Timed and Targeted Counselling for Health and Nutrition

Facilitator's Manual for Training in ttC

Module 1: Healthy Pregnancy

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

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Authors: Michele Gaudrault and Polly Walker

Contributors: Sue England, Danielle Chekaraou, Alison Schafer, Annette Ghee, Tina Monique James, Fe Garcia and Carmen Tse

Updates to the 2nd edition: Polly Walker 2014.

Publishing Coordination: Katie Fike. Developmental Editor: Marina Mafani. Interior Layout: Alice Contreras.

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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 and Action
DPA	Development Programme Approach
EBF	Exclusive breastfeeding
EmOC	Emergency obstetric care
EmONC	Emergency obstetric and newborn care
FP	Family planning
GBV	Gender-based violence
HIV	Human Immunodeficiency Virus
HTSP	Healthy Timing and Spacing of Pregnancy
HVs	Home Visitors
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

PREFACE TO TTC MODULE 1: HEALTHY PREGNANCY

How to use this document

This is Module 1 of the ttC technical content curriculum, which should proceed from the Facilitator's Manual for Training in ttC: The Methodology. Countries may use the World Vision core curriculum instead of a locally develop MoH-led curriculum. We have deliberately taken a modular approach to enable individual modules to be selected in or out during curriculum adaptation. As such, certain modules may be able to stand alone or can be appended to a revision session for existing ttC-HVs.

Please note that sessions are numbered according to the flow of the full ttC curriculum so that no single module has the same number. As such, Module 1: Healthy Pregnancy should be ideally conducted following directly on from ttC methodology training, therefore sessions are numbered from 11 to 21 assuming that specific flow.

This document can be used for the following processes:

1. **Curriculum Selection:** use this document to compare side by side with locally available curricula during ttC adaptation phase;
2. **Curriculum adaptation and module selection:** if you are using an MoH curriculum, you may wish to review this document and select elements or modules of interest which do not have equivalents in your MoH training.

    Sessions 14, 16 and 19. Conducting the visits in pregnancy (use as revision sessions)
    Session 20. Supportive care for the most vulnerable pregnancies
    Session 21. Referral, counter referral and follow up
    Session 22. Completing the ttC pregnancy register

3. **Refresher Training for Existing ttC-HVs:** If you have already undergone training on ttC with the first edition of ttC curriculum and your ttC-HVs are due to undergo refresher trainings, you may wish to include the sessions on *new content.* Updated content can be found in Session 15: HIV and AIDS, TB and PMTCT. New content in this second edition of ttC has been included as *additional sessions* and therefore these modules can be used independently during refreshers, specifically:

    Session 20: High risk pregnancies and additional support
    Session 21: Referral, counter referral and follow up
    Session 22: Completing the ttC pregnancy register

Use disclaimer

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- No fees are charged for the workshop and the materials are not sold

ICONS

Ask the group

Technical information

Summarise

Recap the key messages and objective

Use job aids (materials)

Activity

Discussion topic

INTRODUCTION

Welcome to the Facilitator's Manual for Training in Timed and Targeted Counselling, Module 1: Healthy Pregnancy. This is a training course developed by World Vision in partnership with WHO, UNICEF, the American College of Nurse-Midwives, and the USAID Health Care Improvement Project, building substantially from resources produced by these partners, as follows:

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

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

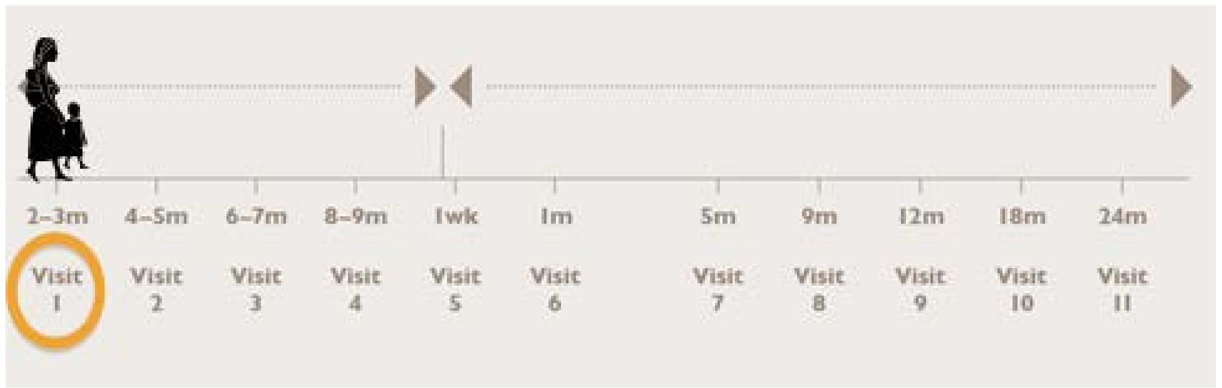
- Taking Care of a Baby at Home After Birth: What Families Need to Do (2011). Core Group, Save the Children, the American College of Nurse-Midwives, and MCHIP.
- WHO Recommendations on Postnatal Care of the Mother and Newborn (2014). World Health Organization. ISBN: 9789241506649 *(Key resource for chlorhexidine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

Training Materials needed for ttC Module 1

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

ttC published resources	Trainers Guide and DVD Facilitator's Manual (one per facilitator) ttC Participant's Manual (one per literate participant) ttC Storybooks 1-3 (1 set per ttC-HV) ttC Household Handbook (one per participant) Food cards (one set per facilitator) ttC Pregnancy register Sample referral / counter referral forms (or use local version) - three per participant
Additional training materials	Flipchart and paper, and markers Projector and screen Sample of maternal health card Samples of local foods (optional) 2-3 dolls for demonstration Items for demonstration: (optional) - Iron and folic acid tablets - Iodized salt (optional) - Long lasting insecticide treated mosquito bed net (optional) - De-worming tablets Plates (for role play) Maize seeds (for role play: optional)

VISIT 1: EARLY PREGNANCY



Session 11: Nutrition in pregnancy

<table>
<tr><td>Session plan</td><td>Activity 1: Determine what they already know
Activity 2: The three food groups
Activity 3: Reinforce the information: The three food groups
Activity 4: Combining foods for greatest benefit
Activity 5: Reinforcing information: Combining foods
Activity 6: Reviewing the food information
Activity 7: Reinforcing the information: Importance of iron
Activity 8: Nutrition for the pregnant woman
Activity 9: Barriers and enablers to good nutrition</td><td>Time:
3h00</td></tr>
<tr><td>Learning objectives</td><td colspan="2">At the end of this session participants will be able to:
• Identify foods in each of the three food groups and explain the importance of each
• Identify foods containing iron, vitamin A, vitamin C and oil
• Understand and explain the importance of good nutrition for pregnant women
• Know how to counsel family members on good nutrition for pregnant women.</td></tr>
<tr><td>Key Messages</td><td colspan="2">Pregnant women should:
• Eat food from all three food groups every day:
   o Go Foods: Energy foods (rice, bread, maize)
   o Grow Foods: Growth foods (fish, meat, eggs, beans)
   o 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.</td></tr>
<tr><td>Preparation and materials</td><td colspan="2">Materials
• Flipchart and paper, and markers
• Photo cards of food: three to four sets should be adequate
• Storybooks for Visit 1
• ttC Household Handbooks
• Samples of local foods (optional: see Activity 4)
Preparation
• Gather all training materials in advance.
• Practise modelling the nutrition counselling and be prepared to model the process for the participants.</td></tr>
</table>

Introduce the session

Ask: What did you eat yesterday? Why did you eat that?

Explain that the purpose of the session is to highlight the importance of good nutrition for all family members, but especially for the pregnant woman and, later, for her newborn baby.

OBJECTIVES OF THE SESSION

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

- Identify foods in each of the three food groups and explain the importance of each
- Identify foods containing iron, vitamin A, vitamin C and oil
- Understand and explain the importance of good nutrition for pregnant women
- Know how to counsel family members on good nutrition for pregnant women.

Activity 1: Determine what they already know

Contextualization: You will only include those photo food cards that show foods that are common in your area and that the ttC-HVs will recognise. You should remove those that are not found in your area. You should also arrange with the project manager to have additional photos taken of important local foods that are not included in this collection.

Organise participants into three to four groups and give each a set of food cards. These cards are just for training purposes, but help to guide on the types of foods that they can counsel families to use during home visits.

Ask: What are the different groups of foods?

They should try to groups the cards into similar types of foods and give a name to each for the groups to explain what characteristic those foods have in common. After 15–20 minutes gather the participants together and review their answers. Ask each group to present one of the groups and why they have grouped them. Capture the key ideas on flipchart.

Activity 2: The three food groups

Contextualization: Countries may have different food guidelines. Adapt this to align with the messages promoted by MoH in your country if necessary.

THE 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.

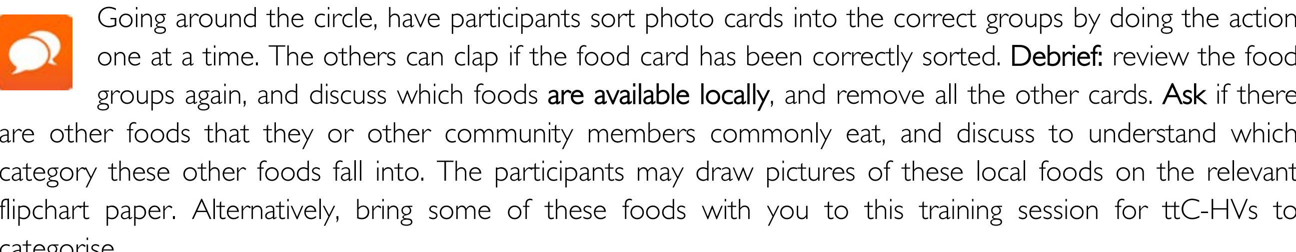
This group is also sometimes called 'protectors' because eating them helps us to fight diseases. Examples include most fruit and vegetables, except those in the 'Go' group, such as: mango, leafy vegetables, orange, sweet potato, banana, papaya, pineapple, squash, avocado, tomato.

- **'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*.

Activity 3: Reinforce the information: The three food groups

Place three sheets of flipchart paper on the floor with the headings Go, Glow, Grow. Have participants in a circle around the flipcharts and distribute all the foods cards (one or two per person). **Review** the three analogies that were used in describing the food groups including an action or movement that reflects it:

1. **'Go' foods**: Like petrol that makes a car go.
    - Action = running around.
2. **'Glow' foods**: Like a lantern or candle that makes a room glow.
    - Action = show off your faces, acting beautiful and glowing.
3. **'Grow' foods:** Like water and good soils that make plants grow
    - Action = stretch upwards as if growing.



Going around the circle, have participants sort photo cards into the correct groups by doing the action one at a time. The others can clap if the food card has been correctly sorted. **Debrief:** review the food groups again, and discuss which foods **are available locally**, and remove all the other cards. **Ask** if there are other foods that they or other community members commonly eat, and discuss to understand which category these other foods fall into. The participants may draw pictures of these local foods on the relevant flipchart paper. Alternatively, bring some of these foods with you to this training session for ttC-HVs to categorise.

A Balanced Diet

After the exercise above you will have three food groups sorted into piles including the local examples you have brought. Now **explain** that a 'balanced' diet means that a pregnant woman eats foods from all three groups every day. Ask for volunteers to come forward and select three cards and **explain** how they could be combined in a meal that local people might eat.

Activity 4: Give relevant information: Combining foods for greatest benefit

Explain: foods can be categorised both by the **food groups** they belong to and also by the **micronutrients** that they contain. **Review** the categories of foods in the box below.

Contextualization: You should add other locally available foods to these lists.

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 and 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

Activity 5: Reinforcing information: Combining foods

Step 1: Working in groups of four to five, sort photo food cards into piles showing foods containing:

Iron Vitamin C Vitamin A Oil

Step 2: Next, ask the groups to come up with two sample meals for a pregnant woman that demonstrate ideal food combinations. That is to say, their meal selections should show a combination of a vitamin A-rich food together with an oil source, and a combination of an iron-rich food together with a vitamin C-rich food. They can post the photo food cards onto flipchart paper and hang the paper on the wall. When the groups have finished they should present their meal selections.

Activity 6: Reviewing the food information

Contextualization: Adapt the table below to include the common foods in your country/area, including locally available foods, and delete those not available. Together with the ttC-HVs select the top five most important foods in each category as the ones that the ttC-HVs will promote with families.

There is a corresponding blank table in the *ttC Participant's Manual*. Have them fill in their table with the correct local foods for each category, then circle the top five in each category in their tables.

Go	Glow	Grow	Iron	Vitamin C	Vitamin A	Oil
Maize						
Rice						
Sorghum						
Millet						
Cassava						
Pap						
Spaghetti						
Potatoes						
Bread						
Orange-fleshed sweet potato (OFSP)					OFSP	
	Dark green leaves		Dark green leaves		Dark green leaves	
	Spinach		Spinach		Spinach	
	Mango			Mango	Mango	
	Carrots				Carrots	
	Papaya			Papaya	Papaya	
	Oranges			Oranges		
	Pineapple			Pineapple		
	Tomatoes			Tomatoes		
	Pumpkin				Pumpkin	
	Bananas					
	Lettuce					
	Cabbage					
	Avocado					Avocado
		Eggs			Eggs (yolk)	
		Liver	Liver		Liver	
		Fish	Fish		Fish (fatty)	
		Insects	Insects			
		Meat	Meat			
		Chicken	Chicken			
		Beans	Beans			
		Nuts	Nuts			Nuts
						Oil
						Coconut

Activity 7: Reinforcing the information: Importance of iron

Explain the information in the box and answer any questions they may have:

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.

Activity 8: Nutrition for the pregnant woman

Ask: What does a pregnant woman needs to eat? Why it is important for her to eat well?

Ask the female ttC-HVs to describe what they ate while they were pregnant, and the male ttC-HVs to describe what their wives ate.

Review the following important messages with regard to nutrition for the pregnant woman:

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 to be born with a mental, hearing or speech disability, or may have delayed physical or mental development. Using iodised salt instead of ordinary salt provides pregnant women with as much iodine as they need. If iodised salt is not available, women should receive iodine supplements from the health facility.

Activity 9: Barriers and enablers to good nutrition

Review the Household Handbook Visit 1. Identify which are the negotiated behaviours that relate to nutrition. For each one (of four), get one group to discuss amongst themselves what are the existing:

- Barriers to the practice – What prevents women and families from doing this action?
- Enablers – What might help women and families to do this action?
- Actions the ttC can do to help the family to overcome barriers and find solutions.

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

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

Ask each group to report back on discussions about each negotiated behaviour

The ttC-HVs may use the table in their manuals to note the key barriers and actions.

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 practices	Increased quantity and variety of foods for pregnant woman	e.g. *Family / culture* *Money*	*Home grown foods* *Family support*	
	Three food groups (discuss locally available foods) – eat a balanced diet. Include micronutrients (iron-rich foods, vitamin A-rich foods)	*Access*		
	Handwashing before preparing food			
	Iodized salt	*Access, money*	*Knowledge of benefits*	

Summarise the session

- Pregnant women need to eat a healthy balanced diet containing 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)
- They should also ensure they eat vitamin A rich foods such as liver, eggs, dairy products, fatty fish, ripe mangoes, papaya, sweet potatoes, green leafy vegetables, carrots and palm oil; vitamin C rich foods such as oranges tomatoes and citrus and iron-rich foods such as liver, eggs and dark green leafy vegetables.
- Iodized salt should be used instead of ordinary salt during pregnancy to help prevent illness; salt should be used in small amounts.

Session 12: Home care for the pregnant woman and danger signs in pregnancy

Session plan	Activity 1: Determine what they already know Activity 2: Home care for the pregnant woman Activity 3: Danger signs in pregnancy Activity 4: The four delays Activity 5: Barriers and enablers of home care and referral	Time: 2h10
Learning objectives	At the end of this session participants will be able to: • Counsel women on how to care for themselves at home during pregnancy • Recognise the danger signs during pregnancy and counsel families on what to do if a danger sign is present.	
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).	

Preparation and materials	*Materials*
	• Flipchart, paper and markers
	• Storybook for Visit 1
	• ttC Household Handbooks
	• Examples of the following (optional):
	  o Iron and Folic Acid tablets
	  o Iodised salt
	  o Long-lasting Insecticide Treated Net
	  o Dark green leafy vegetables
	Preparation
	• Gather all training materials in advance.	

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- Counsel women on how to care for themselves at home during pregnancy
- Recognise the danger signs during pregnancy and counsel families on what to do if a danger sign is present.

Activity 1: Determine what they already know

Ask: From your experience of pregnancy – either your own pregnancy or a family member's – what care do you think pregnant women need at home?

Ask: Do you know any of the signs that indicate that a pregnant woman is in danger and needs to seek immediate care?

Allow time for discussion and write the answers on the flipchart.

Activity 2: Home care for the pregnant woman

Refer the ttC-HVs to the relevant page in their *ttC Participant's Manual* to read this information, then lead a question-and-answer and discussion session. **Note:** Show samples of iron-folate acid (IFA) tablets, and insecticide-treated bed nets (if relevant), in case they are unfamiliar with these.

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

  Note: This last point is only relevant in areas where malaria is common.

Activity 3: Danger signs in pregnancy

Turn to the pages in Storybook for Visit 1'Danger signs in pregnancy', and also the equivalent page in the Household Handbook showing al the danger signs. The first picture shows the woman being taken to a health facility. This is the **action picture** (or the 'negotiation picture'). The remaining pictures illustrate the various danger signs. If a pregnant woman shows any danger signs, she should be taken immediately to the nearest health facility. **Review** the danger signs one by one and discuss them.

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.

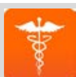
Refer the ttC-HVs to the relevant page in their *ttC Participant's Manual*. Remind the participants of the skills that they have learned for supporting a woman in distress. If a woman is experiencing danger signs or any health complications, ensure that you apply good communication skills, and help the woman to remain calm and feel supported.

Explain:

- **Fits / convulsions:** Fits involve stiffening of the body, with rhythmic movements of arms, legs or face. Usually a person loses consciousness during a fit. This is a very serious condition.
- **Severe abdominal pains:** Severe abdominal pain is very bad pain in the lower abdomen. It is different from labour pains in that it does not come and go at regular intervals but is usually constant. This may mean danger for the baby,
- **Fever in a pregnant woman:** Fever in pregnancy, especially in areas where malaria is common, needs to be taken very seriously, with the woman seeking care as soon as possible.
- **Danger signs:** After discussing care during pregnancy, the ttC-HV should review the danger signs with the woman and family and make sure they know that if any of these problems arise they must go to the hospital immediately.
- **Refer to facility:** Pregnant women may experience a variety of health complaints and symptoms during pregnancy; not all of them are dangerous, but if they are uncertain, it is best to refer to the facility for care.

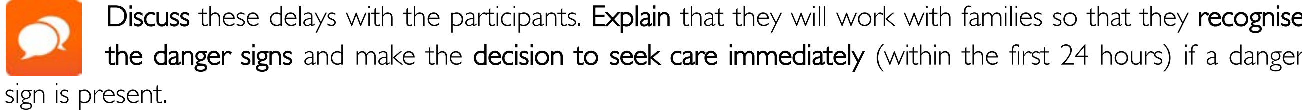
Activity 4: The four delays

Explain to the participants that many maternal deaths are due to one or more of the **four delays:**



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.



Discuss these delays with the participants. **Explain** that they will work with families so that they **recognise the danger signs** and make the **decision to seek care immediately** (within the first 24 hours) if a danger sign is present.

Ask the participants to discuss the situation in their area with regard to delays 3 and 4. Is it difficult for families to reach the health clinic? Once they arrive at the health clinic, are there often delays in receiving service? How can these delays be overcome?

Activity 5: Barriers and enablers of home care and referral

Contextualization: Barriers will differ based on where you are located. For example, if you are working in an urban community, you will not be talking about the agricultural work of the pregnant woman. If you are in a community near to a health facility, long distances to get to the clinic will not be a barrier. Make sure that what you discuss is relevant to their context.

Review the Household Handbook Visit 1. Identify which are the negotiated behaviours that relate to home care. For each one (of four), get one group to discuss amongst themselves what are the existing:

- Barriers to the practice – What prevents women and families from doing this action?
- Enablers – What might help women and families to do this action?
- Actions the ttC can do to help the family to overcome barriers and find solutions.

Ask each group to report on their detailed discussions about each negotiated behaviour and discuss. The ttC-HVs may use the table in their manuals to note the key barriers and actions. (We are only looking at home care behaviours.)

Then discuss the possible difficulties that pregnant women may have in **seeking immediate care in the case of a danger sign.** For example, the health facility may be located at a distance away from the home and the family may not have money for transport. Discuss the ways that the ttC-HVs can counsel the families to help them overcome such barriers, for example, by encouraging the family to put aside money into a fund to cover such emergencies. Make a list on the flipchart of the barriers that ttC-HVs identify, and the possible responses.

Visit 1. Early Pregnancy or First Registration (see ttC Participant's 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
Home Care and Danger Signs	Sleep under LLIN in high malaria prevalent areas			
	Do not smoke or drink alcohol during pregnancy	Knowledge, Beliefs Addiction	Knowledge of risks	
	Adequate rest and assistance from family members	Family / culture	More support in work	
	Take iron and folic acid tablets daily	Access to IFA, belief in effect, constipation, forgetting	Reminder to take, knowing to take with food, treat constipation	
	Refer woman to health facility immediately if danger sign is present (see list of signs)	Knowledge	Knowledge of danger signs, family support	

Summarise the main points of the session

- 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.

Session 13: Promoting antenatal care

<table>
<tr><td>Session plan</td><td>Activity 1: Determine what they already know
Activity 2: Importance of antenatal care
Activity 3: Discussion of barriers and enablers to ANC</td><td>Time:
1h30</td></tr>
<tr><td>Learning objectives</td><td colspan="2">At the end of this session participants will be able to:
• Explain why pregnant women should attend ANC and the services they are expected to receive
• Explain when to start going for ANC and how many visits are recommended
• Help families solve problems in attending ANC.</td></tr>
<tr><td>Key Messages</td><td colspan="2">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.</td></tr>
<tr><td>Preparation and materials</td><td colspan="2">Materials:
• Flipchart, paper and markers
• Storybook for Visit 1
• ttC Household Handbooks
• IFA tablets
• De-worming tablets
• Mosquito nets (optional)
Preparation:
• Gather all training materials in advance.</td></tr>
</table>

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- Explain why pregnant women should attend ANC and the services they are expected to receive
- Explain when to start going for ANC and how many visits are recommended
- Help families solve problems in attending ANC.

Activity 1: Determine what they already know

Ask: did they or anyone in their family received ANC during their pregnancies?

Ask a few women who say 'yes' to explain what care is given and why ANC is important for pregnant mothers.

Listen to their answers and write the correct answers on the flipchart. Use this list during the next training step (compare it with the overview of ANC below)

Activity 2: Give relevant information: Importance of antenatal care

Contextualization: You will only talk about the ANC services that are *actually provided* to pregnant women in your country. If de-worming tablets are not given, for example, you will not talk about them. Review and modify the box below as necessary. The recommendation of four ANC visits is the minimum. This recommendation should be adapted based on the national policy in your country.

Explain or read aloud, and review:

You may also show the different items to the ttC-HVs so that they know how to confirm in the household visit has these items.

OVERVIEW OF CARE GIVEN DURING ANTENATAL VISITS

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

- **Examination** of the pregnant woman; blood pressure, eyes, weight, urine, blood tests
- **IFA tablets** to prevent anaemia and strengthen blood
- At least two **TT** immunisations to prevent tetanus
- Testing for infections such as **HIV, TB and STIs**, and treatment and care if needed – treatment of STIs can help prevent miscarriages and stillbirths; testing can be for both the woman and her partner
- **Advice** on home care for the pregnant woman and to ensure that the baby grows well
- **Preparing for birth** including preparing for a health facility delivery and informing the family about **danger signs** and the importance of early care seeking for them
- **De-worming** tablets at four months in areas where intestinal worms are common
- Long-lasting insecticide-treated **bed nets** and intermittent preventive treatment (**IPTp**) to prevent malaria in areas where malaria is very common.

Ask: How many times a woman should go for ANC?

Listen to the answers and then continue to explain or read aloud:

The minimum number of ANC visits recommended is four; the first visit early in pregnancy as soon as the woman thinks she is pregnant, then if there are no problems, around 28 weeks, 32 weeks and 36 weeks.

Refer the ttC-HVs to the *ttC Participant's Manual* where the above information is found.

Activity 3: Discussion of barriers and enablers of antenatal care

Ask: Why do some women not go for ANC?

Listen to the answers and discuss. Common reasons include:

- Distance to clinic
- Hidden costs
- Poor attitude of the health workers
- Too much work to do at home.

Ask: even if a mother goes to ANC, might there be some services she does not receive? Why / why not?

- Stock out of commodities
- Partners don't wish to attend HIV testing.

Review the Household Handbook Visit 1, and see the list below. Lead a discussion about the four behaviours listed and request that groups deal with the behaviours listed below, and then report back:

- Barriers to the practice – What prevents women and families from doing this action?
- Enablers – What might help women and families to do this action?
- Actions the ttC can do to help the family to overcome barriers and find solutions

Complete this section in the ttC Participants Manual

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
Antenatal Care and access to services	Prepare savings for costs of pregnancy / birth planning and preparation		Family support	
	4 ANC visits* attend as early as possible Services at ANC (iron-folate, tetanus vaccine, prevention of malaria, deworming)	Access, distance, money Stock outs of commodities	Family support, money Savings	
	HIV testing for both the woman and her partner	Partner not participating,	Family support, counselling	

		beliefs, knowledge		
	TB testing for the woman and her partner	Knowledge	Counselling and support	

Summarise the main points of the session

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

Session 14: Conducting the first visit during pregnancy

Session plan	Activity 1: Understanding the story Activity 2 Principles of ttC home visiting Activity 3: First home visit in pregnancy Activity 4: Practice the first visit – Facilitator demonstration Activity 5: Practice the first visit – Participant role play Activity 6: Practice with the visuals – Small group work Activity 7: Debrief in plenary	Time: 2h40
Learning objectives	At the end of this session participants will be able to: • Demonstrate how to conduct a first visit to a pregnant woman and her family • Demonstrate how to use the visuals appropriately during the counselling visit • Be prepared to conduct Visit 1 and engage effectively and appropriately with HH members.	
Key Messages	• All ttC home visits should be conducted with the pregnant woman or mother accompanied by the husband, birth companion or other family member that she identifies as being her significant supporter in the home. • Identify her chosen supporter/s and write these names in the household handbook, and ensure that these people attend each time you come. • Conduct positive and negative stories of 'Nutrition, Home Care and ANC' using the Storybook for Visit 1 and the guiding questions. • Give relevant information to the family on danger signs in pregnancy and food groups. • Negotiate the Visit 1 practices using the household handbooks.	
Preparation and materials	*Materials* • Flipchart, paper and markers • Storybook for Visit 1 • ttC Household Handbooks *Preparation* • Gather all training materials in advance.	

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- Demonstrate how to conduct a first visit to a pregnant woman and her family
- Demonstrate how to use the visuals appropriately during the counselling visit
- Be prepared to conduct Visit 1 and engage effectively and appropriately with HH members.

Activity 1: Understanding the story

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

Working in groups each with a copy of Storybook for Visit 1 and one facilitator/ helper per table, ask the facilitator to read the story to the group. Remember to apply the good techniques of storytelling.

Good techniques of storytelling:

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, tell it.
Make sure everyone can see the pictures as you are telling the story.
Engage the audience in the story (ask questions, encourage comment).
Use a good 'tone' in your voice. If you have a dull flat tone, you can send people to sleep!

Read the stories to the group and at the end of the story the group should go around in a circle and identify the positive and negative practices from the stories. The facilitator or note taker (if not literate), should use the tables below as a checklist to tick off all of the practices in the stories. Keep participants guessing until they have all of them!

Module 1. Storybook messages

Story book #	Positive story messages	Negative story messages
1	• Mary is eating enough food. She eats more than usual when she is pregnant • She eats different kinds of foods, from all of the food groups • Mary and David don't sell all of their nutritious food. • They wash their hands • David and Mary saved money for the pregnancy and for any emergencies • Mary goes for antenatal care at the clinic • Mary's family / husband helps her with her work so that she can rest • David and Mary understand the danger signs in pregnancy and always check to make sure Mary is not showing any of the danger signs • They prepare to refer to the clinic immediately if she has a problem • Mary sleeps under a bed net	• Biba had *too much work*. She was pushing her body too much. Her husband didn't help her at all • She was lifting heavy things • She was not eating enough food • She wasn't eating a variety of foods • She *didn't go to the clinic* for antenatal care • She didn't understand that the bleeding was dangerous, or tell anyone *about the danger signs.* • Her husband didn't have an emergency *plan for transportation* • She doesn't *wash her hands*, which might cause disease • Her husband is spending money on himself that could be used for his wife and children instead.

Activity 2: Principles of ttC home visiting

Ask: Who should be present in a ttC home visit? Where should we conduct ttC visits?

WhWhen should we conduct the home visits?

Discuss their answers and then present the information below, from their manuals.

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.

Activity 3: First home visit in pregnancy

Review the sequence of the first home visit with the participants, in the *ttC Participant's Manual*. The ttC-HVs should be familiar with this process from *ttC Methodology* training. Below we give the process in detail for Visit 1. In subsequent sessions for Visits 2 and 3 we will only review the full process in brief. If they are *not literate proceed directly to the demonstration.*

VISIT 1 IN PREGNANCY FROM START TO FINISH

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?

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.

ttC Counselling Process

Step 1: Review the previous meeting

- Review Household Handbook pages from the previous visit. This step isn't needed in Visit 1

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 *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 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.

Step 3b: Conduct technical session: 'Danger signs in pregnancy'.

- Run through all of the danger signs in pregnancy with the mother and supporters to ensure they understand them.

Step 4: Negotiate new actions using the 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 (pages two to four of handbook).

    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 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?' 'Why do you think that is' Write the identified barriers in the space provided for that visit. Remember to try and get to the root

cause of the barriers through probing questions.

- 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.
- 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.

Activity 4: Practice the first visit (facilitator demonstration, with visuals)

Facilitators will model the process but in subsequent sessions the participants will role play the process themselves. You need at least two facilitators for this activity, to play the ttC-HV and the mother, and select volunteers can play the husband and mother in law. The facilitators will proceed through the steps of a household counselling visit, as in the steps above, with prompts from the participants about the next steps (using their ttC Participant Manuals).

Activity 5: Practice the first visit (participant role play)

Ask six volunteers to now role play the visit in plenary. Explain that everyone will role play the counselling in plenary by the end of the week of training. The volunteers should go through the steps of the household counselling process. The first ttC-HV will role play the first step (Before Starting) the second ttC-HV will role play the second step (Identify and respond to any difficulties), and so on, until Visit 1 is completed.

Advise the observers to take note of what the ttC-HVs do well and what needs improvement. Ask them to make notes, but using the counselling skills guide as a prompt, and make comments or questions as they go through.

Activity 6: Practising with the visuals (small group work)

Working in groups of four, ask them to role play Visit 1. Each ttC-HV should choose one step to model, whilst the remaining group members play the roles of mother, husband, mother-in-law, etc. One facilitator / helper should be assigned to each group and provide input whenever they feel that a ttC-HV needs this assistance. This is the chance for ttC-HVs to ask any questions; stopping the role play at any time to ask for clarification if needed. Afterwards, remaining in the small groups, debrief the counselling process with the following guiding questions:

How do you feel the process went?

Were there parts you found difficult to understand or carry out? If so, what further help do you need to feel confident in your ability to carry them out?

Do you feel prepared to carry out this session with HHs in the community? What further support do you need?

What types of clients and contexts can they imagine might make the process more difficult than others? (*think, adolescent mother, woman in distress).*

Activity 7: Debrief in plenary

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

The counselling process: Guiding questions

What is **Step 2** in the HH counselling process?

- Where did we see this step? What happened?

What is **Step 3** in the HH counselling process?

- Where did we see this step? What happened?

Was there an additional **Step 3b** in this counselling session? If so, what was it?

- (**Answer:** Technical session on food groups; Danger signs in pregnancy)
- What happened?

What is **Step** 4 in the HH counselling process?

- Where did we see this step? What happened?

Counselling skills: Guiding questions

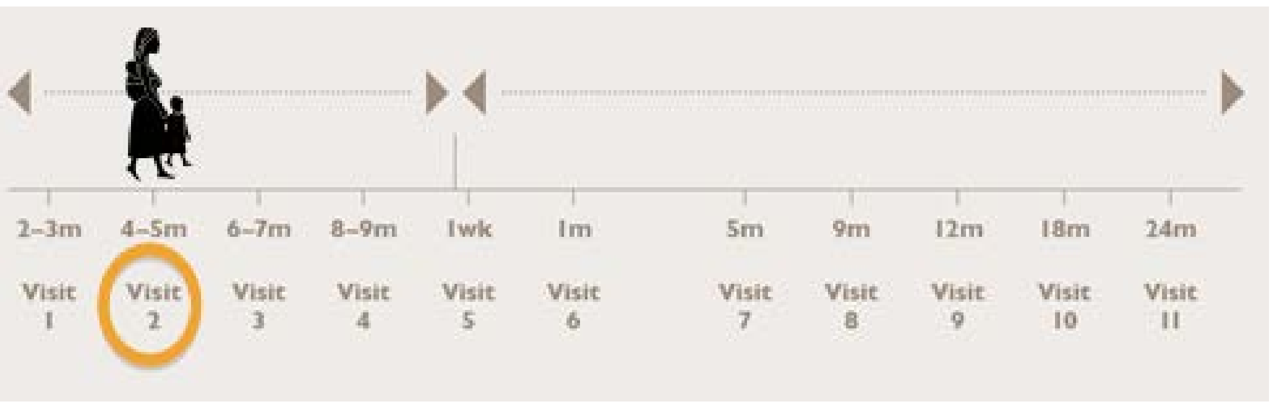
Which of the counselling skills did the ttC-HV demonstrate? What could they have done better?

Respectful manner
Giving praise
Body language
Handling concerns, appropriate use of PFA skills
Good listening
Use of visuals
Good story telling technique
Good negotiation technique (root cause questions)
Good solution finding
Giving health information

Summarise the main points of the session

- During the first pregnancy visit you will identify the appropriate partner or support person/s for the ttC visits, then encourage these members to participate in all the visits, *provided the woman feel comfortable with that.*
- During the first pregnancy visit, you will tell two stories and ask the corresponding guiding questions: (1) problem story: 'Nutrition, Home care and ANC', (2) positive story: 'Nutrition, Home care and ANC". Reinforce the messages with two technical sessions: (1) 'food groups' (if photocards are given) and (2) 'Danger signs in pregnancy'. Follow the four steps in the counselling process.
- Remember that how you interact with a pregnant woman and her family will affect how relaxed and confident she feels and whether she decides to follow your advice.
- The visual stories and *ttC Household Handbooks* will help guide you on how to promote home care of the pregnant woman and ANC, and to teach the family to recognise danger signs in pregnancy.

VISIT 2: MID-PREGNANCY



Session 15: HIV and AIDS, TB, and PMTCT

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.

Session plan	Activity 1: Determine what they already know Activity 2: HIV and AIDS during pregnancy and childbirth Activity 3: HIV and AIDS after birth Activity 4: Tuberculosis Activity 5: Reinforcing the information: Forum theatre Activity 6: Counselling the HIV-positive mother Activity 7: Barriers and enablers to HIV care	Time: 2h00
Learning objectives	At the end of this session participants will be able to: • Understand the basic facts (and myths) about HIV and AIDS, and tuberculosis • Understand the importance of testing for HIV, TB and STIs for both the mother and her partner, and counsel families to do this at any time, but especially during pregnancy. • Explain the importance of all women, but especially HIV-positive women, delivering in a health facility, both for the special care of the mother and to reduce risk of HIV transmission to the baby • Counsel and assist HHs to adhere to HIV and TB treatment regimes • Counsel families on the two reasons why the baby of an HIV-positive mother must be taken to the health clinic at 4–6 weeks of age: both for early testing of the baby for HIV if this is available, and to receive the medication that will protect the baby from infection such as pneumonia.	
Key Messages	• 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.
Preparation and materials	*Materials* • Flipchart, paper and markers *Preparation* • Gather all training materials in advance. • Practise the 'forum theatre' (Activity 6) and be prepared to role play it for the participants.

Introduce the session

Have the ttC-HVs open their manuals to the relevant page. **Explain or read aloud:**

OBJECTIVES OF THE SESSION

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

- Understand the basic facts (and myths) about HIV and AIDS, and tuberculosis
- understand the importance of testing for HIV, TB and STIs for both the mother and her partner, and counsel families to do this at any time, but especially during pregnancy
- explain the importance of all women, but especially HIV-positive women, delivering in a health facility, both for the special care of the mother and to reduce risk of HIV transmission to the baby
- Counsel and assist HHs to adhere to HIV and TB treatment regimes
- counsel families on the two reasons why the baby of an HIV-positive mother must be taken to the health clinic at 4–6 weeks of age: both for early testing of the baby for HIV if this is available, and to receive the medication that will protect the baby from infection such as pneumonia.

Activity 1: Determine what they already know

Ask: has there been any information campaigns or programmes in their communities about HIV and AIDS? What did you learn in these campaigns?

What do you know about HIV and AIDS?

Allow time for discussion around the many facts (and perhaps myths) that the ttC-HVs come up with. You may write their answers on flipcharts, with one flipchart for facts, and the other for myths. At the end, **clarify** any misconceptions around HIV and AIDS.

Ask: How can you reduce the risk of transmitting HIV from a mother to her baby?

Listen to their answers and discuss any experiences they may have had in this regard.

Ask: Why is it also important to test older children, if the mother is HIV-positive?

Explain: Children initiated on ART tend to respond well to treatment. ART is usually free and available at their local health centre. If the mother is HIV-positive, then it is possible that some of the older children will also be positive. It is best to get everyone tested to be sure.

Activity 2: Give relevant information: 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.**

Explain or read aloud the following from the *ttC Participants Manual*

KEY MESSAGES: 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.

Activity 3: Give relevant information: 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.

HIV AND 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.

Activity 4: Give relevant information: Tuberculosis

Ask: What do you know about tuberculosis? What are the symptoms and how is it transmitted?

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.

Additional technical information OPTIONAL ACTIVITY

Contextualization: If additional programming for HIV and AIDS is available or needed, coordinate with these other programmes to provide additional technical training here. See ttC planners guide for further recommendations on integrating PMTCT with ttC.

Activity 5: Reinforcing the information: Forum theatre

WHAT IS A FORUM THEATRE?

A 'forum theatre' is a role play where the main character makes a series of poor decisions, all of which have consequences. A forum theatre is carried out by the facilitators, with the participants observing the poor decisions the main character makes. After the first presentation, the facilitators debrief with the participants to review each decision, and the consequences of that decision.

The forum theatre is then carried out a second time, but this time the facilitators will stop the action before the main character makes his first poor decision. At this point the facilitators will ask the participants, 'What did the main character do at this point in the story and what were the consequences?' The facilitators will then ask, 'What could the main character do differently at this point to change the outcome of the story?' The participants will give an answer – an alternative decision – which the facilitators will then act out. Acting out this alternative decision will change the course of the story for the better.

The role play will continue until the facilitators reach the second poor decision, then again 'stop the action' and ask the participants what the main character could do differently to change the course of the story, and they will then act out this alternative outcome. They carry on this way to the end of the role play, with this second role play showing the positive story in contrast to the negative.

Carrying out the forum theatre

Present a forum theatre in which the main characters played by facilitators – the pregnant woman and her husband – make a series of poor decisions, as follows:

Note: The narrator should explain that the woman is HIV-positive, but she does not know it.

1. The woman is pregnant but she does not attend ANC until late pregnancy even though the health facility is nearby. At ANC she does not get an HIV test, and doesn't wish to bring her husband for HIV testing either (critical point 1).
2. The time comes for the birth and the woman and her husband decide to give birth at home instead of at the health facility, even though the health facility is nearby. (critical point 2)

Note: The narrator explains the woman is woman is therefore not receiving any medication for HIV, and her baby is at risk of contracting the HIV virus during the birth.

3. When the baby is born she also does not go for HIV testing, as she herself doesn't know that she is infected and therefore might have passed it to the baby (critical point 3).
4. The woman does not exclusively breastfeed her baby. She breastfeeds sometimes, but also gives her baby water and porridge. (critical point 4)
5. Because the baby is not taking preventative co-trimoxazole the baby catches pneumonia. At the end, the baby dies.

Repeat the role play, this time stopping and starting the action at four critical points, as described in the box below. The participants should explain the choices that the woman and her husband could make to change the outcome of the story. This comparison is provided in the table below.

First role play	Alternative positive decisions
Do not attend ANC early, do not get HIV test, and do not know status.	Attend ANC visit early, get HIV test with partner, and learn of HIV-positive status. Receive medications for mother and baby to reduce risk of transmission of HIV virus to baby.
Do not deliver in health facility; do not receive medications for mother and baby. It is more likely that the HIV virus is passed on to the baby during the birth.	Deliver in health facility
Does not test the baby, or uptake co-trimoxazole to prevent pneumonia.	Early HIV testing of baby and co-trimoxazole to prevent pneumonia.
Doesn't exclusively breastfeed, further increasing the risk of HIV transmission from mother to baby, as well as the risk of malnutrition and other illnesses.	Exclusively breastfeeds the baby, thereby doing as much as possible to keep the baby healthy and well nourished.
Outcome	**Outcome**
Baby dies.	Baby lives.

Activity 6: Counselling the HIV-positive mother

If a mother reveals to you during a home visit that she has been for an HIV test and found out that she is HIV-positive, ask the group what effect this might have on her? Talk through the actions of counselling an HIV-positive mother applying the principles of psychological first aid.

KEY ACTIONS 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.

Activity 7: Barriers and enablers to HIV Care

Review the Household Handbook Visit 1, and see the list below. Lead a discussion about the four behaviours listed and each groups discuss one of the behaviours listed below, and then report back:

Barriers to the practice – what prevents women and families from doing this action
Enablers – what might help women and families to do this action
Actions the ttC can do to help the family to overcome barriers and find solutions

Complete this section in the ttC Participant's Manual

Topics	Key Messages and additional information	Barriers: *What makes it difficult to do?*	Enablers: *What would make it easier to do?*	Counselling response or solution
HIV and AIDS, TB and PMTCT	Testing during pregnancy for HIV, TB and other STIs for women and their partners (Visit 1)	Partner testing, culture, stigma, fear	Family support	
	Accessing HIV and TB treatment and taking medicines every day (ART adherence for HIV-positive mothers)	Stigma, access to medicines, family influencers, side effects	Reminders, support for side effects, connecting to existing HIV support groups	
	Early infant diagnosis and Co-Trimoxazole preventive treatment	Access, beliefs	Partner participation, knowledge	

	Condoms during sexual intercourse while pregnant and breastfeeding to prevent re-infection	Gender power dynamics, myths and inappropriate beliefs, knowledge, attitudes concerning condoms	Partner participation, increased knowledge, increased self efficacy in negotiating and using condoms consistently	
	All women, but especially HIV-positive women deliver in a health facility for special care and PMTCT	Access to care, distance from health centre, costs ,lack of funds for facility delivery kit	Increased facilitated alliance with TBAs, modified social norms that demand facility delivery	
	Nutrition, rest and antenatal care for the for HIV-positive mother	Family attitudes, work, poverty	Family support	
	Early and exclusive breastfeeding	Beliefs, fear, familial, pressure to supplement feeding	Knowledge, support from family community	

Summarise the main points of the session

- All women and their partners should undergo testing during pregnancy for HIV, TB and other STIs. Children not previously tested for HIV should be tested if either parent is HIV positive.
- It is important to test children for TB if child or anyone in the home has been diagnosed with TB. Refer any person experiencing TB symptoms: persistent cough, night sweats, weight loss (or stagnant weight gain in children) malaise, fever.
- TB and HIV can be treated using medicines given at the clinic. You must take all the medicines as prescribed, without break (treatment-adherence) otherwise you can become ill.
- All women, but especially HIV-positive women deliver in a health facility.
- Infants born to HIV positive mother should be taken for HIV test *as early as possible* after the birth for early detection and treatment.
- All women, but especially HIV positive women, should exclusively breastfeed the child to six months of age, and continue until two years if they are taking ART treatment.

Session 16: Conducting the second pregnancy visit

Session plan	Activity 1: Understanding the story Activity 2: Second home visit during pregnancy Activity 3: Practise with the visuals: Small group work Activity 4: Facilitators demonstration and debrief in plenary	Time: 1h30
Learning objectives	At the end of this session participants will be able to: • Understand the key messages in Storybook 2 • Demonstrate how to conduct a second visit to a pregnant woman and her family • Demonstrate how to use the visuals appropriately during the counselling visit	
Key Messages	• During the second pregnancy visit you will dialogue, negotiate and encourage families to get tested for HIV and TB, to follow treatment guidelines, deliver in a health facility especially if the mother is HIV-positive, and plan for early HIV testing of the baby if the mother is HIV-positive. • During the second pregnancy visit, you will tell two stories and ask the corresponding guiding questions: (1) problem story: 'HIV (2) positive story: 'HIV', and negotiate using the household handbook. • Remember that how you interact with family will affect how relaxed and confident she feels and whether she decides to follow your advice.	
Preparation and materials	*Materials:* • Flipchart, paper and markers • Storybook stories for Visit 2 • ttC Household Handbooks *Preparation:* • Gather all training materials in advance.	

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- Understand the key messages in Storybook 2
- Demonstrate how to conduct a second visit to a pregnant woman and her family
- Demonstrate how to use the visuals appropriately during the counselling visit

Activity 1: Understanding the story

Distribute copies of Storybook 2. **Working in groups** with one facilitator/ helper per table, ask the facilitator to read the story to the group, applying good techniques of storytelling. Then at the end of the story the group should go

around in a circle and identify the positive and negative practices. The facilitator or note taker (if not literate), should use the table below as a checklist.

Module 2. Storybook messages

Story book #	Positive story messages	Negative story messages
2	• They should go for *antenatal care, and get HIV and TB tests* for both the husband and wife and any children they have at home • An HIV-positive woman needs special nutrition and extra rest • *HIV-positive women should deliver in a health facility*, to protect the baby from getting infected with HIV during birth • HIV and TB-positive people need to *take medicine*, and it is very important to take all the medicines as prescribed. • HIV-positive people should *use condoms* during sexual intercourse, especially during pregnancy • An HIV-positive mother should *exclusively breastfeed during the first 6 months*. No other foods or liquids should be given. • The baby should *be tested for HIV* as soon as possible after birth	• 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 birth. • 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.

VISIT 2

Activity 2: Give relevant information: Second home visit during pregnancy

Review the sequence of the 2nd home visit with the participants, in the *ttC Participant Manuals* (brief recap). If they are *not literate proceed directly to conduct a demonstration.*

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.

Activity 3: Practise with the visuals (small group work)

Distribute *Storybook* 2 to participants. **Divide** the ttC-HVs into groups of four with one facilitator / helper per group. **Remind** them that the counselling process is divided into four steps. Each ttC-HVs should choose different steps to model (from the ones they modelled in the previous sessions). In groups, the ttC-HVs should go through the four steps of the HH counselling process, as described below. The first ttC-HV will model the first step, while the remaining group members play the roles of mother, husband, mother-in-law, etc. The second ttC-HV will then model the second step, and so on, until the complete sequence has been role played. Remind the group about the importance of applying the PFA skills for counselling a mother on HIV, and also of responding to her needs and concerns before you start the stories.

Activity 4: Facilitators demonstration and debrief in plenary

Now ask for five volunteers (not those selected for this activity in Session 14) to role play the home visit in plenary for this session. Volunteers should divide the steps among themselves: the first ttC-HV will role play the step 'identifying and responding to concerns', the second ttC-HV will role play the Step 1, and so on, until the whole second home visit has been completed. The remaining participants will act as plenary and may reply to ttC-HV questions when they wish.

Advise the plenary observers that they should take note of what the ttC-HVs do well in the role plays and what needs improvement, using the **counselling skills guide** for reference, found on the last page of the ttC-HV manual.

Carry out a plenary discussion with the participants, asking the following questions about what they observed in the role play HH counselling.

The counselling process: Guiding questions

- What is **Step 2** in the HH counselling process?
  - o Where did we see this step? What happened?
- What is **Step 3** in the HH counselling process?
  - o Where did we see this step? What happened?
- Was there an additional **Step 3b** in this counselling session? If so, what was it?
  - o (**Answer: no**)
  - o What happened?
- What is **Step** 4 in the HH counselling process?
  - o Where did we see this step? What happened?

Counselling skills: Guiding questions

Which of the counselling skills did the ttC-HV demonstrate? What could they have done better?

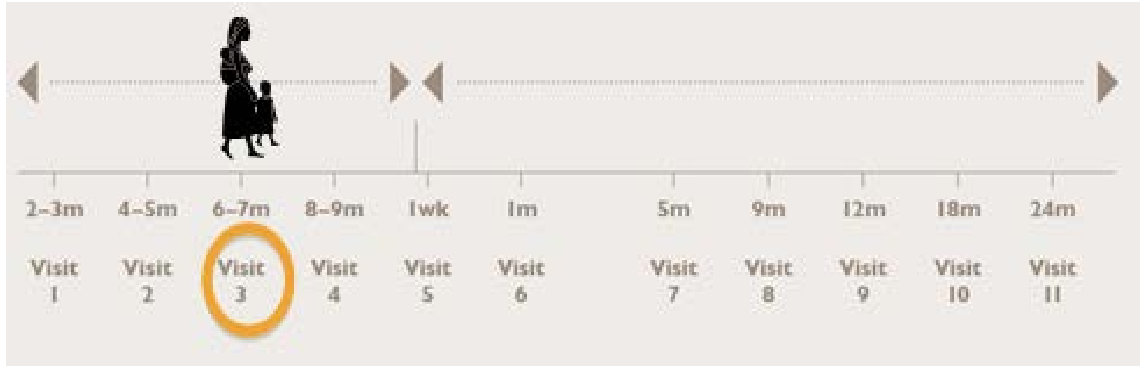
- Respectful manner
- Giving praise

- Body language
- Handling concerns, appropriate use of PFA skills
- Good listening
- Use of visuals
- Good story telling technique
- Good negotiation technique (root cause questions)
- Good solution finding
- Giving health information

Summarise the main points of the session

- During the second pregnancy visit you will dialogue, negotiate and encourage families to get tested for HIV and TB, to follow treatment guidelines, deliver in a health facility especially if the mother is HIV-positive, and plan for early HIV testing of the baby if the mother is HIV-positive.
- During the second pregnancy visit, you will tell two stories and ask the corresponding guiding questions: problem story: 'HIV', positive story: 'HIV', and negotiate using the HH handbook.
- Remember that how you interact with family will affect how relaxed and confident she feels and whether she decides to follow your advice.

VISIT 3: MID-PREGNANCY



VISIT 3

Session 17: The birth plan

Session plan	Activity 1: Determine what they already know Activity 2: Involving family members in birth planning Activity 3: Preparing for birth Activity 4: The importance of a facility birth for HIV-positive women Activity 5: Barriers to health facility delivery Activity 6: Discussion: Barriers to birth planning	Time: 1h45
Learning objectives	At the end of this session, participants will be able to: • Explain to a family the importance of having a skilled birth attendant care for the woman during labour and birth • Understand and explain to families why all women, but especially HIV-positive women should deliver in a health facility • Help the family prepare for birth, either in a health facility or at home • Identify problems that families may have in preparing for birth and work with them to find potential solutions.	
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.	
Preparation and materials	*Materials* • Flipchart, paper and markers • Storybook for Visit 2 • ttC Household Handbooks *Preparation* • Gather all training materials in advance.	

Introduce the session

OBJECTIVES OF THE SESSION

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

- Explain to a family the importance of having skilled birth attendant to care for the woman during labour and birth
- Understand and explain to a family why all women, but especially HIV-positive women should deliver in a health facility
- Help the family prepare for birth, either at home or in a health facility
- Identify problems that families may have in preparing for birth and work with them to find potential solutions.

Activity 1: Determine what they already know

Ask the female ttC-HVs where they have given birth and ask the male ttC-HVs where their wives have given birth, as applicable.

Were their labour and births assisted by a skilled (trained) birth attendant?

What they did to prepare for the birth in the months leading up to it?

Activity 2: Give relevant information: Involving family members in birth planning

Explain or read aloud:

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.

Ask: do you think it is important to include husbands and other family members in discussions about place of birth? Why?

In the follow-up discussion with participants, **ensure** that the following reasons are given:

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.

Activity 3: Give relevant information: Preparing for birth

Contextualization: Review the information in the boxes below and make any changes according to your context.

Explain or read aloud:

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.

Now **review** the following birth preparations with the participants. **Compare** these with the list they wrote on the flipchart in the previous step.

BIRTH PLANNING

Practices listed in the HH Handbook:

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

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

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

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

5. **Gather the supplies needed for home or facility birth.** (Adapt list for your country). Women need to bring: a clean delivery kit including clean blade and chlorhexidine solution, soap, gloves, cord ties, a plastic sheet, sanitary napkins/ pads and clean clothes for the mother and the baby. It is important to keep the items clean, and ready in a bag during late pregnancy so they can easily found when needed. These supplies are also needed for a home birth.

Not in the handbook, but also to be discussed:

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

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

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

Activity 4: The 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.

Activity 5: Barriers to health facility delivery

Ask: Why do some women in your community do not deliver in a health facility?

Write the responses on the flipchart. Discuss with the training participants, adding any of the below reasons not mentioned by the ttC-HVs.

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.

Working in groups: assign each group one or two of the reasons mentioned for not delivering in the health facility. The groups should discuss possible ways of overcoming these barriers in your community. **Circulate** in the room and observe the discussion, clarifying points if needed. After 10–15 minutes **bring** the groups back together into a large group. Have each group present the solutions they discussed. As you talk through the solutions – share the following suggestions.

Problem	Possible advice
Cost of birth	• Let families know how much a health facility delivery costs; include 'hidden costs' even if the delivery itself is free. • Help them see how saving a very small amount of money each week adds up to a significant amount over the pregnancy, especially if the entire family is involved. • Stress that delivering in a health facility helps ensure a safer birth and a healthy baby. If complications occur during home birth, it will cost much more to get emergency

	treatment than the cost of a facility birth.
Perception of home births as safe	• Explain to the family that the health facility is the best place to prevent and treat birth complications. • Explain that complications such as prolonged labour, delayed placenta and bleeding after birth can happen to any woman, even those who have had safe deliveries.
Feeling comfortable with delivering with TBA at home	• Acknowledge the importance to the woman of having a TBA who she feels comfortable with at the birth, but if complications occur the mother or the baby could pay with their lives. • Suggest that possibly the TBA could go with you to the health facility and be a support (or birth companion) during labour and childbirth.
Lack of transport	• Toward the end of pregnancy, encourage the woman to try to find a place to stay (with a relative or friend) close to the facility. • Help families identify a means of getting to the facility for the birth either in day or night time, and in bad weather. • Encourage families to make advance arrangements with a vehicle owner, including taking his or her phone number. • Encourage community planning to provide transport for birth and emergencies.
Fear of health facility procedures and health worker attitudes	• Explain to the family that if medical procedures are not conducted when they are required, the woman or her baby can be severely injured or die. • Encourage the family to identify a birth companion who could accompany the pregnant woman and help communicate with health facility staff, ensuring she is treated with respect. This could be the ttC-HV if appropriate.
Birth sometimes occurs very quickly	• Explain that it is important to go to health facility for the birth as soon as labour starts. That is why it is important to plan for the birth during pregnancy. • Help families ensure that they have everything they need for a safe home birth in case the labour is very quick. • Toward the end of pregnancy, encourage the woman to try to find a place to stay (with a relative or friend) close to the facility.
Influence of family members	• Engage with those family members who make household decisions in your discussions. If they are not in the house, arrange for them to come, or to attend next time and conduct the barriers analysis with them.

Activity 6: Barriers to birth planning (discussion)

Working in groups: Review the Household Handbook Visit 3, and see the list below. Lead a discussion about the behaviours listed. The first behaviour (facility birth) has already been done by the whole group. give each group one behaviour to discuss as previously and then report back

Complete this section in the ttC Participants Manual

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

Topics	Key Messages and additional information	Barriers: *What makes it difficult to do?*	Enablers: *What would make it easier to do?*	Counselling response or solution
Birth Planning	All women, but especially HIV-positive women should deliver in a health facility with a skilled birth attendant*			Activity 2 outcomes.
	Developing a birth plan			
	Arranging finances			
	Preparation for the birth and materials (clean birth kit)			

Summarise the main points of the session

- It is safest for a mother and her baby to deliver in a health facility with a skilled birth attendant. Even if the mother is healthy, she can have problems during birth that require medicines, equipment and/or skilled health professionals to save her and her baby.
- HIV-positive women should always give birth in a health facility because they will receive special care to help prevent the HIV virus from being passed from the mother to the baby.
- Mothers with risk factors such as HIV or other vulnerabilities (Session 20) should give birth in a facility and aim to stay close to the facility before their due date if they live far away.
- Families should have a clear birth plan in place, to include saving money, arranging transport and collecting supplies.
- The ttC-HV can play a very important role in helping the family to overcome difficulties in having the birth in a facility, and to help them prepare for the birth.

Session 18: Healthy Timing and Spacing of Pregnancies

Session plan	Activity 1: Determine what they already know Activity 2: Birth spacing Activity 3: Preventing adolescent pregnancy Activity 4: Reinforcing the information: role play Activity 5: Barriers and enablers to Healthy Timing and Spacing of Pregnancy (HTSP)	Time: 2h00
Learning objectives	At the end of this session, participants will be able to: • Understand and explain the reasons for spacing pregnancies and for limiting pregnancies to the healthy child-bearing years of 18–35 • Know the different methods of family planning • Counsel families on healthy timing and spacing of pregnancies and help them to overcome difficulties in using a family planning method.	
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	
Preparation and materials	*Materials:* • Flipchart, paper and markers • Storybook for Visit 3 • ttC Household Handbooks • Two dolls (for role play) • Plates (for role play) • Maize seeds (for role play: optional) *Preparation:* • Gather all training materials in advance. • Practise the narration of the role play (Activity 5)	

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- Understand and explain why pregnancies should be spaced apart by two years from a birth to the next pregnancy
- Understand why young girls should delay their first pregnancy until after they are 18 years of age.
- Understand where to go to get information on the different methods of family planning

VISIT 3

- Counsel families on healthy timing and spacing of pregnancies after the birth of their baby and help them to overcome any difficulties in using a family planning method.

Activity 1: Determine what they already know

Ask: why is it important to space pregnancies? That is to say, why it is important to wait for a certain length of time after a birth or a miscarriage before trying to get pregnant again?

W *What different methods are there for women to avoid getting pregnant?*
Write these on the flipchart. You may discuss their experiences in using these different methods, if they feel comfortable sharing this.

Ask: What methods are easiest, most difficult to use and why?

Activity 2: Give relevant information: Birth Spacing

BIRTH SPACING

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

   One of the greatest threats to the health and growth of a young child under the age of two is a pregnancy and birth of a new baby. Breastfeeding for the older child stops too soon, and the mother has less energy and time to prepare the special foods a young child needs. As a result, children born less than two years apart usually do not develop or grow as well, physically or mentally, as children born two years apart or more. Two years will give enough time for a woman's body to fully recover fully from pregnancy and childbirth.

2. To allow the woman's body to recover, a couple should also wait for six months after a miscarriage before trying for a new pregnancy.

   A woman's body needs about six months to recover fully from a miscarriage.

3. Family planning services provide people with the knowledge and the means to plan when to begin having children, how many to have and how far apart to have them, and when to stop. There are many safe and acceptable ways of avoiding pregnancy.

   Health clinics should offer advice to help people choose a family planning method that is acceptable, safe, convenient, effective and affordable. Of the various contraceptive methods, only condoms protect against both pregnancy and STIs, including HIV and AIDS.

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

   Men as well as women must take responsibility for preventing unplanned pregnancies. They should have access to information and advice from a health worker so that they are aware of the various methods of family planning that are available. Encourage men to go with their wives to discuss family planning with the clinic staff.

Activity 3: Give relevant information: Preventing adolescent pregnancy

Ask: Is it common in your communities for girls to marry or become pregnant before the age of 18 years? Why is that / why not?

Are there cultural norms which promote this? Does early marriage happen in your communities?

Are girls educated on the importance of delayed sexual debut and how to prevent pregnancies?

Now ask the group to try to dig for the root-cause. Ask questions (recall the root cause questions from the last module). For the two problems listed below, let's try to get to the underlying root causes of the problems 'why does that happen?' Raise the points listed below also.

Contextualisation: Adjust the list below for the circumstances you find in your country. If early marriage is not a problem you can focus on early sexual debut. However – almost all countries have a problem with early sexual debut, even in restrictive cultures,

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 wont 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?

Explain or read aloud

PREVENTING 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

VISIT 3

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.

Activity 4: Reinforcing the information (role play)

OPTIONAL ACTIVITY: You may carry out this activity or develop an activity of your own

This role play will help the ttC-HVs to make the comparison between good plant spacing in agriculture and healthy spacing of births, in terms of good outcomes. Ask for volunteers to come up and act out the scenarios, while the facilitators narrates what is happening. (e.g. the facilitator says 'Thomas is a farmer, he is planting his maize field' then the volunteer pretends to plant maize)

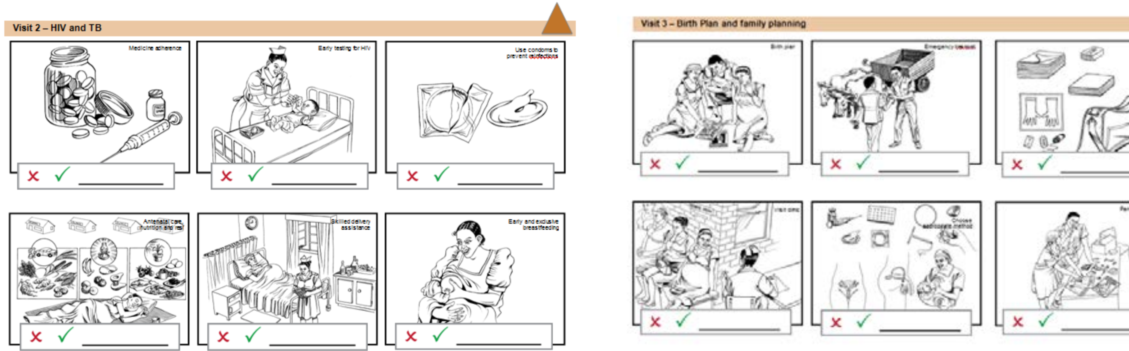
- **Ask** for five or six volunteers to come up. The first volunteers will play the role of a farmer sowing his field. The farmer will sow the seeds very close together. Now ask the other volunteers to line up as if they are maize stalks. They should stand very close to each other, crowding each other for space. As the farmer sprinkles fertiliser among them, they will all compete for this 'food', and as the farmer irrigates the crop they will all aggressively compete to 'drink'. Over time, two of the maize stalks may grow to become healthy, while the others will wither and die from lack of sufficient water and nutrients.
- Now **ask** for four or five different volunteers to come up. One volunteer will play the role of a pregnant woman, while the remaining play the roles of her children. The woman is carrying one baby on her back, is breastfeeding another baby, and has two or three children in the yard. (**Note:** You may want to arrange two dolls to represent the breastfeeding baby and the baby on the back.) When the mother puts a plate of food down on the floor, the children in the yard compete with each other and quarrel over the food. Both the baby on the back and the breastfeeding baby are crying because they are not receiving enough to eat. The mother rubs her belly to show that her pregnancy is making her tired. Over time, the breastfeeding baby, who is not getting enough food, dies. The mother is very sad.
- **Ask** for five or six different volunteers to come to the front of the room. Once again, one of the volunteers will play the role of the farmer sowing his field. This time, the farmer will plant the seeds with sufficient spacing between them. The other volunteers will line up as if they are maize stalks, but this time with more distance between them. As the farmer sprinkles fertiliser among them, they all have enough to 'eat', and as the farmer irrigates, they all have enough to 'drink'. All the maize stalks grow up strong and healthy.
- Finally, the last volunteers will play the role of a pregnant woman with three healthy children of different ages. This woman does not have a baby on her back, nor does she have a breastfeeding baby. When it is time to eat, all of the children get enough, and when the woman eventually gives birth, her baby is normal weight and healthy. (**Note:** You may use a doll to represent the new baby.)

Debrief with the participants asking them to explain what they saw in the different scenarios. What are the main messages that they understand from what they have seen?

Activity 5: Barriers and enablers to Healthy Timing and Spacing of Pregnancy (HTSP)

Ask: Why do some women not practice family planning after birth?

Facilitate a discussion concerning the difficulties women and families have in timing and spacing pregnancies, e.g. a wife may want to use family planning, while the husband may not. **Discuss** the ways that ttC-HVs can help families; perhaps by counselling both the husband and the wife at the same time on the benefits of practising healthy timing and spacing of pregnancies, and the potential dangers to the mother and children of not doing so. Review the HH Handbook and see the list below. Lead a discussion about the behaviours listed and note solutions in their manuals. **Complete this section in the ttC Participants Manual.**



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

Topics	Key Messages and additional information	Barriers: *What makes it difficult to do?*	Enablers: *What would make it easier to do?*	Counselling response or solution
Healthy Timing and Spacing of Pregnancy	Family planning post partum (as soon as possible after birth and before the baby is 6 months old)	*Beliefs, perceived risks (that they cannot get pregnant)*		
	Limit pregnancy to the healthy childbearing years of 18–35	*Early marriage preference in some cultures* *Adolescent peer pressure* *Sexual coercion to start early*	*Education* *Family support*	
	Wait at least two years after a birth before trying to get pregnant again	*Knowledge, beliefs, wish to have large families,*		
	Wait at least six months after a miscarriage before trying to get			

	pregnant again			
	Using family planning modern methods available at health facility (provide list)	Knowledge, beliefs, skills, preference for traditional methods, family / partner opinion		

Summarise the main points of the session

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

Session 19: Conducting the third pregnancy visit

Session plan	Activity 1: Understanding the story Activity 2: The third home visit in pregnancy Activity 3: Practice the third home visit in pregnancy Activity 4: Practice with the visuals (small group work) Activity 5: Debrief in plenary	Time: 2h00
Learning objectives	At the end of this session, participants will be able to: • Demonstrate how to conduct a third visit to a pregnant woman and her family • Demonstrate how to use the visuals appropriately during the counselling visit • Be prepared to conduct Visit 3 and engage effectively and appropriately with household members.	
Key messages	• During the 3rd pregnancy visit, dialogue, negotiate and encourage families to make a birth plan, prepare for birth, and consider family planning to avoid getting pregnant again too quickly. • During the 3rd pregnancy visit, you will tell three stories and ask the corresponding guiding questions: (1) problem story: 'Birth plan', 'Birth spacing' and (2) positive story: 'Birth plan' and (3) positive story: 'Birth spacing'. Follow the four steps in the counselling process. • Remember that how you interact with a pregnant woman and her family will affect how relaxed and confident she feels and whether she decides to follow your advice.	
Preparation and materials	*Materials:* • Flipchart, paper and markers • Storybook for Visit 3 • ttC Household Handbooks *Preparation:* • Gather all training materials in advance	

Introduce the session

OBJECTIVES OF THE SESSION

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

- Demonstrate how to conduct a third visit to a pregnant woman and her family
- Demonstrate how to use the visuals appropriately during the counselling visit
- Be prepared to conduct Visit 3 and engage effectively and appropriately with household members.

Activity 1: Understanding the story

Distribute copies of Storybook 3. **Working in groups** with one facilitator/ helper per table, ask the facilitator to read the story to the group, applying good techniques of storytelling. Then at the end of the story the group should go around in a circle and identify the positive and negative practices. The facilitator or note taker (if not literate), should use the table below as a checklist.

VISIT 3

Storybook 3 messages

Story book #	Positive story messages	Negative story messages
3	• They *saved money for the birth*, and for a possible emergency • The community was organized for transportation • Blessing identified the transport they would use, ahead of time • They bought clean supplies for the birth • Faith goes for a postnatal consultation after she has given birth. • They chose a family planning method to avoid getting pregnant again too soon.	• Patience had too much work • She didn't tell anyone when her fever and chills began • Her labour was prolonged and nobody understood that that was dangerous • The family had no emergency plan; the husband had not saved money or made arrangements for transport • They did not go to the front of the line at the health facility • They did not tell the health staff what happened

Activity 2: Give relevant information: The third home visit in pregnancy

Review the sequence of the 3rd home visit with the participants, in the *ttC Participant Manuals* (brief recap). If they are *not literate proceed directly to conduct a demonstration.*

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 *(we will do this at the end)*.

End the visit: Decide with the family when you will visit again (mid-pregnancy). Thank the family.

Activity 3: Practise the third visit in pregnancy (participants plenary)

Ask for five volunteers to role play the household counselling in plenary for this session. These should be different volunteers from those who role played this activity previously.

The remaining trainee participants will act as plenary and may reply to ttC-HV questionswhenever they wish.

The volunteers should go through the steps of the household counselling process. The first ttC-HV will role play the first step, the second ttC-HV will role play the second step, and so on, until the complete sequence of the third home visit has been completed.

Advise the plenary observers that they should take note of what the ttC-HVs do well in the role plays and what needs improvement, using the counselling skills guide for reference, found on the last page of the ttC-HV manual.

Activity 4: Practise with the visuals (small group work)

Distribute the following ttC Storybook 3 stories to the ttC-HVs. **Remind** them that the guiding questions are found at the end of each story:

Problem story: 'Birth plan, birth spacing
Positive story: 'Birth plan'.

Divide the ttC-HVs into groups of four. The ttC-HVs should go through the four steps of the HH counselling process, as described below. The first ttC-HV will model the first step, while the remaining group members play the roles of mother, husband, mother-in-law, etc. The second ttC-HV will then model the second step, and so on, to complete the sequence. Each group should have **one facilitator**. Once they have each had a chance to practice, the facilitator **should debrief** the counselling process with them, asking the following guiding questions:

How do you feel the process went?
What did you find difficult to understand or carry out? What further help do you need?
What parts of the process are easy to understand and carry out?
Do you feel ready to carry out this session with households in the community? What further support do you need?

Activity 5: Debrief in plenary

Carry out a plenary discussion with the participants, asking the following questions about what they observed in the role play household counselling,

The counselling process: Guiding questions

- What is **Step 2** in the HH counselling process?
  - Where did we see this step? What happened?
- What is **Step 3** in the HH counselling process?
  - Where did we see this step? What happened?
- Was there an additional **Step 3b** in this counselling session? If so, what was it?
  - What happened?
- What is **Step** 4 in the HH counselling process?
  - Where did we see this step? What happened?

Counselling skills: Guiding questions

Which of the counselling skills did the ttC-HV demonstrate? What could they have done better?

Respectful manner
Giving praise
Body language
Handling concerns, appropriate use of PFA skills
Good listening
Use of visuals
Good story telling technique
Good negotiation technique (root cause questions)
Good solution finding
Giving health information

Summarise the main points of the session

- During the 3rd pregnancy visit, dialogue, negotiate and encourage families to make a birth plan, prepare for birth, and consider family planning to avoid getting pregnant again too quickly.
- During the 3rd pregnancy visit, you will tell three stories and ask the corresponding guiding questions: (1) problem story: 'Birth plan', 'Birth spacing' and (2) positive story: 'Birth plan' and (3) positive story: 'Birth spacing'. Follow the four steps in the counselling process.
- Remember that how you interact with a pregnant woman and her family will affect how relaxed and confident she feels and whether she decides to follow your advice.

MONITORING AND REFERRAL FOR PREGNANCY

Session 20: Supportive care for vulnerable pregnancies

<table>
<tr><td>Session plan</td><td>Activity 1: Discussion – Vulnerable pregnancy factors
Activity 2: Discussion – Birth planning, additional support and care
Activity 3: Vulnerable pregnancy case studies</td><td>Time:
1h30</td></tr>
<tr><td>Learning objectives</td><td colspan="2">By the end of this session the participants should be able to
• Describe some conditions which may make a pregnant woman more vulnerable or 'to complications and psychosocial problems during pregnancy and childbirth.
• Describe two ways in which the ttC-HV might be able to provide additional care and support to vulnerable mothers and pregnant women</td></tr>
<tr><td>Key Messages</td><td colspan="2">• 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</td></tr>
<tr><td>Preparation and materials</td><td colspan="2">• No additional materials required</td></tr>
</table>

Introduce the session

Objectives of the session

- Describe some conditions which may make a pregnant woman more vulnerable or 'to complications and psychosocial problems during pregnancy and childbirth.
- Describe two ways in which the ttC-HV might be able to provide additional care and support to vulnerable mothers and pregnant women.

Activity 1: Discussion of vulnerable pregnancy factors

Ask the group to think about all the pregnant women in their communities.

Ask: Are some women MORE LIKELY to have problems during pregnancy or birth? Why? Have they experienced problems in the past?

Do they have physical characteristics which make their pregnancy more likely to have complications? What are they?

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

Write down their answers on the board, then invite the health staff to circle those women who may have more chances of developing complications to explain what the risks are and why they need extra support. , or use the table to discuss specific issues,

Ask: What might be the additional needs of these women compare to other pregnant women?

RECAP THE 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.

Activity 2: Discussion of birth planning, additional support and care

Discussion points

Ask: WHAT is a birth plan? A birth plan means that the woman and her family have considered the various needs including money and essential items required for the birth of a baby and have clear and viable ideas about how they can meet these needs in advance.

Ask: WHY have a birth plan? Many tragedies occur during labour and birth because the woman or family did not consider before the event what might be needed and the possible complications of giving birth

Ask: WHO should be involved in the birth plan and why?

The pregnant woman;

Midwife or nurse – may conduct an assessment and approve the plan;

CHW or ttC-HV – be aware of the birth plan, and support the woman and her family;

Birth companion – chosen accompanying person during the birth, such as the husband, sister, mother-in-law, or a friend.

WHEN should the birth plan be ready? All women should have developed a birth plan *at least two months* prior to birth, and this should be revised in any subsequent visits.

WHAT is included in the birth plan? All women should develop a birth plan including birth location, chosen assistant, birth companion, clean delivery kit, emergency transport and money saved to cover any potential costs of procedures, medicines or hospital stay.

ADDITIONAL BIRTH PLAN SUPPORT FOR 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
-

Ask: What additional questions / considerations might a vulnerable mother need to take when making her birth plan?

Where to deliver: in a hospital or a higher-level health facility.

When to travel to the facility (expected date of delivery): Aim to be close to a facility which has emergency care available day and night towards the end of your pregnancy. If you live far from a health centre, plan to move and stay nearer if possible.

Who will accompany the mother?: Vulnerable mothers should travel with a chosen birth companion so they have someone to take care of them.

Danger signs: Family members should be made aware of any health or risk factors and danger signs to look out for, and what to do in the event of a danger sign. Make sure the family is made aware and are vigilant for danger signs.

Activity 3: Case studies

Read the case studies. Participants can discuss in pairs, then vote if the case is to be considered a case which has HIGH support needs?

Case study	Answer
• Fatima is 38 years old. She has four healthy children, but during her last delivery she suffered fits and convulsions and had to be taken to the health centre for treatment.	HIGH
• Sally is 25 years old and this is her third pregnancy. She has had a healthy pregnancy and her previous deliveries were without complications.	
• Quinta is 23 years old and this is her 2nd pregnancy. She has had no complications and her previous deliveries went fine. She has been told she is carrying twins.	HIGH
• Carmen and her husband tested positive for HIV and started ARV treatments during the pregnancy. She reports she is healthy and has not experienced problems. Her husband has been unwell, and is unable to work so Carmen is working to support them.	HIGH
• Eugenia is 21 years old, this is her second pregnancy. Her first went fine, and she has not suffered complications during this pregnancy.	
• Caroline is 16 years old and is pregnant. She is healthy and has no problems in this pregnancy so far, but has not attended ANC, Of additional concern is that she lives very far from any transport links, and rarely attends clinics for this reason.	HIGH

Now ask the participants to get into groups, giving each group a case study in which one of the women is at risk. After this ask each group to discuss what the woman's needs are, what additional actions they

might take from the list below, and how they can counsel her and her family. The four groups should then feed back to other participants.

- Additional home visiting and supportive counselling
- Monitoring and supporting medicine adherence for HIV-positive / TB positive mothers
- Improved birth plan including travel / stay near facility prior to due date

Summarise the main points of the session

- 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

Session 21: Referral, counter-referral and follow up

<table>
<tr><td>Session plan</td><td>Activity 1: Revision of danger signs –To refer or not to refer?
Activity 2: Making a referral
Activity 3: Home-based post-referral follow up
Activity 4: Interpreting counter referral forms</td><td>Time:
1h40min</td></tr>
<tr><td>Learning objectives</td><td colspan="2">At the end of this session participants will be able to:
• Describe some consideration when transporting a pregnant woman with a complication (emergency evacuation)
• Complete a written referral form to the best of their ability (literate HVs)
• Explain home based referral follow up, when and what to assess during a visit.
• Interpret counter referrals from the health facility (literate HVs)</td></tr>
<tr><td>Key Messages</td><td colspan="2">• Seek help immediately at the nearest health centre if you experience any of these signs:
o Severe headache
o High temperature or fever
o Vaginal bleeding
o Vaginal irritation or discharge
o Fainting, dizziness and severe fatigue
o Swelling of feet hands or face
o Abdominal pain
o No baby movements for 24 hours (6–9 months)
• During an emergency referral she the woman is: accompanied by family member or ttC-HVS, comfortable, carries food and water, all medical records or cards, materials needed for a hospital stay.
• A written referral form communicates to health facility staff important information during an evacuation such as:
o Previous or long term medical problems
o Since when has she been unwell
o Medicines she has already tried / taken for the problem
o Who to contact if there are further problems (ttC-HVS / family contact)
• During a home-based post-referral visit a ttCHV should ensure the patient received the medical care and medicines they needed, are feeling fully recovered, following the treatment and self-care guidance given to them.
• A written counter-referral (*facility discharge note), may be written by facilities, with the patient's consent and can communicate important information about the care of the patient which might be important for the ttCHV, ttC-HVS or family such as:
o Medical conditions identified which need extra care
o When the patient should return for follow up
o Medicines the patient should be taking
o Danger signs to look out for and care guidance to follow
o When the ttCHV or ttC-HVS should follow up in the home.</td></tr>
<tr><td>Preparation and materials</td><td colspan="2">Materials:
• Sample referral / counter referral forms or local version: three per participant
Preparation:</td></tr>
</table>

	• Distribute referral forms

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- Describe some considerations when transporting a pregnant woman with a complication (emergency)
- Complete a written referral form to the best of their ability (literate HVs)
- Explain home based referral follow up, when and what to assess during a visit.
- Interpret counter referrals from the health facility (literate HVs)

Activity 1: Revision of danger signs – To refer or not to refer?

Ask the group to recap what are the most important danger signs in pregnancy? Ask them to use their Storybook for Visit 1 to review the danger signs.

Seek help immediately at the nearest health centre if you experience any of these signs:

- Severe headache
- High temperature or fever
- Vaginal bleeding
- Vaginal irritation or discharge
- Fainting, dizziness and severe fatigue
- Swelling of feet hands or face
- Abdominal pain
- No baby movements in 24 hours (6–9 month)

Explain to the group that in this activity we are going to listen to some cases and determine what they should recommend, from three possible actions: RED= urgent referral; ORANGE = non-urgent referral; YELLOW = manage the case at home. You can do this moving around the room, with one place for each action. Read the case then give them a minute to get into place. Ask volunteers why they made that choice and discuss any recommendations.

A woman is two months pregnant and has severe morning sickness, and does not want to eat anything as it makes her feel more nauseous.
YELLOW

A woman is suffering back pains in 3rd trimester, she says she cannot sleep well or carry water anymore.
YELLOW

During a home visit, a woman reports she is feeling dizzy often, breathless and is always tired and is in the 9th month of pregnancy.
RED

A woman in 4th month of pregnancy reports she has bad haemorrhoids that she cannot sit down, and she is scared to go to the toilet because of the pain.
ORANGE

During a routine visit a woman shows very swollen feet and hands. She is also complaining of headaches and stomach aches. She is in the 3rd trimester.
RED

One woman's husband comes to see you in the middle of the night – his wife has bad pain in her belly and high fever, she is shivering.
RED

A woman is being visited every week during the last trimester of her pregnancy, by the local TBA. The TBA tells you that the baby is lying across the belly, and now she is in 9th month.
ORANGE

Ask the group to share some of their own experiences and discuss the options if time permits.

Activity 2: Making a referral

Ask the group if anyone has ever made an 'emergency referral' in their village? What recommendations should they normally give a family when they have to travel with a pregnant woman who is unwell?

During an emergency referral she the woman is: accompanied by family member or *ttC-HVS*, comfortable, carries food and water, all medical records or cards, materials needed for a hospital stay.

Discuss their answers and stress:

- Pregnant women should travel with a family member, or *ttC-HVS* and not travel alone
- She should carry all her health documents
- If she is in the third trimester she may need birth kit and birth materials with her

What information might the health centre need to know about the case?

A written referral form communicates to health facility staff important information during an evacuation such as:

- Previous or long term medical problems, events preceding the symptoms
- Since when has she been unwell
- Medicines she has already tried / taken for the problem
- Who to contact if there are further problems (*ttC-HVS* / family contact)

Writing A Referral Note

If you have given treatment in the village – and plan to further evacuate a sick person, it is sensible to send relevant information to inform the health centre.

Contextualisation: If in your country you have emergency services and specific referral notes in a format that ttC-HVSs can fill out, please replace the system below with these.

Features of the referral / counter referral form

Each referral sheet has two sides; one is completed by the *ttC-HVS* / HV who is *referring the women to the health facility.* The other side should be left blank and it is to be completed by the facility *if there is information which the facility needs to communicate with the ttC-HVS/HV.*

Always write clearly or in CAPITAL LETTERS

Copy the ID information from the ttC register or from the woman's health card.

Do not write too much information, just the most important necessary information.

Describe all relevant symptoms or previous conditions; and tick the indicated state of the patient at the time. They may well worsen on the road.

Clearly list any medicines you have given/ the patient has taken, dose amount and number of times given.

Training Exercises

Work in your teams. Consider the two cases below and complete sample forms. When you have finished. Discuss the results together in groups and with the trainer. If you have facility staff present in the group, ask them to receive the referral slips and to confirm the information is communicated correctly, clearly and completely. Ask the group for cases from their own experience for additional cases, or to present problematic cases that you can discuss how to solve in groups.

1.) Mariama Cisse # 0023 is in 3rd trimester of her fourth pregnancy. Her waters have broken and there is no sign of labour, no dilation. She is conscious and able to walk, but complains of abdominal cramps and she has a fever. She has already had one miscarriage and one still birth in the past. Give relevant treatments, counselling for her and the TBA who has offered to travel with her and complete the form according to what you agree in groups.

2.) Aissatu Balde # 0043 in her second trimester of pregnancy. She had a fever in the previous three nights, and bought *an unknown medicine* for malaria from a market seller, and some herbs she prepared at home. Today she continues to have fever, but now she is also vomiting. Her condition is serious but she can walk with support. Counsel her family, and complete the referral form.

Activity 3: Give relevant information: Home-based post-referral follow up

Ask the group about what they think might happen at the clinic.

- Will she have been able to access all the medicines that she was recommended at the clinic?
- Will she complete medicines and care recommendations when she returns home?
- What might happen if she continues to be unwell at home after return from the clinic?

Ask the group about any experiences where they have seen any complications occurring after the patient has returned home from the clinic.

Discuss their answers and stress:

Patients may experience stock outs or cannot afford medicines prescribed, or may end up buying from unofficial suppliers selling medicines of lower quality.

Patients may not always complete medications due to side effects, forgetting or not knowing when to stop taking them (*explain for e.g. dangers of not completing course of antibiotics or anti-malarials)#*

If the first treatment was not successful they may seek care from other providers, putting themselves and their children at risk.

Many child deaths actually happen in the home after discharge from the clinic, therefore home based follow up is really important to prevent these deaths and ensure patients are referred back to the clinic again if they don't recover.

Explain the purpose of home visiting after an emergency referral:

During a home visit post-referral a ttCHV should ensure the patient received the medical care and medicines they needed, are feeling fully recovered, and are following the treatment and self-care guidance given to them.

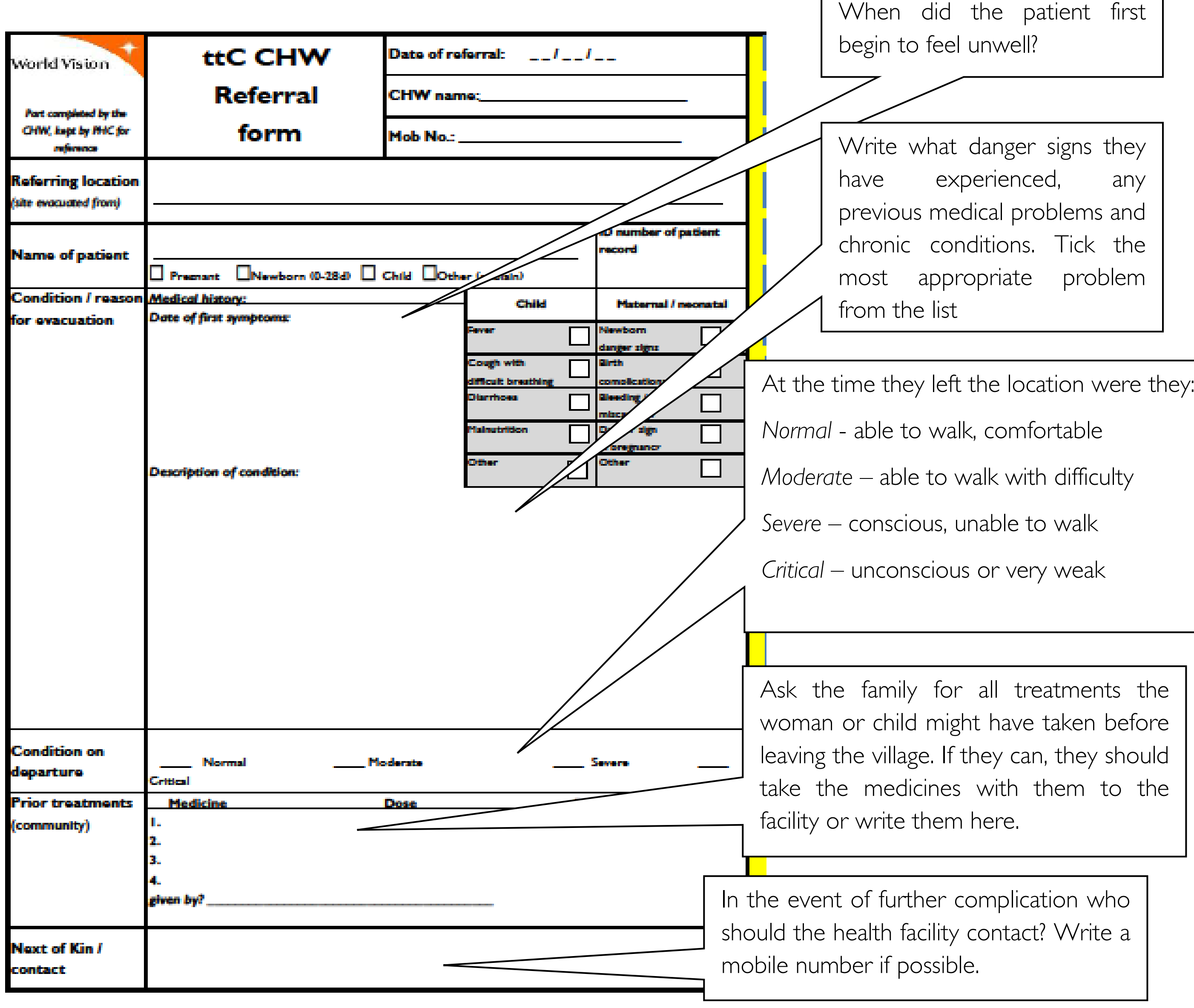
Activity 4: Interpreting counter referral forms

A written counter-referral (*facility discharge note), may be written by facilities, with the patient's consent and can communicate important information about the care of the patient which might be important for the ttCHV, *ttC-HVS* or family such as:

- Medical conditions identified which need extra care
- When the patient should return for follow up
- Medicines the patient should be taking
- Danger signs to look out for and care guidance to follow
- When the ttCHV or ttC-HVS should follow up in the home.

Summarise the main points of the session

- Seek help immediately at the nearest health centre if you experience any danger signs.
- During an emergency referral she the woman is: accompanied by family member or *ttC-HVS*, comfortable, carries food and water, all medical records or cards, materials needed for a hospital stay.
- A written referral form communicates to health facility staff important information during an evacuation such as: previous or long term medical problems, timing of illness, medicines currently or previously taken, who to contact (family).
- During a home-based post-referral visit a ttCHV should ensure the patient received the medical care and medicines they needed, are feeling fully recovered, following the treatment and self-care guidance given to them.
- A written counter-referral (*facility discharge note), may be written by facilities, with the patient's consent and can communicate important information about the care of the patient which might be important for the ttCHV, *ttC-HVS* or family such as: condition identified, when to return, medicines being taken, possible danger signs and when to follow up at home.



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Part completed by the CHW, kept by PHC for reference

ttC CHW Referral form

Date of referral: __/__/__

CHW name:______________________

Mob No.: ______________________

Referring location *(site evacuated from)*

Name of patient

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

ID number of patient record

Condition / reason for evacuation

Medical history:

Date of first symptoms:

Description of condition:

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

Condition on departure

___ Normal ___ Moderate ___ Severe ___ Critical

Prior treatments (community)

Medicine	Dose
1.	
2.	
3.	
4.	

given by? ______________________

Next of Kin / contact

Explain that during a home visit, you can ask the woman is she was given a discharge notice (or the count page of the referral form above). The trainer should (or ask the health facility staff in the training) *complete* the following 3 cases. The ttCHVs should be able to read and interpret forms. Then read the italics and discuss (with health staff if possible) how to handle the case.

- Mary Smith was discharged from Saint Audrey's hospital on the 4th of June 2014. She was pregnant, but sadly miscarried in the 5th month and was kept in observation for two days at the facility. She was given iron tablets (60mg), to be taken twice daily for a month. It was recommended that she rest well, eat well and return for follow up in one weeks' time at the clinic. They also recommended that she return immediately in the event of fever, fainting or further bleeding. They recommend the ttC-HV visit her twice a week for 3 weeks.

During the home visit in the 2nd week the ttC-HV discovers that Mary has not been back to the facility, furthermore as the pharmacy only had 12 IFA tablets in stock she has run out and stopped taking them. She feels well and has returned to her normal work schedule. What should be recommended to the family?

Answer= counsel the family on delaying return to work, ensure she gets IFA tablets, follow up as guided

- Josefina Carlos was seen at Quimbale health facility on 16th May, and was treated for malaria in pregnancy. The clinic report that she completed treatment in the facility, and was discharged without further medicines but recommend she continue to take IFA once daily, and return if she has any fever. They recommend one follow up visit a week for two weeks.

During the home visit the ttCHVs discovers Josefina has been suffering bad headaches and muscle cramps since she returned home six days ago. She also has had fever for two days. What should you recommend?

Answer= refer immediately

- One week after Imelda Kamwazi delivered her twins in the Tombali regional hospital she was discharged on 30th April, and had undergone caesarean section, without further complications. The facility recommended that she return after 10 days for an outpatient follow up in her local clinic and that she is home visited once weekly for six weeks. The say she should rest well, eat well, and change her dressings twice daily. Return immediately if there are signs of fever, bleeding or lower abdominal pain.

You visit Imelda at home and find she is caring for her twins at home alone. However, Imelda is recovering well, and reports no symptoms, and that she is doing fine. What should you recommend?

Answer= counsel the family on assisting her to care for the babies, continue to follow up as guided.

Example of how to complete the referral form

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

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

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

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

Message to the *TTC-HVS* to check (if needed):

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

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Part completed by PHC returns to CHW

ttC-CHW Counter-referral form

Date of discharge: __/__/__

Health staff name ____________

Contact no.PHC: ____________

Receiving institution	☐ MCHP ☐ CH post ☐ CHC ☐ Hospital			
Name of patient	☐ Pregnant ☐ Post partum ☐ Newborn (0-28d) ☐ Infant ☐ Child			ID number of patient record
Conditions treated at facility	Medical history		Child	Maternal / neonatal
	Conditions:		Malaria ☐	Neonatal infection ☐
			ARI ☐	Complex delivery ☐
			Diarrhea / dehydration ☐	Miscarriage ☐
	Treatment given:		Malnutrition M / S ☐	Malaria ☐
			Other infection ☐	Danger sign in pregnancy ☐
			Other ☐	Other ☐
Condition on discharge	___ Normal ___ Moderate ___ Severe ___ Critical			
Instruction to CHW				
Date return to PHC		Return immediately if:		
Follow up schedule	Home visit patient ______ times per week for ______ weeks			
CHW to check during follow up	Medicine adherence schedule Possible danger signs Counselling			
Signature of Health staff				

Session 22: Completing the ttC Pregnancy Register

Session 22	Activity 1: Review of the forms Activity 2: Example cases and completing the forms Activity 3: Validating information using maternal health records Activity 4: Discussion and practice	Time: 2h15
Learning objectives	After this session participants should be able to: • Complete the pregnancy register for the first registration of pregnancy • Complete the pregnancy register for all consecutive follow up visits in pregnancy	
Key Messages	• The pregnancy register serves as a record of all important health practices being done by the household at the time of the visit, and can be used to report progress. • For all practices the ttCHVs should mark a tick for a positive answer and a cross for a negative answer, aligned to the gestational age at the home visit.	
Preparation and materials	*Materials:* • Pregnancy registers (three per participant) • Example registers – printed or projected on screen	

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- Complete the pregnancy register for the first registration of pregnancy
- Complete the pregnancy register for all consecutive follow up visits in pregnancy

Contextualization: Your national office will have contextualized the monitoring systems. This process involves making changes to the list of indicators and to the ttC Registers, adding or removing indicators for your context. Make sure you are working with the final versions of the ttC register for pregnancy as adapted by your NO or your project.

Activity 1: Review of the forms

Distribute a copy of the ttC Pregnancy Register to each participant.

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

The pregnancy register serves as a record of all important health practices being done by the household at the time of the visit, and can be used to report progress.

For all practices the ttCHVs should mark a tick for a positive answer and a cross for a negative answer, aligned to the gestational age at the home visit.

Explain the structure of the forms:

Universal Register Information: *contextual change:* this section of the form shows where the project is, the ID numbers of the ttCHVs, communities and nearest health district and facility, name of mother and ID (if assigned). These data will be modified as part of contextualisation.

Column structure and timing: Each of the registers has a column structure –fill in each visit in a vertical column aligned to gestational age at the time of the visit and complete the register *downwards*. Look at the gestational ages (*pregnant mother symbols, with months across the bottom).* There are two columns – one for visits in month 1–4 of pregnancy (early pregnancy visits), and one column for visits occurring in months 5–9. In the worked example – see how ticks and crosses are all aligned under 4 months. You can find out the gestational age in three ways:

Check the antenatal card for her expected date of delivery
Ask the mother, *if she knows,* or calculate from the last menstrual period.
Confirm gestational age by palpation if you are trained in this (e.g. ttC-HVS / trained TBA only).

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

Indicators: Each row corresponds to one of the health practices the ttCHVs will have promoted using the stories and household handbook. In completing the register they will tick ✓ for when the mother has already started or completed the practice. You will put a cross ✖ when the practice has not yet been completed (*unlike the household handbook, do not mark intention to try*). In the worked example, the data shows Lara's husband didn't participate, and that she was using a mosquito net.

Danger signs and referral: At the start of each household visit you will have enquired about danger signs. If she has a danger sign and you recommend referral – you could write the date of referral or a tick if the ttCHVs are not literate. If you must refer immediately come back and complete the ttC visit on another day. If there is no danger sign write a cross. If you have referred her, wait until you have confirmed that she *went to the health facility* before marking referral as completed. In the worked example below show how Lara was referred on the day of the ttC visit, and that you have not yet completed the referral confirmation.

Activity 2: Example cases and completing the forms

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

Contextualization: You will need to cross-check the story examples below with the final versions of the ttC Register you are using. Only include information or data in the examples below if it is also found on the *ttC-HVS* Register for the first visit during pregnancy.

Ask participants to turn to the ttC Participants Manual with the example below, and read them aloud. Explain that the example refers to the *ttC-HVS* as 'you'.

EXAMPLE 1: LARA

- You visit Lara on the 15th of May. Lara is about four months pregnant and lives on the outskirts of the village and her house is right next to the primary school. Her husband, Hussein, does not participate in the visit.
- She has already been to the health centre for her first ANC visit. She has no signs indicating she has a high risk pregnancy. She was offered an HIV test but did not take it yet, and has not therefore got her results.

- She has started taking iron and folate tablets every day, and she reports that she always sleeps under a mosquito net at night. She doesn't have a birth plan yet.
- You have just completed counselling her on antenatal visits, home care and nutrition and danger signs in pregnancy. Lara reports that due to morning sickness she is eating less than usual.
- Lara is not feeling well and you recommend that she goes to the health facility. You will follow her up in two days to find out if she went ad if she is feeling better.
- Lara and her family want you to visit them again about two months from now for the 2nd ttC counselling visit.

Worked Example: Lara

COMPLETE THE REGISTER IN EVERY HOME VISIT		Pregnancy V1 V2 (1m 2m 3m 4m)	Pregnancy V3 V4 (5m 6m 7m 8m 9m)	data code	Totals
Death in pregnancy *(write date)*				D1	*Maternal Death? Yes or no*
Miscarriage				D2	*Woman experienced miscarriage?*
Visits Planned *(write date for planned visit)*		14/5	17/6	*	*verify date against gestation*
Home ttC Visits *(write date of visit)*		15/ 5 or ✓		P1A	*1st visit before 16 weeks?*
				P1B	*4 visits in pregnancy?*
Husband / partner participated in ttC visit?		✗		P2	*Husband / partner participation in most of ttC visits?*
High risk pregnancies		✗		P3	*Woman was high risk at any point in pregnancy?*
Bednet use consistently since last visit		✓		P4	*Did the woman sleep under a net during most of the pregnancy?*
Antenatal visits completed		✓		P5A	*1st ANC before 16 weeks?*
				P5B	*4 ANC during pregnancy?*
HIV test done		✗		P6	*Woman did HIV test during this pregnancy?*
Obtained HIV test result		✗		P6	*Woman obtained test result during this pregnancy?*

Woman has taken iron tablets regularly during last month		Mother has started taking IFA? ✓	Mother has taken IFA for more than 4 months?	P7	Mother took at least 4 months of IFA during this pregnancy?
Woman has eaten more than usual		✗		P8	Woman reported eating more than usual (3 meals + snack) at all visits?
Birth plan		✗		P9	Woman had developed a birth plan at any point?
Danger signs in pregnancy		1 5/ 5 or ✓		E1	Total events
Referral completed				E1A	Total events
Post-referral home visit completed				E1B	Total events

EXAMPLE 2: SHEILA

Visit 1

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

Visit 2

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

EXAMPLE 3: SATUMINA

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

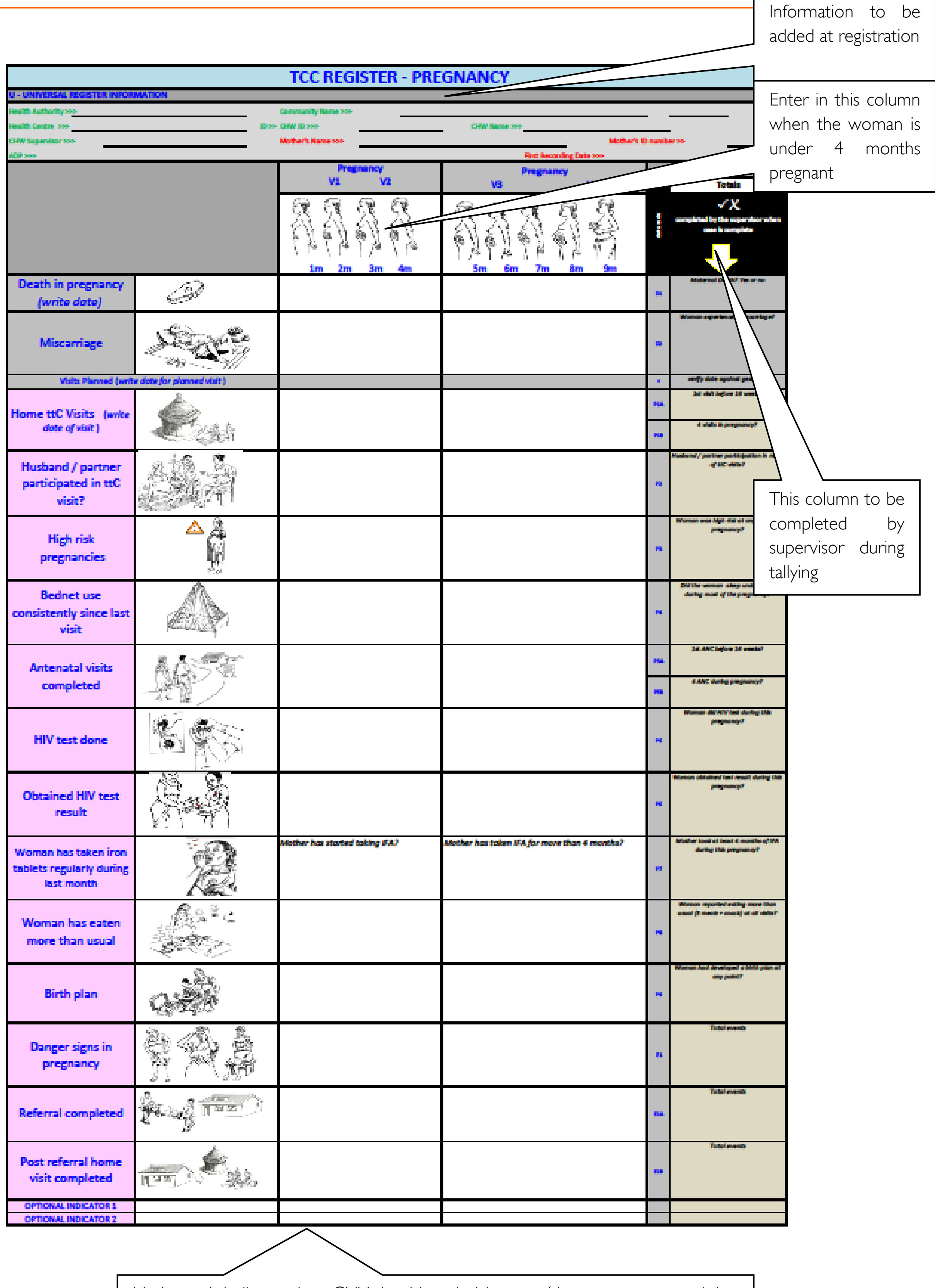
Note: When the participants have finished filling in the Registers, ask them to talk in pairs about how they would counsel each family based on the information she has given them.

Activity 3: Validating Information using the maternal health record (literate ttC-HVs)

Contextualization: Provide examples of maternal health records from your country.

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

- Antenatal clinic attendance
- Expected date of delivery or date of last menstrual period
- Tetanus vaccines given
- IPT doses given
- HIV test results (if consent given)
- Any complication or observations during antenatal care



Under each indicator the ttCHV should mark tick = yes (the woman reported that she has or is doing this practice. Or X = no, she has not done or is not doing at this time.

Activity 4: Discussion and practice

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

Debrief

Carry out a plenary with participants and discuss their experience filling out the register and what they learned. Answer any queries they may have.

Universal register information: What are the details that need to be filled here?

Planned and completed dates: Were they able to calculate the date for the next visit? What challenges did they face in doing this?

Health practices: What details are required here? What are the details for Lara that need to be filled here? What about Sheila sand Satumina? In what places are the cases different?

Getting information through open ended questions: What did they learn out of the second set of role plays, done without the help of stories? Were they able to ask the right questions to get the information they needed? What challenges did they face in asking questions? What challenges did the other in the pair face in understanding the questions and responding to them?

For non-literate *ttC-HVSs*:

Ask how they felt filling in the ttC REGISTER

Were they able to ask the right questions to get the information they needed? What challenges did they face in asking questions? What challenges did the other in the pair face in understanding the questions and responding to them?

What challenges do they think may find when they actually fill this record during a home visit?

Summarise the main points of the session

- The pregnancy register serves as a record of all important health practices being done by the household at the time of the visit, and can be used to report progress.
- For all practices the ttCHVs should mark a tick for a positive answer and a cross for a negative answer, aligned to the gestational age at the home visit.

FOR FURTHER INFORMATION

PLEASE CONTACT:

WVI Offices

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

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

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

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

WVI Regional Offices

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

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

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

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

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

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

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

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