

TIMED AND TARGETED COUNSELLING FOR HEALTH & NUTRITION

Participants Training Manual in TTC



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

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ABBREVIATIONS

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

SESSION 1: INTRODUCTION TO TIMED AND TARGETED COUNSELLING.

TOPICS:

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

WHY DO PREGNANT WOMEN NEED EXTRA CARE?

EXTRA CARE FOR THE PREGNANT WOMAN

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

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

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

WHY DO NEWBORN BABIES NEED EXTRA CARE?

THE NEONATAL PERIOD

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

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

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

to infections, being unable to breathe, or being born too early³.

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

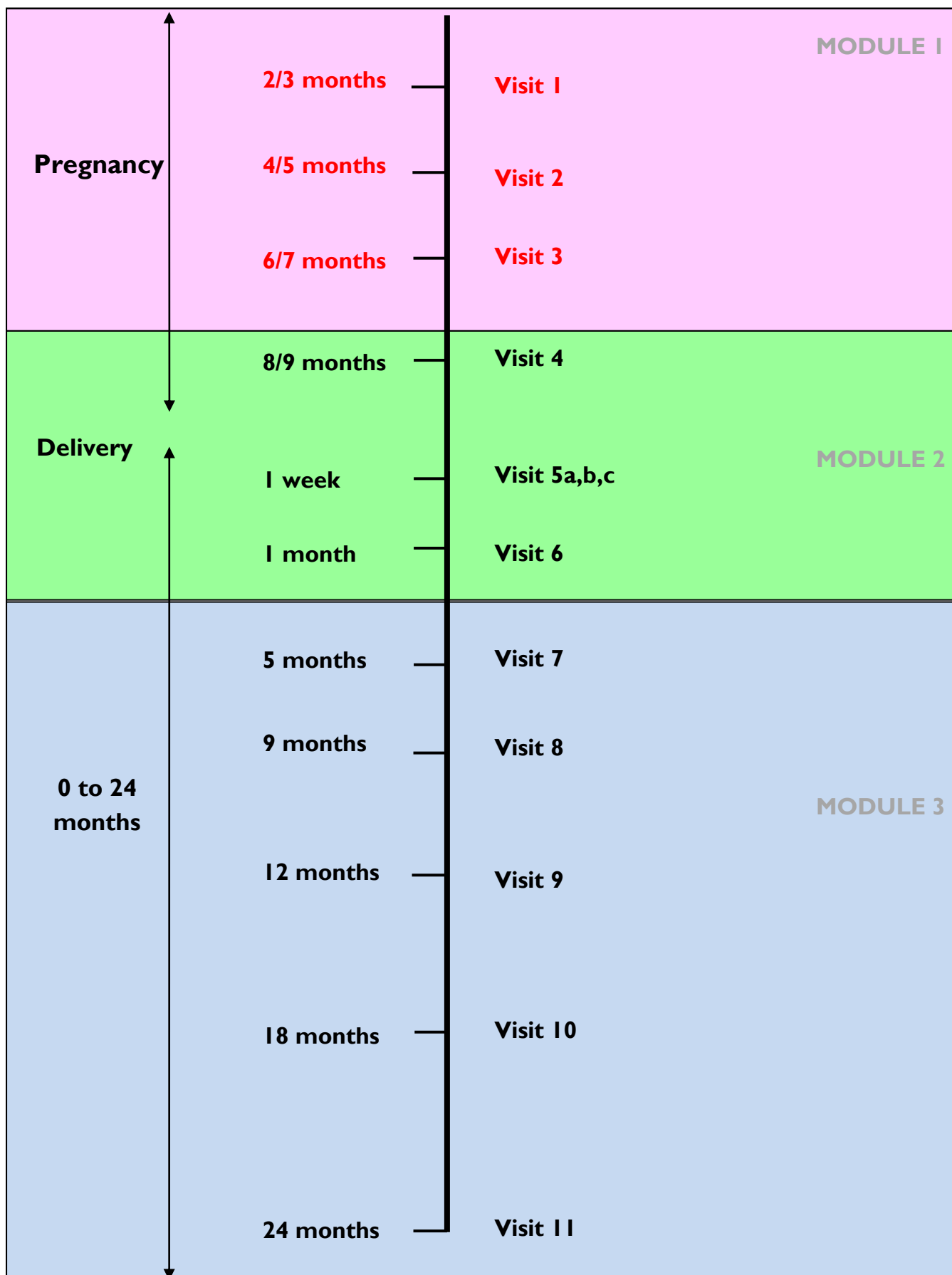
OVERVIEW OF ttC-HV TASKS

OVERVIEW OF TTC-HV TASKS

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

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

TTC-HV Visiting Schedule



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

SUMMARIZING THE SITUATION IN THE COUNTRY

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

Diarrhoea

Infant and child mortality

Vitamin A deficiency

Stunting

Maternal anaemia

Perinatal Depression

Notes:

SESSION 3: IDENTIFYING EARLY PREGNANCIES AND REACHING VULNERABLE HOUSEHOLDS

TOPICS

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

Key Messages

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

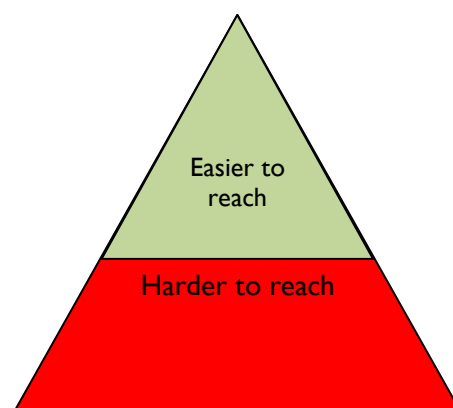
REACHING VULNERABLE HOUSEHOLDS

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

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

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

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



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

IDENTIFYING ALL WOMEN, EARLY IN PREGNANCY

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

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

HOW CAN WE IDENTIFY ALL WOMEN IN THE COMMUNITY?

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

HOW TO IDENTIFY PREGNANT WOMEN IN THE COMMUNITY?

IDENTIFYING PREGNANT WOMEN EARLY IN THEIR PREGNANCIES

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

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

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

ACCESSING THE MOST VULNERABLE

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

PLANNING & PRACTISING YOUR TTC INTRODUCTION VISITS

“HOW TO CONDUCT A SENSITIZATION VISIT”

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

Notes:

SESSION 3B. REGISTRATION OF ELIGIBLE WOMEN AND GIRLS

TOPICS:

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

KEY MESSAGES

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

COMPLETING THE ELIGIBLE WOMEN AND GIRL REGISTER

WHO IS ELIGIBLE FOR REGISTRATION?

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

PLANNING & PRACTISING REGISTRATION VISITS

“HOW TO CONDUCT A REGISTRATION VISIT”

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

COMPLETING THE REGISTER

Information about the CHW or HV

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

Information about each woman

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

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

WHO SHOULD STORE THE EWG REGISTER

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

SESSION 4: BEHAVIOUR CHANGE COMMUNICATION

TOPICS

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

UNDERSTANDING BEHAVIOR CHANGE

Key messages

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

Activity

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

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

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

WHAT TYPES OF BARRIERS ARE THERE?

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

OVERCOMING THE BARRIERS

Activity

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

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

Notes:

SESSION 5: COMMUNICATION SKILLS

Key messages

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

Communication skills

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

I. TWO-WAY COMMUNICATION

Two-way communication

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

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

2. SHOWING RESPECT

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

3. BODY LANGUAGE

Body language

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

4. ASKING QUESTIONS

CLOSED- AND OPEN-ENDED QUESTIONS

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

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

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

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

JUDGMENTAL AND NON-JUDGMENTAL QUESTIONS

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

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

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

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

happening?

5. LISTENING

How to show that you are listening through body language

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

How to show you are listening through responses

A. Reflect back

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

Mother: I'm worried about my baby.

ttC-HV: So you say you are worried.

Mother: My baby was crying too much last night.

ttC-HV: He was crying a lot?

How to show you are listening through responses

B. Empathy

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

Mother: I am tired all the time now.

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

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

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

6. PRAISING

PRAISE WHEN APPROPRIATE

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

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

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

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

7. RESPONDING APPROPRIATELY

FIRST INTERACTION:

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

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

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

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

SECOND INTERACTION:

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

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

Ask: Is this response appropriate?

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

THIRD INTERACTION:

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

RESPONDING APPROPRIATELY

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

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

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

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

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

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

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

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

8. CHECK UNDERSTANDING

CHECKING UNDERSTANDING

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

Notes:

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

Key messages

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

Summary:

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

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

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

Common signs of mental / emotional distress to look for:

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

PRINCIPLES OF PSYCHOLOGICAL FIRST AID

In every visit to the home:

LOOK:

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

LISTEN:

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

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

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

LINK:

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

END ASSISTANCE WELL & FOLLOW UP:

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

APPLYING THESE TECHNIQUES TO TTC

RESPONDING TO DISTRESS

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

INTIMATE PARTNER VIOLENCE

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

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

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

How common is the problem?

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

Increased risk in pregnancy

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

Responding to IPV

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

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

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

Responding to a recent SV incident

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

Providers should ensure:

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

Sources:

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

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

Examples of Coping Strategies

positive	negative
<p>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.</p>	<p>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).</p>

Promote positive coping to prevent emotional distress from building up:

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

Notes:

SESSION 7: THE DIALOGUE COUNSELLING APPROACH

Key messages

Household counselling process:

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

WORDS USED IN THIS TRAINING

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

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

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

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

STEPS OF THE HOUSEHOLD COUNSELLING PROCESS

HOUSEHOLD COUNSELLING PROCESS: OVERVIEW

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

HOUSEHOLD COUNSELLING PROCESS: DETAILS OF EACH STEP

Before Starting

Greet the family and develop good relations.

Explain the purpose of the visit

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

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

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

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

Conduct referral if needed.

Apply Psychological first aid principles if needed.

Step 1: Review the previous meeting

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

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

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

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

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

Step 3+: Technical information (some visits)

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

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

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

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

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

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

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

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

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

GOOD TECHNIQUES OF STORYTELLING:

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

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

SESSION 8. NEGOTIATION USING OF THE HOUSEHOLD HANDBOOKS

Key messages

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

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

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

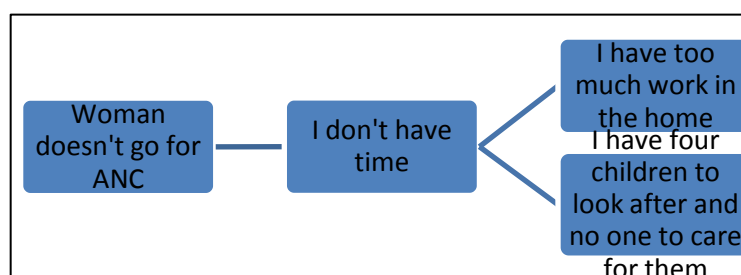
- **Identify behaviours done / not done** – present each drawing (or key behaviour) one at a time and ask if they are already doing it
- **If the family is doing the behaviour:** circle the ✓ mark then praise them for doing this.
- **If the family is not doing the behaviour:** circle the * mark then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

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

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

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

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



Getting to the cause – example:

EXAMPLE 1

ttC-HV: So, you say that you don't go to antenatal care at the clinic?
Woman: No, I don't go.
ttC-HV: **What makes it difficult for you** to go to ANC do you think?
Woman: I don't have time for that
ttC-HV: I see. **Why** is it that you don't have time to go to the clinic?
Woman: I have too much work to do
ttC-HV: ok, **why** do you have too much work?
Woman: I have a lot to do in the home, and four children and no one to help care for them

Finding a solution – example:

EXAMPLE 2

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

Notes:

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

OBJECTIVES OF THE SESSION

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

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

Review: Activities to address the determinants

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

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

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

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

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

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



Visit 2. Mid Pregnancy

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

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

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



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

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

<p>Danger Signs in Labour and Delivery</p>	<p>Take woman to health facility if danger sign is present (if home birth). During labour evacuate immediately if the mother has one of these signs:</p> <ul style="list-style-type: none"> - Woman feels no/reduced movement of the baby - Water breaks without labour commencing after 6 hours - Bleeding in labour but before the birth - Prolonged labour /birth delay (12 hours or more) - Fever and chills - fits or loss of consciousness - Severe head ache <p>Remember:</p> <p>As part of the birth plan families should have all materials for birth, transport plan and money for emergencies ready before labour starts. If labour comes early or a danger sign occurs the woman can be quickly taken to the facility.</p>	<p><i>Lack of awareness, no transport. Poor birth preparation</i></p> <p><i>Financial constraints, access to transport</i></p>	<p><i>Knowledge about the danger signs</i></p> <p><i>Having the emergency plans and birth materials read in advance</i></p>	
<p>Danger signs in newborns</p>	<p>Refer newborn urgently if danger sign is present:</p> <ul style="list-style-type: none"> - Unconscious, lethargy - Unable to breastfeed - Fits / convulsions - Fever - Fast or difficult breathing - Chest indrawing - Jaundice - Skin pustules - Eye infection - Redness pus or swelling of cord stump 			

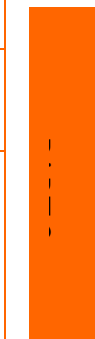


Visit 5: First week of Life

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



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



Visit 6. One Month

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

	Diarrhoea with very sunken eyes Swelling of both feet			
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Visit 7. 5th Month – Complementary feeding

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

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



Visit 8. 9 months

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

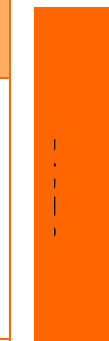
Visit 10. 12 months

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



Visit 11. The 18 month old child

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



SESSION 10. REVIEW OF THE TTC STORYBOOKS MESSAGES

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

OBJECTIVES OF THE SESSION

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

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

Module 1. Storybook messages

Story book #	Positive story messages	Negative story messages
1	<ul style="list-style-type: none"> • Mary is eating enough food. She eats more than usual when she is pregnant • She eats different kinds of foods, <i>from all of the food groups</i> • Mary and David don't sell all of their nutritious food. • They wash their hands • David and Mary saved money for the pregnancy and for any emergencies • Mary goes for antenatal care at the clinic • Mary's family / husband helps her with her work so that she can rest • David and Mary <i>understand the danger signs</i> in pregnancy and always check to make sure Mary is not showing any of the danger signs • They prepare to refer to the clinic immediately if she has a problem • Mary sleeps under a bed net 	<ul style="list-style-type: none"> • Biba had <i>too much work</i>. She was pushing her body too much. Her husband didn't help her at all • She was lifting heavy things • She was not eating enough food • She wasn't eating a variety of foods • She <i>didn't go to the clinic</i> for antenatal care • She didn't understand that the bleeding was dangerous, or tell anyone <i>about the danger signs</i>. • Her husband didn't have an emergency <i>plan for transportation</i> • She doesn't <i>wash her hands</i>, which might cause disease • Her husband is spending money on himself that could be used for his wife and children instead.
2	<ul style="list-style-type: none"> • They should go for <i>antenatal care</i>, and get <i>HIV and TB tests</i> for both the husband and wife and any children they have at home • An HIV-positive woman needs special nutrition and extra rest • An <i>HIV-positive women should deliver in a health facility</i>, to protect the baby from getting infected with HIV during delivery • HIV and TB-positive people need to <i>take medicine</i>, and it is very 	<ul style="list-style-type: none"> • Both Cadija and Braima should have gone for the HIV test and gotten treatment • Cadija did not take the HIV medicines which might have prevented her baby from getting HIV • Cadija gave birth at home increasing the risk of HIV transmission to the baby during delivery.

	<p>important to take all the medicines as prescribed.</p> <ul style="list-style-type: none"> • HIV-positive people should use <i>condoms</i> during sexual intercourse, especially during pregnancy • An HIV-positive mother should <i>exclusively breastfeed during the first 6 months</i>. No other foods or liquids should be given. • The baby should be <i>tested for HIV</i> as soon as possible after delivery 	<ul style="list-style-type: none"> • When the baby was born they should have taken the baby to be HIV tested immediately, so the baby could initiate ART as soon as possible.
3	<ul style="list-style-type: none"> • They <i>saved money for the birth</i>, and for a possible emergency • The community was organized for transportation • Blessing identified the transport they would use, ahead of time • They bought clean supplies for the birth • Faith goes for a postnatal consultation after she has given birth. • They chose a family planning method to avoid getting pregnant again too soon. 	<ul style="list-style-type: none"> • Patience had too much work • She didn't tell anyone when her fever and chills began • Her labour was prolonged and nobody understood that that was dangerous • The family had no emergency plan; the husband had not saved money or made arrangements for transport • They did not go to the front of the line at the health facility • They did not tell the health staff what happened

Module 2. Storybook messages

Story book #	Positive story messages	Negative story messages
4	<ul style="list-style-type: none"> • Monica understands the signs of danger during labour and delivery • Monica tells her mother when she is not feeling well 	<ul style="list-style-type: none"> • Grace and Emmanuel did not understand that labour longer than 12 hours is dangerous • They did not understand that a fever during

	<ul style="list-style-type: none"> • They go to the clinic as soon as they realize that she is in danger • The nurse takes Monica to the maternity ward, without delay • Both Monica and the baby survive, even though Monica was in danger <p>Essential newborn and maternal care:</p> <ul style="list-style-type: none"> • Prepared in advance and bought supplies • Delayed cord clamping • Hygiene: Handwashing by TBA • Hygiene: Clean surface for mother • Hygiene: Uses clean delivery kit and razor • Keeps baby dry and warm, not washing, skin to skin • Immediate breastfeeding • Rubbing and stimulation • Handwashing before touching baby • Exclusive breastfeeding • Early immunization • Post partum consultation and check 	<p>delivery is dangerous</p> <ul style="list-style-type: none"> • They did not take Grace to the health facility immediately when she had these problems
5	<ul style="list-style-type: none"> • Lesedi receives advice on how to breastfeed her baby • Lesedi breastfeeds her baby exclusively • Massage breasts from back to front to encourage milk forward • Make sure baby is correctly attached to the breast • Emptying the breast completely before switching, switch on next feed • Don't give bottles to the baby 	<ul style="list-style-type: none"> • Madupe doesn't have confidence about her breastfeeding • She doesn't know express milk to help the milk to come • She gives goat's milk to the baby • She doesn't wash her hands • She feeds the baby using a bottle, which is not

	<ul style="list-style-type: none"> • Feed every 2 to 3 hours • Talk and sing to the baby • Massage the baby's back and legs • Monitoring the growth of the baby • Immunizations for the baby • Vitamin A for Lesedi postpartum • Birth registration • Baby sleeps under bednet with mother 	<p>sterile (they are not clean enough, even if Madupe washes the bottle)</p> <ul style="list-style-type: none"> • The baby is in unclean surroundings • She gives water to the baby • Madupe and her mother wait too long to get help for baby • The baby is kept naked: the baby is not warm
6	<ul style="list-style-type: none"> • Exclusive breastfeeding • Sleeping under bed net • They understand the danger signs in a child (difficult breathing) • They take the baby to the clinic immediately. • Mariana continues to breastfeed when the child is ill 	<ul style="list-style-type: none"> • Meena and Peter don't sleep under bednet • Daniel and Meena don't understanding that a fever in a baby requires immediate medical care • They wait too long to take him to the clinic

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

Story book #	Positive story messages	Negative story messages
7	<ul style="list-style-type: none"> • Habiba and Uma take their children for growth monitoring • They bring their growth monitoring cards with them to the meeting • They participate in the food demonstration • Mothers are learning how to prepare foods from all the food groups • The children are receiving iron supplements at 6 months • They should continue to breastfeed • Wash their hands before preparing food and before feeding the baby • They should begin to give complementary foods now • They should feed these foods to the child two or three times a day, from all the food groups • They should mash the foods up so the child can easily swallow • The mothers should be patient when feeding the children • Make sure the water is purified • Even HIV-positive mothers should continue to breastfeed, until the child is at least 12 months old • Three or more watery stools a day is diarrhoea • Crying with no tears, eyes that look sunken and skin that seems tight are all signs of dehydration • Diarrhoea is very dangerous for children because the water that their bodies need is lost • If a child has three or more watery stools in a day, the family should take the child to the clinic right away 	<ul style="list-style-type: none"> • Not happy, not energetic • Skinny • Reddish hair • Distended stomach

	<ul style="list-style-type: none"> • It is okay to vaccinate the child even if the child has diarrhoea or another illness • The mother should continue to breastfeed even when the child has diarrhoea. • The child was given oral rehydration solution and zinc to help diarrhoea • The child was given a vaccine to prevent measles • The child was given vitamin A for good vision and good protection against diseases • Mother sings to the baby • Father hangs the mosquito net 	
8	<ul style="list-style-type: none"> • Measles • Night blindness • Diarrhoea 	
9	<ul style="list-style-type: none"> • Thomas washing his hands • Thomas has his own bowl • Thomas eating fruits and vegetables • Elizabeth helps Thomas to eat six times a day • Elizabeth gives Thomas foods that are rich in iron, like liver and dark green leafy vegetables • They go to the clinic and Thomas gets de-worming medicine • Elizabeth is sure to take Thomas to the clinic every month to monitor his growth • Thomas gets a Vitamin A drop 	
10	<ul style="list-style-type: none"> • Leila washing her hands • Leila snacking all day long, and her mother giving her good choices for snacks • Mother preparing nutritious meals, putting nutritious ingredients into the sauce • Bed net 	

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



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TIMED AND TARGETED COUNSELLING FOR HEALTH & NUTRITION

TTC Technical Modules 1, 2 and 3: Participants
Manual



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Abbreviations

ADP	Area Development Programme
ARI	Acute Respiratory Infection
ARV	Antiretroviral
ART	Antiretroviral Therapy
ANC	Antenatal Care
CHW/ V	Community Health Worker / Volunteer
COH	Channels of Hope
COMM	Community Health Committee
CVA	Citizens Voice & Action
DPA	Development Programme Approach
EBF	Exclusive Breast-Feeding
EMOC	Emergency Obstetric Care
EMONC	Emergency Obstetric and Newborn Care
FP	Family Planning
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
HTSP	Healthy Timing & Spacing of Pregnancy
HVS	Home Visitors
KMC	Kangaroo Mother Care
LBW	Low Birth Weight (Baby)
LLIN	Long-Lasting Insecticidal Net
MHPSS	Mental Health and Psychosocial Support
MNCH	Maternal, Newborn and Child Health
MOH	Ministry Of Health
NGO	Non-Governmental Organisation
NO	National Office
PHC	Primary Health Care
PLW	Pregnant and Lactating Women
PMTCT	Prevention of Mother-To-Child Transmission of HIV
PNC	Postnatal Care
PSS	Psychosocial Support
RH	Reproductive Health
SAM	Severe Acute Malnutrition

SBA	Skilled Birth Attendant
SC	Stabilisation Centre
SO	Support Office
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TA	Technical Approach
TBA	Traditional Birth Attendant
TTC	Timed and Targeted Counselling
ttC-HVS	ttC- Home Visitors
U5MR	Under-5 Mortality Rate
VCT	Voluntary Counselling and Testing
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme
WHO	World Health Organization
WV	World Vision

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Module I: Pregnancy

Visit 1: Early pregnancy

Visit 2: Mid-pregnancy

Visit

3:

Mid-pregnancy

Visit 1: Early pregnancy



SESSION I I: GENERAL NUTRITION

Key messages

Pregnant women should:

Eat food from all three food groups every day:

Go Foods: Energy foods (rice, bread, maize)

Grow Foods: Growth foods (fish, meat, eggs, beans)

Glow foods: Protective Foods (fruit, vegetables)

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

Take extra care with hygiene: always wash hands with soap or ash after using latrine, before preparing or eating food, or feeding children

Increase the quantity and number of times a day that they eat, by having one additional meal and a nutritious snack

- Use iodized salt during pregnancy to help prevent illness; salt should be used in small amounts.



THREE FOOD GROUPS

'Go' foods give the body energy, the same way that gasoline or petrol makes a car 'go'. These carbohydrates fill the stomach and make the person feel like he/she has strength. 'Go' foods are usually the 'staple' foods that families eat every day. 'Go' foods are also sometimes known as 'energy foods'. Examples include: *Maize, cassava, sorghum, millet, rice, sweet potato, potato, bread, pasta, noodles*. Sugar is also in this group, however, remind participants that it is *not healthy to consume large amounts of sugar*.

'Glow' foods make the body healthy and protect it from illness, due to the vitamins and minerals they contain. This health is represented by things like shiny hair, skin that shines, eyes that are bright, and thus make the body 'glow'. 'Glow' foods should be eaten daily if possible, or at least three or four times a week. This group is also sometimes called 'protectors' because eating them helps us to fight diseases. Examples include most fruit and vegetables, except those in the 'Go' group, such as: *mango, leafy vegetables, orange, sweet potato, banana, papaya, pineapple, squash, avocado, tomato*.

'Grow' foods build strength and enable growth. These foods, containing protein, can be thought of as similar to the water and good soils that enable a plant to grow. 'Grow' foods should be eaten daily if possible, or at least three to four times a week in pregnancy. Examples include: *meat, fish, liver, chicken, eggs, groundnuts, beans*.



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, 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 maintaining 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, keeps you warm and helps your body absorb nutrients from the diet. Too much fat and oil in our diet can cause you to become overweight, as they contain a lot of energy. Oil, groundnuts, coconut milk, avocado, palm fruit

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

VITAMIN A + OIL



IRON + VITAMIN C



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

Handwashing: 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.


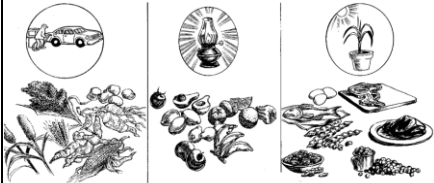
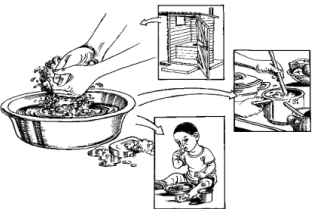

Eat from all three food groups: Pregnant women should eat food from all three food groups every day if possible, or at least three to four times per week, for the benefit of both the woman and her unborn baby.

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.

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

Notes:

BARRIERS AND ENABLERS FOR HEALTHY PREGNANCY

Key messages and additional information	Barriers: <i>What makes it difficult to do?</i>	Enablers: <i>What would make it easier to do?</i>	Counselling response or solution
<p>Increased quantity and variety of foods for pregnant woman</p> 			
<p>Three food groups (discuss locally available foods) – eat a balanced diet. Include micronutrients (iron-rich foods, vitamin A-rich foods)</p> 			
<p>Hand-washing before preparing food</p> 			
<p>Iodized salt</p> 			

SESSION 12: HOME CARE FOR THE PREGNANT WOMAN AND DANGER SIGNS IN PREGNANCY

Key Messages

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.

Evacuate woman to health facility immediately (within 24 hours of onset).

HOME CARE FOR THE PREGNANT WOMAN



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.

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

During pregnancy, labour and after the birth a woman needs strong 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 clinic.

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



DANGER SIGNS DURING PREGNANCY

Any vaginal bleeding

Seizure or fits

Fever

Severe abdominal pain

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.

THE FOUR DELAYS




Danger: Delay in recognising the danger sign



Decision: Delay in deciding to seek care

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

Service: Delay in receiving care.

BARRIERS AND ENABLERS FOR HEALTHY PREGNANCY

Key messages and additional information	Barriers: <i>What makes it difficult to do?</i>	Enablers: <i>What would make it easier to do?</i>	Counselling response or solution
Sleep under LLIN in high malaria prevalent areas 			
Do not smoke or drink alcohol during pregnancy 			
Adequate rest & assistance from family members 			

<p>Take iron and folic acid tablets daily</p> 			
<p>Refer woman to health facility immediately if danger sign is present (see list of signs)</p> 			

SESSION 13: PROMOTE ANTENATAL CARE

Key messages

Pregnant women should attend at least four ANC visits. Pregnant women should receive the following services during ANC visits:

Iron-folate acid (IFA) tablets during pregnancy to be taken daily





Two tetanus toxoid (TT) immunisations during pregnancy

De-worming tablets when they reach the fourth month of pregnancy, if living in an area where intestinal worms are common

All pregnant women and their partners should be tested for HIV, TB and other sexually transmitted infections (STIs)

In areas of high malaria prevalence, pregnant women should receive intermittent presumptive treatment for malaria (IPTp) and may also receive an insecticide-treated bed net known as an LLIN

In areas of high malaria prevalence, pregnant women should sleep under an LLIN.

Key messages and additional information	Barriers: <i>What makes it difficult to do?</i>	Enablers: <i>What would make it easier to do?</i>	Counselling response or solution
<p>Prepare savings for costs of pregnancy / birth planning and preparation</p> 			
<p>4 ANC visits* attend as early as possible- Services at ANC (iron-folate, tetanus vaccine, prevention of malaria, deworming)</p> 			
<p>HIV testing for both the woman and her partner</p> 			
<p>TB testing for the woman and her partner</p> 			

SESSION 14: CONDUCTING THE FIRST VISIT DURING PREGNANCY

TOPICS COVERED IN THE FIRST VISIT IN PREGNANCY

Identification of husband, birth companion or other family member that she identifies as being her significant supporter in the home and who will participate in home visits
 Identify her chosen supporter/s and write these names in the household handbook, and ensure that these people attend each time you come.
 Home care in pregnancy, nutrition, antenatal care.
 Danger signs in pregnancy



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 other 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 household handbook, 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?

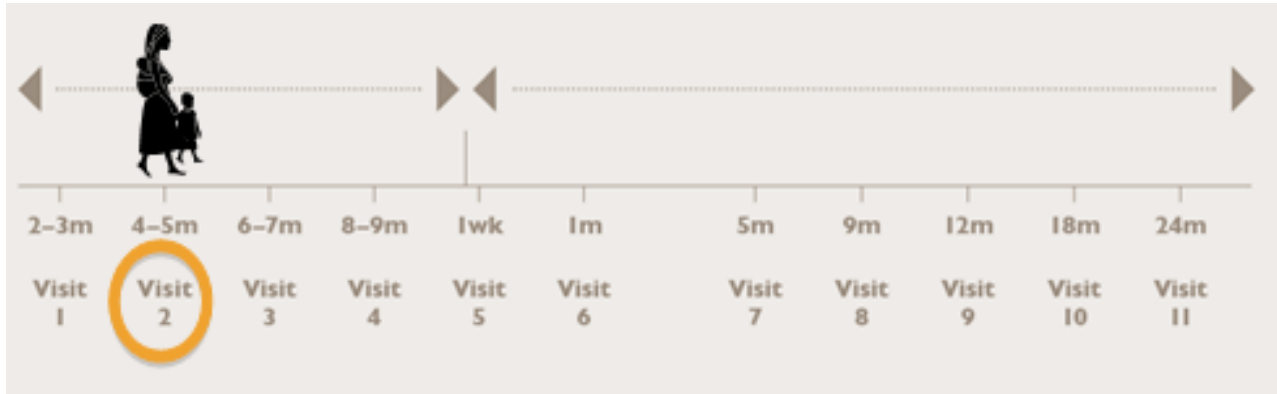
Make sure that this is at a convenient time of the day or evening for the family, when the supporter will all be able to participate. Check in advance if possible to ensure that this is a good time, and fix the day and time before you arrive.

Visit I: Early pregnancy

VISIT I IN PREGNANCY FROM START TO FINISH	
<p>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:</p> <ul style="list-style-type: none"> - Who – are all the identified supporters present? (go and fetch them or reschedule) - When – is this a convenient time? - Where – is the location for the visit comfortable and private? 	<p>The diagram shows a horizontal timeline from 2-3m to 24m. Below the timeline, visits are marked: Visit 1 (2-3m), Visit 2 (4-5m), Visit 3 (6-7m), Visit 4 (8-9m), Visit 5 (1wk), Visit 6 (1m), Visit 7 (5m), Visit 8 (9m), Visit 9 (12m), Visit 10 (18m), and Visit 11 (24m). Visit 1 is circled in yellow.</p>
<p>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.</p>	

Apply Psychological first aid principles if needed.	
<p>ttC Counselling Process</p> <p>Step 1: Review the previous meeting Review Household Handbook pages from the previous visit. This step isn’t needed in Visit I</p> <p>Step 2: Present and reflect on the problem: Problem story: ‘Nutrition, Home Care and ANC’, and 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 ttC-HV will tell the story using the illustrated <i>ttC Storybook</i>. The problem story is followed up by guiding questions to help the family members to reflect on the problem.</p> <p>Step 3: Present information: positive story: ‘Nutrition, Home Care and ANC’, and guiding questions. Next, the ttC-HV presents information on the positive health actions through the positive story ‘Nutrition Home Care and ANC’. Remember to present the information in a way to build on what households already know, not assuming they don’t already know. Use the guiding questions above to lead discussion on the practices observed and outcomes.</p> <p>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.</p> <p>Step 4: Negotiate new actions using the Household Handbook In this step, the ttC-HV will look at the Household Handbook together with the family, turning to the pages that go with the visit (<u>pages two to four of handbook</u>).</p>	
Record the results of the meeting Fill in the <i>ttC Register</i> for this visit	
End the visit: Decide with the family when you will visit again (mid-pregnancy). Thank the family.	

Visit 2: Mid-pregnancy



SESSION 5: HIV & AIDS, TUBERCULOSIS AND PREVENTION OF MOTHER TO CHILD TRANSMISSION OF HIV

Key Messages: HIV and AIDS and Tuberculosis during pregnancy and childbirth

All women and their partners should undergo testing during pregnancy for HIV, TB and other STIs, Their children who have not been tested for HIV should also be tested at this time, especially if either parent is HIV positive.

It is important to test children for TB if child or anyone in the home has been diagnosed with TB.

Symptoms of TB include: persistent cough, night sweats, weight loss (or stagnant weight gain in children) malaise, fever. Refer any person or child experiencing these symptoms to a health centre.

All women, but especially HIV-positive women deliver in a health facility for special care and PMTCT.

Condoms should be used during sexual intercourse while pregnant and breastfeeding to protect against HIV infection during pregnancy.

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.

Infants born to HIV positive mother should be taken for HIV test as early as possible after the birth, for early detection and treatment using ART and co-trimoxazole preventive treatment to keep them from becoming ill.

All women, but especially those HIV positive women, should exclusively breastfeed the child to six months of age. If they are taking ART therapy they may continue to breastfeed until the child is two years.

HIV AND AIDS DURING PREGNANCY AND CHILDBIRTH

Contextualization: You will emphasise HIV to a greater or lesser extent based on the context you are working in. Review the information in the box below and modify as needed, based on your context and MoH policies.



HIV AND AIDS AND TUBERCULOSIS DURING PREGNANCY AND CHILDBIRTH

HIV, the virus that causes AIDS, spreads through unprotected sex (intercourse without a condom), transfusions of unscreened blood, contaminated needles and syringes, and from an infected woman to her child during pregnancy, childbirth 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, TB and other STIs as part of ANC. It is very important that their 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 gain 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 or childbirth or through breastfeeding. This can be prevented if the mother takes ART medicines during and after her pregnancy as guided by the health facility.

Once she has started taking ART, a mother should not miss her treatments but make sure she takes her tablets as prescribed (treatment-adherence). If she stops treatment at any time, the baby can be at risk of infection or she could suffer health problems. If she experiences any side effects from the medicines seek medical help immediately.

Infants born to HIV-positive mother should be taken for HIV test *as early as possible* after the 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. If they are taking ART therapy they may continue to breastfeed until the child is two years.

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), 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, 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. ttC-HVs will need to be particularly sensitive and aware of this when addressing the issue of HIV in the home.

HIV AND AIDS AFTER BIRTH

Contextualization: See the two notes in the box below and train on these points as appropriate, based on your context.



IND AIDS: AFTER BIRTH

It is important to test the baby to find out if he/she has contracted HIV from the mother. In some countries, special tests are available to test the baby at 4 or 6 weeks. If this test is available in the country, the family should take the baby to the health clinic once the baby reaches that age. It is important to find out as soon as possible if the baby is HIV infected, so correct treatment may be given. In other countries, the special early test is not available. In these cases, the family will take the baby to the health clinic to be tested preferably before six months of age.

Note: Find out whether or not early infant diagnosis – the special early test – is available in your community, and advise the ttC-HVs accordingly.

If the baby is found to be HIV-positive then they will need to be given the ART (HIV medicines) as soon as possible, which will control the infection and prevent them from becoming sick.

If the baby is HIV-positive, or if the baby's HIV status is not known, the baby would also receive medication to prevent other infections such as pneumonia. This medication is known as **co-trimoxazole**, and will be given when the baby reaches 4–6 weeks of age. The ttC-HV should advise HIV-positive mothers to take the baby to the health clinic when the baby reaches this 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 or longer. 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. **Note:** Check national guidelines for breastfeeding for HIV-positive women.

TUBERCULOSIS



TUBERCULOSIS

Tuberculosis (TB) is a bacterial infection spread through inhaling tiny droplets from the coughs or sneezes of an infected person. It is a serious condition but can be cured with proper treatment. TB mainly affects the lungs.

Symptoms of TB include: persistent cough, Night Sweats, Weight loss (or stagnant weight gain in children) Malaise, Fever. Any person or child experiencing these symptoms should be referred to a health centre, and have a TB test.

Children also should be tested if anyone in the home has tested positive for TB, especially where there is overcrowding in the home, or if the child is also HIV-positive.

Those who test positive for TB must be enrolled in a treatment programme. The health staff will provide information on this. The treatment programme must be completed without stopping the medicines.

COUNSELLING THE HIV-POSITIVE MOTHER



INSTRUCTIONS FOR COUNSELLING HIV-POSITIVE WOMEN AND THEIR FAMILIES:

Reassure:

Explain that HIV infection can be controlled with the right medicines and that you will help her to access all the medicines and care that she needs.

Use positive language, listen and empathise with her worries.

Her family about ART treatment access and availability in your area

Recommend: the key counselling messages

Partners of HIV-positive women should go for testing and treatment also.

HIV infection of the baby can be prevented by taking ART medicines (antiretroviral therapy) during and after her pregnancy as guided by the health facility, and by giving birth in a health facility.

Once she has started taking ART make sure she takes her tablets every day to prevent 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.






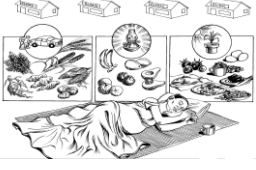

It is especially important for an HIV-positive to have good nutrition during pregnancy, to rest well, prevent infections (hygiene and handwashing) and attend four or more antenatal visits.

Refer: for further support services

In the community (HIV support workers if they exist)

HIV clinics / health facilities for follow up services.

BARRIERS AND ENABLERS TO HIV CARE

Key Messages and additional information	Barriers: <i>What makes it difficult to do?</i>	Enablers: <i>What would make it easier to do?</i>	Counselling response or solution
Testing during pregnancy for HIV, TB and other STIs for women and their partners (visit 1) 			
Accessing HIV & TB treatment and taking medicines every day (ART adherence for HIV positive mothers) 			
Early infant diagnosis and Co-Trimoxazole preventive treatment 			
Condoms during sexual intercourse while pregnant and breastfeeding to prevent re-infection 			
All women, but especially HIV-positive women deliver in a health facility for special care and PMTCT 			
Nutrition, rest and antenatal care for the for HIV-positive mother 			
Early and exclusive breastfeeding 			

SESSION 16: CONDUCTING THE SECOND VISIT DURING PREGNANCY

TOPICS COVERED DURING THE SECOND VISIT IN PREGNANCY

Dialogue, negotiate and encourage families to get tested for HIV and TB and to follow treatment guidelines and self care

Importance of facility delivery, especially if the mother is HIV-positive

Plan for early HIV testing of the baby if the mother is HIV-positive.

Visit 2: Mid-pregnancy

SECOND HOME VISIT DURING PREGNANCY FROM START TO FINISH: HIV AND AIDS, AND TB



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 Household Handbook 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 ‘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 using the Household Handbook

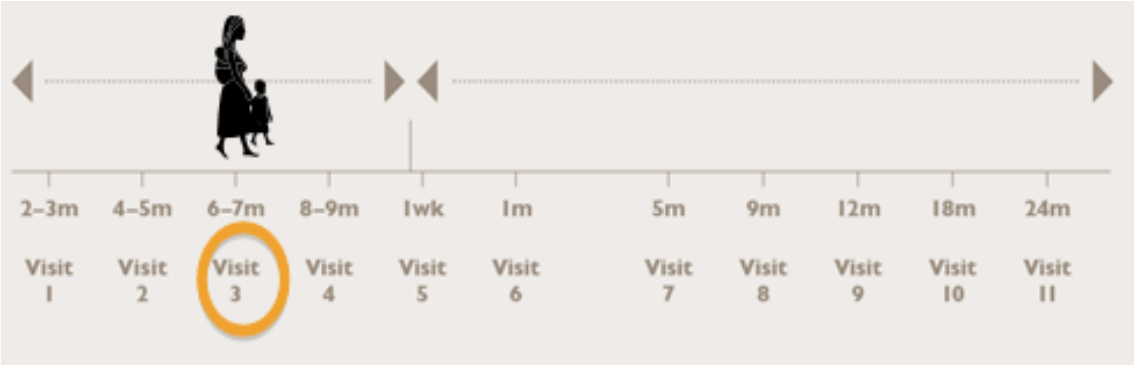
Remember the ‘getting to the cause’ questions (what makes it difficult; why is that)

Remember getting to 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 (mid-pregnancy). Thank the family.

Visit 3: Mid-pregnancy



SESSION 17: THE BIRTH PLAN

Key messages

- All women, but especially HIV-positive women should deliver in a health facility.
- They need a skilled birth attendant.
- They need to develop a birth plan.
- They need a transportation plan.
- They need birth supplies.

INVOLVING FAMILY MEMBERS IN BIRTH PLANNING



PREPARING FOR BIRTH

During the 3rd visit in pregnancy the ttC-HV 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. 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.

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 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

A key aim of your visit during pregnancy is to help families to prepare for birth. Birth-planning helps families think ahead to what is needed for a safe birth and decide how to overcome any difficulty they may have. 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.



BIRTH PLANNING

Components of a birth plan:

- Prepare for birth, in a health facility or at home.
- Decide how the family will ensure a skilled birth attendant is present during labour and birth.
- Identify transport to get to the health facility.
- Save money for transport and other expenses at the health facility.
- Gather the supplies needed for home or facility birth.
- Go to the health facility early in labour or stay close to the facility before labour begins.
- Identify a supportive birth companion who will accompany the mother to the facility.
- Plan who will care for the household while pregnant woman and family are in the facility.

IMPORTANCE OF A FACILITY BIRTH, ESPECIALLY FOR HIV-POSITIVE WOMEN

It is safest for all women to deliver with a **skilled birth attendant** and in a **health facility** because health workers have the skills, equipment and medication needed to help ensure a safe birth and a healthy baby. Sometimes problems arise during labour and birth, like bleeding or fits, which require skilled health workers, medications and equipment to treat, without which the mother and/or baby could die. 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.

The ttC-HV should strongly encourage HIV-positive women, and any woman identified as high risk (refer to Session 20) 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.

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




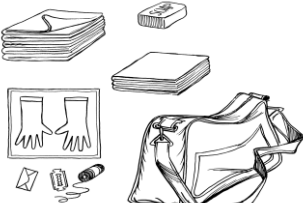
Lack of transport

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.

BARRIERS TO BIRTH PLANNING

Key Messages and additional information	Barriers: <i>What makes it difficult to do?</i>	Enablers: <i>What would make it easier to do?</i>	Counselling response or solution
<p>All women, but especially HIV-positive women should deliver in a health facility with a skilled birth attendant*</p> 			
<p>Developing a birth plan</p> 			
<p>Arranging finances</p> 			
<p>Preparation for the birth and materials (clean birth kit)</p> 			

Notes:

SESSION 8: HEALTHY TIMING AND SPACING OF PREGNANCIES

Key messages

Limit pregnancy to the healthy childbearing years of 18–35

Wait at least two years after a birth before trying to get pregnant again

Wait at least six months after a miscarriage before trying to get pregnant again

Modern methods of family planning available in country (provide local list)

Avoid an unplanned pregnancy by starting a postpartum family planning method of your choice before the baby is 6 months old

BIRTH SPACING



HEALTHY SPACING

- 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.
- 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.
- 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.
- Family planning is the responsibility of both men and women; everyone needs to know about the health benefits.

PREVENTING ADOLESCENT PREGNANCY

Contextualisation: Adjust the list below for the circumstances you find in your country.

What is the problem?	What are the root causes?
Girls getting married too young and become pregnant	Access to and knowledge about birth control Pressures from family Arranged marriages Fear that the girls won't marry well if they don't marry early Financial worries Fear that girls will become sexually active before marriage Men's preference for younger brides? Others?
Adolescent girls having sex too young (outside of marriage) and becoming pregnant	Lack of education on how they can become pregnant Girls unaware of risks of becoming pregnant Pressure from peer group to become sexually active Coercion or pressure from young boys and men Lack of negotiating power Access to and knowledge about birth control Financial interests (e.g. gifts and money from boyfriends) Others?




DELAYING ADOLESCENT PREGNANCY

Pregnancy before the age of 18 increases the health risks for the mother and her baby. Young women should delay their first pregnancy until age 18 or older.

Risks of adolescent pregnancy: A girl is not physically ready to bear children until she is 18 years of age. Childbirth is more likely to be difficult and dangerous for an adolescent than for an adult, and is more likely to suffer complications in labour. Adolescents may not be emotionally mature enough to care for their young child, and may also suffer isolation from their families and friends which can lead to poor psychosocial wellbeing. Babies born to very young mothers are much more likely to die in the first year of life. The younger the mother, the greater the risks.

Early marriage: Girls who marry too soon may have limited decision-making power in their marriage. Her husband and her new family members may not want her to delay pregnancy until she is 18. So these girls and their families need extra support and health education in your programmes to ensure the girl is supported to access family planning and delay pregnancy until after 18 years of age. This may include challenging cultural norms of early marriage, education about risks of adolescent pregnancy and how girls can protect themselves against becoming pregnant.

BARRIERS AND ENABLERS TO HEALTHY TIMING AND SPACING OF PREGNANCY (HTSP)

Key Messages and additional information	Barriers: <i>What makes it difficult to do?</i>	Enablers: <i>What would make it easier to do?</i>	Counselling response or solution
Family planning post partum (as soon as possible after birth and before the baby is 6 months old) 			
Limit pregnancy to the healthy childbearing years of 18-35			
Wait at least two years after a birth before trying to get pregnant again			
Wait at least six months after a miscarriage before trying to get pregnant again			

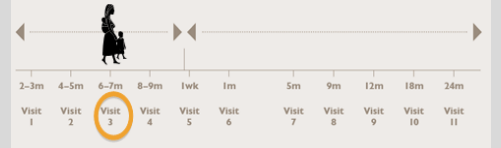
SESSION 9: CONDUCTING THE THIRD PREGNANCY VISIT

TOPICS COVERED IN THE THIRD VISIT IN PREGNANCY

Dialogue, negotiate and encourage families to make a birth plan, prepare for birth, and consider family planning to avoid getting pregnant again too quickly.

Visit 3: Mid-pregnancy

SEQUENCE FOR THIRD HOME VISIT DURING 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 Household Handbook 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 Household Handbook: Remember ‘getting to the root cause’ questions (what makes it difficult; why is that the case?); Remember getting to solution questions (what would make that easier, how can we help 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.

Notes:

SESSION 20: SUPPORTIVE CARE FOR VULNERABLE PREGNANCIES

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 moving closer to the hospital in late pregnancy and before the start of labour.

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

DISCUSSION OF VULNERABLE PREGNANCY FACTORS

Vulnerability 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	Increase vigilance for danger signs, improved self-care, planned hospital birth

	psychosocial issues in the home such as GBV/ IPV.	
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, give examples.	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 PLANNING, ADDITIONAL SUPPORT AND CARE



ADDITIONAL BIRTH PLAN SUPPORT FOR VULNERABLE 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.

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:

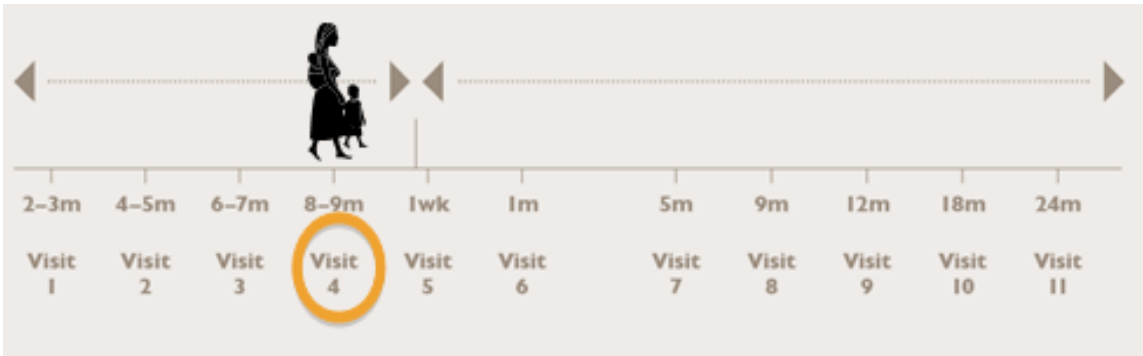
Module 2: Childbirth and Newborn Care

Visit 4: Late Pregnancy

Visit 5 a, b, c: First week of life

Visit 6: First Month

Visit 4: Late Pregnancy



SESSION 1: DANGER SIGNS DURING LABOUR AND BIRTH

Key messages

- ✓ As part of the birth plan, families should have all materials for birth, a plan for transport and money for emergencies ready before labour starts. If labour comes early or a danger sign occurs, the woman can be quickly taken to the facility.
- ✓ Take woman to a health facility if a danger sign is present (if home birth). During labour, go immediately if the mother has one of these signs:
 - feels no movement or reduced movement of the baby
 - water breaks without labour commencing after 6 hours
 - bleeding
 - any bleeding during labour but before birth
 - too much bleeding immediately after birth
 - fever and chills
 - prolonged labour/birth delay (12 hours or more)
 - fits or loss of consciousness.

DANGER SIGNS IN LABOUR AND DELIVERY



DANGER SIGNS IN LABOUR AND DELIVERY

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

DANGER SIGNS DURING LABOUR AND DELIVERY (SEE HOUSEHOLD HANDBOOK)

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

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

- ✓ placenta not delivered or incomplete after birth

- ✓ dark green liquid expelled from womb during labour.

Necessary actions

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

THE FOUR DELAYS

Danger: Delay in recognising the danger sign

Decision: Delay in deciding to seek care

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

Service: Delay in receiving effective care.

EMERGENCY PREPARATIONS

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

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

SESSION 2: IMMEDIATE ESSENTIAL CARE OF THE NEWBORN AFTER BIRTH

Key messages

- ✓ The SBA should give immediate essential care of the newborn during the first hour of life, including the following actions:
 - Dry the baby immediately after birth using clean warm cloths to remove blood and fluid from the body, face and head.
 - Begin rubbing and stimulation to help breathing.
 - Clean the baby's airway if needed: nose and mouth to assist breathing.
 - Keep the baby warm by providing a warm room, hat and socks.
- ✓ Place the baby in skin-to-skin contact with mother during the first hour of life.
 - Cut the cord with a clean blade from the clean birthing kit.
 - Do not bathe baby for first 24 hours.
 - Help the baby to breastfeed within 30 to 60 minutes after birth; give colostrum.
 - Observe the baby's colour and breathing – lips, tongue and mouth should be pink, not grey or blue, and check breathing regularly for several hours after birth.
- If a birth occurs at home, the family should give immediate essential newborn care and encourage the mother and baby to attend postnatal care at a health clinic as soon as possible after the home birth. As soon as possible after delivery, take the infant for immunisations and a check-up at the clinic.



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.

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

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

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

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

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



IMMEDIATE ESSENTIAL NEWBORN CARE

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

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



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

Refer newborn urgently if a danger sign is present:

- ✓ unconscious, 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	Barriers: <i>What makes it difficult to do?</i>	Enablers: <i>What would make it easier to do?</i>	Counselling response or solution
<p>Hand washing with soap before touching the newborn baby or mother in delivery</p> 			
<p>Help the baby breathe: clear baby's airway: nose and mouth and ensure baby is breathing clearly during first hour of life*</p> <ul style="list-style-type: none"> - Dry baby immediately after birth - Rubbing and stimulation 			
<p>Keep the baby warm:</p> <ul style="list-style-type: none"> - Put baby skin-to-skin with mother - Warm room, hat, socks, blanket - Do not bathe baby for first 24 hours 			
<p>Post-natal care at health clinic; mother and babyAs soon as possible after delivery take the mother and infant for a check up at the clinic and immunizations</p> 			
<p>Refer newborn urgently if danger sign is present:</p> <ul style="list-style-type: none"> - Unconscious, lethargy - Chest indrawing - Unable to breastfeed - Fits / convulsions - Fast or difficult breathing - Fever 			

SESSION 3: PROMOTE EARLY INITIATION OF EXCLUSIVE BREAST-FEEDING

Key messages

- ✓ Put baby to the breast within 30 to 60 minutes after birth.
- ✓ Do not discard first milk (colostrum) and do not give any other substance to eat or drink.
- ✓ Exclusively breastfeed: Babies should be given only breast milk to eat and drink during the first 6 months of life. Most healthy mothers have sufficient milk, and additional fluids or foods, including water, are not needed, provided you breastfeed the baby regularly and on demand (8 to 12 times per day).
- Help a mother to express breast milk if she is unconscious or ill following delivery.



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 newborn and 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

- ✓ To express breast milk, follow these steps:
 - a. Wash your hands with soap.
 - b. Massage the breast to help the milk come down.
 - c. Place thumb and index finger on either side of the nipple, 3 – 5 cm back from the nipple.
 - d. Press gently inward towards the rib cage.
 - e. Roll fingers together in a slight downward motion.
 - f. Repeat all around the nipple if desired.

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

SESSION 4: HAND-WASHING SKILLS

Key messages

- ✓ Family members must always wash their hands before they touch a newborn, as this will prevent bringing germs or infection to the baby.
- ✓ Family members should wash their hands more carefully than usual, as they have practiced, before touching a baby.
- Everyone in the home should wash their hands after using the toilet/latrine, before cooking, before eating and before handling a newborn.

TEACHING THE FAMILY HAND WASHING



NEWBORN HYGIENE

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



STEPS OF CORRECT HAND WASHING

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

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

WHEN TO WASH HANDS

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

BARRIER TO HAND WASHING AND HYGIENE

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

SESSION 5: CONDUCTING VISIT 4: LATE PREGNANCY

TOPICS COVERED IN THE FOURTH VISIT IN PREGNANCY

- Dialogue, negotiate and encourage families to take action in the case of delivery complications, and be prepared to carry out the appropriate actions immediately after the birth of the baby.
- Check that the birth materials are all ready and the emergency plan is in place.
- Demonstrate proper hand washing and practice with the family.
- Check hygiene practices and the availability of hand washing facilities and soap in the home.

Visit 4: Late Pregnancy

SEQUENCE FOR FOURTH HOME VISIT DURING PREGNANCY	
<p>Before starting: Greet the family. Explain the purpose of the visit. Ensure that the identified supporters are all present.</p>	
<p>Identify and respond to any difficulties: Ask the mother if she has any danger signs, including any emotional distress. Conduct referral if needed. Apply psychological first aid principles if needed.</p>	
<p>ttC counselling process:</p> <p>Step 1: Review the previous meeting Review household handbook pages from the previous visit (Visit 3). Review any negotiated behaviours that she agreed to try and praise any progress. Renegotiate if the family is still struggling.</p> <p>Step 2: Present and reflect on the problem story: ‘Complications in labour’ – tell the story and ask the guiding questions.</p> <p>Step 3: Present information: positive story: ‘Complications in labour’ – tell the story and ask guiding questions.</p> <p>Step 2 (Second story): Present and reflect on the problem story: ‘Essential newborn and maternal care’ – tell the story and ask the guiding questions.</p> <p>Step 3: Present information: positive story: ‘Essential newborn and maternal care’ – tell the story and ask guiding questions.</p> <p>There is no step 3b (technical information)</p> <p>Step 4: Negotiate new actions using the household handbook: Remember ‘getting to the root cause’ questions (what makes it difficult; why is that the case?) Remember getting to solution questions (what would make that easier, how can we help to ensure that happens?)</p>	
<p>Step 5: ttC-HV additional actions:</p> <ul style="list-style-type: none"> ✓ Check that the birth materials are all ready and the emergency plan is in place. ✓ Demonstrate proper hand washing and practise with the family. ✓ Check hygiene practices and the availability of hand washing facilities and soap in the home. 	
<p>Record the results of the meeting: Fill in the <i>ttC Register</i> for this visit. <i>(We will do this at the end.)</i></p>	
<p>End the visit: Decide with the family when you will visit again (ensure that they inform you as soon as possible when the woman is in labour or when they return from the facility after the birth). Thank the family.</p>	

SPECIAL SESSION: CHLORHEXIDINE CLEANING OF THE UMBILICAL CORD STUMP

Key messages

- ✓ Prepare for the birth by having the MoH approved CHX for umbilical cord care available and ready with your clean birth kit. (This is provided by health staff, CHW/ttC-HV or purchased by the family).
- ✓ Apply the CHX solution or gel as soon as possible after the cord is cut and within the first 24 hours.
- ✓ Apply CHX daily to the cord and skin around it for 7 days
- ✓ Any family member or a CHW can apply the CHX after training.
- ✓ Do not put anything else on the umbilical cord after applying the CHX.

CHLORHEXIDINE CLEANING OF THE CORD STUMP



TECHNICAL INFORMATION: APPLICATION OF CHLORHEXIDINE TO THE CORD STUMP

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

Key messages for families planning a home birth

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



HOW TO APPLY THE CHLORHEXIDINE:

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

COUNSEL THE FAMILY:

Before the birth:

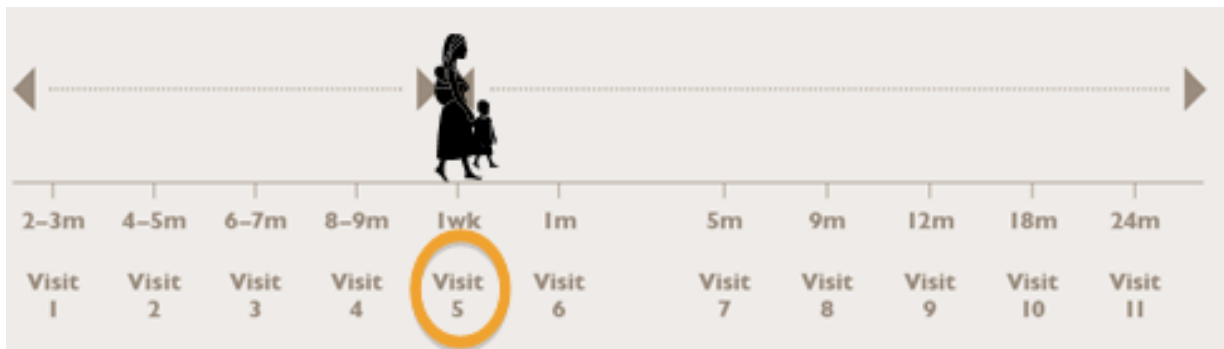
- ✓ Ensure that the family has CHX solution ready with the birth kit.
- ✓ Advise them how they can access this: Health staff, CHW or pharmacy.
- ✓ Apply the CHX solution or gel as soon as possible after the cord is cut and within the first 24 hours.

After the birth:

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

Notes:

Visits 5a, 5b, 5c: First week of life



SESSION 6: ESSENTIAL NEWBORN CARE IN FIRST WEEK OF LIFE

Key messages

Essential newborn care in the first week of life

- Keep the baby **warm**
 - Do not bathe the baby until after the first 24 hours.
 - Bathe the baby in **warm** water only.
 - Keep a hat on the baby's head.
 - Wrap the baby in two extra layers than adults OR keep close to mother in skin-to-skin contact.
- Protect from infections through **hygiene** – eyes, cord, skin
 - Wash your hands with soap before touching the baby.
 - Keep the cord area clean and dry, and do not cover with a bandage.
 - Do not put anything on the cord.
 - Keep the baby's eyes clean.
 - Wash the baby daily and change soiled clothes regularly.

Routine newborn care

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

ESSENTIAL ACTIONS FOR NEWBORN CARE



ACTION #1: KEEP THE NEWBORN WARM

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

PREVENTING INFECTIONS

Where on the body?	How can they become infected?	How to prevent it?
Eyes	Dirty hands, dirty cloths used for cleaning Also through infection during delivery	Clean the eyes, checking for infections and treat with tetracycline ointment if infected. Bathe regularly. Wash hands before handling the baby.
Ears	Germs in the air, and hands, not washing	Check for infection. Bathe regularly.
Mouth	Eating or drinking any food and water other than breast milk Using bottles or cups that aren't clean Putting dirty hands in the mouth	Encourage exclusive breastfeeding – no bottles. Change the baby when it soils itself. Keep the baby away from animals. Wash hands before handling the baby.
Nose and throat	Breathing in germs in the air, such as from people with colds and coughs	Keep the baby away from ill people who are coughing or sneezing.
Umbilicus	Germs on the blade, on your hands Germs in substances like palm or mustard oil, cow dung, mud or ash	Clean it daily with soap and water and dry well. Do not put anything on the cord (other than CHX). Wash hands before handling the baby and cord. Do not touch or pick or pull the cord stump, do not cover with bandage.



ACTION #2: PREVENT INFECTION IN THE NEWBORN, HYGIENE

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

ROUTINE CARE OF THE NEWBORN



ACTION #3: MALARIA PREVENTION FOR THE NEWBORN

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

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

ACTION #4: INFANT IMMUNISATIONS

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

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

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

ACTION #5: JAUNDICE (YELLOW SKIN AND EYES)

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

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.

Notes:

SESSION 7: CARING FOR THE MOTHER AFTER BIRTH

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 postpartum mother should rest well, and have the support of her family.
- ✓ Danger signs in postpartum mother: Take the mother to the health facility urgently if she experiences:
 - heavy bleeding
 - severe abdominal pain
 - fever or chill
 - mastitis – swelling or redness of the breast.

CARE OF THE MOTHER AFTER BIRTH



THE POSTPARTUM PHASE

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

IMMEDIATELY AFTER THE BIRTH

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

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

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

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

Essential maternal care

Action #1: Postpartum follow-up care:

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

and within 45 days after a facility delivery.

Action #2: Maternal hygiene:

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

Action #3: Good nutrition and iron intake:

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

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

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

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

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

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

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

POSTPARTUM RISKS

Postpartum haemorrhage (PPH)

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

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

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

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

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

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

Problem	Why might this happen?	Counselling solutions
Engorgement of the breast	Poor position and attachment Baby is not feeding enough	Continue breastfeeding. Increase feeds. Make sure she is breastfeeding on both breasts equally. Use warm compresses (cloth soaked in warm water) on the breast, or gently massage around the nipples.
Sore or cracked nipples	Poor position and attachment Poor hygiene Use of substances on breast that irritates or infects the nipples	Continue breastfeeding. Check position and attachment. Wash breasts with soap and water before feeding and dry carefully after feeds. Wear loose clothing, do not wear a bra, and don't put any substance on the breast.
Breast infection Mastitis: red, swollen, painful and hot area on the breast, fever	Infection in the breast due to too much milk or the breast not being emptied well due to poor attachment or any of the above problems	Continue breastfeeding. All the above messages apply, plus: See a health care worker immediately. The mother may need to take medicine.



MATERNAL DEPRESSION AFTER THE BIRTH

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

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

Postpartum depression symptoms may include:

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

- ✓ frightening thoughts or extreme worry.

What are the risks?

Women experiencing maternal mental health problems may not get adequate support, or be able to care for themselves by eating well, practising good hygiene, seeking care or taking medicines when needed. Mental health problems can affect the child too as the mother is less able to responsively breastfeed, stimulate and play with the child and respond to its needs. The children of depressed mothers MAY experience more disease, malnutrition, and development problems.



CARE OF THE MOTHER WHO HAS EXPERIENCED BIRTH COMPLICATIONS

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

What happens during 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.

CHECKING THE MOTHER POSTPARTUM

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?

BARRIERS AND ENABLERS FOR POSTPARTUM CARE

Key Messages and additional information	Barriers: <i>What makes it difficult to do?</i>	Enablers: <i>What would make it easier to do?</i>	Counselling response or solution
Post-natal care at health facility as soon as possible after a home birth and within 45 days after delivery. 			
Maternal hygiene – washing her all over with soap twice a day for five days, especially around the perineum and any wound or tear.			
Mothers should continue to eat well and take iron and folic acid as recommended 			
Post partum mother should rest well, and have support of the family to not return to heavy work too soon 			
Danger signs in post partum mother: Take the mother to the health facility urgently			

if she experiences



SESSION 8: INFANT FEEDING: ESTABLISHING EXCLUSIVE BREAST-FEEDING

Key messages

- Put baby to breast within 30-60 minutes after birth;
- Do not discard first milk (colostrum) and do not give any other substance to eat or drink. Do not use bottles.
- Babies should be given only breastmilk to eat and drink during the first six months of life. Most healthy mothers have sufficient milk, and additional fluids or foods including water are not needed provided you breastfeed the baby regularly and on demand (8-12 times per day).
- If baby cannot breastfeed express the colostrum and feed it with a cup
- Correct positioning and attachment to the breast will help prevent breastfeeding problems
- A HIV-positive mother can protect her baby from HIV by following all these practices described above

ACTIVITY 1: TRUE OR FALSE

Complete the answers true or false for the following statements.

Statement	Answer
1. Throw away the mother's first milk before putting a newborn to the breast because the first milk, which has been waiting in the warm breast, can be sour.	
2. Putting a baby to the breast too soon could risk the life of a mother who is weak and bleeding after giving birth.	
3. If the baby cannot latch on right away, you should squeeze the breast milk into a clean cup and give it to the baby.	
4. The first milk contains substances that protect the baby from infections.	
5. Infants should be given fewer feedings during illness.	
6. Breastfeeding on a three-hour schedule helps an infant learn the self-discipline to wait for attention.	
7. A mother should not talk to her infant while breastfeeding because talking distracts the infant from getting enough breast milk.	
8. A 5-month-old infant should be breastfed as often as he/she wants, day and night.	
9. A mother living with HIV should never breastfeed her infant.	
10. Cooked and mashed squash is a good, nutritious food for most 4-month-old infants.	
11. In very hot weather, an infant may need water, in addition to breast milk.	

12. At age 3 months, give food to an infant who begins to show an interest in family food.	
13. Put the newborn to the breast as soon as the cord is cut, without waiting to clean the newborn or waiting for the mother's milk to come.	



FEEDING RECOMMENDATIONS FOR THE NEWBORN

1. Give the first milk (colostrum)

Colostrum contains many infection-fighting properties and helps the baby be strong and healthy. It should not be thrown away. 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

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

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

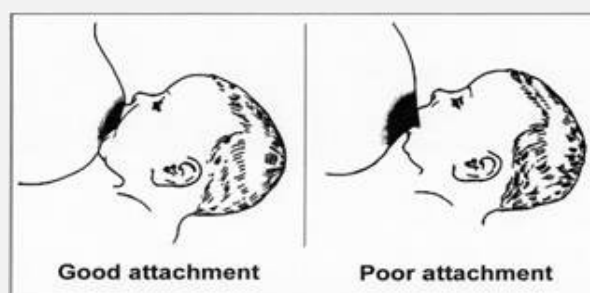
If the baby is too small or weak. It may be necessary to express milk from the breast, and give it to the newborn in small sips using a spoon or a small cup. The ttC-HV will need to provide step-by-step instructions on hand expression.

5. Hand expression

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

6. Ensure good attachment

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.

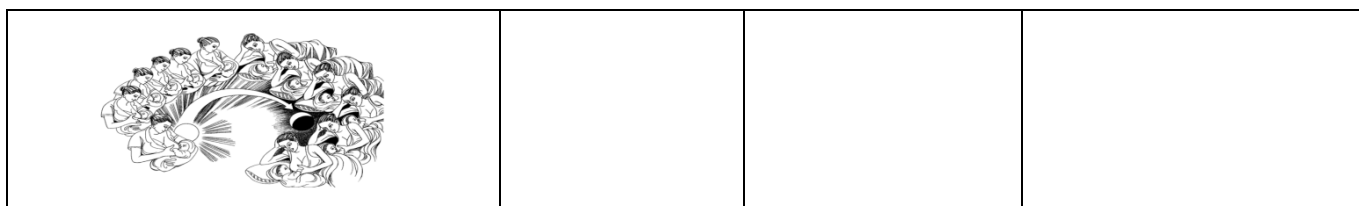
- ✓ Other food or fluid may be too **diluted** or thin. This happens when the caregiver cannot afford enough breast-milk substitutes for the child, or the substitute is prepared incorrectly.
- ✓ Other milk may not contain enough **vitamin a**.
- ✓ **Iron** from cows or goat milk is poorly absorbed.
- ✓ Newborns have **difficulty digesting animal milk**. Animal milk may cause **diarrhoea**, rashes, or other symptoms of allergies, or lead 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**.
- ✓ A mother should feed her child whenever the child is hungry, '**on demand**', day and night, at least eight times every 24 hours.
- ✓ 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
- ✓ 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.

BARRIERS AND ENABLERS FOR BREASTFEEDING

Key Messages and additional information	Barriers: <i>What makes it difficult to do?</i>	Enablers: <i>What would make it easier to do?</i>	Counselling response or solution
Exclusive breastfeeding to six months* - No other foods or water* - No bottles or utensils 			
Breastfeeding on demand - at least 8 times in 24 hours*			



SESSION 9: EARLY CHILD DEVELOPMENT

Key messages

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

EARLY CHILD DEVELOPMENT



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

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




NEWBORN BABIES NEED LOVE AND COMMUNICATION TO DEVELOP FULLY.

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

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!

COUNSEL THE FAMILY ON PLAY AND COMMUNICATION

Age of young infant	Recommendations for family
<p data-bbox="140 333 461 400">Newborn, birth up to 1 week</p>  <p data-bbox="212 667 304 689">newborn</p>	<p data-bbox="483 342 831 376">Your baby learns from birth.</p> <p data-bbox="483 394 536 427">Play</p> <ul data-bbox="483 443 1452 577" style="list-style-type: none">✓ Provide ways for your baby to see, hear, move arms and legs freely, and touch you.✓ Gently soothe, stroke, and hold your child.✓ Skin-to-skin contact is good. <p data-bbox="483 595 655 629">Communicate</p> <ul data-bbox="483 645 1452 745" style="list-style-type: none">✓ Look into your baby's eyes, and talk to your baby.✓ When you are breastfeeding is a good time. Even a newborn baby can see your face and hear your voice.  

Notes:

SESSION 10: DANGER SIGNS IN THE NEWBORN

Key messages

If the mother or father (or any other family member) suspects any danger sign in the newborn, they should go urgently to a health facility. Danger signs in the newborn include:

- ✓ lethargic or unusually sleepy
- ✓ unable to breastfeed
- ✓ fits/convulsions
- ✓ chest indrawing and difficult or fast breathing
- ✓ fever or skin unusually cold
- ✓ skin pustules
- ✓ redness of the umbilical cord stump
- ✓ jaundice – dangerous especially if accompanied by lethargy/poor feeding
- ✓ small baby (below 2 kg).

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

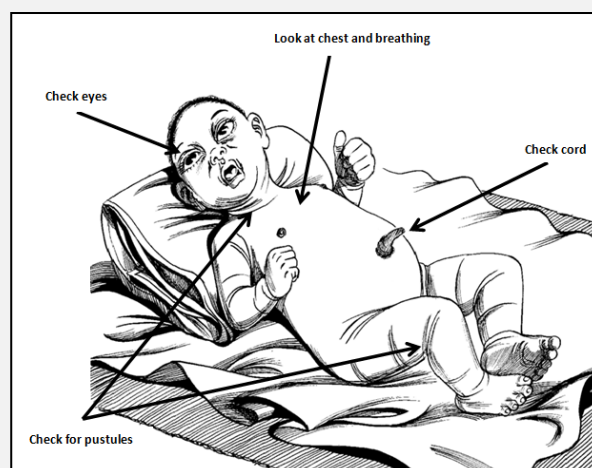
ASSESSING THE NEWBORN BABY

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



ASSESSING THE BABY

During all home visits in the first week, carry out an assessment. 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 signs.



Ask the mother:	Check the baby:
<ul style="list-style-type: none"> • How is the baby today? • How is the baby feeding? How often? • Have you noticed any changes in the baby's activity? • Has the baby has any convulsion or muscle tension 	<ul style="list-style-type: none"> • Activity and response • Listen to the breathing and observe the chest movements • Check skin temperature and colour • Look for skin pustules, especially near the cord stump and in the creases of skin • Check the eyes • Check the umbilical cord, is it clean and dry? • Weigh the baby (if you have scales)

BARRIERS AND ENABLERS TO CARE SEEKING

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

SESSION 11: SPECIAL CARE OF THE SMALL BABY IN THE FIRST MONTH

Key messages

- ✓ Small babies need special care to keep them warm using skin-to-skin KMC.
- ✓ Small babies may need extra help breastfeeding or be fed expressed breast milk.
- ✓ Small babies can become very sick and die quickly compared to healthy sized babies, so know the danger signs and have a plan to get help quickly.
- ✓ Small babies need extra home visits by ttC-HVs and extra visits to the clinic for check-ups in the first month of life.
- ✓ Small babies need extra care for development such as interacting or communicating with them, softly singing, talking, when the baby is awake or during feeding.

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 gestational age.

SPECIAL CARE OF THE SMALL BABY

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

FACILITY-BASED CARE OF THE SMALL BABY

If the small baby was born at home, he/she requires urgent referral to a health facility. A small baby should not be cared for in the community unless mother and baby have been discharged by the

facility. The ttC-HV can support the mother by initiating feeding and introducing skin-to-skin contact, then should transport the mother and baby to the facility whilst carrying the baby 'kangaroo style'. In the facility, the staff will provide any treatment the baby might need and help the mother to care for the baby, teaching the importance of feeding, warmth and hygiene. When the baby is stabilised, mother and baby may be discharged, but will need regular follow-up care in the home that the ttC-HV can support.

COMMUNITY-BASED CARE OF THE SMALL BABY

EXTRA HYGIENE

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

EXTRA FEEDING

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

EXTRA WARMTH

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

EXTRA MONITORING

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

EXTRA PLAY AND LOVING INTERACTIONS WITH CAREGIVER

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

SESSION 12: CONDUCTING THE FIRST VISIT AFTER BIRTH (VISIT 5A, B, C)

TOPICS COVERED IN THE FIRST WEEK OF LIFE VISITS

- Conduct Visit 5a as soon as possible after the baby has been born, within 24 hours of a home birth and as soon as they return home after a facility delivery. In this extended visit, learn about the birth, assess the mother and baby for danger signs, apply cord care, assess and support establishing breastfeeding and check vaccinations as well as the basic visit story and handbook counselling activities. Refer all home births.
- Conduct, if possible, two more visits in the first week of life. During these shorter visits, assess the mother and newborn for danger signs, apply cord care, and assess breastfeeding if problem has been reported.



THE IMPORTANCE OF NEWBORN VISITS

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

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

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

Visits 5a, 5b, 5c: First week of life

SEQUENCE FOR VISIT 5A (FIRST HOME VISIT AFTER DELIVERY)	
<p>Before starting:</p> <p>Greet the family. Explain the purpose of the visit. Ensure that all identified supporters are present.</p>	
<p>Identify and respond to any difficulties:</p> <p>Ask the mother if she has any danger signs, including any emotional distress. Apply psychological first-aid principles if needed. (<i>Proceed directly to the checks if mother doesn't raise issues immediately.</i>)</p>	
<p>Assessment steps:</p> <ul style="list-style-type: none"> ✓ Assessing the mother: <ul style="list-style-type: none"> ○ 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. 	

<ul style="list-style-type: none"> ✓ Assessing the newborn <ul style="list-style-type: none"> ○ Ask the mother: How the baby is, feeding progress, movements, crying, any danger signs. ○ Check the baby: Movement and crying, breathing, skin temperature and colour, look for pustules, check the eyes, check the umbilical cord. ○ Weigh the baby (optional) ✓ Clean the umbilical cord with chlorhexidine solution (if approved) 	
<p>ttC counselling process:</p> <p>Step 1: Review the previous meeting Review household handbook pages from previous visit (Visit 4). Review negotiated behaviours around the birth and determine if they were met.</p> <p>Step 2: Present and reflect on the problem: Problem story: 'Essential newborn care and breastfeeding' Tell the story and ask the guiding questions.</p> <p>Step 3: Present information: positive story: 'Essential newborn care and breastfeeding' Tell the story and ask the guiding questions. Present and reflect on the positive story: 'Postnatal care' – tell the story and ask the guiding questions.</p> <p>Step 3b: Present 'Breastfeeding problems' and 'Danger signs birth to 1 month'</p> <p>Step 4: Negotiate new actions using the household handbook</p> <p>Remember 'getting to the root cause' questions (what makes it difficult; why is that the case?) Remember 'getting to solution' questions (what would make it easier, how can we help ensure it happens?)</p>	
<p>Step 5: ttC-HV actions</p> <p>Observe the mother breastfeeding her baby and provide any assistance as necessary. Encourage exclusive breastfeeding. Ensure baby has been taken for first immunisations. Refer all home births.</p>	
<p>Record the results of the meeting: Fill in the <i>ttC Register</i> for this visit</p>	
<p>End the visit: Decide with the family when you will visit again in the next few days (Visits 5b and 5c). Thank the family.</p>	
SEQUENCE FOR VISIT 5B AND 5C (FOLLOW-UP VISITS IN FIRST WEEK OF LIFE)	
<p>Before starting: Greet the family. Explain the purpose of the visit. Ensure that the identified supporters are all present.</p>	
<p>Assessment steps</p> <ul style="list-style-type: none"> • Assessing the mother <ul style="list-style-type: none"> ○ How are you feeling now? ○ Ask about bleeding, fever, abdominal pain, tiredness, breast problems as before. • Assessing the newborn <ul style="list-style-type: none"> ○ Ask the mother: How the baby is, feeding progress, movement and crying, any danger signs. ○ Check the baby: Movement and crying, breathing, skin temperature and colour, look for pustules, check the eyes, check the umbilical cord. ○ Weigh the baby (optional) • Clean the umbilical cord with chlorhexidine solution 	
<p>Step 5: ttC-HV actions:</p> <ul style="list-style-type: none"> ○ Only observe a feed again if the mother reports any difficulties, or previously had problems. ○ Ensure that the baby has been taken for his/her first immunisations. ○ Ensure that home births were taken to be checked at the facility. 	
<p>Record the results of the meeting: Fill in the <i>ttC Register</i> for this visit</p>	
<p>End the visit. Decide with the family when you will visit again. Thank the family</p>	

Visit 6: First Month



SESSION 13: CARE SEEKING FOR FEVER AND ACUTE RESPIRATORY ILLNESS

Key messages

- If the baby has fever, go urgently to the nearest health facility within 24 hours. Look out for general danger signs with fever:
 - unable to breastfeed or drink
 - vomiting everything
 - convulsions
 - lethargic or unconscious.
- Take the child with cough to the clinic urgently if they have any of these signs:
 - fast or difficult breathing
 - noisy breathing or grunting
 - chest draws inwards when infant breathes in.
 - unable to feed or breastfeed
 - vomiting everything
 - lethargic or unconscious
 - convulsions.
- When an infant has a cough or cold, to prevent pneumonia: wrap the baby warmly, clean mucus from the nose frequently, wash hands with soap every time you handle the baby, and allow plenty of rest.
- Ensure that you breastfeed more frequently and for more time during illness to make sure the baby recovers well, both during and after the illness. Give more to eat and drink than usual for infants over 6 months.
- All infants must sleep under an LLIN-treated bed net every night to protect from mosquito bites, from birth until 6 years old, in all seasons.

MALARIA



INFORMATION ABOUT MALARIA

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

than 6 months need plenty of liquids and food.



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 times in one day
- ✓ fever – body temperature higher than usual
- ✓ cough – sign of a throat or chest infection or a cold.

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

General danger signs (urgent medical care)

- ✓ The child is unable to suck, or eat or drink anything.
- ✓ The child has persistent vomiting, vomits everything.

- ✓ The child has seizures (fits).
- ✓ The child is unusually sleepy or unconscious.

Danger signs (needs to be referred)

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



ASSESSING THE SICK CHILD AGED 2 TO 59 MONTHS

Ask: IS THE CHILD ABLE TO DRINK OR BREASTFEED?

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

Ask: DOES THE CHILD VOMIT EVERYTHING?

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

Ask: HAS THE CHILD HAD FITS OR CONVULSIONS?

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

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

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

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

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

SESSION 14: ROUTINE CARE OF THE 1 MONTH OLD CHILD: SERVICES, BIRTH REGISTRATION AND PLAY

Key messages

- ✓ Children must complete 5 rounds of vaccinations, at birth; 6, 10, and 14 weeks and 9 months.
- ✓ Ensure that all children have complete vaccination records, that you attend clinics at the time needed, and that you keep vaccination cards in a safe and dry place.
- ✓ Children's growth should be monitored on a regular basis. Weight and growth should be measured monthly at your local health facility.
- ✓ Mothers should use family-planning methods to prevent unwanted pregnancies and practise healthy timing and spacing of pregnancies.

GROWTH MONITORING



GROWTH MONITORING

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

IMMUNISATION AND VACCINE-PREVENTABLE DISEASES



INFORMATION ON IMMUNISATIONS

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

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

9 months	Measles	Yellow fever
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FAMILY PLANNING



POSTPARTUM FAMILY PLANNING

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

COUNSEL THE FAMILY ON PLAY AND COMMUNICATION

Age of young infant	Recommendations for family
1 to 6 months 	<p><i>Play</i></p> <ul style="list-style-type: none"> • Provide ways for your child to see, hear, feel, move freely and touch you. • Slowly move colourful things for your child to see and reach for. • Sample toys: shaker rattle, ring on a string. <p><i>Communicate</i></p> <ul style="list-style-type: none"> • Smile and laugh with your child. • Talk to your child. • Get a conversation going by copying your child’s sounds or gestures. 

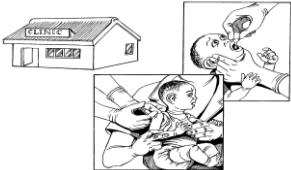
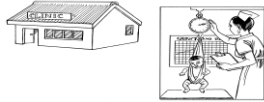


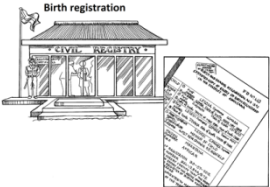
BIRTH REGISTRATION

BIRTH REGISTRATION

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

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

BARRIERS AND ENABLERS FOR THE RECOMMENDED PRACTICES


Key messages and additional information	Barriers: <i>What makes it difficult to do?</i>	Enablers: <i>What would make it easier to do?</i>	Counselling response solution
<p>Attend clinic to update immunizations</p> <p>The importance of immunizations; DPT and OPV at six weeks – risk of vaccine preventable diseases: Polio, measles, diphtheria, pertussis, pneumonia,</p> 			
<p>Attend clinic to complete growth monitoring of the child</p> 			
<p>Family planning</p> 			
<p>Stimulation and play for the 1 – 6 month old</p> 			
<p>Birth registration</p> 			

SESSION 15: CONDUCTING VISIT 6: FIRST MONTH

TOPICS COVERED IN THE 6TH HOME VISIT

- Dialogue, negotiate and encourage mothers and families to recognise the danger signs in children and seek immediate care as needed, and to take the child to the health facility for routine growth monitoring and immunisations.

Visit 6: First Month

SEQUENCE FOR VISIT 6	
<p>Before starting: Greet the family. Explain the purpose of the visit. Ensure that all of the identified supporters are present.</p>	
<p>Identify and respond to any difficulties: Ask the mother if she has any danger signs, including any emotional distress. Conduct referral if needed. Apply psychological first-aid principles if needed.</p> <p>Assess the child: Check the baby for danger signs, refer if any danger signs are present.</p>	
<p>ttC counselling process:</p> <p>Step 1: Review the previous meeting Review household handbook pages from the previous visit (Visit 5). Review negotiated behaviours and praise any progress. Renegotiate if the family is still struggling.</p> <p>Step 2: Present and reflect on the problem: Problem story: 'Care seeking for fever ARI' – tell the story and ask the guiding questions.</p> <p>Step 3a: Present information: positive story: 'Routine clinical visits, care seeking for fever, ARI, birth spacing' and 'Essential newborn and maternal care' – tell the story and ask the guiding questions.</p> <p>Step 3b: Conduct technical session: Danger signs in children and vaccine-preventable diseases</p> <p>Step 4: Negotiate new actions using the household handbook</p>	
<p>Step 5: ttC-HV additional actions:</p> <p>Observe the mother breastfeeding the baby and provide any assistance as necessary.</p> <p>Ask about choice of family planning.</p> <p>Remind about 6-week clinic visit for growth monitoring and immunisations.</p> <p>Remind about clinic visits 10 and 14 weeks for growth monitoring and immunisations.</p> <p>If the mother is HIV-positive, remind about HIV testing and co-trimoxazole treatment.</p>	
<p>Record the results of the meeting: Fill in the <i>ttC Register</i> for this visit</p>	
<p>End the visit: Decide with the family when you will visit again (at 6 months). Thank the family.</p>	

SESSION 16: CHILDREN BORN TO HIV POSITIVE MOTHERS

Key messages

- ✓ It is very important to know as soon as possible whether or not the baby is HIV positive so that they can receive correct medicines and care.
- ✓ HIV-positive infants should begin lifelong treatment for HIV (ART) as soon as they are diagnosed, and be supported to continue to take the medicines to protect them from becoming ill.
- ✓ HIV-exposed infants should be given co-trimoxazole preventive therapy as soon as possible after birth whilst waiting for HIV test results.
- ✓ When a mother is HIV-positive it is **even more important that she exclusively breastfeed** her baby until 6 months of age.
- Newborns and young infants who have been exposed to HIV or become HIV positive after birth respond very well to treatment and if they are given their ARVs correctly they will go on to live productive, healthy and potentially long lives.

HIV TESTING FOR THE HIV-EXPOSED INFANT



BABIES BORN TO HIV-POSITIVE MOTHERS

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

BREASTFEEDING FOR THE HIV-POSITIVE MOTHER



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

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

COUNSELLING FOR THE HIV-POSITIVE CHILD

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

CHILDREN BORN TO HIV POSITIVE MOTHERS- BARRIERS AND ENABLERS

Topics	Key Messages and additional information	Barriers: <i>What makes it difficult to do?</i>	Enablers: <i>What would make it easier to do?</i>	Counselling response or solution
Care for the HIV positive infant	HIV positive mother – have the HIV exposed baby tested for HIV as soon as possible 			
	HIV positive mother – ensure that the child take preventive cotrimoxazole treatment 			
	ART treatment for the HIV positive baby is started early and continued every day			
	Access to community and facility support, attendance of clinic appointments for follow up care			
	Exclusive breastfeeding until 6 months of age 			

SESSION 17: ADDITIONAL SUPPORT FOR HIGH RISK NEWBORNS & MOTHERS

Key messages

- ✓ A high-risk postpartum mother is more likely to experience complications or danger signs postpartum, one who may have difficulties caring for her infant, or who needs additional medical care
- ✓ Risk factors common in postpartum mothers include: HIV-positive mothers, women who have undergone Caesarean or other delivery complication, adolescent mothers and mother's experiencing mental health and psychosocial difficulties, or who have lost a pregnancy due to miscarriage or still birth.
- ✓ A 'high-risk' newborn is one that is more likely to experience complications, danger signs, or difficulty feeding, or who may require additional medical care.
- ✓ Risk factors common in the newborn period include small babies (LBW, prematurity) or those who experienced difficulties during delivery, HIV-exposed, maternal orphan, congenital malformation or disability, and twins.
- ✓ High-risk newborns and high-risk postpartum mothers can receive additional support:
 - additional home visits, counselling support or breastfeeding support.
 - monitoring and supporting medicine adherence and clinic attendance
 - increased vigilance for danger signs and hygiene promotion
 - referral if required.

DISCUSSION OF RISK FACTORS FOR NEWBORNS AND MOTHERS

High-risk postpartum case	What is the risk?	Additional home-based care needs	Additional medical care needs
HIV-positive mother	Transmission of HIV to child, risk of illness and infections in mother, side effects of medicines	ARV treatment support, PMTCT support, increased vigilance for danger signs, improved diet and self-care Exclusive breastfeeding	Attend ARV support clinic
Caesarean delivery	Increased risk of infection, rupture of wound	Wound care and hygiene Support to complete medicines if taking antibiotics or iron; Increased vigilance for danger signs Increased rest and family support with the baby	Attend follow-up clinic to check wound repair
Complication in labour such as haemorrhage, tearing.	Increased risk of infection, obstetric fistula, rupture of wound, haemorrhage	Wound care and hygiene Increased vigilance for danger signs Support to complete medicines if taking antibiotics or iron	Attend follow-up clinic more regularly

Adolescent mother or single unsupported mother	Potential difficulties caring for herself, the child or breastfeeding May be more likely to have had a difficult delivery	Increased family or community support Breastfeeding support	Ensure access to medical care
Mother with postpartum mental health and/or psychosocial difficulties	Difficulties caring for herself and/or her child May stop breastfeeding Poor caregiver-infant attachment and child development risk of GBV / IPV	Supportive counselling, including Psychological First Aid for response to distress Support to implement stress management techniques Increased social support	Access medical care May require a mental health referral or access support services
Woman who has experienced pregnancy loss due to miscarriage or still birth	May not attend postpartum care May become pregnant again too soon May be vulnerable to perinatal mental health problems	Supportive counselling, including Psychological First Aid for response to distress Support to implement stress management techniques Increased social support	Access to services May require a mental health referral or access support services

HIGH RISK NEWBORNS

High-risk newborn case	What is the risk?	Additional home-based care needs	Additional medical care needs
Small baby (LBW and born too soon Premature baby) or twins/multiples	Increased risk of infection Risk of hypothermia (cold) Increased likelihood of breastfeeding problems Increased risk of danger signs	May need breastfeeding support, or expression of breast milk Promote hygiene Promote skin-to-skin contact and warmth Monitor regularly for danger signs	Hospitalisation likely if under 2 kilos Regular check-ups May need kangaroo care May need special feeding or incubation
Complications in labour (prolonged labour, asphyxia or resuscitation, other)	Increased risk of complications in the first week of life	Increased vigilance for danger signs, especially breathing (cyanosis)	Only if referral
HIV-exposed infant (any born to HIV-positive mother)	Transmission of HIV to child if breastfed incorrectly, or if mother stops taking ARV Risk of developing illness	Support to exclusively breastfeed; ARV adherence for the mother	Attend HIV clinic for testing for the baby, ensure regular ARV clinic attendance for mother
Congenital malformation or disability	May have difficulties feeding e.g. cleft palate Parents may struggle to care for the baby as per their needs	Increased family support Breastfeeding support	Only if referral
Maternal orphan	Increased risk of child death (15 times higher!)	Support with feeding, identify adoptive parent/mother Support father to care for baby	Only if referral

Module 3: Child Health, Nutrition and Development

Visit 7: Fifth Month

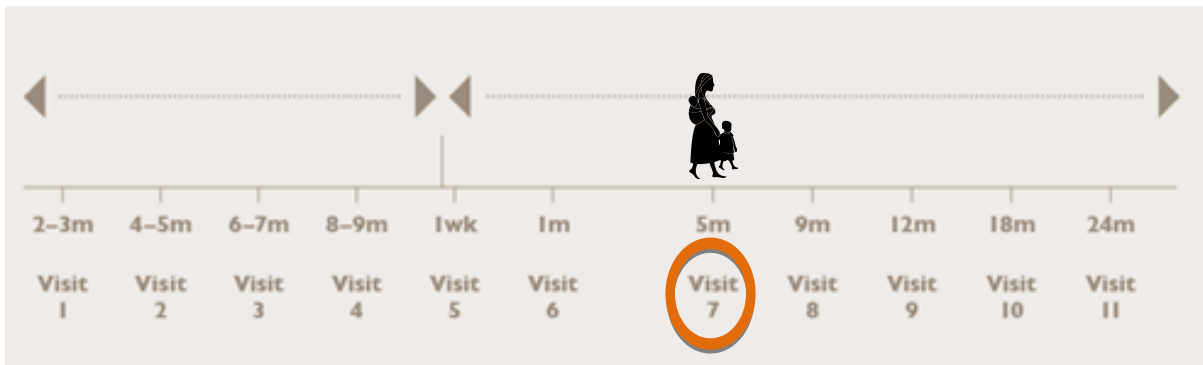
Visit 8: Ninth Month

Visit 9: Twelfth Month

Visit 10: Eighteenth Month

Visit 11: Twenty-Fourth Month

Visit 7: Fifth Month



SESSION 1: CHILD FEEDING: 6–9 MONTHS

Key messages

- Give complementary foods from 6 months: 2 to 3 times daily between 6 and 8 months plus semi-solid nutritious snacks 1 to 2 times a day, as desired.
- Feed in response to their hunger, until the baby is full. It is not necessary to force-feed.
- Children need iron to grow strong and resist diseases. Iron-rich foods include eggs, red meat, green leafy vegetables, and iron-fortified grains.
- Breastfeed whenever and as much as the baby wants to feed, and more frequently during illness. Keep breastfeeding until 2 years old for healthy growth and nutrition.



FEEDING RECOMMENDATIONS FROM 6 TO 9 MONTHS

- **Continue to breastfeed** - From 6 months children still benefit from breastfeeding as breast milk continues to 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 with added oil or milk, fruits, vegetables, 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. There may also be specially made iron-fortified products for young children like *Sprinkles**, added to the child's food.
- **Amounts/preparation** - Start giving two to three spoonfuls of thick porridge and well-mashed foods during two to three meals each day. Gradually increase to about half a cup each meal. Offer one or two semi-solid snacks between meals.
- **Help the child eat** - Until the child can feed him/herself (above 2 years old), an adult or older sibling should sit with the child during meals and encourage the child to eat. Soon the child will try to grab small pieces of food. They should be allowed to develop this skill. Giving the child food to eat with his/her fingers can increase the child's interest in eating. However, whilst learning to feed themselves, they still need to be fed most of the food, to make sure that they eat enough.
- **Separate plate** - The child should not have to compete with older brothers and sisters for food from a common plate, where it is difficult to know how much each child has eaten.
- **Handwashing (with soap or ash)** - It is important to wash hands before preparing food and before eating, including the infant's hands.
- **Growth monitoring** - Continue to take the child to be weighed every month.

RESPONSIVE FEEDING FOR CHILD DEVELOPMENT**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.

EXERCISE: FACTS AND MYTHS

Statement	Answer
Children aged 6 to 24 months should not be allowed to eat fish as this is bad for them.	
Children who eat a lot sugar and sweet drinks may suffer from obesity, and suffer from teeth problems.	
Children aged 6 to 24 months should eat mostly rice mixed with water as they cannot digest other foods.	
Children should eat red meat and green vegetables to prevent them from getting anaemia.	
Children aged 6 to 24 months who eat a diet including fruit and vegetables are less likely to suffer from diseases.	
A balanced diet is when each of the food groups weighs the same amount.	
Foods rich in protein such as meat fish and eggs will help a child to grow.	
If you teach a child to eat eggs they will grow up to become a thief.	
Sweet fizzy drinks are an excellent source of energy for a young baby.	
Children should not eat eggs before the age of 2 because it is bad for them.	
Children who eat a large plate of rice every day will not suffer from malnutrition.	
A child who does not eat rice will definitely suffer from malnutrition.	
Children under the age of 1 should not eat food with added salt.	
Meat cooked in a sauce can be served up to two days after making it.	

HYGIENE, GROWTH MONITORING AND SUPPLEMENTS**HANDWASHING IN THE HOME**

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. Weight and growth should be measured monthly at your local health facility. Ideally, a child should be taken for growth monitoring once per month until 2 years of age. If the child shows lack of growth, or weight loss, they may want to do further tests to find an underlying cause, counsel the mother on infant feeding, or refer to additional feeding support if available.



VITAMIN A



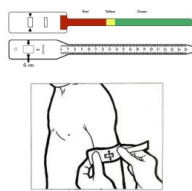

Lack of vitamin A can cause blindness and serious illnesses. From 6 months of age, children need a vitamin A dose once every 6 months from the health services. The ttC-HV should encourage all families to attend a clinic or outreach service to obtain vitamin A drops for the child at 6 months, and every 6 months to aged 5 years.

FAMILY PLANNING

A gap of 2 years between each child 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. It is important to remind families that if they become pregnant again this could mean they are less able to breastfeed their baby to 2 years of age, meaning they will grow less strong and healthy as a result.

COMPLEMENTARY FEEDING: BARRIERS AND ENABLERS

Key Messages and additional information	Barriers: <i>What makes it difficult to do?</i>	Enablers: <i>What would make it easier to do?</i>	Counselling response or solution
Complementary feeding: importance of dietary diversity – 3 food groups 			
Continued breastfeeding* to 24 months in addition to giving foods 			
Give foods rich in iron: meat, chicken, fish, green leaves, fortified foods			

			
<p>Vitamin A supplements from six months</p> 			
<p>Continue regular growth monitoring at the clinic and community (MUAC)</p> 			
<p>Family Planning (HTSP)*</p> 			

SESSION 2: COMPLEMENTARY FEEDING

Key Messages

- Prepare complementary foods for a child aged 6 to 12 months:
 - Wash hands with soap or ash before preparing and feeding, use clean utensils, plates. Cook thoroughly and serve straight away, as mashed or pureed food.
 - For children under 2, give their own plate of food in order to know how much is being consumed.
 - Don't prepare watery or runny food as the baby will not receive enough nutrition for healthy growth.
- Wash hands with soap after defecation and before preparing food, eating and feeding.

SUGGESTIONS FOR COMPLEMENTARY FOOD PREPARATIONS FOR CHILDREN AGED 6-9 MONTHS

Note: porridge should not be too thin or runny. It should be of a consistency that stays on the spoon when the spoon is tilted, as in the illustration below.



RECIPE 1

Ingredients

3 tablespoons of flour (maize, rice, cassava, 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, cassava, 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, cassava, 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, cassava, 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

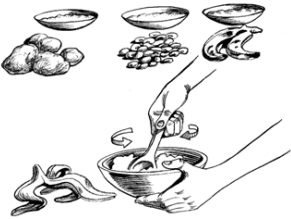


1-2 tablespoons of greens, ground and cooked

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.

VISIT 7. 5TH MONTH – COMPLEMENTARY FEEDING

Key Messages and additional information	Barriers: <i>What makes it difficult to do?</i>	Enablers: <i>What would make it easier to do?</i>	Counselling response or solution
<p>Preparation of complementary foods for 6 to 9 month child*: give 2 to 3 meals a day</p> <ul style="list-style-type: none"> - Feed in response to child’s hunger. (responsive feeding) - Give food on a separate plate 			
<p>Handwashing with soap / hygiene during food preparation* (preventing diarrhoea)</p> 			
<p>From six months give water to drink – should be boiled or purified water</p> 			

SESSION 3: THE MAJOR KILLERS AND FEEDING DURING ILLNESS

KEY MESSAGES

- 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.
- From 6 months until 2 years, continue to breastfeed the baby every day, whenever the baby is hungry. Breastfeed longer and more frequently than usual during and after illness.
- During illness a child will need to eat and drink more than usual during and especially after the illness. Encourage mothers to patiently feed children small, frequent meals during illness until they are better.
- If a child is unable to drink or breastfeed at all, this is a danger sign for urgent referral.

DIARRHOEA



DIARRHOEA

Diarrhoea is defined as **three or more watery stools** in a day.

- **Prevent diarrhoea:** Diarrhoea becomes more frequent once complementary foods and water are introduced, sometimes due to unsanitary food preparation, poor food quality or unclean drinking water. Good hygiene practices protect against diarrhoea. It is important to wash hands with soap and running water after using the latrine and before cooking and eating. It is also important to dispose of faeces in a latrine or bury them.
- **Prevent dehydration in a child with diarrhoea:** Diarrhoea kills by draining liquid from the body, dehydrating the child. As soon as diarrhoea starts, the child must be given extra fluids along with regular foods. Breastfeeding reduces the severity and frequency of diarrhoea. Mothers should continue to breastfeed their child on demand.
- **Treat diarrhoea with ORS/zinc:** All diarrhoea in a child under 5 years of age needs treatment with ORS and zinc. ORS in water prevents and treats dehydration. Zinc helps to reduce the seriousness of diarrhoea and even prevent future diarrhoea episodes. Zinc also improves appetite and growth of children. ORS and zinc can be obtained at the health clinic or pharmacy.
- **Feeding during illness:** A child with diarrhoea needs to continue eating regularly. Whilst recovering from diarrhoea, the child needs an extra meal every day for at least two weeks.
- **Look out for danger signs with diarrhoea:** Seek immediate help from a trained health worker if any of these danger signs are seen in a child with diarrhoea:

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 blood in the stools.

DIARRHOEA: PREPARING AND GIVING ORS¹



MAKING ORS

- Wash your hands with soap and running water.
- Pour all the powder from one packet into a clean 1-litre container such as a jar, bowl or bottle.
- Measure 1 litre of clean water (or correct amount for packet used). It is best to boil and cool the water, but if this is not possible, use the cleanest drinking water available.
- Pour the water into the container. Mix well until the powder is completely dissolved.
- Always mix fresh ORS solution each day in a clean covered container, and throw away any solution remaining from the day before.

GIVING ORS

ORS should be given after every loose stool:

- **Up to 2 years** 50 to 100 ml after each loose stool (half to one cup)
- **2 years or more** 100 to 200 ml after each loose stool (1-2 cups)

How to give ORS:

- Give frequent small sips from a cup or spoon. Use a spoon to give fluid to a young child.
- If the child vomits, wait 10 minutes before giving more, then resume giving fluid, more slowly.
- Continue giving extra fluid until the diarrhoea stops.

GIVING ZINC

Dose

- Children <6 mo: ½ 20mg tablet once per day for 10 or 14 days
- Children ≥6 mo: 1 tablet per day for 10 or 14 days

Giving zinc:

- Children still breastfeeding: Dissolve tablet in a small amount of breastmilk, ORS, or clean water
- Children not breastfeeding or older: Tablets can be chewed or dissolved in clean water
- It is important to give the full course even if the diarrhoea ends.

FEEDING DURING ILLNESS



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)

¹ WHO (2005) *Handbook of Integrated Management of Childhood Illnesses*.
<http://whqlibdoc.who.int/publications/2005/9241546441.pdf>.

- 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: FEEDING DURING ILLNESS

Contextualisation: replace this box below with that adapted from national IMCI guidelines

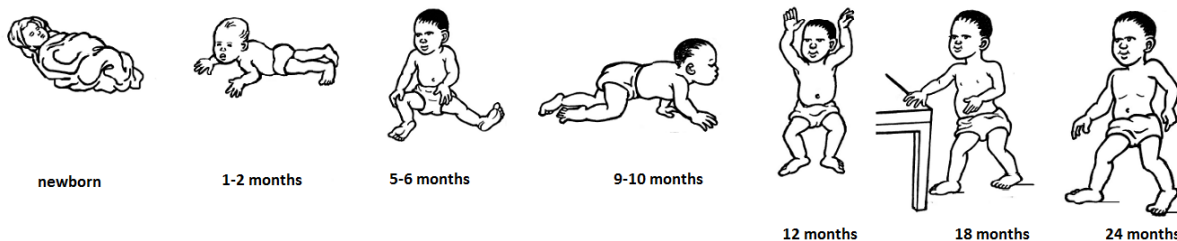
Under 6 months	6 months to 12 months	12 months to 2 years	2 years and older
<p>Breastfeed as often as the child wants, day and night. Feed at least 8 times in 24 hours. Do not give other foods or fluids.</p> 	 <p>Continue to breastfeed as often as the child wants. Give 3 servings of nutritious complementary 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</p>	 <p>Continue to breastfeed as often as the child wants, and also give nutritious 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</p>	 <p>Continue to breastfeed as often as the child wants. Give at least 5 adequate nutritious feeds. Increase variety and quantity of family foods: Mix margarine, fat, oil, peanut butter or groundnuts 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.</p>

SESSION 4: COUNSELLING THE FAMILY ON CARE FOR CHILD DEVELOPMENT

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.
- 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 ttC-HV have about development should be referred to a health facility.
- Babies' growth and development, especially the brain, is most rapid *in utero* and during the first two years of life, and largely influenced by the babies' environment and their interactions with mother/caregivers.
- 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 (e.g. intellect/cognitive, motor/physical, language / communication, social, emotional).
- 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)
- 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 ttC-HV.
- As primary caregiver, the mother's state of wellbeing is critical to her ability to interact with her child, recognise and respond to their needs and support their development.

WHAT CAN A BABY DO?



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 ttC-HV 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 that they develop, and reaching milestones at different times may not be a problem. These norms help us understand patterns of development, but understanding there is wide variation between individual children.

INTERACTIONS WITH CAREGIVERS



EARLY CHILD DEVELOPMENT: THE IMPORTANCE OF POSITIVE CAREGIVER INTERACTIONS

During home visits: watch and encourage parents to do these things with their baby from birth:

1. **LOOK/SMILE:** Babies can see 8 and 12 inches at birth - the distance between the mother's and baby's face during breastfeeding. The baby loves faces, especially the mother's. Babies love to respond to smiles and sounds and after 4 - 6 weeks of age they begin smiling and making noises to make the mother smile.
2. **TALK/SING:** At birth, babies can hear and learn sounds like the mother, father and family members' voices. Before they understand language, body language like eye contact, facial expressions, cooing and babbling are important and a prelude to using words. Talking is critical for the development of babies' language and intellect.
3. **HUG / TOUCH:** The mother's body (her touch, heat, sounds, smell) helps the baby to feel calm and safe, which is the beginning of a baby's *emotional attachment* to her. This early connection between mother and baby is really important because it lays the foundation for good social and emotional relationships and mental health in life. When the caregiver responds with touch and hugs the baby learns to feel safe and loved.
4. **PLAY:** For their brains to develop, babies also need to explore and play, when they can see, hear, feel, move freely, and experiment which is a part of learning. Between swaddling, allow the baby to move freely, massage and exercise the baby's arms and legs to make it stronger every day. By one month, many babies can hold their head up briefly, and begin to support their own body weight. Putting the baby with tummy on the bed/surface (tummy time) can help them develop stronger muscles. Parents can begin giving the baby age-appropriate toys and safe objects to explore, touch and play with as part of learning.
5. **READ:** Reading to a child or book reading with pictures by pointing and describing a pictorial book stimulates language development: age-appropriate communication, a rich vocabulary, and a shared interest with the child. This can begin at age 6 months.

PRINCIPLES OF LEARNING AND DEVELOPMENT









Babies' brains at birth are not fully mature. The "back & forth" interaction between baby and caregiver helps to build the developing brain and prepare them for life. Four principles²:

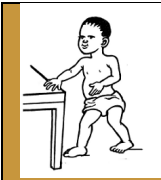
- Much of what children learn, they learn when they are very young (i.e. under 2 years of age)
- Children need a safe environment as they learn
- Children need consistent loving attention from at least one person
- Children learn by playing and trying things out, and by observing & copying what others do

LANGUAGE, STIMULATION AND PLAY THROUGH THE LIFECYCLE

Needs contextualization for the toys and objects typically used or available in that community.

² WHO/UNICEF: Counselling the Family on Care for Child Development

Age of young infant	Recommendations for family
<p>Newborn, birth up to 1 week</p> 	<p>Your baby learns from birth.</p> <ul style="list-style-type: none"> • Play: <ul style="list-style-type: none"> ○ Provide ways for your baby to see, hear, move arms and legs freely, and touch you. ○ Gently soothe, stroke, and hold your child. Skin to skin is good. • Communicate: <ul style="list-style-type: none"> ○ Look into baby’s eyes, and talk to your baby. ○ When you are breastfeeding is a good time. Even a newborn ○ Baby sees your face and hears your voice. 
<p>1 week up to 6 months</p> 	<ul style="list-style-type: none"> • Play: <ul style="list-style-type: none"> ○ Provide ways for your child to see, hear, feel, move freely, and touch you. ○ Slowly move colourful things for your child to see and reach for. ○ Sample toys: shaker rattle, ring on a string. • Communicate: <ul style="list-style-type: none"> ○ Smile and laugh with your child. Talk to your child. ○ Get a conversation going by copying your child’s sounds or gestures. 
<p>6 months up to 9 months</p> 	<ul style="list-style-type: none"> • Play: <ul style="list-style-type: none"> ○ Give your child clean, safe household things to handle, bang, and drop. ○ Sample toys: containers with lids, metal pot and spoon. • Communicate: <ul style="list-style-type: none"> ○ Respond to your child’s sounds and interests. ○ Call the child’s name, and see your child respond. 
<p>9 months up to 12 months</p> 	<ul style="list-style-type: none"> • Play: <ul style="list-style-type: none"> ○ Hide a child’s favourite toy under a cloth or box. See if the child can find it. ○ Play peek-a-boo. • Communicate: <ul style="list-style-type: none"> ○ 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. 
<p>12 months up to 2 years</p>	<ul style="list-style-type: none"> • Play: <ul style="list-style-type: none"> ○ 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.



ASSESS AND COUNSEL THE FAMILY ON CARE FOR CHILD DEVELOPMENT**COUNSELLING FOR CHILD DEVELOPMENT: ASK / OBSERVE**

- **Ask the mother / caregiver:**
 - How do you play with your baby?
 - How do you talk with your baby?
 - How do you get your baby to smile?
 - Ask her to show you how she plays and talks with the baby. Then ask her to show what she does to get her baby to smile.
- **Observe the mother's demonstration,**
 - If there is no difficulty, praise the mother.
 - If the mother has difficulties playing or talking with her baby, or trying to get the baby to smile, explain that it is sometimes difficult when the child is this age. Ask her to play a game with her baby: look closely into the baby's face, and copy the baby's sounds and gestures. The baby will show pleasure, which will help the mother respond playfully. Ask the mother when she could play with her child at home. Games, like copying, will help the mother and baby to learn to communicate and will prepare the baby for talking later.
- **Ask the father or family member** (father should be encouraged to attend ttC visits*)
 - How much time do you spend with your baby / child?
 - How do you play or talk to the baby or try to get the baby to smile?
 - Remind or encourage the father that his positive interactions with the child are as important as the mothers for the child to grow, learn and develop well.

*remember: ensure single parent families are supported by a companion or relative during ttC visits.

COUNSEL ON PROBLEMS IN CARING FOR THE CHILD'S DEVELOPMENT

Problem identified by caregiver	Counselling response
If the caregiver does not know what the child does to play or communicate	<ul style="list-style-type: none"> • Remind the caregiver that children play and communicate from birth. Demonstrate how the child responds to his activities.
If the caregiver feels that she is too burdened or stressed to play and communicate with the child	<ul style="list-style-type: none"> • Listen to her feelings, and help her identify a key person who can share her feelings and help her with her child. • Build her confidence by demonstrating her ability to carry out a simple activity. • Refer her to a local service, if needed and available.
If caregivers feel that they do not have time to play and communicate with the child:	<ul style="list-style-type: none"> • Encourage them to combine play and communication activities with other care for the child. • Ask other family members to help care for the child or help with chores.
If caregiver has no toys for her child to play with:	<ul style="list-style-type: none"> • Use any household objects that are clean and safe. • Make simple toys. • Play with her child. The child will learn by playing with her and others.
If the child is not responding,	<ul style="list-style-type: none"> • Encourage family to do extra play and communication activities with

or seems “slow”, or the parents report concerns that they think this:	<p>child.</p> <ul style="list-style-type: none"> • Check to see whether the child is able to see and to hear. • Refer the child with difficulties to special services. • Encourage the family to play and communicate with the child through touch and movement.
If the mother or father has to leave the child with someone else for a period of time:	<ul style="list-style-type: none"> • Identify at least one person who can care for the child regularly, and give the child love and attention. • Get the child used to being with the new person gradually. • Encourage mother and father to spend time with the child when possible.
If it seems that the child is being treated harshly:	<ul style="list-style-type: none"> • Recommend better ways of dealing with the child. • Encourage family to look for opportunities to praise the child for good behaviour. • Respect the child's feelings. Try to understand why child is sad or angry. • Give the child choices about what to do, instead of saying “don't”.

BARRIERS TO CHILD DEVELOPMENT

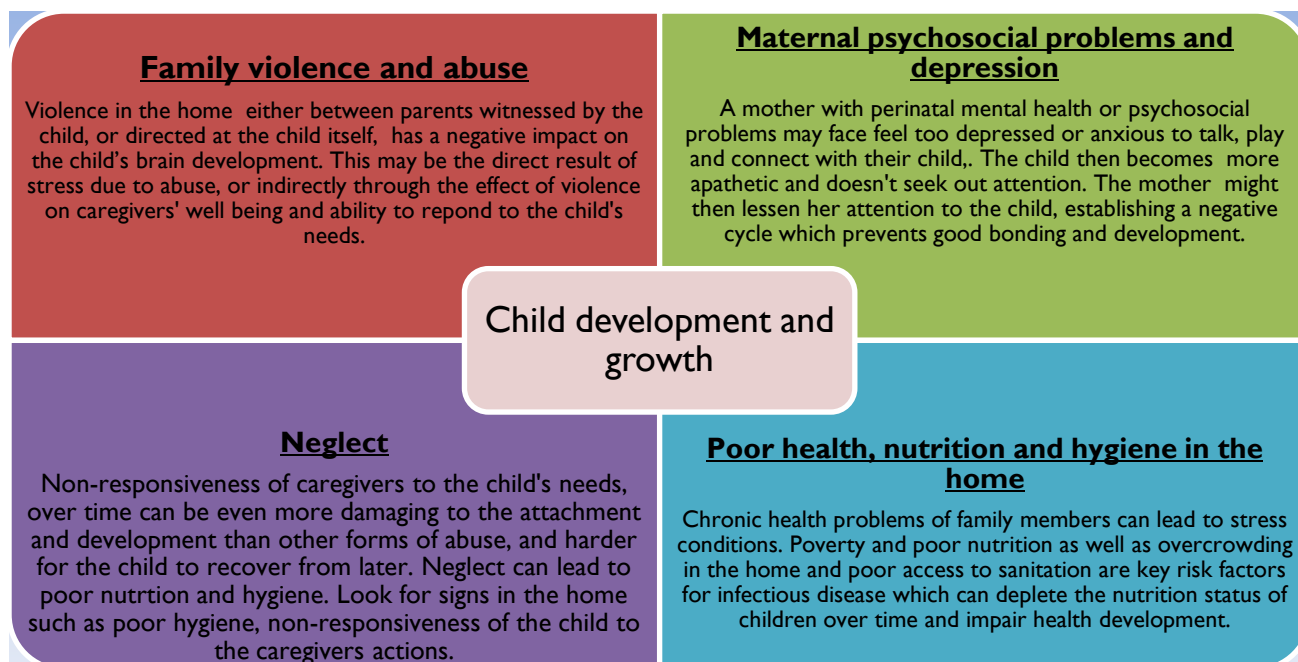
WHAT HINDERS EARLY CHILD DEVELOPMENT?

Important message:

“All families need some support to learn how to develop and apply sensitivity and responsiveness in their childcare practices. There are, however, both *biological and environmental factors that can negatively impact on attachment*. These include low birth weight, malnutrition and infections, poverty and its associations, conflict and domestic violence, and mental health problems such as maternal depression. In these instances, external support for families is particularly important.”³

- The most important underlying causes of developmental delay are **psychosocial risks like low education, single parents, poverty, mental health problems** e.g. post-partum depression, family violence, alcoholism, and equally poor parenting skills that hinder optimum child development.
- **The importance of early experiences** Events in the first two years of life, and even in the mother's uterus as a growing baby, can influence the child for the rest of their lives. During these early years the babies “Emotional memory” is born, as they learn how to react to stress. Once ‘programmed’ to stress in the form of neglect, physical or emotional abuse, it is hard to change this pattern in later life. Although they cannot remember their earliest experiences, their bodies react to similar stressors in the same ways. They can grow up to become adults with low self esteem, anxiety and depression. For example:
 - A child who becomes used to being neglected and not having their needs met, may grow into and adult who fears to be alone, or becomes anxious about separation from loved ones;
 - a child who has experienced abuse may become fearful of relationships later in life, or conversely, may go on to behave abusively to others.

³ Source: WHO. Early child development: a powerful equalizer: final report for the World Health Organization's Commission on the Social Determinants of Health (2007). Arjumand Siddiqi, Lori G. Irwin, Dr. Clyde Hertzman, Human Early Learning Partnership; Commission on Social Determinants of Health



POSSIBLE SIGNS OF ABUSE OR NEGLECT: WHAT TO LOOK FOR DURING THE HOME VISIT:

- If the baby cries, can you see that the mother is able to comfort the baby?
- Does she recognise what the baby wants and respond to the baby's needs?
- Is the baby looking at the mother when they are talking?
- Is the child well nourished*, well cared for, clean, has hygienic sanitation and clothing?

If the answers to questions above are NO, ask the mother more about how she interacts with and cares for her baby and explore ways they can become more closely attached. Counsel her how to meet the nutrition and hygiene needs of the child, and get more support from family. *Consider referral for under nutrition.

SOME MORE VULNERABLE CHILDREN NEED EXTRA CARE AND STIMULATION

- Babies born prematurely or with low birth weight;
- Malnourished children;
- Children who have experienced neglect in the early years;
- Children whose mother/primary caregiver is under prolonged/high stress;
- Children with disability (physical and /or mental);
- Children who have been orphaned;
- HIV positive kids;
- Children who potentially currently subject to neglect and abuse.

Spend more time with these families encouraging them to play, talk, touch & hug and read to the child, as well as responsive feeding to stimulate growth and development. These children can have difficulties like being easily upset or timid, be harder to feed, communicate less or have difficult behaviours, which in time might make caregivers less likely to feed, play or communicate frequently with them.

SESSION 5: CONDUCTING VISIT 7 – FIFTH MONTH

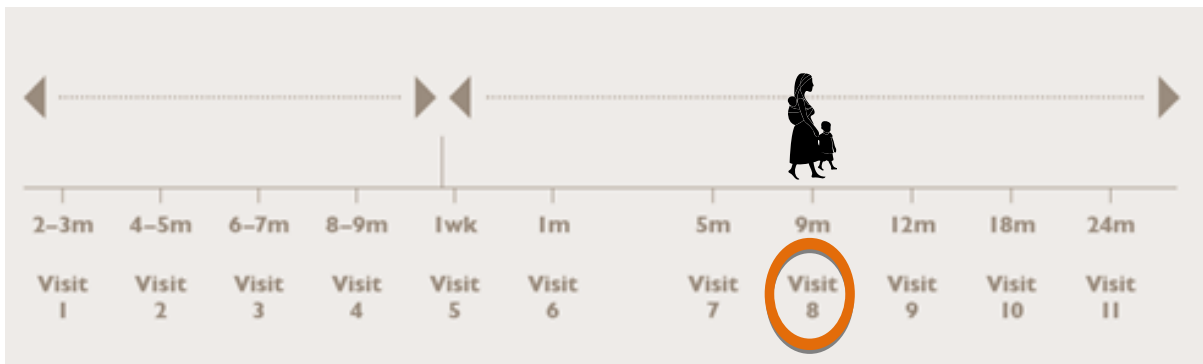
Topics covered in Visit 5

- Child feeding: 6–9 months
- Child feeding for the HIV-positive mother
- Complementary foods
- Routine health services: growth monitoring and supplements
- Major killers – diarrhoea, pneumonia and malaria

Visit 7: Fifth Month

SEQUENCE FOR VISIT 7: 5TH MONTH	
<p>The diagram shows a horizontal timeline from 2-3m to 24m. Visits are marked at 2-3m, 4-5m, 6-7m, 8-9m, 1wk, 1m, 5m, 9m, 12m, 18m, and 24m. Below these are labels for Visit 1 through Visit 11. Visit 7 (5m) is circled in red and has a person icon above it. A double-headed arrow spans from 2-3m to 1wk, and another from 1wk to 24m.</p>	
<p>Before starting: Greet the family. Ensure that the identified supporters are all present.</p>	
<p>Identify and respond to any difficulties: Ask the mother if she has any danger signs, including any emotional distress. Conduct referral if needed. Apply psychological first aid principles if needed.</p> <p>Assess the child: If the mother reports the child is sick, check for danger signs and refer if any are present.</p>	
<p>ttC Counselling process:</p> <ol style="list-style-type: none"> Step 1: Review the previous meeting (visit 6) and update the household handbook for new practices completed. Step 2: Present and reflect on the problem: problem scenario: 'Malnutrition' and ask the guiding questions. Step 3: Present information: positive story: 'Complementary feeding' and ask the guiding questions Step 2: Present and reflect on the problem: problem scenario: 'Diarrhoea' and ask the guiding questions Step 3: Present information: positive story: 'Diarrhoea' and ask the guiding questions. Step 4: Negotiate new actions using the household handbook 	
<p>Step 5: ttC-HV additional actions:</p> <ul style="list-style-type: none"> ○ Ask about continuing breastfeeding and provide advice as necessary. ○ Ask about family-planning choice. ○ Check child health card for growth monitoring and/or immunisations, and remind about vitamin A. ○ Demonstrate water purification. ○ Demonstrate enriched porridge (optional). ○ Ask and observe: Counsel family on care for child development 	
<p>Record the results of the meeting: Fill in the <i>ttC Register</i> for this visit</p>	
<p>End the visit: Decide with the family when you will visit again (at 9 months). Thank the family.</p>	

Visit 8: Ninth Month



SESSION 7: CHILD NUTRITION AND DEVELOPMENT AT NINE MONTHS

Key messages

- At 9 months of age, children need to eat more frequently and in greater amounts. Children should be given complementary foods at least four times per day at this age as well as continue to breastfeed.
- It is important that children receive 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 per year from 6 months to 5 years of age. In some situations, children will also be given iron supplements.
- Encourage the mother and family members to play and communicate with the child to help them feel loved and to grow and develop fully.

CHILD FEEDING AT 9 MONTHS



CHILD FEEDING AT 9 MONTHS

- All 9-month-old babies should continue to breastfeed.
- Children at this age 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.
- The mother should make sure that the child is eating foods rich in iron and 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.
- All family members should wash their hands before preparing food and before eating.
- Continue to take the child to be weighed every month.

MICRONUTRIENTS



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).



FEEDING AS AN OPPORTUNITY FOR HOLISTIC CHILD DEVELOPMENT


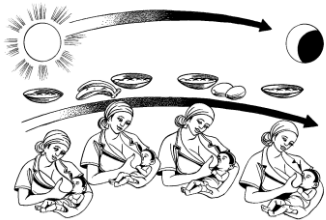
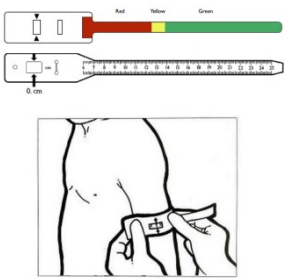



CHILD DEVELOPMENT

- **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.

BARRIERS AND ENABLERS

Key Messages and additional information	Barriers: <i>What makes it difficult to do?</i>	Enablers: <i>What would make it easier to do?</i>	Counselling response or solution
<p>Continued breastfeeding* alongside complementary foods</p> 			
<p>Give vitamin A rich foods*</p> 			

<p>Micronutrients: Vitamin A supplementation from 6 months</p> 			
<p>Preparation of complementary foods for 9 to 12 month child*: give 3 to 4 meals a day</p> <ul style="list-style-type: none"> - Feed in response to child's hunger (responsive feeding) - Give food on a separate plate 			
<p>Continued growth monitoring at clinic and community (MUAC)</p> 			
<p>Holistic Child Development, stimulation and play</p> 			

SESSION 8: DETECTING AND REFERRING ACUTE MALNUTRITION

Key messages

- ✓ Malnutrition is the condition of being undernourished caused by multiple factors. There are three major causes of malnutrition and two forms of malnutrition chronic and acute.
- ✓ A child with severe acute malnutrition is characterized by
 - Presence of bilateral pitting oedema of both feet (*kwashiorkor*)
 - Very low weight for the height resulting in severe visible wasting indicated by 'baggy pants' appearance of the buttocks (*Marasmus*).
 - A middle upper arm circumference (MUAC) less than 11.5 cm (check for national cut-off).
- ✓ Severely malnourished children are 9 times more likely to die before the age of 5 than children with good nutrition,
- ✓ Cases of severe acute malnutrition should be referred urgently to the health facility.
- ✓ After a child has been treated in a facility for acute malnutrition, the family may need special support in the home to ensure that:
 - the family adopts improved feeding practices for the child
 - the child attends growth monitoring and promotion sessions
 - the child is gaining weight and not experiencing further problems.

MALNUTRITION

- Malnutrition is the condition of being undernourished caused by multiple factors. The 3 major causes are
 - **Immediate causes:** inadequate intake and diseases and infections, which forms a vicious cycle
 - **Underlying causes:** household food insecurity, inadequate care practices and access to health care and inadequate access to safe water and poor hygiene and sanitation practices
 - **Underlying factors:** factors related to socio-cultural, economic, political and policy ,

CHRONIC AND ACUTE MALNUTRITION

- '*Chronic*' malnutrition means the child has suffered a lack of food or lack of certain foods over a long period of time. This could be:
 - Stunting: a condition where the child has very low length/height for the age
 - Underweight: a condition where a child has very low weight for the age
- *Acute malnutrition* means that the child has had a lack of food or suffered a sudden weight loss due to illness or inadequate intake. A child with severe acute malnutrition is characterized by
 - Presence of bilateral swelling of both feet (pitting oedema), also called kwashiorkor
 - Very low weight for the height resulting in severe visible wasting indicated by 'baggy pants' appearance of the buttocks (also called Marasmus).
 - A middle upper arm circumference (MUAC) less than 11.5 cm (check for national cut-off)
- Nearly 52 million children under age five suffer from severe acute malnutrition worldwide. Every year, 1 million children die from SAM, many of these in Africa and Asia.

- Severe acutely malnourished children are nine times more likely to die before age five than children with good nutrition.
- Malnutrition can cause death in children both directly (starvation), or indirectly through increased vulnerability to illness and infection.
- **Vicious cycle of illness and malnutrition:** When children get an infection or illness such as diarrhoea, it weakens their defenses and they may lose weight due to poor appetite, and they can lose more weight. The more underweight a child becomes, the more likely they are to catch infections, and so the cycle continues.

HOME-BASED FOLLOW-UP OF THE MALNOURISHED CHILD

Contextualisation: modify the following box according to the country guidelines.

HOME-BASED FOLLOW-UP FOR THE MALNOURISHED CHILD

Following referral for severe acute malnutrition, once the child is stabilised the mother will need special support in the home to ensure that:

- the family adopts improved feeding practices for the child to sustain the growth
- the child attends follow up and growth monitoring and promotion as per recommendations
- the child is gaining weight
- the child does not have any similar danger signs

During the home visit, conduct the following checks:

- Check when the child was treated at the facility, verify discharge note or counter-referral slips.
- Check when the child is due to be seen again at the facility for follow-up and ensure the family goes.
- Ask the mother how she is feeding the child now. Possibly the family were not following the recommended practices.
- Counsel on recommended feeding practices and demonstrate how the family can make nutrient dense and diversified complementary foods.
- Counsel the family on the feeding needs of the child, trying to understand how the child may have become malnourished in the first instance.
- Check MUAC for wasting
- Check for bilateral pitting oedema on both feet

Note: If the child is in a therapeutic feeding scheme, ensure that he/she is connected with the appropriate community support worker and programme.

Notes:

OPTIONAL SESSION 8B: SCREENING FOR ACUTE MALNUTRITION USING MUAC

Key messages

- MUAC screening is a quick and simple way of identifying a child who may be suffering from acute malnutrition.
- It is not appropriate to do an MUAC screening for a child under the age of 6 months.
- ttC-HVs can do MUAC screening during or after an acute illness in which the child may have suffered weight loss, and during routine home visits.
- Children with an MUAC of below 11.5 cm (yellow or red) should be referred to the nearest facility for nutrition support and medical attention.

MUAC SCREENING FOR ACUTE MALNUTRITION



MUAC SCREENING

- MUAC helps us to quickly determine the level of malnutrition in large groups of people.
- MUAC is a simple and easy to use measurement tool that is often used for screening in emergency situations and is also used in nutrition surveys in development contexts.
- MUAC helps us to quickly determine the level of malnutrition in large groups of people.
- MUAC is based on the fact that a small or decreasing arm circumference signals the loss of muscle mass. ('Circumference' means 'outside edge of a circle'.) Muscle mass is known to be important in maintaining body functions and in fighting infections.
- MUAC is a good predictor of immediate risk of death. This is why we usually use MUAC in emergency situations, for a quick assessment of nutritional status.
- MUAC is not used to measure malnutrition in children under 6 months because we don't have established cut-off levels for this age group.
- MUAC can be used with children and adults to find the recent under-nutrition rates in a population.
- For monitoring growth we use weight and age. To measure stunting we use height and age. Wasting is measured using weight and height. MUAC should be used to identify acute malnutrition and to estimate beneficiary numbers for emergency nutrition programmes in nutrition surveys.

PRACTISE TAKING AN MUAC READING



TAKING A MUAC READING

1. Work at eye level. Sit down if possible.
2. Ask the mother to remove any clothing that covers the child's left arm.
3. Locate the tip of the child's shoulder with your fingertips.
4. Bend the child's elbow to a right angle.
5. Place a mark on the child's arm halfway between the shoulder tip and the elbow.

6. Straighten the child's arm.
7. Wrap the MUAC band around the child's left arm at the mid-point mark you have just made. Insert the end of the band through the thin opening at the other end of the band.
 - a) Keep the colours or numbers on the band right side up so that you can see them, and be sure that the band is flat against the skin.
 - b) Make sure the band is not too tight (if the band is too tight, this bunches up the skin and we do not get an accurate reading).
 - c) Make sure the band is not too loose (the band is too loose if you can fit a pencil under it).
 - d) Make sure the band is horizontal around the child's arm.
8. Read the measurement aloud (either the colour or the number that shows most completely in the wide window on the band). Ask the assistant to repeat the measurement and to record it on the form.
 - a) Check that the measurement is recorded correctly.
 - b) Gently remove the band from the child's arm. Thank the mother and the child for their cooperation.

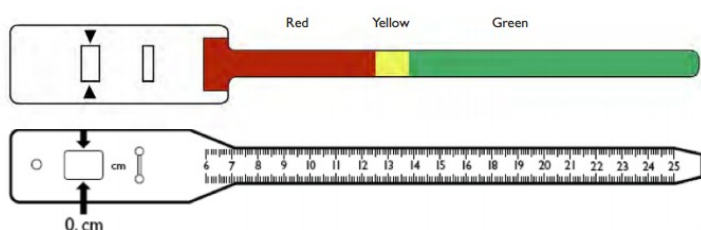
Interpreting MUAC

We use a 'cut-off' point of 11.5 cm to identify severely malnourished children. Any child whose MUAC measurement is below 11.5 cm (red) is considered severely acutely malnourished and at risk of death, and requires immediate medical attention.

Those children with a MUAC between 11.5 cm and 12.4 cm (yellow) are classified as moderately malnourished. These children are at risk of developing severe form of acute malnutrition. Hence they need to be referred to local supplementary feeding program if available. If not they need to participate in community nutrition sessions such as PD Hearth to to rehabilitate them and equip the family in feeding practices prevent future malnutrition.

A child whose MUAC is 12.5 cm or greater (green) is classified as having a normal mid-upper arm circumference.

- This cutoff is based on the global recommendation and it is recommended to check the national cut-off points for MUAC before making the decision for referral



Notes:

SESSION 9: CONDUCTING VISIT 8 – NINTH MONTH

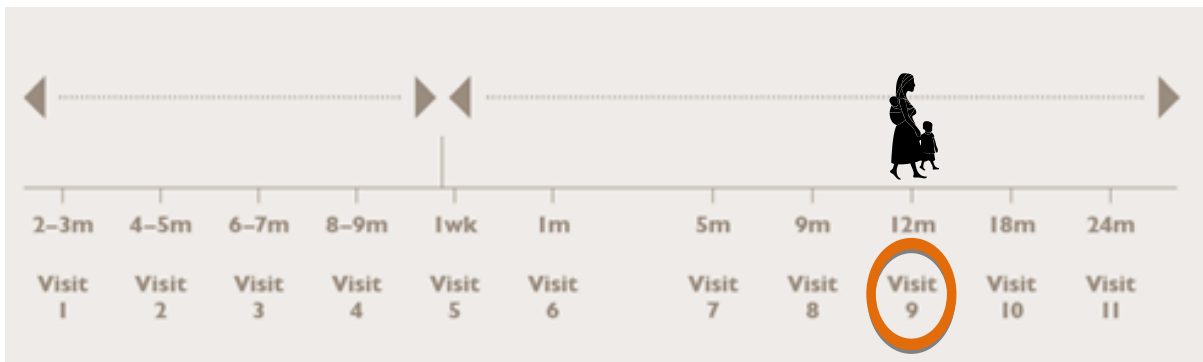
Key messages

- Dialogue, negotiate and encourage mothers and families to appropriately feed their 9-month-old babies, increasing the quantity of complementary foods to include foods rich in iron and vitamin A, and to recognise the danger signs of diarrhoea and seek care when needed. You will also teach the families how to prepare ORS.
- During Visit 8 you will show two problem scenarios: (1) vitamin A deficiency and (2) diarrhoea, and tell one story: positive story: 'Diarrhoea, complementary feeding and vitamin A', and ask the corresponding guiding questions.
- Following the negotiation steps, you will carry out several other important actions, including advising on continued breastfeeding, checking that the child health card is up-to-date, screening for MUAC, and reminding them about measles vaccination (and yellow fever if given) at 9 months.
- Lastly, you should counsel the family on care for child development including the 'ask/observe' steps outlined previously, encouraging the whole family to participate. Provide further support or counselling if needed.

Visit 8:Ninth Month

SEQUENCE FOR VISIT 8: 9TH MONTH	
<p>The diagram shows a horizontal timeline from 2-3m to 24m. Visits are marked at 2-3m (Visit 1), 4-5m (Visit 2), 6-7m (Visit 3), 8-9m (Visit 4), 1wk (Visit 5), 1m (Visit 6), 5m (Visit 7), 9m (Visit 8), 12m (Visit 9), 18m (Visit 10), and 24m (Visit 11). Visit 8 is circled in red and has a silhouette of a person on a horse above it.</p>	
<p>Before starting: Greet the family. Ensure that the identified supporters are all present.</p>	
<p>Identify and respond to any difficulties: Ask the mother if she has any danger signs, including any emotional distress. Conduct referral if needed. Apply psychological first aid principles if needed.</p>	
<p>Assess the child: If the mother reports that the child is sick, check for danger signs and refer if any are present.</p>	
<p>ttC Counselling process: Diarrhoea, complementary feeding, vitamin A</p> <ol style="list-style-type: none"> 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 household handbook 	
<p>Step 5: ttC-HV additional actions:</p> <ul style="list-style-type: none"> • Ask about continuing breastfeeding and provide advice as necessary. • Check child health card for growth monitoring and/or immunisations, and remind about vitamin A and measles vaccine. • Screen for MUAC (optional). • Ask what the child ate in the previous day; check for iron-rich and vitamin A-rich foods, and a balanced diet. • Ask and observe: Counsel family on care for child development. 	
<p>Record the results of the meeting: Fill in the <i>ttC Register</i> for this visit</p>	
<p>End the visit: Decide with the family when you will visit again (at 9 months). Thank the family.</p>	

Visit 9: Twelfth Month



SESSION 10: CHILD DEVELOPMENT AND NUTRITION AT ONE YEAR

Key messages

- Children at this age 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. They should continue to be breastfed.
- Growth monitoring and promotion: Continue to take the child to be weighed every month.
- 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.
- Vitamin A: All children over the age of 6 months are given vitamin A supplements once 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.
- 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.

CHILD FEEDING AT 12 MONTHS

CHILD FEEDING AT 12 MONTHS

- 12-month-old babies should continue to breastfeed.
- Children at this age 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 child should eat from a separate plate so the mother can be sure that he/she is getting enough to eat.
- All family members should wash their hands before preparing food and before eating.
- Continue to take the child to be weighed every month.
- Answer any questions the participants may have.

DEWORMING

Contextualisation: adjust for national policy on deworming

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.



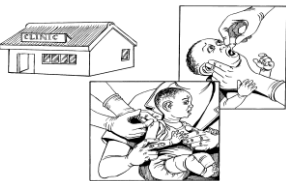
Raw meat may contain worms, so hands and utensils should be washed carefully after handling it, and meat should be thoroughly cooked before eating.

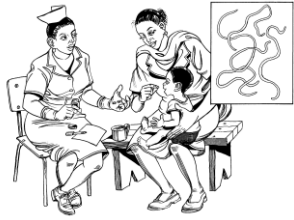

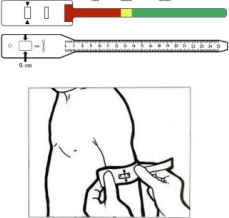

Children living in areas where worms are common should be treated with deworming medicine two to three times a year, according to the policy in the country.

COUNSEL THE FAMILY ON PLAY AND COMMUNICATION

Age of young infant	Recommendations for family
<p>12 months up to 2 years</p> 	<p>Play:</p> <ul style="list-style-type: none"> • 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. <p>Communicate:</p> <ul style="list-style-type: none"> • Ask your child simple questions. • Respond to your child’s attempts to talk. • Show and talk about nature, pictures and things.  

BARRIERS AND ENABLERS TO NEGOTIATED PRACTICES

Key Messages and additional information	Barriers: <i>What makes it difficult to do?</i>	Enablers: <i>What would make it easier to do?</i>	Counselling response or solution
<p>Continued breastfeeding* alongside complementary foods</p> 			
<p>Give iron rich foods</p> 			
<p>Routine Health Services: Growth Monitoring and Immunizations (immunization)*(immunizations should be complete)</p> 			


<p>De-worming from 12 months</p> 			
<p>Vitamin A supplement at 12 months*</p> 			
<p>Growth monitoring and promotion at clinic and the community (MUAC)</p> 			
<p>Holistic Child Development – stimulation and play</p> 			

SESSION 11: CONDUCTING VISIT 9.

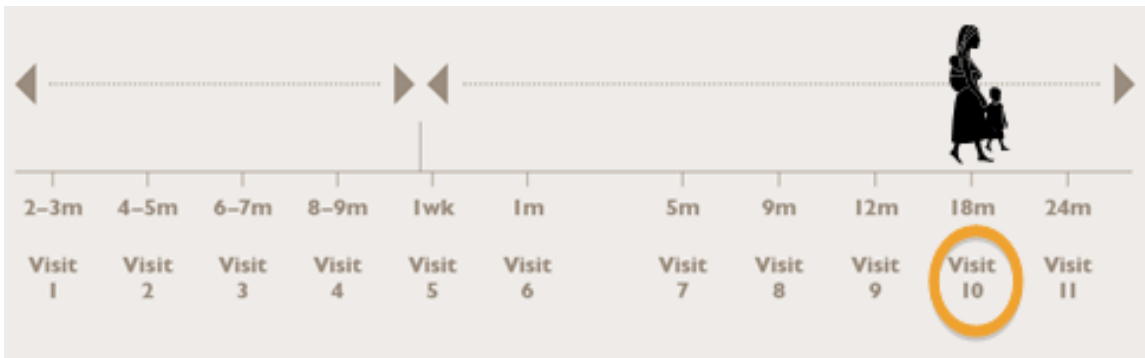
Key messages

- Visit 9 takes place when the child is 12 months old. During this home visit, ttC-HVs will dialogue, negotiate and encourage mothers and families to appropriately feed their 12-month old babies, adding complementary foods to breastfeeding. You will also assess the child for danger signs and refer if necessary.
- During Visit 9 you will present only the positive story: 'Complementary feeding, deworming and vitamin A', and ask the corresponding guiding questions.
- Following the negotiation steps, you will carry out several other important actions, including advising on continued breastfeeding, asking about family planning, checking that the child health card is up-to-date, reminding about vitamin A, checking if the child has received a deworming tablet and reminding them to have this at 12 months, and screening any sick or recently sick child for signs of malnutrition.
- Lastly, you should counsel the family on care for child development including the 'ask/observe' steps outlined previously, encouraging the whole family to participate. Provide further support or counselling if needed.

Visit 9: Twelfth Month

SEQUENCE FOR VISIT 9: 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: <ol style="list-style-type: none"> Step 1: Review the previous meeting (Visit 8) and update the household handbook. 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 of Thomas. Step 4: Negotiate new actions using the household handbook Step 5: ttC-HV additional actions: 	
additional check in visit 9 <ul style="list-style-type: none"> ✓ Ask about continuing breastfeeding and provide advice as necessary. ✓ Ask what the child has eaten the previous day, checking for iron-rich and vitamin A-rich foods, and a balanced diet. ✓ Check child health card for growth monitoring and/or immunisations, and remind about vitamin A. ✓ Refer for deworming if the child has not already had it at 12 months. ✓ Screen sick or recently sick children for signs of malnutrition. ✓ Ask and observe: Counsel family on care for child development. 	
Record the results of the meeting: Fill in the <i>ttC Register</i> for this visit	
End the visit: Decide with the family when you will visit again (at 18 months). Thank the family.	

Visit 10: Eighteenth Month



SESSION 12: CHILD NUTRITION & DEVELOPMENT AT 18 MONTHS

KEY MESSAGES

- Child feeding at 18 months and beyond: 18-month-old babies should continue to breastfeed. They 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 child should eat from a separate plate so the mother can be sure he/she is getting enough to eat.
- Continued monitoring and promotion of nutrition: Continue to take the child to be weighed on a regular basis, and ensure that the child receives vitamin A supplement and deworming tablet at 18 months.
- Continued promotion of hygiene and hand washing: All family members should wash their hands before preparing food and before eating. As children learn to feed themselves it is even more important that the family ensures that children wash their hands with soap or ash before eating.

PROMOTING HEALTH AND NUTRITION AT 18 MONTHS



CHILD FEEDING AT 18 MONTHS AND BEYOND

- 18-month-old babies should continue to breastfeed.
- Children at this age 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 child should eat from a separate plate so the mother can be sure he/she is getting enough to eat.




CONTINUED MONITORING AND PROMOTION OF NUTRITION

- Continue to take the child to be weighed on a regular basis.
- Children need to receive vitamin A supplement and deworming tablet at 18 months.







CONTINUED PROMOTION OF HYGIENE AND HAND WASHING

- All family members should wash their hands before preparing food and before eating.
- By now, children will be more independent, and they will be mostly feeding themselves. It is even more important that the family ensures that children wash hands with soap or ash before eating.
- Children can start to learn about hand washing for themselves. ttC-HVs should encourage mothers to teach children hand washing early so they will maintain the habit throughout their lives.

COUNSEL THE FAMILY ON PLAY AND COMMUNICATION

Age of young infant	Recommendations for family
<p>2 years and older</p> 	<p><i>Play:</i></p> <ul style="list-style-type: none"> • Help your child count, name and compare things. • Make simple toys for your child. • Sample toys: Objects of different colours and shapes to sort, stick or chalkboard, puzzle. <p><i>Communicate:</i></p> <ul style="list-style-type: none"> • Encourage your child to talk and answer your child’s questions. • Teach your child stories, songs and games. Talk about pictures or books. • Sample toy: book with pictures.  

VISIT 10. THE 18 MONTH OLD CHILD

Key Messages and additional information	Barriers: <i>What makes it difficult to do?</i>	Enablers: <i>What would make it easier to do?</i>	Counselling response or solution
<p>Preparation of complementary foods for 18 month child*: give 3 to 4 meals a day</p> <ul style="list-style-type: none"> - Feed in response to child’s hunger. (responsive feeding) - Give food on a separate plate 			
<p>Give iron rich foods</p> 			
<p>Vitamin A and deworming at 18 months</p> 			
<p>Child should sleep under a bednet</p> 			
<p>Family to consider birth spacing interval (from 2 years)</p> 			
<p>Holistic child development – play and stimulation</p> 			

SESSION 13: CONDUCTING VISIT 10: 18 MONTHS

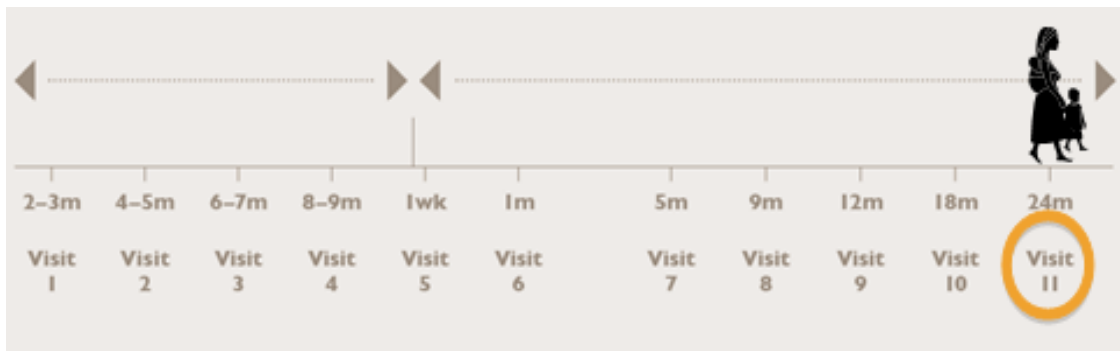
Key messages

- Visit 10 will take place when the child is 18 months of age. During Visit 10 ttC-HVs will dialogue, negotiate and encourage mothers and families to appropriately feed their child, adding complementary foods to breastfeeding. You will also assess the child for danger signs and refer if necessary.
- During Visit 10 you will present only the positive story: 'Complementary feeding, deworming and vitamin A' and ask the corresponding guiding questions.
- Following the negotiation steps you will carry out several other important actions, including advising on continued breastfeeding, asking about family planning, checking the child health card is up-to-date, reminding about vitamin A, checking if the child has received a deworming tablet and remind them to have this at 18 months, and screening any sick or recently sick child for signs of malnutrition.
- ttC-HVs should counsel the family on care for child development, including the 'ask/observe' steps outlined previously, encouraging the whole family to participate. Provide further support or counselling if needed.

Visit 10: Eighteenth Month

SEQUENCE FOR VISIT 10: 18 MONTHS	
<p>Timeline: 2-3m (Visit 1), 4-5m (Visit 2), 6-7m (Visit 3), 8-9m (Visit 4), 1wk (Visit 5), 1m (Visit 6), 5m (Visit 7), 9m (Visit 8), 12m (Visit 9), 18m (Visit 10), 24m (Visit 11). Visit 10 is circled in red and has a woman icon above it.</p>	
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 mother reports that the child is sick, check for danger signs and refer if any are present.
ttC Counselling process:	<ol style="list-style-type: none"> Step 1: Review the previous meeting (Visit 9) and update the household handbook. Step 2: Present and reflect on the problem (there is no problem story in this visit). Step 3: Tell the positive story: 'Complementary feeding, danger signs, birth spacing' using the appropriate flipbook visuals that show the story of Leila. Step 4: Negotiate new actions using the household handbook
Step 5: ttC-HV additional actions:	<ul style="list-style-type: none"> • Ask about continuing breastfeeding and provide advice as necessary. • Ask what the child has eaten in the previous day, checking for iron-rich and vitamin A-rich foods, and a balanced diet. • Check child health card for growth monitoring and immunisations, and remind about vitamin A. • Refer for deworming if the child has not already had it at 18 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 <i>ttC Register</i> for this visit
End the visit:	Decide with the family when you will visit again (at 24 months). Thank the family.

Visit 11: Twenty-Fourth Month



SESSION 14: CONDUCTING VISIT 11- THE EXIT INTERVIEW AT 24 MONTHS

Key topics to discuss at exit interview

- Complementary feeding: child eats five to six times per day
- Danger signs in children
- Birth spacing/family planning: may consider another pregnancy



CHILD FEEDING AT 2 YEARS

- 2-year-old children may continue breastfeeding for as long as it is agreeable for both the mother and the child. But if the mother wishes to stop breastfeeding now, it is okay for her to do so.
- 2-year-old children should continue to eat five to 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 the child should eat foods rich in iron and in vitamin A. Children are able to eat solid foods at this age.
- The child should continue to eat from a separate plate so that the mother can be sure that he/she is getting enough to eat.
- All family members, including the child, should wash their hands with soap or ash before preparing food and before eating.



FAMILY PLANNING

Now that the child has reached 2 years of age, if the family wants more children they can begin to think about another pregnancy. If the mother is planning to become pregnant she should see a health provider to ensure that she is healthy and ready for a new pregnancy. They may advise the mother on nutrition and self-care for becoming pregnant, taking iron and folic acid whilst trying to become pregnant, or taking an HIV test if she has not done so already.

Visit 11: Twenty-Fourth Month

SEQUENCE FOR VISIT 11: 24 MONTHS	
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 mother reports that the child is sick, check for danger signs and refer if any are present.	
Revise key messages: <ul style="list-style-type: none"> • Complementary feeding: child eats five to six times per day • Danger signs in children • Birth spacing/family planning: may consider another pregnancy 	
Record the results of the meeting: Fill in the <i>ttC Register</i> for this visit	
End the visit: Decide with the family when you will visit again (at 24 months). Thank the family.	

SESSION 15: SUPPORTIVE CARE FOR THE HIGH RISK CHILD

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.
- Risk factors common in children: 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, such as mother experiencing psychosocial problems, previous child death, neglect or abuse of children, abuse and violence within the family home, caregivers with chronic or serious health problems, extreme poverty and poor living conditions.
- 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
 - connect them to other community- and facility-based services.
- 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.

High-risk case	What is the risk?	Additional home-based care needs	Additional medical care needs
A child who has previously experienced malnutrition	<i>Increased risk of becoming malnourished again if feeding practices do not improve</i>	<i>May need feeding support and counselling for the family</i>	<i>May require follow-up care</i>
HIV-positive child	<i>Increased risk of infections and malnutrition Risk of ART non-adherence</i>	<i>Support for access to health-care services, nutrition and medicine adherence</i>	<i>Needs regular health checks</i>
Child with disability	<i>May have difficulty feeding, e.g. cleft palate Parents may struggle to care for child as per their needs</i>	<i>Increased family support</i>	<i>Only if referral</i>
Child who is not breastfed	<i>Increased risk of malnutrition and illness</i>	<i>Support with feeding</i>	<i>Only if danger signs</i>
Maternal orphan	<i>Increased risk of child death (15 times higher!)</i>	<i>Support with feeding, identify adoptive parent/mother Support father to care for baby</i>	<i>Only if referral</i>

COMBINING RISKS: SOCIAL AND VULNERABILITY FACTORS

Children at risk	Social and vulnerability factors – what is going on in their home environment?
<ul style="list-style-type: none"> • A child who has or has previously experienced malnutrition • HIV-positive child • Child with disability • Child who is not breastfed • Maternal orphan 	<ul style="list-style-type: none"> • Mother with psychosocial problems or depression • Previous child deaths • Evidence of neglect or abuse of children • Abuse and violence within the family home • Caregivers with chronic or serious health problems • Extreme poverty • Poor living conditions • Many children • Adolescent or single mother • Others.... <i>discuss</i>



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.

Notes:
