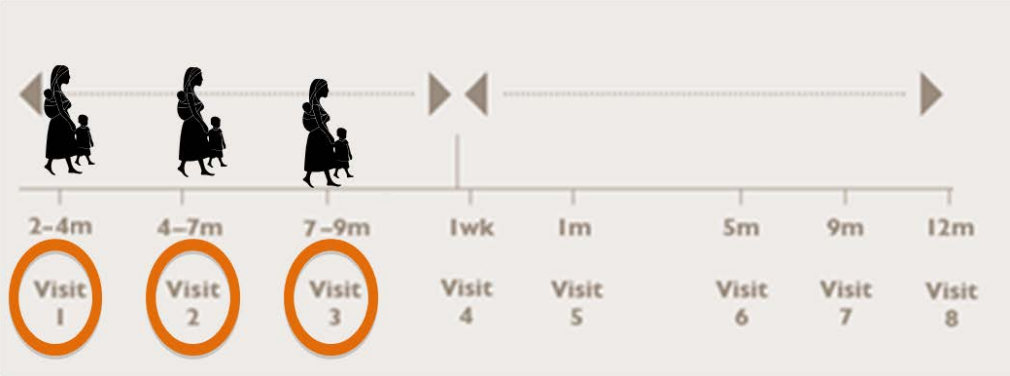
		facility should not discharge a mother and baby until they are breastfeeding comfortably.
Performing other activities after birth	Knowledge/skills	Families or TBAs may think that the mother or the baby needs to be bathed before they start breastfeeding, or may not know the importance of starting immediately. 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.

Key Messages

- Newborns must be kept warm after delivery because if they get cold, they can become ill. We can keep newborn babies warm by:
  - drying them as soon as they are born and removing the wet cloth
  - putting them in skin-to-skin contact with the mother and covering with a dry cloth
  - helping them breastfeed very soon after birth (usually within 30 minutes)
  - Avoiding bathing them on the first day after birth.
- Breastfeeding immediately after birth has many advantages for both the baby and the mother. The first milk given to the baby just after birth is like a vaccine because it protects the baby from disease.
- A mother can breastfeed immediately after she gives birth even if she does not feel that her breasts are full. Breastfeeding frequently will help her produce more milk.
- If a mother cannot breastfeed immediately after giving birth because of complications in delivery such that the mother is ill or unconscious, the nurse or TBA should express the milk from her breasts and feed it to the baby from a clean cup.
- The mother should breastfeed her baby **exclusively**. This means that no other food or liquids should be given to the baby – breast milk provides everything the baby needs for the first 6 months
- Other important actions that must be taken immediately when a baby is born include cleaning the nose and mouth to ensure that there are no obstructions to the baby's breathing, and rubbing the baby's back and legs to stimulate breathing.
- It is important to take the baby to the health facility as soon as possible for his or her first immunisations, and for a general post-delivery check-up.

Notes:

CLASSROOM PRACTICUM #1: VISITS 1, 2 AND 3



CONDUCTING VISITS 1, 2 AND 3

PRINCIPLES OF TTC HOME VISITING

Partner and Family Support

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

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

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

Identify her *chosen supporters* and write these names in the family health card and ensure that these people attend each time you come.

Location

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

Planning a home visit: when?

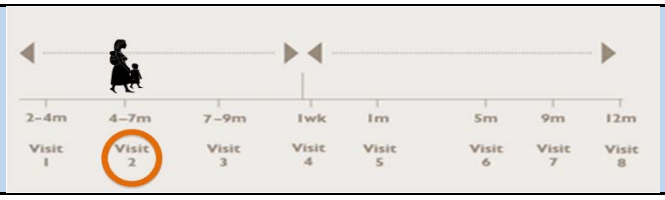
Make sure that this is at a convenient time of the day or evening for the family, when the supporter will all be able to participate. Check in advance if possible to ensure that this is a good time, and fix the day and time before you arrive.

Visit 1 (early pregnancy)

VISIT 1 IN PREGNANCY

Before Starting

- Greet the family and develop good relations.

• Explain the purpose of the visit. • Ensure that you have the basic principles right: - *Who – are all the identified supporters present? (go and fetch them or reschedule)* - *When – is this a convenient time?* - *Where – is the location for the visit comfortable and private?*	
<u>Identify and respond to any difficulties</u> (do not proceed if the woman is unwell or distressed). • Ask the mother if she has any danger signs, including any emotional distress. • Conduct referral if needed. • Apply psychological first aid principles if needed.	
<u>ttC Counselling Process (There is no Step 1 for this visit)</u> **Step 2: Present and reflect on the problem: Problem story: 'Nutrition, Home Care and ANC'; and ask the guiding questions.** • The main messages for the current visit are then presented to the families, first in the form of the **problem or problems** that may happen if the recommendations are not practised as laid out in the **problem story**. The CHW will tell the story using the illustrated ttC Storybook. • The problem story is followed up by **guiding questions** to help the family members to **reflect** on the problem. • Step 3: Present information: share the positive story: 'Nutrition, Home Care and ANC', and ask the guiding questions. • Next, the CHW presents information on the positive health actions through the positive story 'Nutrition Home Care and ANC'. Remember to present the information in a way to build on what households already know, not assuming they don't already know. Use the guiding questions above to lead discussion on the practices observed and outcomes. **Step 3b: Conduct technical session: 'Danger signs in pregnancy'.** • Run through all of the danger signs in pregnancy with the mother and supporters to ensure they understand them. **Step 4: Negotiate new actions using the Family Health Card** In this step, the CHW will look at the Family Health Card together with the family Remember the 'getting to the cause' questions (what makes it difficult? why is that) Remember the getting to the solution questions (what would make that easier? how can we help ensure that happens)	
• Record the results of the meeting. Fill in the TTC Register for this visit.	
End the visit: Decide with the family when you will visit again (mid-pregnancy). Thank the family.	
VISIT 2 (MID PREGNANCY) 	
<u>Before Starting</u>: Greet the family and develop good relations. Explain the purpose of the visit. Ensure that the identified supporters are all present.	
<u>Identify and respond to any difficulties:</u>	

Ask mother if she has any danger signs, including any emotional distress. Conduct referral if needed. Apply psychological first aid principles if needed.	
ttC counselling process: **Step 1: Review the previous meeting** • Review the Family Health Card pages from the previous visit. Review the negotiated behaviours that the woman agreed to try and praise any progress. Renegotiate if the family are still struggling. **Step 2: Present and reflect on the problem:** Problem story 'HIV'. Tell the story and ask the guiding questions. **Step 3: Present information:** Positive story 'HIV'. Tell story and ask guiding questions. (There is no Step 3b in Visit 2) **Step 4: Negotiate new actions** Remember the 'getting to the cause' questions (what makes it difficult? why is that) • Remember the getting to the solution questions (what would make that easier? how can we help ensure that happens)	
Record the results of the meeting: Fill in the *TTC Register* for this visit *(we will do this at the end)*	
End the visit: Decide with the family when you will visit again (late-pregnancy). Thank the family.	

Family Did Not Carry Out Behaviours/Actions Agreed In the Previous Visit	
Reason	**Solution**
The family did not understand the agreement	• Talk to the family to help them understand the agreement • Explain the importance of the new behaviour
The family is against the agreement	• Find out why who in the family is against the behaviour • Solve problem and negotiate again • If necessary find compromise behaviour.
There were difficulties carrying out the agreement	• Talk about the problem and help them solve it. • If not possible compromise and negotiate solutions
They forgot to carry out the agreement	• Talk again about it and show pictures • Encourage the family to carry out the agreement

VISIT 3 (LATE PREGNANCY)		
Before starting: Greet the family and develop good relations. Explain the purpose of the visit. Ensure that the identified supporters are all present.		
Identify and respond to any difficulties: Ask mother if she has any danger signs, including any emotional distress. Conduct referral if needed. Apply psychological first aid principles if needed.		

ttC counselling process: Step 1: Review the previous meeting: Review Family Health Card pages from the previous visit. Review the negotiated behaviours that she agreed to try and praise any progress. Renegotiate if the family are still struggling. **Step 2: Present and reflect on the problem: problem story 'Birth Plan, Birth Spacing'**. Tell the story and ask the guiding questions. **Step 3: Present information: positive story 'Birth Plan, Birth Spacing'.** Tell story and ask guiding questions. (There is no Step 3b in Visit 3.) **Step 4: Negotiate new actions** using the Family Health Card Remember 'getting to the root cause' questions (what makes it difficult? Why is that the case?); Remember getting to the solution questions (what would make that easier? how can we help ensure that happens)	
Record the results of the meeting: Fill in the *TTC Register* for this visit	
End the visit: Decide with the family when you will visit again (1-2 days after delivery). Thank the family.	

Key Messages

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

Notes:

COMPLETING THE TTC REGISTER FOR VISITS 1, 2 AND 3

Example 1: Akosua

- You visit Akosua on the 15th of May. Akosua is about 4 months pregnant and lives on the outskirts of the village and her house is right next to the primary school. Her husband, Hussein, does not participate in the visit.
- She has already been to the health centre for her first ANC visit. She has no signs indicating she has a high risk pregnancy. She was offered an HIV test but did not take it yet, and has not therefore got her results.
- She has started taking iron and folate tablets every day, and she reports that she always sleeps under a mosquito net at night. She doesn't have a birth plan yet.
- You have just completed counselling her on antenatal visits, home care and nutrition and danger signs in pregnancy. Akosua reports that due to morning sickness she is eating less than usual.
- Akosua is not feeling well and you recommend that she goes to the health facility. You will follow her up in 2 days to find out if she went ad if she is feeling better.
- Akosua and her family want you to visit them again about 2 months from now for the 2nd ttC counselling visit.

Example 2: Kukuwaah

Visit 1

- Kukuwaah is four months pregnant and lives next to your friend Pinky's house near the weekly market. Kukuwaah's husband's name is Aman and participated in the visit.
- She has already been to the health centre for one ANC and has had one TT vaccination. You check her health card and confirm the ANC, TT1 and IPTp1. She was not told that she was high risk.
- She has had her HIV test and has received the results.
- Kukuwaah's health card shows her expected date of delivery to be August 20, 2010. You have just completed counselling her on antenatal visits, home care and nutrition and danger signs in pregnancy. She is using her mosquito net at all times.
- Kukuwaah is feeling well and does not have any danger sign
- Kukuwaah's family would like to have you visit them again about 1 month from now.

Visit 2

- You visit Kukuwaah 1 month later, for visit 2 but her husband is away at the time. You find that she has had one more ANC visit, she is still eating well, and using her mosquito net. She is also taking her iron tablet regularly.
- She reports that she has been feeling very faint and exhausted all the time, and you refer her to go back to the health facility. She goes to the clinic and two days later you follow up to confirm that she has gone. She has been given some extra iron tablets and is feeling better.

Example 3: Serwa Akoto

- Serwa Akoto is in the 6th month of her pregnancy, her husband's name is Manuel and he is not home when you visit.
- She has already been to the health centre for one ANC and has had one TT vaccination. You check her health card and confirm the ANC, TT1 and IPTp1. She had an HIV test but has not returned for the results yet.
- During the consultation she was told that she is high risk. This is her 4th child and she has suffered with hypertension in previous pregnancies, and in this one. She has been given some tablet to take and told to come for a check-up more regularly.
- You have just completed counselling her on antenatal visits, home care and nutrition and danger signs in pregnancy. She does not have a mosquito net for her bed yet as she says that she finds it too hot. She reports that she is eating well and taking her iron tablets. She is feeling well today.
- Her family would like to have you visit them again about 1 month from now.

Key messages

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

Notes:

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

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

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.

ACTION #2: PREVENT INFECTION IN THE NEWBORN, HYGIENE

Care-givers and visitors wash hands before handling the baby, using soap if available or ash or lemon juice if there is no soap.
Keep the baby's eyes clean.
Clean the baby's skin by washing in warm water daily and every time he/she passes stools or urine.
Put clean clothes or wraps on the baby every day.

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

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

ACTION #3: MALARIA PREVENTION FOR THE NEWBORN

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

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

ACTION #4: INFANT IMMUNISATIONS

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

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

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

ACTION #5: JAUNDICE (YELLOW SKIN AND EYES)

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

HOW TO APPLY CHLORHEXIDINE: (WHEN IT BECOMES AVAILABLE)

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.

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.

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.

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!

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.  

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.

Key messages

- Keep the baby **warm**
  - Do not bathe the baby until after the first 24 hours.
  - Bathe the baby in **warm** water only.
  - Keep a hat on the baby's head.
  - Wrap the baby in two extra layers than adults OR keep close to mother in skin-to-skin contact.
- Protect from infections through **hygiene** – eyes, cord, skin
  - Wash your hands with soap before touching the baby.
  - Apply CHX daily to the cord and skin around it for 7 days. Any family member or a CHW can apply the CHX after training.
  - Do not put anything else on the umbilical cord after applying the CHX.

- Keep the baby's eyes clean.
- Wash the baby daily and change soiled clothes regularly.

Routine newborn care

- To protect against malaria, mother and newborn should both sleep under a long-lasting insecticidal net (LLIN).
- If a home delivery, mother and baby should be taken to a health clinic for postnatal care as soon as possible for birth immunisations and a check-up.
- Talk, sing, smile, touch and interact with your baby especially when breastfeeding.

Notes:

SESSION 5.2: INFANT FEEDING: ESTABLISHING EXCLUSIVE BREASTFEEDING

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 the hands or crying), whenever they want to be fed and for as long as they want to feed, day or night. Typically this will be every 2 to 3 hours or at least 8 times in 24 hours if the baby is emptying the breast during a feed. If the baby does not wake him/herself at night, the mother should wake the baby for feeding after 3 hours.

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

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

5. Hand expression

Wash your hands.

Place thumb and index finger on either side of the nipple, about 3 to 5 centimetres (1 to 2 inches) back from the nipple.

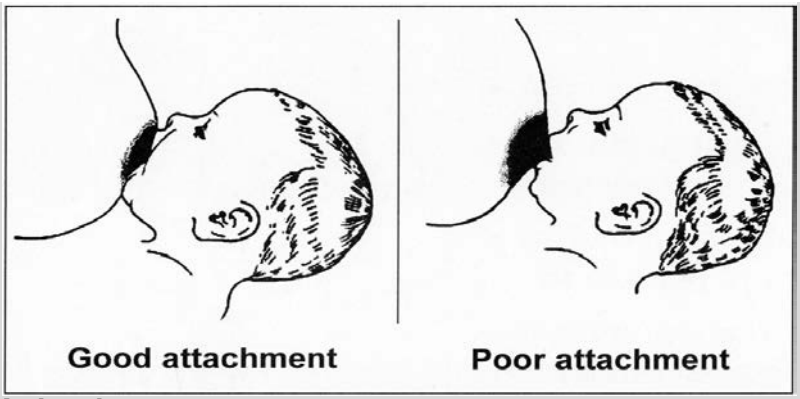
Press gently inward towards the rib cage.

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.

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.

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.

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.

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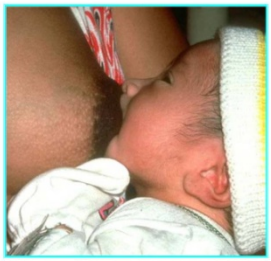
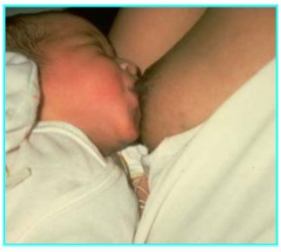
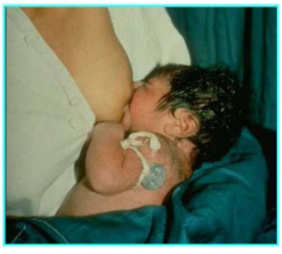
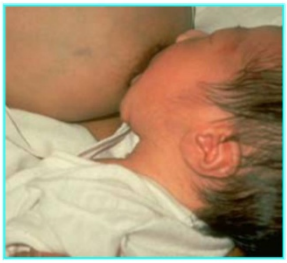
3 

4 

5 

6 

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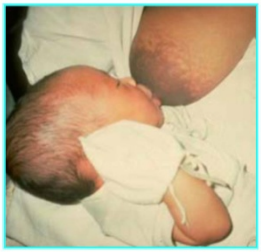
9 

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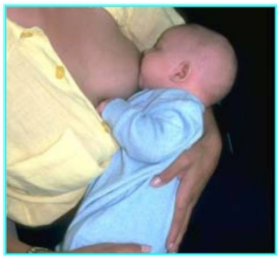
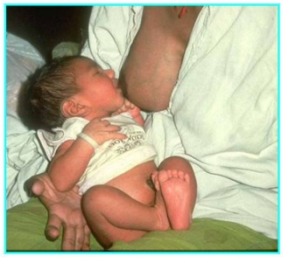
11 

12 

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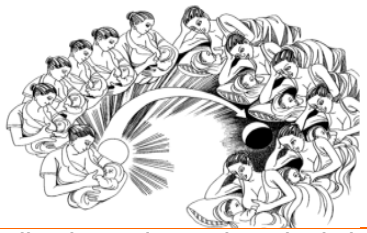
Breastfeeding Attachment – Trainer Guide

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

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

Barriers and enablers to exclusive breastfeeding

KEY MESSAGES AND ADDITIONAL INFORMATION	ROOT CAUSES *What makes it difficult to do?*	SOLUTIONS *What would make it easier to do?*
Exclusive breastfeeding to six months* - No other foods or water* - No bottles or utensils. 		
Breastfeeding on demand day and night - at least 8 times in 24 hours* 		
Holistic child development: talk, play and stimulate the baby for language and emotional development. 		

Key messages

- Ensuring good nutrition in the early years of life is critical for children's long-term physical growth and mental development.
- The first milk (the colostrum) should be given to the baby within 30 to 60 minutes of birth. This milk provides important vitamins and minerals for the baby and protects him/her from illness.
- Breast milk alone is the only food and drink that a baby needs from birth to 6 months of age. No other food or liquid is required – not even water.

- In most cases, an HIV-positive woman will breastfeed until her baby is 6 months of age. It is very important that she gives no additional food or water to the baby during this time.
- Almost every mother can breastfeed successfully. A woman who is having difficulty breastfeeding may be helped in various ways.

Notes:

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

THE POSTNATAL PHASE

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

CARING FOR THE MOTHER IMMEDIATELY AFTER THE BIRTH

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

bleeding too much
fever and chills, which might indicate an infection
loss of consciousness/fainting/fits or seizures

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

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

Essential maternal care

Action #1: Postnatal follow-up care:

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

If the baby was born at a clinic, the mother and baby should see a health worker within 6-7 days after birth.

Action #2: Maternal hygiene and care:

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

The mother should sleep under an insecticide treated net along with her baby

Action #3: Good nutrition and iron intake:

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

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

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

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

DANGER SIGNS IN THE POSTNATAL MOTHER

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

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

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

heavy bleeding
fever or chills
abdominal pain
Mastitis – swelling or redness of the breast.
Fits/seizures

Postnatal 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 postnatal 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.

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

How can a woman catch a postnatal 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 postnatal 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 postnatal phase Regularly changing sanitary cloths, washing them carefully with hot water Washing after each time she passes faeces.
How can we detect a postnatal 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.

Breast problems or painful breastfeeding

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

Sore or cracked nipples	Poor position and attachment Poor hygiene Use of substances on breast that irritates or infects the nipples	Continue breastfeeding. Check position and attachment. Do not wash the nipple and areola with soap or chemicals 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.

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.

Postnatal 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.

CARE OF THE MOTHER WHO HAS EXPERIENCED BIRTH COMPLICATIONS

Women who experienced complications in pregnancy may also be more vulnerable in the postnatal 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.

CARE FOR MOTHER WHO HAS LOST HER BABY

A mother who has lost her baby during delivery (stillbirth) or soon after birth needs the same care during the postnatal period:

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

Checking the mother postnatal

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?

KEY MESSAGES AND ADDITIONAL INFORMATION	**ROOT CAUSES** *What makes it difficult to do?*	**SOLUTIONS** *What would make it easier to do?*
Mother and baby sleep under long lasting insecticide treated bed net 		
Postnatal care at health facility as soon as possible after a home birth and within 45 days after delivery. 		
Maternal hygiene – washing her all over with soap twice a day for five days, especially around the perineum and any wound or tear.		
Mothers should continue to eat well and take iron and folic acid as recommended 		
Postnatal mother should rest well, and have support of the family to not return to heavy work too soon. 		
Danger signs in postnatal mother: Take the mother to the health facility urgently if she experiences: - abdominal pain - bleeding - fever and chills - painful breastfeeding, swelling redness of breast. 		

Key messages

- Attend postnatal care at a health facility as soon as possible after a home birth and within 4 to 5 days after delivery.
- Maternal hygiene: Mothers should wash all over using soap twice a day for 5 days, especially the perineum and any wound or tear.
- Mothers should continue to eat nutritious food and take iron and folic acid for three months after giving birth.
- A postnatal mother should rest well, and have the support of her family.
- Danger signs in postnatal mother: Take the mother to the health facility urgently if she experiences:

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

Notes:

SESSION 5.4: DANGER SIGNS IN THE NEWBORN

Danger signs in a newborn

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

Spot the difference – Umbilical cord infections (optional)

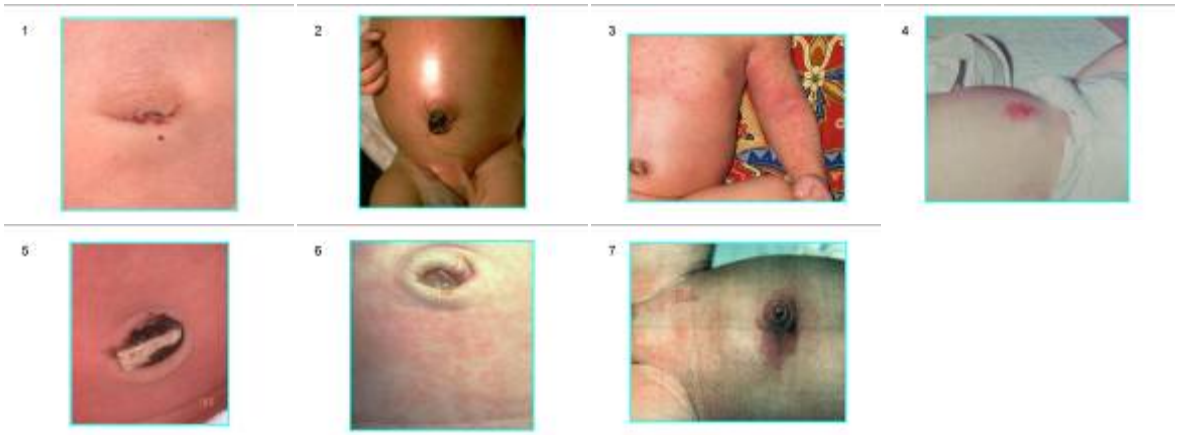


Photo	Description	
1	Normal umbilical cord	OK
2	Severe umbilical infection – redness extending to skin	REFER
3	Umbilical infection, with extensive skin pustules	REFER
4	Some redness, not extended to skin	TREAT, FOLLOW UP
5	Normal umbilical cord	OK
6	Umbilical infection – pus filled and skin pustules.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

Assessing the newborn baby

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	Birth complication or infection or too small baby

		are dark/bluish in colour	
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:

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

DECIDE IF DANGER SIGN *DIFFICULT BREATHING* IS PRESENT. WHICH ACTION WILL YOU TAKE?				
	Danger sign	Not a danger sign	Referred	Not referred

Breathing appears very fast				
Baby is making some noise when breathing in				
Baby is sleeping and breathing easily, normally				
Breathing appears fast				
Baby is breathing as if fighting for air				
The mother says that the baby's breathing has changed since last night				

HIGH OR LOW BODY TEMPERATURE

Babies are not able to control their temperature as adult do. Their bodies are small, their skin is thin and they are not able to stay warm on their own.
If the baby is cold it may be a sign that the baby is sick. A hot body is also a sign of illness. Thus, both being too cold or too hot are signs of severe sickness in a baby.
The best way to decide if the baby has fever or it is cold is to measure temperature by using a thermometer.

If a baby has temperature:

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

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

TAKING A BABY'S TEMPERATURE

1. Take thermometer out of the box, hold at broad end. Clean the shining tip with cotton wool and spirit.
2. Make sure that there is enough light to see the temperature reading. Gently lift the baby's shirt or open the wrap so you can access the armpit.
3. Press the "on" button once to turn the thermometer on. Hold the thermometer upward and place it in the middle of the baby's armpit with the display side out - press the arm against the side of the baby to hold the thermometer firmly in place. Do not change the position and make sure that the tip of the thermometer does not stick out at the other side of the baby's armpit.
4. When you hear 3 short beeps or the numbers stop changing (after at least 4 minutes), remove the thermometer. Read the number in the display window.
5. Turn the thermometer off, clean the shining tip with cotton wool and spirit and place it in the storage case.

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

35.4 ° C				
39 ° C				

Referring a Sick Newborn

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

BARRIER	POSSIBLE COUNSELLING ADVICE
Family thinks they should take a sick baby to a faith healer first. (beliefs > delay in decision)	
Family has fear of the health facility. (beliefs > delay in decision)	
Family thinks it would cost them too much to get treatment. (finances > delay in decision)	
Family does not have any transport to take the baby to the health facility. (access > delay in reaching care)	
Mother thinks that the baby's symptoms are not due to a medical problem (beliefs > delay in danger)	

Key messages

- Danger signs in the newborn are difficult to detect and it's important that the family be aware of the signs and observe the baby carefully at all times. They should inform the CHW or go directly to the health facility if they suspect that the baby has a danger sign. During each home visit in the first week of life they should assess the baby and give the top to toe check to ensure that the baby is well

- Even if only one danger sign present it is enough to say that the baby is sick and needs help
- Families can overcome the barriers to care seeking by being aware of danger signs and ready to leave quickly if the baby shows any signs. Mother and baby should be accompanied to the nearest hospital.

Notes:

SESSION 5.5: SPECIAL CARE OF THE SMALL BABY IN THE FIRST MONTH

Preterm and low birth weight babies

SIGNS THAT A BABY WAS BORN TOO SOON

Skin – may appear thin and with visible blood vessels
Feet and hands – no creases on the palms of hands or soles of feet
Arms and legs – thin and floppy, do not resist pressure
Hair – may have a light coating of fine hair on face, back
Genitals – in boys, the testes have not descended; in girls, the genitals appear larger/exposed.
Low birth weight – All newborn babies should be weighed as soon as possible after delivery. All home births should be referred to the health facility as soon as possible.
Healthy baby – Weighs more than 2.5 kg at birth
Small baby needing special care – Weighs between 2 and 2.5 kg
Small baby needing urgent referral (and likely hospital care) – Weighs less than 2 kg
What causes babies to be small:

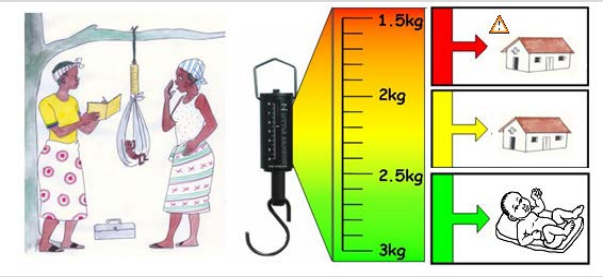
being born too soon
small for gestational age.

Caring for the small baby

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 CHW can support the mother by initiating feeding and introducing skin-to-skin contact, then should transport the mother and baby to the facility whilst carrying the baby 'kangaroo style'.

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 CHW can support.

COMMUNITY-BASED CARE OF THE SMALL BABY

Extra hygiene

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

Extra feeding

If the baby is able to suck and feed successfully, allow it to feed as often and as long as it wants. It should feed at least every two hours, day and night, which may mean waking the baby to feed.

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 indoors, very carefully and quickly, and should wear a hat and socks at all times.

Extra monitoring

Keep extra vigilant for danger signs.
Make home visits for a small baby more frequently and maintain until they are growing and well.

Take the baby to the clinic for a check-up regularly – every 1 to 2 weeks in the first month.

Extra play and loving interactions with caregiver

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

Carrying the baby skin-to-skin

The baby should be naked and held upright. Place the baby inside the clothes (skin-to-skin contact), between the breasts. The legs and hands should be spread apart against the mother's chest (like a frog) and the head to one side, not flat against the chest.

Wrap the cloth around the baby 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.

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.

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

Key messages

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

Notes:

SESSION 5.6: CARE FOR HIV EXPOSED BABIES

BABIES BORN TO HIV-POSITIVE MOTHERS

- Babies born to HIV positive mothers will be started on HIV drugs soon after birth, for up to six weeks, when they can be tested
- It is recommended to test the HIV-exposed baby for HIV when he/she reaches 6 weeks of age.
- If the baby's HIV status is positive the baby should continue the medications that the facility provides for him/her.
- HIV-positive mothers 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 referred.

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.

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.

COUNSELLING POINTS FOR THE HIV-POSITIVE MOTHER

- Prophylaxis: All babies born to HIV-positive mothers should be started on HIV medicines at birth and continue until they can be tested at six weeks

All children born to an HIV-positive parent should be tested for HIV at 6 weeks of age. Ensure that testing has been completed in Visit 6.

COUNSELLING FOR THE HIV-POSITIVE CHILD

Identify additional community support: Family members should seek guidance on adherence and specialised counselling for caring for HIV-positive children through the facility or community-based programmes, ensuring the family is aware of any activities in your communities that can support them.

Attend routine follow-up care for the mother and child: The mother and HIV-positive baby will need to attend clinics more regularly for care, growth monitoring and check-ups.

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.

KEY MESSAGES AND ADDITIONAL INFORMATION	ROOT CAUSES *What makes it difficult to do? Why is that?*	SOLUTIONS What would make it easier to do?
Start the baby on HIV medicines at birth.		
Have the HIV-exposed baby tested for HIV at six weeks		
ART treatment for the HIV-positive baby is started early and continued every day.		
Enable access to community and facility support, attendance at clinic appointments for follow-up care.		
Engage in exclusive breastfeeding until baby is 6 months old.		

Key messages

- Which babies need HIV tests and when? All babies born to an HIV-positive parent should be taken for HIV testing as soon as possible.
- Which babies should be given co-trimoxazole treatment from birth? All babies born to HIV-positive mothers, even if the HIV status of the baby is unknown.
- How should an HIV-positive mother breastfeed the baby? HIV-positive mother should exclusively breastfed to 6 months. If they are taking ARV they can continue to breastfeed the baby normally to 2 years of age.

Notes:

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

CONDUCTING VISITS 4 A, B, C

The first visit after birth

SEQUENCE FOR VISIT 4A 	
Before starting: Greet the family. Explain the purpose of the visit. Ensure that all identified supporters are present.	
Identify and respond to any difficulties: Ask the mother if she has any danger signs, including any emotional distress. Apply psychological first-aid principles if needed. (*Proceed directly to the assessment if mother doesn't raise issues immediately.)*	
Assessment steps: Assessing the mother: Understand the birth story: where, who present, what happened (complications, tears, bleeding). How are you feeling now? Ask about bleeding, fever, abdominal pain, tiredness, breast problems. Assessing the newborn **Ask the mother:** How the baby is, feeding progress, movements, crying, any danger signs and if the if mother has cleaned the cord stump with CHX gel (what it becomes available) **Check the baby:** Movement and crying, breathing, skin temperature and colour, look for pustules, check the eyes, check the umbilical cord.	
TTC counselling process: **Step 1: Review the previous meeting:** Review family health card pages from previous visit (Visit 4). Review negotiated behaviours around the birth and determine if they were met. **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. **Step 3b**: Present **'Breastfeeding problems' and 'Danger signs birth to1 month'** **Step 4: Negotiate new actions using the Family health card** Remember 'getting to the root cause' questions ("What makes it difficult? Why is that the case?") Remember **'**getting to the solution' questions ("what would make it easier? How can we help ensure it happens?")	
• **Step 5: CHW actions** Observe the mother breastfeeding her baby and provide any assistance as necessary. Encourage exclusive breastfeeding. Ensure baby has been taken for first immunisations. Refer all home births.	
Record the results of the meeting: Fill in the *TTC register* for this visit	
End the visit: Decide with the family when you will visit again in the next few days (Visits 4b and 4c). Thank the family.	

Conducting Visits 4b and 4c

SEQUENCE FOR VISIT 4B AND 4C (FOLLOW-UP VISITS IN FIRST WEEK OF LIFE)	
Before starting: Greet the family. Explain the purpose of the visit. Ensure that the identified supporters are all present.	
Assessment steps • **Assessing the mother** o How is she feeling now? o Ask about bleeding, fever, abdominal pain, tiredness, breast problems as before. • **Assessing the newborn** o Ask the mother: How the baby is, feeding progress, movement and crying, any danger signs. o Check the baby: Movement and crying, breathing, skin temperature and colour, look for pustules, check the eyes, check the umbilical cord. o Weigh the baby (optional) •	
Step 5: CHW actions: o Only observe a feed again if the mother reports difficulties, or previously had problems. o Ensure that the baby has been taken for his/her first immunisations. o 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.	
End the visit. Decide with the family when you will visit again. Thank the family.	

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

Example cases and completing the forms

Example 1: Akosua
Visit 4a

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

Newborn Visits 2 and 3

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

Example 2: Kukuwaah
Visit 4a

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

Visits 4 b and c

- You planned to visit Kukuwaah's home after 2 days but get called to their home the day after your first visit
- Kukuwaah informs you that the baby has been dull and sleepy and has not fed well since that morning. You examine the baby and also find that the baby has fast breathing, and you refer them to the health centre.
- Kukuwaah's husband is present and prepares to take the mother and baby to the health centre immediately.

- You remind Kukuwaah to pack the bed net, as you are not sure if the health centre has sufficient nets.
- At the facility, the nurse examines the baby and confirms that she has ARI, and starts the baby on antibiotics. The nurse advises the family to stay overnight to see how the baby responds to treatment
- You visit the health centre the following day to check on the mother and baby. The baby is doing well, and is now able to breastfeed. The nurse informs you that they will be discharged in the evening
- You visit Kukuwaah and the baby in their home the following day, (this is both the third newborn visit as well as a follow up after the illness)
- Kukuwaah and the baby are doing well. The baby is feeding well.
- Both baby and the mother sleep under a bed net.
- Kukuwaah's husband is present during the discussions.

Example 3: Serwa Akoto

Visit 4a

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

Visits 4 b and c

- You visit Serwa Akoto 2 days later.
- You find that Serwa Akoto and the baby had been to the health centre the day before, and had weighed the baby. You find the birth weight mentioned in the baby health card as 2.5 kg
- You also note that the baby has received BCG and OPV 0 vaccinations
- The baby is feeding well.
- Serwa Akoto and the baby have been sleeping under a net since your first visit.
- Neither has any danger sign.

Serwa Akoto's husband was not present during the discussions

Key messages

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

UNIT 6: VISIT 5 – FIRST MONTH

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

GROWTH MONITORING

A child is expected to grow well and gain weight rapidly. From birth to age 2, children should be weighed every month. If a child has not gained weight for about two months, something is wrong.

If a child does not gain weight for 2 months, he or she may need larger or more frequent servings or more nutritious food. This child may be sick, or may need more attention and care. Parents and health workers need to act quickly to discover the cause of the problem.

Each child should have a growth chart. The child's weight is marked with a dot on the growth chart each time he or she is weighed, and the dots should be connected after each weighing. This will produce a line that shows how well the child is growing. If the line goes up, the child is doing well. A line that stays flat or goes down indicates cause for concern.

IMMUNISATIONS

Immunisation is very important. Every child needs a series of vaccinations during the first year of life.

Immunisation protects against several dangerous diseases, including tuberculosis, polio, diphtheria, tetanus, pertussis and measles. A child who is not vaccinated is more likely to suffer from several illness, which may result in becoming permanently disabled, or undernourished and or possibly die.

It is safe to immunise a child who has a minor illness, a disability or who is malnourished.

Immunisations	Vaccinations	
At birth	BCG Polio (OPV)	Hepatitis B
6 weeks	Penta Polio	Hepatitis B Hib PCV rotavirus
10 weeks	Penta Polio	Hepatitis B Hib PCV rotavirus
14 weeks	Penta Polio	Hepatitis B Hib PCV rotavirus
9 months	Measles	Yellow fever

Beliefs regarding immunisations

Inaccurate belief	Counselling response
Infants should not be given any injection during the first month.	Giving BCG and polio vaccine to an infant does not have any ill effect. Even premature babies can be vaccinated. Delaying vaccination is not beneficial for the infants. Delay in vaccination can be fatal.
Infants with fevers and colds should not be immunised.	Immunise as per the health worker's advice. It is usually safe to vaccinate a child who has a minor illness.

The infant will have a fever after being vaccinated.	It is true that the infant will have a fever and restlessness for a day after being vaccinated but there is no need to fear. The infant's body needs to be wiped with a cloth dipped in lukewarm water and the mother should continue to breastfeed. If the child has a high fever then he/she should be taken to the health centre.
Only one vaccine can be given at a time.	BCG, DTP, polio and measles vaccines can all be given at the same time through injections in different parts of the body. This is especially useful for families living in remote villages, and for older children who were not given BCG or DTP in the first year.

POSTNATAL FAMILY PLANNING

- Family Planning is an essential component of health care provided during antenatal period, immediately after delivery and during the first year of child birth. Postnatal family planning is the prevention of unintended pregnancy and closely spaced pregnancies through the first 12months following childbirth.
- Normally it is advised that women resume normal sexual activity after 6 weeks postnatal, 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.
- CHWs should counsel mothers to discuss with partners to take up family planning *as soon as possible after delivery* to prevent new pregnancies until the baby is at least 2 years of age. This prevents health problems for both mother and child, caused by close birth spacing.
- Family planning services are available at the health facilities. The health worker will take the mother and partner through the available methods and allow them select the option that best suits them.

BIRTH REGISTRATION

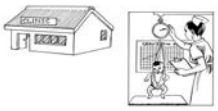
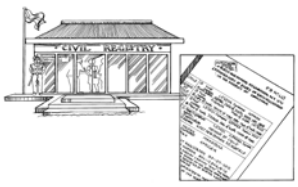
Registering the birth of a newborn baby will ensure that the child receives the social services to which he/she is entitled. Birth registration shows that the child's life is valued and that the child deserves to be counted. It is needed to start school.

Birth registration helps the government to plan for the development of the community and the entire country.

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

Birth registration at the Birth and Death Registry is free for the first 12 month after the baby's birth.

KEY MESSAGES AND ADDITIONAL INFORMATION	ROOT CAUSES What makes it difficult to do? Why is that?	SOLUTIONS What would make it easier to do?

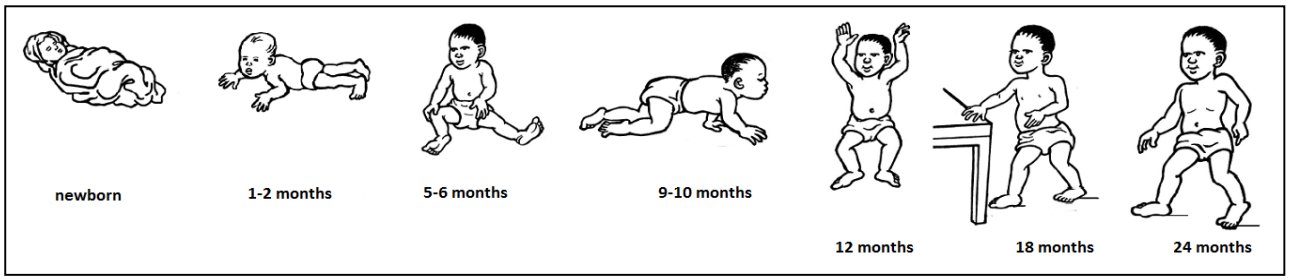
Attend clinic to update immunizations			
Attend clinic to complete growth monitoring of the child			
Family planning (HTSP).			
Birth registration for the newborn			

Key messages

- A young child should grow well and gain weight rapidly. From birth to age 2, children should be weighed every month. If a child has not gained weight for about 2 months, something is wrong.
- Immunisation is urgent. Every child needs a series of 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 CHWs 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.

Notes:

SESSION 6.2: EARLY CHILD DEVELOPMENT



CHILD DEVELOPMENT AND MILESTONES

- Each child is unique at birth and grows and develops at an individual rate, but there are some key milestones that will help identify if a child is developing appropriately.
- If a child cannot yet do something at a particular age yet it does not necessarily mean there is a problem, as most likely they will 'catch up' in time. Any concerns the family or CHW have about development should be referred to a health facility.

MILESTONE – A DEFINITION

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

At birth?	Newborn can see: 8-12 inches, the distance between baby's and mother's eyes during breastfeeding Newborn can smell: becomes sensitive to the smell of mother and caregivers. Newborn can hear: and remember the voices of caregivers from when it was in the womb!
by 2 months?	Baby looks at her/his hand Baby makes sounds other than crying Baby smiles back when caregiver smiles at the baby Baby tries to keep her/his head steady
by 7 months?	Baby can sit upright alone Baby keeps lips closed or turns away if given more food than the baby wants Baby holds out arms to caregiver when they want to be picked up Baby makes sounds or "talks" when s/he holds a toy or sees a pet
by 10 months?	Baby tries to reach for toys that are out of reach or tries to grab caregivers fingers Baby stops and looks at caregivers when they say baby's name Baby can say different sounds such as 'bah', dah', 'mah',' gah' Baby may start to crawl or roll about on their bottoms
by 1 year?	Baby can drink (not suck) from a cup Baby looks around for an object when asked "where is (object)" – (shows understanding) Baby makes lots of sounds together that sound like "talking" and say some words Baby may start to take steps with some help from caregiver
by 2 years?	Toddler can stack blocks or similar Toddler may help caregiver dressing her/him by holding out an arm or foot Toddler can point to some body parts when caregiver says "where is your eyes? nose? ears?" Toddler tries to jump even if both feet stay on the ground.

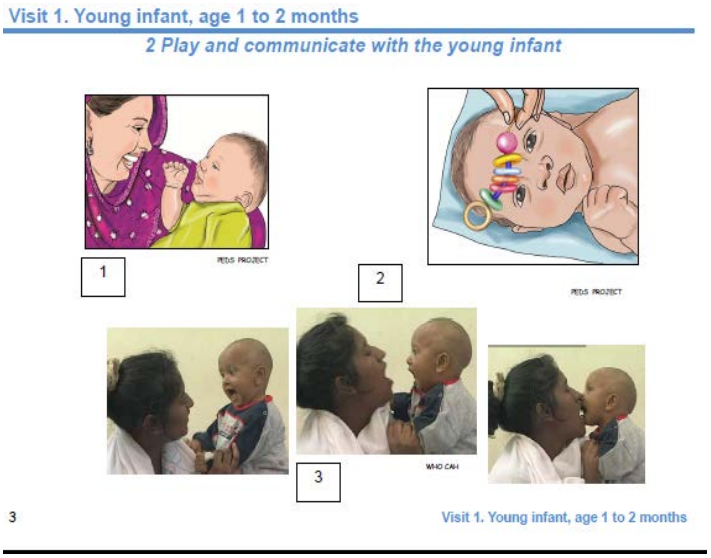
Source: Parent Evaluation of Developmental Status: Developmental Milestones (PEDS:DM): A tool for Surveillance and Screening Professional's Manual 2008 by Glascoe F and Robertshaw N.

Play and communicate with the young infant (WHO counselling cards)

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.



Key messages

- Every interaction we have with infants is important to their physical (motor), cognitive, emotional and social development. The most important time for this is birth to 3 years.
- Exposure to stresses such as family violence, sexual abuse, or neglect (physical and / or emotional) can cause a stress reaction in the brain, damaging or limiting neural pathways and development.
- Positive interactions between parent and child strengthen their attachment while simultaneously building the child's brain. The child learns that others can be trusted and are responsive to their needs. Such positive interactions with caregivers can counter-balance negative influences and prevent damaging effect they can have on the child's development.
- In this early phase they are *learning* how to feel and manage and express their own feelings to others. If parents aren't responsive or respond negatively and the negative interactions dominate, then it can lead to a lack of trust and secure attachment with them. This can limit child's mental and emotional development, which go on to affect social interactions and relationships throughout their lives.

Counselling the family on play and communication for babies aged 1-5 months

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.  

KEY MESSAGE	BARRIERS(ROOT CAUSES) "what makes it difficult for you to do this"	ENABLERS (SOLUTIONS) "what would make it easier for you to do this"	COUNSELLING RESPONSE CHW actions
Caregivers (including the mother father and other family members) should engage their child in positive interactions play and stimulation for development.	lack of time Mother depressed or 'feeling low' Beliefs and culture Access to toys and learning materials Poverty Culture or attitudes of fathers	Family having knowledge and learning skills for ECD Having more time Fathers making time to play with kids Toy making	*Educate* the family on the importance of play and stimulation for development *Teach:* demonstrate techniques for play and stimulation *Teach:* show family how to make age appropriate toys *Refer:* to appropriate health or social services *Counsel:* apply psychological first aid principles where need and refer / link to community or public service support

Key messages

- Each child is unique at birth and grows and develops at an individual rate, but there are some key milestones that will help identify if a child is developing appropriately. Any concerns the family or CHW have about development should be referred to a health facility.
- Babies develop deep emotional attachment to their primary caregivers, which provides them with the security they need to actively learn and build foundational life skills
- A baby who is cared for consistently by their mother, father & family members - who receives responsive love, attention, stimulation, minimal stress and safety - have significantly better adult outcomes (in health, education, employment and society). Mothers and family members should look, hug, talk, sing and play with their baby every day, right from birth.
- Babies who are sick, premature, low birth weight or stunted, orphaned, HIV positive or have a disability will need extra love, stimulation and attention from caregivers and from the CHW.
- Change and growth of the brain occurs most rapidly in the first years of a baby's life with good nutrition, good health and strong parent-infant connection.
- Exclusive breastfeeding, bathing, changing diapers, soothing/calming babies when they cry are all opportunities for the mother/caregiver to interact/connect with the baby.

Notes:

SESSION 6.3: CARE SEEKING FOR FEVER AND ACUTE RESPIRATORY ILLNESS

Malaria, ARI and Danger signs

INFORMATION ABOUT MALARIA

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

DIARRHEA

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

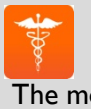
- Diarrhoea is defined as 3 or more loose stools within 24 hours (for children older than 6 months)
- Cases of diarrhoea that have lasted less than 7 days and do not have blood in stool can be treated in the home using oral rehydration salts (ORS) solution and Zinc. The caregiver can obtain these at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

CHWs are responsible for identifying and assessing the condition of children with diarrhoea. CHWs are also responsible for treating the child and engaging the caregiver in an active discussion on how to improve the child's condition, as well as how to prevent diarrhoea in the future.

ACUTE RESPIRATORY ILLNESSES

- Typically a cough or cold is not a sign of a serious problem. Children catch them frequently and if they are cared for well in the home, it will not develop into something more serious.
- A cough can sometimes develop into a serious chest infection. An infant or child who is breathing rapidly or with difficulty might have pneumonia, a chest infection whereby the lungs fill with fluid and the baby cannot breathe. Pneumonia is a life-threatening illness needing immediate treatment at a health facility.

- Many children die of pneumonia at home because their caregivers do not realise the seriousness of the illness and the need for immediate medical care.
- Families can help **prevent** pneumonia by making sure that babies are exclusively breastfed for the first 6 months and that all children are well nourished and fully immunised.
- **TB risk:** A child with a harsh cough also needs immediate medical attention. The child may have tuberculosis, another type of infection in the lungs. Any child who has been living in the home with an adult who has tuberculosis, or who suffers a persistent cough lasting over 2 weeks should be referred.
- **Risk of indoor woodstoves:** Children and pregnant women are particularly at risk of pneumonia when exposed to smoke from tobacco or cooking fires.
- **Care of a child with cough** to prevent pneumonia:
    - Wrap the baby warmly.
    - Clear mucus from the nose frequently.
    - Wash hands with soap every time you handle the baby.
    - Breastfeed frequently and more than usual.
    - Give more to eat and drink than usual.
    - Allow plenty of rest.



GENERAL DANGER SIGNS

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

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

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

General danger signs (urgent medical care)

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

Danger signs (needs to be referred)

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

Care of the infant during referral

FOR THE SICK INFANT:

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

Feeding during illness

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.

Key messages

- Young children are at risk of malaria and can die within 24 hours when not treated. The best way to prevent malaria is by sleeping under a long-lasting insecticide-treated bed net.
- Nets must be hanged correctly, tucked under beds or mats
- Checked for holes and sew up to prevent mosquitoes from entering through any spaces.
- A child with a fever must be taken to a health facility or trained health worker within 24 hours to confirm using a rapid diagnostic test kits before malaria treatment is given.
- Coughs and colds are common in children and are not usually a problem. Sometimes a cough can lead to a serious problem, called pneumonia. This is a life-threatening illness requiring immediate treatment at a health facility, or tuberculosis, which also requires immediate care.
- The mother should continue breastfeeding during illness and increase breastfeeding after illness

Notes:

UNIT 7: VISIT 6 – 5TH MONTH

SESSION 7.1: CHILD FEEDING: 6 TO 9 MONTHS

FEEDING RECOMMENDATIONS FROM 6 TO 9 MONTHS

- **Continue to breastfeed -** From 6 months children still benefit from breastfeeding. Breast milk protect them from illnesses, and provides energy and nutrients to help them grow. All mothers, including those who are HIV positive, should continue to breastfeed the child as often as the child wants.
- **But breast milk is not enough -** However, at 6 months of age, breast milk alone cannot meet all of a child's nutritional needs. Without additional food, children can lose weight and falter during this critical period.
- **Complementary foods -** Encourage the family to introduce complementary foods to the child when he/she reaches 6 months of age. Examples of appropriate complementary foods are thick cereal (e.g. maize, wheat, millet, etc.) with added oil or milk, fruits, vegetables, (e.g. kontomire, alefu, boko, etc.), pulses, meat, eggs, fish and milk products. Suggest locally available, nutritious grains, legumes, seeds, nuts or vegetables to make a thick porridge, and emphasise the need for nutritious food from animal sources. Provide ideas on how to prepare and mash foods so that the young child can safely eat them.
- **Sources of iron -** Some of the most important types of complementary foods are those that are rich in iron. By the time an infant is 6 months of age, breast milk can no longer meet their iron needs and anaemia is likely if the infant is not also given foods that are rich in iron. Iron-rich foods include liver, other animal foods, and dark green leafy vegetables. In some areas, it is also possible to find iron-fortified foods such as maize flour, sorghum flour or bread to which iron has been added.
- **Amounts/preparation -** Start giving two to three spoonful's of thick porridge and well-mashed foods during two to three meals each day. Gradually increase to about half a cup each meal. Offer one or two semi-solid snacks between meals.
- **Help the child eat -** Until the child can feed him/herself (above 2 years old), an adult or older sibling should sit with the child during meals and encourage the child to eat. Soon the child will try to grab small pieces of food. They should be allowed to develop this skill. Giving the child food to eat with his/her fingers can increase the child's interest in eating. However, whilst learning to feed themselves, they still need to be fed most of the food, to make sure that they eat enough.
- **Separate plate -**The child should not have to compete with older brothers and sisters for food from a common plate, where it is difficult to know how much each child has eaten.

- **Handwashing (with soap or ash) -** It is important to wash hands before preparing food and before eating, including the infant's hands.
- **Growth monitoring -** Continue to take the child to be weighed every month.

Food combinations for the greatest benefit

VITAMIN A + OIL
IRON + VITAMIN C

RESPONSIVE FEEDING

- Feed infants directly and help older children when they feed themselves. Feed slowly and patiently, and encourage children to eat, but do not force them.
- If children refuse many foods, experiment with different food combinations, tastes, textures and methods of encouragement. If the child refuses a particular food, wait a few days and offer the food again. Repeat this several times over a period of weeks. Do not try to introduce too many foods at the same time.
- Minimise distractions during meals if the child easily loses interest.
- Remember that feeding times are periods of learning and love. Encourage the family to talk to children during feeding, with eye-to-eye contact.

ROUTINE CARE FOR THE 5-MONTH OLD

Handwashing: Family members and children should wash hands with soap after defecation, and before preparing food, eating and feeding. From the age of 6 months, children should get into the habit of always having their hands washed before a meal, from around 2 years they may even start doing this themselves.
Growth monitoring: Children's growth should be monitored on a regular basis until he or she is 2 years old
Vitamin A supplements: From 6 months of age, children need a vitamin A dose once every 6 months from the health services.
Family planning: A gap of 2 years between the birth of a child and getting pregnant again is better for your health and the health of your family. A suitable family-planning method can be provided at the clinic. By this time mothers should all be using family-planning methods.

Note: The consistency of porridge should not be too thin or runny. It should be of a consistency that stays on the spoon when the spoon is tilted.

No: Too runny	Yes: just right
	

Recipes for enriched porridge

RECIPE 1

Ingredients
3 tablespoons of flour (maize, rice, sorghum, millet)
Mashed fruit (or 1 spoon of sugar to sweeten)
1 teaspoon oil, or 4 teaspoons coconut milk
4 teaspoons of ground roasted groundnut
Boiled water

Preparation
Prepare the porridge in a pan with boiled water.
If adding oil or coconut milk, add at the time of cooking the porridge.
If adding groundnut, add at the end of cooking.
At the end, add mashed fruit or sugar and stir.

RECIPE 2

Ingredients
3 tablespoons of flour (maize, rice, sorghum, millet)
1 teaspoon oil, or 4 teaspoons coconut milk
1 egg, beaten
Salt to taste (iodised)
Boiled water

Preparation
Cook the porridge in a pan with boiled water, adding the oil or coconut milk.
Before removing pan from heat, add the previously beaten egg.
Add salt at end and stir.

RECIPE 3

Ingredients
3 tablespoons flour (maize, rice, sorghum, millet)
3 tablespoons beans (any kind), cooked and mashed
3 tablespoons greens (any kind)
1 teaspoon oil or 4 teaspoons coconut milk, or the seeds of sunflower, sesame, pumpkin or watermelon, toasted and ground
Boiled water

Preparation
Cook the flour with boiled water to make porridge.
If using oil or coconut milk, add at the time of cooking, together with the greens, if these are fast-cooking greens such as pumpkin leaves, or sweet potato leaves. If cassava leaves, these must be cooked beforehand.
If using the seeds of sunflower, sesame, pumpkin or watermelon, add these at the end of cooking.
The beans must be cooked separately, mashed and added at the end of cooking.

RECIPE 4

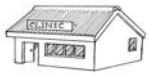
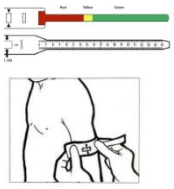
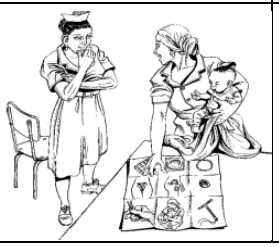
Ingredients
3 tablespoons flour (maize, rice, sorghum, millet)
3 tablespoons fish (any type), cooked and mashed or smoked and pounded
3 tablespoons greens (any type)
1 teaspoon of oil, or 4 teaspoons coconut milk, or the seeds of sunflower, sesame, watermelon or pumpkin, toasted and ground.
Boiled water

Preparation
Cook the flour with boiled water to make porridge
If using oil or coconut milk, add at the time of cooking, together with the greens, if these are fast-cooking greens such as pumpkin leaves, or sweet potato leaves. If cassava leaves, these must be cooked beforehand.
If using the seeds of sunflower, sesame, pumpkin or watermelon, add these at the end of cooking.
The fish must be cooked separately and mashed. If the fish is dried fish, it should be toasted and ground /pounded and added at the end.

RECIPE 5

Ingredients
4 tablespoons of cassava flour, or of cooked and mashed cassava
2 tablespoons of groundnut or cashews toasted and ground
1-2 tablespoons of greens, ground and cooked
Boiled water

Preparation
Cook the flour in a pot with boiled water to make porridge. Add the groundnut or cashew at the end of the cooking, along with the previously cooked greens. If using fresh cassava, cooked and mashed first.

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

Key messages

- When a child reaches 6 months of age, breast milk alone cannot meet all of the child's nutritional needs.
- The child therefore needs to be given appropriate complementary foods two to three times per day. Food should be semi-solid and mashed so that the child can easily swallow it.

- All mothers, including those who are HIV positive, should continue to breastfeed the child as often as the child wants.
- Feed the child iron-rich foods.
- Combine different foods to maximise absorption of nutrients in the body.
- Ideally, a child should be taken for growth monitoring once per month until 2 years of age.
- Lack of vitamin A can cause blindness and serious illnesses. To prevent this, from 6 months of age, children need a vitamin A dose once every six months from the clinic.
- Family planning is especially important for breastfeeding mothers. Becoming pregnant too early could mean they are less able to breastfeed their baby to 2 years of age, so they will be less well nourished.

Notes:

SESSION 7.2: FEEDING DURING ILLNESS

MAJOR KILLERS OF CHILDREN – A RECAP

- Most deaths of infants under 2 years are due to pneumonia, malaria or diarrhoea, which are diseases that are preventable or can be treated.
- Diarrhoea can be treated at home by the family using ORS and continued feeding.
- Pneumonia and malaria need to be treated by a trained health worker.

FEEDING DURING ILLNESS FOR THE CHILD OVER 6 MONTHS

Breastfeeding: Tell the mother to breastfeed more frequently and for longer at each feed, especially if the child is exclusively breastfed. Breastfed children under 6 months of age should first be offered a breastfeed then given ORS and no other fluids.

For children not breastfed or over 6 months, give additional fluids: Give as much fluid as the child will take, as soon as the diarrhoea starts. This is to replace the fluid lost in diarrhoea and prevent dehydration. Give one or more of the following:

ORS solution (for diarrhoea only)

Food-based fluids (soups, rice water and yoghurt drinks)

Clean water (preferably given along with food).

Give additional foods: When sick, children may be less inclined to eat solids. Mothers should breastfeed as much as possible, and encourage the child to eat small snacks, or soft liquid foods. Give small quantities frequently rather than a large meal if this is easier. If the child vomits, wait some time and try again. If the child vomits everything ingested this is an urgent danger sign.

Active feeding: It is important to actively feed the child, encouraging the child to eat. The child should not have to compete with older brothers and sisters for food from a common plate, but should have his/her own serving. Until the child can feed him/herself, the mother or caretaker should help the child to feed. This is especially important during illness when the child may need more encouragement or help than usual to feed adequately.

WHO recommendations on feeding during illness

FEEDING DURING ILLNESS			
UNDER 6 MONTHS	**6 MONTHS TO 12 MONTHS**	**12 MONTHS TO 2 YEARS**	**2 YEARS AND OLDER**
• Breastfeed as often as the child wants, day and night. • Feed at least 8 times in 24 hours. • Do not give other foods or fluids.	 • Continue to breastfeed as often as the child wants. • Give 3 servings of nutritious complementary	 • Continue to breastfeed as often as the child wants, and also give nutritious	 • Continue to breastfeed as often as the child wants. • Give at least 5 adequate nutritious feeds.

	foods. Always mix margarine, fat, oil, peanut butter or groundnuts with porridge. • Also add: chicken, egg, beans, fish or full cream milk, or mashed fruit and vegetables, at least once each day. • If baby is not breastfed, give 3 cups (3 x 200 ml) of full cream milk as well. • If baby gets no milk, give 6 complementary feeds a day	complementary foods. • Give at least 5 adequate nutritious feeds. • Increase variety and quantity of family foods: • Mix margarine, fat, oil, peanut butter or groundnuts in porridge. • Give egg, meat, fish or beans daily. • Give fruit or vegetables twice every day. • Give milk every day, especially if no longer breastfeeding. • Feed actively with baby's own serving	• Increase variety and quantity of family foods: • Mix margarine, fat, oil, peanut butter or ground nuts with porridge • Give egg, meat, fish or beans daily • Give fruit/ vegetables twice every day • Give milk every day, especially if no longer breastfeeding. • Feed actively with baby's own serving.

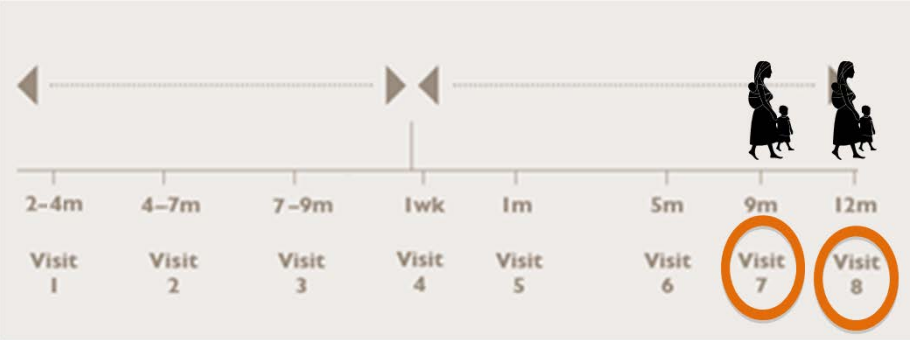
Key recommended practice	Common misconceptions or barriers	Counselling responses
Care seeking for the major killers within 24 hours	Lack of knowledge Belief the child may get better without treatment. Belief in local/home remedies.	Under the age of 2 years if a child has diarrhoea, fever or cough with fast breathing, then they need medical treatment. If they also have danger signs they need urgent care. A child under 2 can become very ill if you wait longer than 24 hours.
Active feeding	The child should learn to eat from the family plate. The child will be able to eat as much as it needs without active feeding.	Explain: when plates are shared they cannot ensure the sick child gets enough to eat. If diarrhoea, the child may pass infection to other family members. The child may not have strength to eat as much as they need by themselves.
Increased feeding and fluids during illness	If the child does not have an appetite during illness, then it's okay to give only fluids. When a child has diarrhoea, they need to 'dry out' by having fewer fluids.	The child may eat smaller portions than usual and prefer fluids to solids. Give smaller meals and snacks to prevent malnutrition during illness. Also give fluid foods such as soups, which might be easier to eat. During illness, especially diarrhoea, the child needs more fluids than usual. Breastfeed more than usual and for longer, and if the child is over 6 months, give other fluids.

Key messages

- The major killers of children under 2 years of age are diarrhoea, malaria and pneumonia, and seeking medical help within the first day of illness can prevent serious complications and death.
- A child with diarrhoea needs to be treated with ORS and zinc as instructed by the clinic.
- During the illness and for two weeks after, the child should drink and eat more than usual. They also need to breastfeed more than usual and for longer at each feed, and (if over 6 months) and be given additional fluids and food. For example, give at least one extra meal a day for two weeks.
- Active feeding is especially important during illness. Encourage the child to eat, even if vomiting or low appetite, and give small meals frequently between breastfeeds.

Notes:

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



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

CHILD FEEDING AT 9-12 MONTHS

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

Children at 9 months should eat four times per day instead of three times. Food should be given from all three food groups and may be finely chopped or mashed.

After 12 months, the child should eat six times per day. Three or four of these feedings should be from the family food supply, whilst the others may be snacks such as fruits, eggs or peanuts. Food should be given from all three food groups and should be finely chopped or mashed.

The mother should make sure that the child is eating foods rich in iron and foods rich in vitamin A.

The child should eat from a separate plate so the mother can be sure he/she is getting enough food.

By 9 months babies will start to try feeding themselves but will continue to need to be actively fed, and the mother or caregiver must ensure that the babies get enough to eat at each meal.

VITAMIN A

Until children are 6 months of age, breast milk provides them with all the vitamin A they need, as long as the mother herself has enough vitamin A from her diet or supplements.

Children older than 6 months need to get vitamin A from other foods or supplements.

Vitamin A is found in liver, eggs (yolk), some fatty fish, ripe mangoes and papayas, yellow or orange sweet potatoes, dark green leafy vegetables and carrots.

When children do not have enough vitamin A, they are at risk of night blindness. This is when it is difficult for them to see when the light is dim, such as in the evening or at night. If not treated with vitamin A, this condition can lead to permanent blindness.

Children also need vitamin A to resist illness. A child who does not have enough vitamin A will become ill more often, and the illness will be more severe, possibly leading to death.

Children should receive vitamin A capsules twice per year between 6 months and 5 years of age.

IRON

Children need iron-rich foods to protect their physical and mental abilities. The best sources of iron are liver, lean meats, fish, insects, and dark green leafy vegetables.

The child may also get iron from iron-fortified foods or iron supplements. The health worker may recommend iron supplements in some situations.

Anaemia (a lack of iron) can impair physical and mental development. Even mild anaemia in young children can slow mental development. Anaemia is the most common nutritional disorder in the world.

Malaria and hookworm can cause or worsen anaemia.

IODINE

Small amounts of iodine are essential for children's growth and development. If a child does not get enough iodine, or if his/her mother is iodine-deficient during pregnancy, the child is likely to be born with a mental, hearing or speech disability, or may have delayed physical or mental development.

Using iodised salt instead of ordinary salt gives pregnant women and children as much iodine as they need.

If iodised salt is not available, iodine supplements may be provided by the health facility (according to country policy).

INTESTINAL WORMS

- Intestinal worms can cause or worsen anaemia (low levels of iron in the blood) in children, which can harm the child's physical and mental development. Worms can also lead to increased cases of diarrhoea, causing children to lose vitamin stores in their bodies, and contribute to a child becoming malnourished.
- Intestinal worms enter the body through the soil or water. You can prevent intestinal worms through good hygiene. Children should not play near the latrine, and should wash hands with soap often.
- Once children start walking, they should wear shoes to prevent getting worms.
- Raw meat may contain worms, so hands and utensils should be washed carefully after handling it, and meat should be thoroughly cooked before eating.
- Children living in areas where worms are common should be treated with deworming medicine two to three times a year

Child development at 9-12 months

CHILD DEVELOPMENT

- **Touch:** It is important to give the baby loving affection. Feeding is a time when the baby can be held and his/her arms and legs rubbed gently.

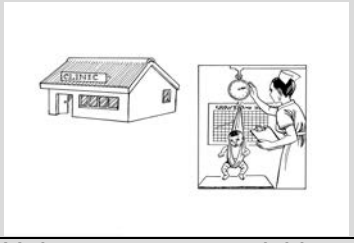
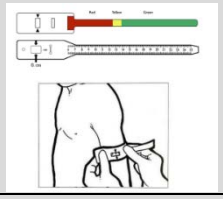
- **Communication:** Feeding is also a good time to communicate with the baby, which will help them keep calm and comforted, and help them to learn to speak. Talk to the baby about the food, encourage self-feeding, and praise when they manage it. Feed in response to the child's hunger – it shouldn't be necessary to force feed the child.

Age of young infant	Recommendations for family
9 months up to 12 months 	*Play:* Hide a child's favourite toy under a cloth or box. See if the child can find it. Play peek-a-boo. *Communicate:* Tell your child the names of things and people. Show your child how to say things with hands, like 'bye-bye'. Sample toy: doll with face.  

Age of young infant	Recommendations for family
12 months up to 2 years 	• Play: Give your child things to stack up, and to put into containers and take out. Sample toys: Nesting and stacking objects, container and clothes clips. • Communicate: Ask your child simple questions. Respond to your child's attempts to talk. Show and talk about nature, pictures and things.  

Vaccination, vitamin A, deworming and growth monitoring

- **Vaccination:** By the age of 1 year the child should have completed all of the vaccines. If there are some gaps in the vaccine register, then refer them at this time, as many countries policies don't support vaccinating children after the age of one year.
- **Vitamin A:** All children over the age of 6 months are given vitamin A supplements every 6 months until they are 5 years of age, which prevents night blindness and protects from other diseases. The mother can obtain this from the health facility, or during outreach campaigns.
- **Growth monitoring and promotion:** Children should be monitored ideally once a month until they are 2 years of age, although after the age of 1 year this may become less frequent.
- **Deworming:** All children from the age of 1 year are given a deworming tablet once every 6 months. The mother can access this at the health facility or during outreach campaigns.

KEY MESSAGES AND ADDITIONAL INFORMATION	BARRIERS (ROOT CAUSES) What makes it difficult to do?	ENABLERS What would make it easier to do?
Continued breastfeeding* alongside complementary foods 		
Give vitamin A rich foods*		
Micronutrients: Vitamin A supplementation from 6 months 		
Preparation of complementary foods for 6 to 9 month child: give 2 to 3 meals a day - Feed in response to hunger. (responsive child's feeding) - Give food on a separate plate 		
Continue regular growth monitoring at the clinic and community  		
Holistic child development: talk, play and stimulate the baby for language and emotional development. 		

Key messages

- Between 9 and 12 months of age, children need to eat more frequently and in greater amounts. Children should be given complementary foods at least four times a day at this age as well as continue to breastfeed.
- By 12 months of age, children should receive six meals a day, of which two could be snacks such as fruit and eggs. Children should continue to breastfeed
- It is important that children receive have adequate vitamin A, iron and iodine in their diets. Families should understand which foods contain these important micronutrients.

- In addition, children will be given vitamin A supplements twice a year from 6 months to 5 years of age. In some situations, children will also be given iron supplements.
- Intestinal worms can lead to anaemia, diarrhoea and contribute to a child becoming malnourished. Prevent intestinal worms through good hygiene, hand washing, wearing shoes outside, thorough cooking and hygienic handling of raw meat. Give the child deworming medicine every six months from 1 year of age.
- Encourage the mother and family members to play and communicate with the child to help them feel loved and to grow and develop fully.

Notes:

SESSION 8.2: SUPPORTIVE CARE FOR THE HIGH-RISK CHILD

HIGH-RISK AND VULNERABLE CHILDREN

A high-risk child is more likely to die before the age of 5, or to suffer complications such as infections and malnutrition.

Risk factors common in children: being HIV-positive, experiencing malnutrition, not being breastfed, being a maternal orphan and living with disabilities.

FAMILY AND HOME ENVIRONMENT CONTRIBUTES TO RISK

A child may also be considered high risk due to events in the home such as the mother experiencing psychosocial problems, previous child deaths, evidence of neglect or abuse of children, experience of abuse and violence within the family home, caregivers with chronic or serious health problems, extreme poverty and poor living conditions. Whilst not formally marked as high-risk cases, these contexts can exacerbate existing risk factors in such a way as to push a healthy child into a very high risk.

HIGH-RISK NEWBORNS AND HIGH-RISK POSTNATAL MOTHERS CAN RECEIVE ADDITIONAL SUPPORT, SUCH AS:

Additional home visits and counselling or feeding support
Psychosocial support for the mother and family
Monitoring and supporting medicine adherence and clinic attendance
Increased vigilance for danger signs and hygiene promotion
Connect them to other community- and facility-based services.

SPECIAL CARE FOR THE HIV-POSITIVE CHILD

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

Children with HIV may suffer the usual childhood infections more frequently than uninfected children and are especially susceptible to getting TB or becoming malnourished. Children with HIV therefore need extra nutritious meals and snacks or may be provided with multivitamins to protect them from malnutrition. They need to be taken for more regular growth monitoring and health checks at the clinic than those without HIV.

Knowing a child's HIV status can help the ttC-HV to best advise the family. However the ttC-HV must keep this knowledge confidential between the family, themselves and the health facility staff.

Children with HIV require lifelong ARV medicines that need to be taken every day. These will protect and improve their health. Mothers and caregivers need encouragement and support to ensure that they adhere to the treatment regime and never miss giving their child the ARVs. These children can reach adolescence without any severe illnesses if they always take their ARVs.

Key messages

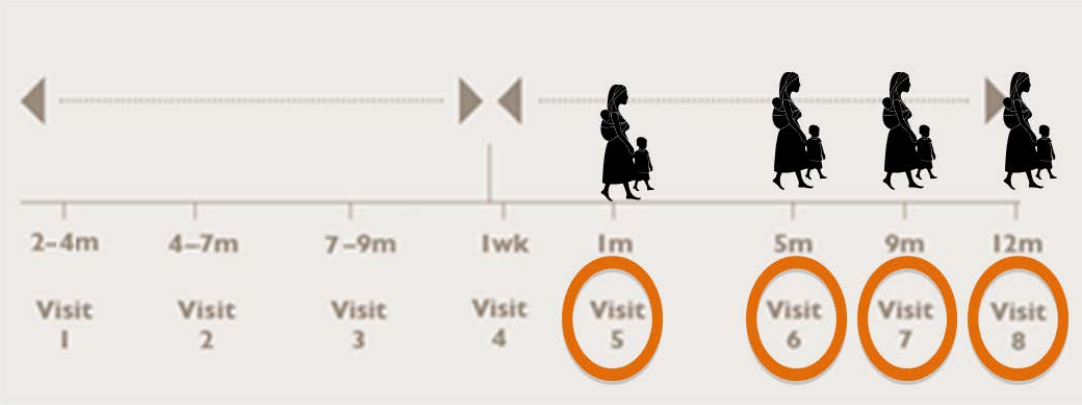
- A high-risk child is more likely to die before the age of 5, or to suffer complications such as infections and malnutrition. This may include being HIV-positive, experiencing malnutrition, not being breastfed, being a maternal orphan and living with disabilities.
- Factors in the family home environment can influence or exacerbate risks.

- High-risk children may be targeted to receive additional support, such as:
- additional home visits, counselling support or breastfeeding support
- psychosocial support for the mother and family
- monitoring and supporting medicine adherence and clinic attendance
- increased vigilance for danger signs and hygiene promotion.

- Children who have HIV are at much higher risk of dying from other illnesses in the first 2 years of life, and are in need of improved nutrition and more access to regular health care than those without HIV. Children with HIV require lifelong ARV medicines that need to be taken every day. Families caring for an HIV-positive child must ensure that they give their ARV medicines every day. If they do so, they can be confident that their child will be healthy and go on to live a productive, healthy and long life no different from any other child.

Notes:

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



CONDUCTING VISITS 5 – 8

SEQUENCE FOR VISIT 5

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 Family Health Card pages from the previous visit (Visit 4). Review the negotiated behaviours and praise any progress. Renegotiate if the family is still struggling. **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 family healthcard**	
Step 5: CHW 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.	
End the visit: Decide with the family when you will visit again (at 5 months). Thank the family.	

SEQUENCE FOR VISIT 6: 5TH MONTH	
Before starting: Greet the family. Ensure that the identified supporters are all present.	
Identify and respond to any difficulties: Ask the mother if she has any danger signs, including any emotional distress. Conduct referral if needed. Apply psychological first aid principles if needed. **Assess the child:** If the mother reports the child is sick, check for danger signs and refer if any are present.	
TTC counselling process: **Step 1: Review the previous meeting** (Visit 5) and update the Family Health Card for new practices completed. **Step 2: Present and reflect on the problem:** problem scenario: 'Malnutrition and diarrhea' and ask the guiding questions. **Step 3: Present information:** positive story: 'Complementary feeding' and ask the guiding questions. **Step 4: Negotiate new actions using the Family Health Card.**	
Step 5: CHW additional actions: • Ask about continuing breastfeeding and provide advice as necessary. • Ask about family-planning choice. • Check child health card for growth monitoring and/or immunisations, and remind about vitamin A. • Demonstrate enriched porridge (optional). • Ask and observe: Counsel family on care for child development.	
Record the results of the meeting: Fill in the TTC register for this visit.	
End the visit: Decide with the family when you will visit again (at 9 months).	

SEQUENCE FOR VISIT 7: NINTH MONTH	
Before starting: Greet the family. Ensure that the identified supporters are all present.	
Identify and respond to any difficulties: Ask the mother if she has any danger signs, including any emotional distress. Conduct referral if needed. Apply psychological first aid principles if needed. **Assess the child:** If the mother reports that the child is sick, check for danger signs and refer if any are present.	
TTC Counselling process: Diarrhoea, complementary feeding, vitamin A **Step 1: Review the previous meeting.** **Step 2a: Present and reflect on the problem:** Problem scenario: 'Vitamin A deficiency', and ask the guiding questions. **Step 2b: Present and reflect on the problem:** Problem scenario: 'Diarrhoea'. **Step 3: Present information:** Positive story: 'Diarrhoea, complementary feeding, vitamin A', and ask the guiding questions. **Step 4: Negotiate new actions** using the Family Health Card.	
Step 5: CHW additional actions: • Ask about continuing breastfeeding and provide advice as necessary. • Check child health card for growth monitoring and/or immunisations, and remind about vitamin A and measles vaccine. • Screen for MUAC (optional/ contextual).	

• Ask what the child ate in the previous day; check for iron-rich and vitamin A-rich foods, and a balanced diet. • Ask and observe: Counsel family on care for child development.	
Record the results of the meeting: Fill in the TTC register for this visit	
End the visit: Decide with the family when you will visit again (at 12 months). Thank the family.	

SEQUENCE FOR VISIT 8: 12TH MONTH	
Before starting: Greet the family. Ensure that the identified supporters are all present.	
Identify and respond to any difficulties: Ask the mother if she has any danger signs, including any emotional distress. Conduct referral if needed. Apply psychological first aid principles if needed.	
Assess the child: If the mother reports that the child is sick, check for danger signs and refer if present.	
TTC Counselling process in visit 9: **Step 1: Review the previous meeting** (Visit 7) and update the Family health card. **Step 2: Present and reflect on the problem** There is no problem story in this visit. **Step 3: Tell the positive story:** 'Complementary feeding, deworming and vitamin A' using the appropriate flipbook visuals that show the story. **Step 4: Negotiate new actions** using the family health card	
Step 5: CHW additional actions: ✓ Ask about continuing breastfeeding and provide advice as necessary. ✓ Ask what the child has eaten the previous day, checking for iron-rich and vitamin A-rich foods, and a balanced diet. ✓ Check child health card for growth monitoring and/or immunisations, and remind about vitamin A. ✓ Refer for deworming if the child has not already had it at 12 months. ✓ Screen sick or recently sick children for signs of malnutrition. ✓ Ask and observe: Counsel family on care for child development.	
Record the results of the meeting: Fill in the *TTC Register* for this visit	
End the visit: Thank the family and inform them that this will be your last TTC visit but that you will continue to visit the home every 6 months (or 3 months for priority households)	

Key messages

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

COMPLETING THE TTC REGISTER FOR VISITS 5-8

TTC Infant Register

TTC Infant Register

		Name of Baby: Individual Code: Name of Father: Priority HH (✓/X)				Name of Baby: Individual Code: Name of Father: Priority HH (✓/X)				Name of Baby: Individual Code: Name of Father: Priority HH (✓/X)				Name of Baby: Individual Code: Name of Father: Priority HH (✓/X)				Name of Baby: Individual Code: Name of Father: Priority HH (✓/X)			
		Date of Birth:				Date of Birth:				Date of Birth:				Date of Birth:				Date of Birth:			
		Boy/Girl:				Boy/Girl:				Boy/Girl:				Boy/Girl:				Boy/Girl:			
		Visit 7, 1month	Visit 8, 5 months	Visit 9, 9 months	Visit 10, 1 year	Visit 7, 1month	Visit 8, 5 months	Visit 9, 9 months	Visit 10, 1 year	Visit 7, 1month	Visit 8, 5 months	Visit 9, 9 months	Visit 10, 1 year	Visit 7, 1month	Visit 8, 5 months	Visit 9, 9 months	Visit 10, 1 year	Visit 7, 1month	Visit 8, 5 months	Visit 9, 9 months	Visit 10, 1 year
A	Planned Visit Date																				
B	Actual Visit Date																				
C	High risk infant (✓/X)																				
D	Husband/Male partner participated in TTC Visit (✓/X)																				
E	Bed net used consistently (✓/X)																				
F	Exclusively breastfeeding (✓/X)																				
G	Taking minimum meal frequency (✓/X)																				
H	Fed from 4+ food groups (✓/X)																				
I	Taking iron rich foods daily (✓/X)																				
J	Penta/OPV 1,2,3 given (✓/X)																				
K	Measles given (✓/X)																				
L	Birth registration done (✓/X)																				
M	Mother/Partner using FP (✓/X)																				
N	Danger sign (✓/X)																				
O	Referral Completed (✓/X)																				
P	Post referral home visit completed (✓/X)																				
Q	Death of baby																				
R	Next Visit Date																				

Example cases and completing the forms

Example 1: Akosua

Visit 6

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

Example 2: Kukuwaah

Visit 6

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

Example 3: Serwa Akoto
Visit 6

- You plan to visit Serwa Akoto's house on March 27th and end up visiting the house as planned
- Serwa Akoto's husband is not present during the discussions
- Serwa Akoto has taken her baby for vaccinations and the baby has received three doses of Penta and three doses of OPV. You verify it from the baby's health card
- The baby has also received her birth certificate
- Both mother and baby sleep under a net
- Serwa Akoto says she has been giving the baby only breast milk. She has not given her water or other fluids/foods
- The baby does not have any danger signs

CHW Monthly Report			Data for this report will come from:	
Month/Year:			Household register tally sheet (done by CHW)	
CHW Name:	Community:		Surveillance register	
CHO Name:	CHPS Zone:		Home based care register	
			TTC registers - pregnancy, newborn and infant	

Data Item	Number
Households	
Total individuals in CHW area	
Total men	
Total women	
Total children under five	
Total women aged 15-49 years	
Total elderly (>60 years)	
Total over 18 years	
Total literate	
Total 6-16y in school	
Total disabled	
Total Households	
Households with access to safe water	
Households treating water before use	
Households with handwashing facility	
Households with functional latrine	
Households with refuse disposal facility	
Households having sufficient LLINs	
Surveillance	
Total Deaths	
Total births	
Boys	
Girls	
Live births	
Stillbirths	
Delivered at facility	
Total cases of notifiable illness reported:	
Acute flaccid paralysis	
Neonatal tetanus	
Measles	
Acute watery diarrhoea	
Cholera	
Viral Haemorrhagic Fevers	
Yellow Fever	
Leishmaniasis	
Guineawork	
Trachoma	

Data Item	Number
Timed and Targeted Counseling	
# women in TTC register who delivered this month	
# women who had male partner presence during TTC	
# women who slept under bed net	
# women who completed 4 ANC	
# women who did HIV test and received result	
# newborns in TTC this month	
# newborns receiving CHX gel application	
# newborns who received BCG and OPV-0	
# infants in TTC completing 1 year this month	
# infants sleeping under bed net	
# infants who received Penta and OPV 3	
# infants who received measles vaccine	
# infants who have had birth registration	
# infants whose mothers or their partners use FP	
CHW Activities of this month	
# household assessments (routine/priority)	
# family health checks	
# TTC visits	
# given home-based care (total)	
# children with SAM given home-based care	
Referrals	
# Pregnant women	
# Postpartum mothers	
# newborns	
# Children with low MUAC (MAM and SAM)	
# Children with fever	
# Children with cough and fast/difficult breathing	
# Children with severe diarrhoea	

Key messages

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

Notes:

REFERRAL, COUNTER-REFERRAL AND FOLLOW UP

Care during referral

FOR THE PREGNANT WOMAN:

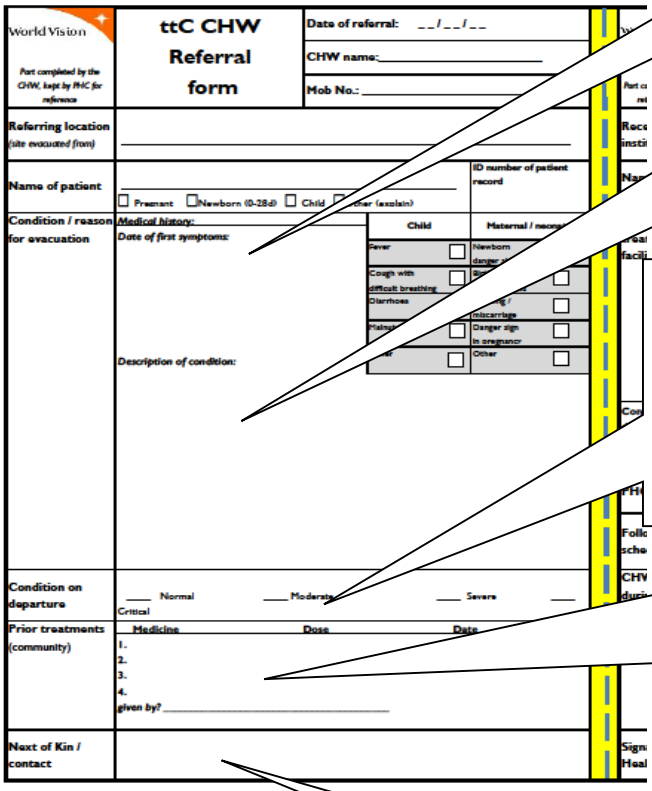
Tell someone immediately – don't hide it or wait to see what might happen
Call for help and take the woman to the health facility immediately. The woman must be accompanied by a family member and/or the CHW
Go to the front of the line and explain the situation to the health staff.
Give liquids to the woman while in transit to the health facility (unless she is having a seizure, in which case liquids should not be given).
Ensure that she carriers her birth materials with her especially if she is in late pregnancy

FOR THE SICK NEWBORN:

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

FOR THE SICK MOTHER:

She should travel with the newborn baby and accompanying family member who can help.
Encourage her to continue to breastfeed the baby if possible.
If she is experiencing bleeding:
Apply a sanitary pad or clean cloths; keep her lying down during transport.
Arrange suitable transport 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 CHW, 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.


World Vision

ttC CHW Referral form

Date of referral: __/__/__

CHW name:

Mob No.:

Part completed by the CHW, kept by PHC for reference

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:

Description of condition:

Child

Maternal / neonatal

Fever

Cough with difficult breathing

Diarrhoea

Danger sign in pregnancy

Other

Condition on departure

Normal Moderate Severe Critical

Prior treatments (community)

Medicine Dose Date

1.
2.
3.
4.

given by?

Next of Kin / contact

When did the patient first begin to feel unwell?

Write what danger signs they have experienced, any previous medical problems and chronic conditions. Tick the most appropriate problem from the list

At the time they left the location were they:
Normal - able to walk, comfortable
Moderate – able to walk with difficulty
Severe – conscious, unable to walk
Critical – unconscious or very weak

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

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

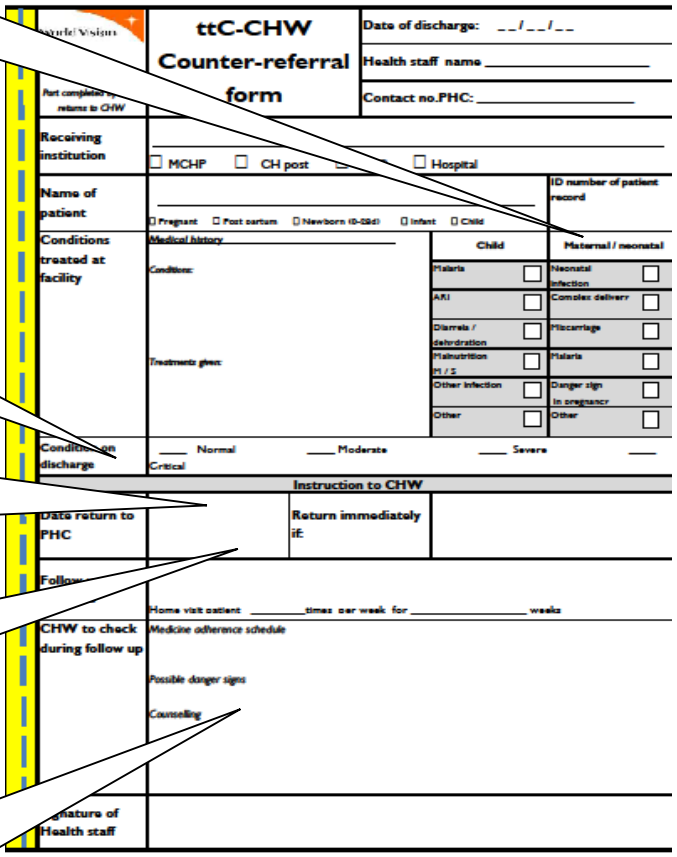
Health staff will write what was the condition and what was treated here (if the mother gives consent to share this information

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

Health staff to list date required for follow up – *CHWS* can ensure this follow up clinic appointment is attended.

Health staff to list danger signs indicating patient should return immediately, *e.g. fever, headache, no improvement.*

Message to the *CHWS* to check (if needed):
Medicines
Danger signs
Self-care guidance for patient



Key Messages

- Seek help immediately at the nearest health centre if a pregnant woman, postpartum mother or baby experiences any danger signs.
- During an emergency referral ensure that the woman or child is: accompanied by family member or *CHWS*, comfortable, carries food and water, all medical records or cards, materials needed for a hospital stay. A baby should be breastfed if possible, during the transfer
- A written referral form communicates to health facility staff important information during an evacuation such as: previous or long term medical problems, timing of illness, medicines currently or previously taken, who to contact (family).
- During a home-based post-referral visit a CHW should ensure the patient received the medical care and medicines they needed, are feeling fully recovered, following the treatment and self-care guidance given to them. Provide breastfeeding support as needed
- 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, *CHWS* or family such as: condition identified, when to return, medicines being taken, possible danger signs and when to follow up at home.

Notes: