World Vision®

Timed and Targeted Counselling for Health and Nutrition

Facilitator's Manual for Training in ttC

Module 3: Child Health, Nutrition and Development

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

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

ADP	Area development programme
ANC	Antenatal care
ARI	Acute respiratory infection
ARV	Antiretroviral
ART	Antiretroviral therapy
CHW/V	Community health worker/volunteer
CMAM	Community-based management of acute malnutrition
CoH	Channels of hope
COMM	Community health committee
CVA	Citizen Voice and Action
DADD	Do, assure, don't do
DPA	Development programme approach
EBF	Exclusive breastfeeding
ECD	Early childhood development
EmOC	Emergency obstetric care
EmONC	Emergency obstetric and newborn care
FP	Family planning
GAM	Global acute malnutrition
GBV	Gender-based violence
GTRN	Global technical resource network
HIV	Human immunodeficiency virus
HMIS	Health management information systems
HTSP	Healthy timing and spacing of pregnancy
HVs	Home visitors
ICCM	Integrated community case management
ICT	Information and communication technologies
IMCI	Integrated management of childhood illnesses
IYCF	Infant and young child feeding
KMC	Kangaroo mother care
LBW	Low birth weight (baby)
LLIN	Long-lasting insecticidal net
MAM	Moderate acute malnutrition
MHPSS	Mental health and psychosocial support
MNCH	Maternal, newborn and child health
MoH	Ministry of Health
MUAC	Mid-upper arm circumference
NGO	Non-governmental organisation
NO	National office
ORS	Oral rehydration solution
PD Hearth	Positive deviance hearth
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
RUSF	Ready-to-use supplementary food
RUTF	Ready-to-use therapeutic food
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-HV	ttC home visitor
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 3: CHILD HEALTH, NUTRITION AND DEVELOPMENT

How to use this document

Welcome to the facilitator's manual for training in timed and targeted counselling (ttC). This is the third module of the technical training component of ttC, which focuses on child health, nutrition and development. Visits cover the fifth month of life (Visit 7), the ninth month (Visit 8), the twelfth month (Visit 9), the eighteenth month (Visit 10), through to when the child is 24 months old and exits the ttC programme (Visit 11). We have deliberately taken a modular approach to enable individual modules to be selected in or out during curriculum adaptation, and for the visiting schedule to be tailored to the country requirements. As such, certain modules may be able to stand alone or can be appended to a revision session for existing ttC-HVs. This document can be used for the following processes:

1. **Initial 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 for technical content, you may wish to review this document and select elements or modules of interest which do not have equivalents in your MoH training.

   Sessions 1, 5, 9, 11 and 13: Conducting the household visits
   Session 16: Referral and follow-up of the sick child
   Session 17: Completing the child register

3. **Refresher trainings for existing ttC home visitors:** if you have already delivered training on ittC 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 and new content can be found in the following sessions:

   Session 3. The major killers and feeding during illness: this is largely a revision from Module 2 about serious diseases in children, plus detailed information about the counselling messages for parent in feeding during illness and recovery.

   Session 4: Counselling the family on care for child development: this is a optional extended workshop to strengthen those key messages around play and interaction from birth incorporated in the earlier sessions and Household Handbook. In this session the ttC-HVs will be introduced to key concepts in early child development, the importance of attachment with caregivers and early experiences. Furthermore, they will explore elements in the family environment which can negatively impact development, including neglect, abuse, violence in the home and poor health, hygiene and nutrition. They will identify vulnerable children who may benefit from additional care and learn how to counsel families if they identify specific problems in caregivers' interactions.

   Session 8. Detection and referral of malnutrition: in this session ttC-HVs will learn some basic facts about undernutrition, its risks and how to identify cases which need referral.

Session 8b. Screening for acute malnutrition using mid-upper arm circumference (MUAC) bands: in this session the ttC-HVs will learn how to check children with a MUAC band, where appropriate to integrate this intervention.

Session 15: Supportive care for the high-risk child: in this session ttC-HVs will learn about additional recommendations for children with specific medical risks, including HIV and recent or current malnutrition, taken into consideration alongside factors in the home and how the ttC-HV can provide support for these vulnerable cases. Recommendations for the care of HIV-positive children have been updated according to the new WHO recommendations.

Use disclaimer

INTRODUCTION

Welcome to the Facilitator's Manual for Training in Timed and Targeted Counselling, Module 3: Child Health, Nutrition and Development. 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 (2010). UNICEF.
- 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: 9789241548205
- 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 prepared in advance.

ttC published resources	Trainer's Guide and DVD Facilitator's Manual (one per facilitator) ttC Participant's Manual (one per literate participant) ttC Storybooks 6-10 (one set per ttC-HV) ttC Household Handbook (one per participant) Food cards (one set per facilitator) Sample referral/counter referral forms (or use local version) - three per participant ttC Infant registers (three per participant) ttC Child registers (three per participant)
Additional training materials	Flipchart, paper and markers Ball Key chain rings x 2 Small prizes (optional) Pens or colour pencils for drawing Cloth (optional) A plate of homemade cookies Beans (small pile for each participant) Strong tape, such as duct tape (optional) Small knife or scissors (optional) MUAC bands (one for each participant) *For video clips* IMCI demonstration DVD if available (Danger signs in children) LCD projector; Links to or downloaded video clips (Session 4) *Printed materials* Child health record (local examples) IMCI photo cards – malnutrition Collection of pictures: intestinal worms Sample child health card from a 1-year-old child Collection of pictures: intestinal worms (optional) *Demonstration materials* Pots, pans, plates, utensils A source of cooking fuel (firewood, gas, charcoal) Handwashing station with soap Ingredients for complementary food preparation (see Session 2 for ingredients list) Clean receptacle able to hold one litre or more of water Water-treatment solution (chlorine), brand most commonly found in the area One litre of pure, clean water (boiled, filtered or bottled) Pack of ORS and zinc tablets, if available

	For Early child development session WHO Counselling cards (Care for Child Development) Printed pictures of lifecycle stages (Session 4) Dolls (4-5 dolls) for role play activities Large ball of wool and scissors Sample toys for demonstration: shaker rattle, ring on a string, containers with lids, metal pot and spoon, doll with face, nesting and stacking objects, container and clothes clips

Icons

 *Ask the group*

 *Technical information*

 *Summarise*

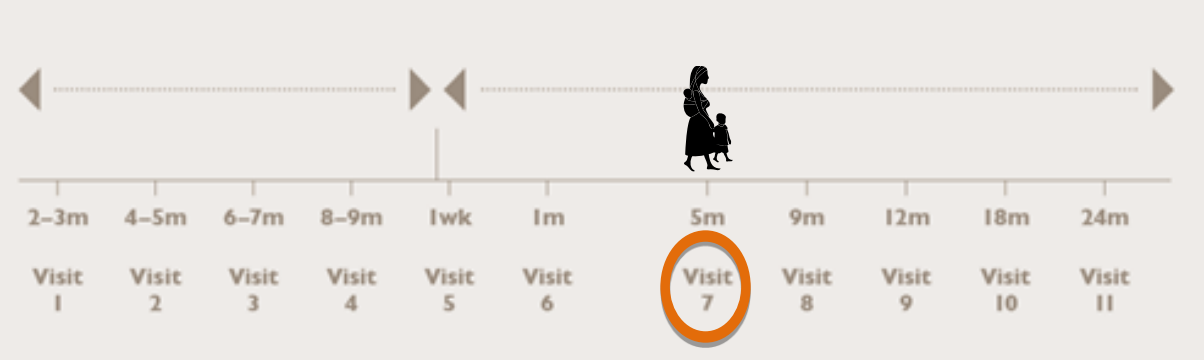
 *Recap the key messages and objective*

 *Use job aids (materials)*

 *Activity*

 *Discussion topic*

VISIT 7: 5-MONTHS VISIT



Session 1: Child Feeding: 6 to 9 Months

Session plan	Activity 1: Determine what they already know Activity 2: Feeding recommendations from 6 to 9 months Activity 3: Reinforcing the information: Food combinations Activity 4: Give relevant information: Responsive feeding for child development Activity 5: Reinforcing the information: Busting the myths about child feeding Activity 6: Give relevant information: Hygiene, growth monitoring and supplements Activity 7: Barriers and enablers for the recommended practices	 **Time: 1h30**
Learning objectives	At the end of this session, participants will be able to: • counsel families on the correct feeding of the infant from 6 to 9 months of age • understand the importance of ensuring sufficient iron from 6 months of age , and identify sources of iron • recognise barriers that families may have in practising the feeding recommendations, and understand how to respond to these concerns.	
Key messages 	• Give complementary foods from 6 months: 2 to 3 times daily between 6 and 8 months plus semi-solid nutritious snacks 1 to 2 times a day, as desired. • Feed in response to hunger, until the baby is full. It is not necessary to force-feed. • Children need iron to grow strong and resist diseases. Iron-rich foods include eggs, red meat, green leafy vegetables, and iron-fortified grains. • Breastfeed whenever and as much as the baby wants to feed, and more frequently during illness. Keep breastfeeding until 2 years of age for healthy growth and nutrition.	
Preparation and materials 	*Materials* • Flipchart, paper and markers • Household Handbooks • Ball • Key chain rings x 2 • Small prizes (optional) *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:

- explain the correct feeding of an infant from 6 to 9 months of age
- understand the importance of iron from 6 months of age and identify sources of iron
- identify barriers that families may have in practising the feeding recommendations, and understand how to respond to these concerns

- describe why birth spacing is so important to help protect against malnutrition.

Activity 1: Determine what they already know

Ask: When do families typically start giving foods to a child? What kinds of foods do they give and how often?

Are there any particular cultural beliefs or practices in the area related to feeding a 6-month-old baby?

For this activity, explain that the participants on one side of the room will represent 'true' and the other side 'false'. Read each statement then ask participants to walk to the side of the room according to their answer. For each statement, discuss the reasons for their choice, identifying common beliefs on child feeding among the participants and, possibly, in the wider community.

Statement	Answer
Children should be given complementary food in addition to breast milk from 6 months of age.	**True**
As the child starts to be given complementary food, he or she should not be breastfed very often, even if the child seems to be seeking the breast.	**False**
Thick porridge is an appropriate complementary food to give to infants when they reach 6 months of age.	**True**
If a family is able to give nutritious food for the 6-month-old, it is okay for the mother to stop using family planning and try for another baby.	**False**
Children should never be given eggs.	**False**
Children do not need to eat fish chicken or meat until they are 2 years of age or older.	**False**
A 6-month-old child should be given his food on a separate plate from his siblings.	**True**
A mother should never talk to the child whilst feeding them, as this will distract them from the food and cause them to eat less	**False**

Activity 2: Feeding recommendations from 6 to 9 months

Contextualisation: As always, when talking about foods, use local examples of foods familiar to participants. You may need to change the examples in the box below. You will want to find out if there are foods fortified with iron in your area. You will also want to find out if iron supplements, such as *Sprinkles,* are available. If working in an area where the prevalence of anaemia in children is greater than 40 per cent and the area is non-malarial, recommend that all children under 5 receive weekly iron supplements (depending on the local policy and availability), in addition to the child eating iron-rich foods. In any area, if a child is found to be anaemic, he/she should be treated with iron supplements (as prescribed by a health worker).

Refer the ttC-HVs to the page in their *ttC Participant's Manual* and answer any questions they may have.

FEEDING RECOMMENDATIONS FROM 6 TO 9 MONTHS

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

***Note:** *Determine if iron-fortified foods or iron supplements for young children such as Sprinkles are available and advise accordingly. Iron-fortified foods for general consumption may not be at the levels required for young children (as they consume small amounts of these foods compared to adults).*

Activity 3: Reinforcing the information: Food combinations

Step 1: Remind the ttC-HVs of the important food combinations that they learnt in Module 1. **Take** a few minutes to review the foods that contain vitamin A, oil, iron and vitamin C by sorting their photo food cards into the correct categories, if the ttC-HVs need this refresher.

VITAMIN A + OIL

IRON + VITAMIN C

Step 2: Have participants form a circle. **Shout** out 'vitamin A' and throw a ball to one of them. The person who catches the ball must name a vitamin A-rich food and come to the centre of the circle. He or she should then throw the ball to another person. This person must say 'oil', and name an oil-source food. He or she will then join the first ttC-HV in the centre of the circle. They will exchange rings to show that they are now 'married', that is, vitamin A is married to oil. (**Note:** You may use simple key chain rings for this game.)

Continue in this way, shouting out any of the four groups above each time the ball is first thrown. If any participant answers incorrectly, he or she is out of the game and must sit down. **Continue** the game until only the final two participants remain. They will be your final 'married couple' and may receive a simple prize.

Activity 4: Give relevant information: Responsive feeding for child development

Explain that responsive feeding means gently encouraging – not forcing – the child to eat. The caregiver can encourage a child to eat by showing interest, smiling or offering an extra bit. Threatening or showing anger at children who refuse to eat should be discouraged. Such actions usually result in children eating less.

Review the ideas in the box below and **use** these ideas to prompt discussion among participants.

RESPONSIVE FEEDING

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

Activity 5: Reinforce the information: Busting the myths about child feeding

Contextualisation: Replace the 'myths' and facts in the list below with those you have identified as common misconceptions in your communities if you have this information available.

Plenary activity: Ask the participants to stand in a circle, give everyone two cards with a tick on one and cross on the other. Explain: People have many beliefs about child nutrition, some are true, and some are false. You may well find that you have to 'bust' myths and beliefs when you counsel mothers, fathers and *sometimes especially* grandparents who may pass on outdated beliefs. Read each example aloud, and ask participants to hold up the tick if it is true and the cross if it's a myth (false belief). If they are right, they stay standing, if they are wrong they have to sit down. The last person standing is the best myth buster!

Statement	Answer
Children aged 6 to 24 months should not be allowed to eat fish as this is bad for them.	Myth! Be careful to cook well and remove the bones!
Children who eat a lot sugar and sweet drinks may suffer from obesity and tooth problems.	Fact
Children aged 6 to 24 months should eat mostly rice mixed with water as they cannot digest other foods.	Myth!
Children should eat red meat and green vegetables to prevent them from getting anaemia.	Fact
Children aged 6 to 24 months who eat a diet including fruit and vegetables are less likely to suffer from diseases.	Fact
A balanced diet is when each of the food groups weighs the same amount.	Myth!
Foods rich in protein, such as meat, fish and eggs, will help a child to grow.	Fact
If you teach a child to eat eggs, he/she will grow up to become a thief.	Myth!
Sweet fizzy drinks are an excellent source of energy for a young baby.	Myth! Sweet sugary drinks can contribute to obesity in children.
Children should not eat eggs before the age of 2 because it is bad for them.	Myth!
Children who eat a large plate of rice every day will not suffer from malnutrition.	Myth! Malnutrition can occur due to not eating a balance of the right foods.
A child who does not eat rice will definitely suffer from malnutrition.	Myth! If rice is not available, the child can be given other kinds of energy foods instead.
Children under the age of 1 should not eat food with added salt.	Fact – Too much salt in a baby's diet is very unhealthy for the baby.
Meat cooked in a sauce can be served up to two days after making it.	Myth! All meat can 'go bad' and should only be eaten on the same day as it is cooked.

Ask the participants to suggest other beliefs from their communities and test each other's knowledge.

Activity 6: Give relevant information: Hygiene, growth monitoring and supplements

Explain that there are several other key practices to be aware of during this time related to feeding and nutrition: hygiene, growth monitoring and vitamin A supplements.

Explain or read aloud:

HANDWASHING IN THE HOME

Family members and children should wash hands with soap after defecation, and before preparing food, eating and feeding. From the age of 6 months, children should get into the habit of always having their hands washed before a meal; from around 2 years, they may even start doing this themselves.

GROWTH MONITORING

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

VITAMIN A

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

FAMILY PLANNING

A gap of 2 years between each child is better for the mother's health and the health of the family. A suitable family-planning method can be provided at the clinic. By this time mothers should all be using family-planning methods. It is important to remind couples that if they become pregnant again, this could mean they are less able to breastfeed their baby to 2 years of age, meaning the baby will grow less strong and healthy as a result.

Activity 7: Barriers and enablers for the recommended practices

Working in groups: Use the Household Handbook to review the negotiated practices for giving the right foods in complementary feeds. Ask participants to think of possible barriers and enablers for families in finding and giving the right foods to the child and maintaining these practices over time. The groups should write notes in the *ttC Participant's Manuals* and present their ideas back to the plenary. In particular consider:

- cultural beliefs or food taboos
- financial concerns
- access and availability of foods
- existing feeding habits: number of meals and sharing of plates.

Visit 7: 5-months visit – Complementary feeding

Key messages and additional information	Barriers What makes it difficult to do?	Enablers What would make it easier to do?	Counselling response or solution
Complementary feeding: importance of dietary diversity – three food groups.			
Continued breastfeeding to 2 years and beyond in addition to giving foods.			
Give foods rich in iron – meat, chicken, fish, green leaves, fortified foods.			
Vitamin A supplements from 6 months.			
Continue regular growth monitoring at the clinic and community (MUAC).			
Family planning (HTSP).			

Summarise the main points of the session

- When a child reaches 6 months of age, breast milk alone cannot meet all of the child's nutritional needs.
- The child therefore needs to be given appropriate complementary foods two to three times per day. Food should be semi-solid and mashed so that the child can easily swallow it.
- All mothers, including those who are HIV-positive, should continue to breastfeed the child as often as the child wants.
- Feed the child iron-rich foods.
- Combine different foods to maximise absorption of nutrients in the body.
- Ideally, a child should be taken for growth monitoring once per month until 2 years of age.
- Lack of vitamin A can cause blindness and serious illnesses. To prevent this, from 6 months of age, children need a vitamin A dose once every six months from the clinic.
- Family planning is especially important for breastfeeding mothers. Becoming pregnant too early could mean they are less able to breastfeed their baby to 2 years of age, so their child will be less well nourished.

Session 2: Complementary Feeding

Session plan	Activity 1: Review relevant information: The three food groups, and iron-rich foods Activity 2: Food preparation: Demonstrations Activity 3: Water treatment Demonstration Activity 4: Barriers and enablers for complementary feeding	 **Time: 2h00**
Learning objectives	At the end of this session, participants will be able to: • prepare nutritious complementary foods appropriate for the 6- to 9-month-old child, using locally available foods • identify the three food groups and correctly categorise different foods • identify the barriers that families may experience in preparing these foods and be able to respond to these concerns.	

Key messages 	• Prepare complementary foods for a child aged 6 to12 months:
	  ○ Wash hands with soap or ash before preparing and feeding; use clean utensils, plates. Cook thoroughly and serve straight away, as mashed or pureed food.
	  ○ For children under 2, give them their own plate of food in order to know how much is being consumed.
	  ○ Don't prepare watery or runny food as the baby will not receive enough nutrition for healthy growth.
	• Wash hands with soap after defecation and before preparing food, eating and feeding.	

Preparation and materials 	*Materials* • Pots, pans, plates, utensils • A source of cooking fuel (firewood, gas, charcoal) • Handwashing station with soap • Ingredients • Photo food cards • Clean receptacle able to hold one litre or more of water • Water-treatment solution (chlorine), brand most commonly found in the area *Preparation* • Consult with ttC-HVs to learn of some local recipes that may be appropriate for demonstration. • Consult with other health centre staff/nutritionist on what is being promoted locally (such as weanimix). This can be reinforced during the demonstration. • Gather all materials and ingredients. In some cases the ttC-HVs may supply some of the materials and/or some of the food ingredients. • Consider preparing some of the recipes ahead of time in order to practise. • Arrange a cooking area prior to the session, including the hand washing station.	

Contextualisation: This session should be based on locally available foods. You will obviously not follow a suggested recipe if the ingredients are not common in your area. Prepare for this session accordingly.

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- prepare nutritious complementary foods appropriate for the 6- to 9-month-old child, using locally available foods
- identify the three food groups and correctly categorise different foods
- identify barriers that families may experience in preparing these foods, and respond to these concerns.

Activity 1: Review relevant information: The three food groups, and iron-rich foods

Working in groups: distribute copies of the food cards between groups of 4-5 participants and ask them to sort the cards into three piles, according to the three food groups. When they are finished have the groups swap places and check the neighbouring groups sorting. Carry on with this exercise until everyone is satisfied with the correct categorisation of the foods.

Follow-up with a discussion on the importance of these three food groups, emphasising that babies over 6 months of age need to get much of their nourishment from foods, and that their diets should include foods from all of the food groups.

Now ask the participants to separate out those cards that show foods that are rich in iron. Ask the ttC-HVs to explain the importance of iron-rich foods for the child.

Activity 2: Food preparation: Demonstration

Preparation for the session

- Decide which foods and recipes to demonstrate in this session, using *locally available foods*. Ask the ttC-HVs, health staff or nutritionists about local foods and ways of preparing food for young children.
- Have ingredients and cooking utensils ready before the session. You may ask the ttC-HVs to bring pots and plates, and perhaps firewood or charcoal, depending on how you plan to do the demonstration. You need one plate/bowl for every participant to sample the food prepared.
- Also ensure that you have a hand washing station and soap.

Demonstration steps

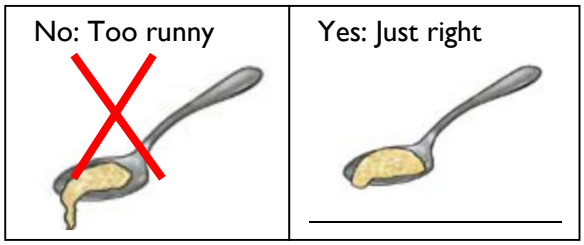
a. **Instruct** everyone to wash their hands with soap before handling the food.
b. **Facilitate** a discussion, asking participants to describe foods they give young children and how they prepare these foods. If you have arranged with the ttC-HVs ahead of time to demonstrate some of the foods they prepare, explain this in the discussion: that everybody will have a chance to see and taste some of the common local food preparations for young children.
c. If the ttC-HVs will be preparing foods that they are already familiar with, **instruct** them to take the lead in the food preparation, doing all of the cooking and explaining.
d. If you will be introducing new recipes, **explain** these recipes. The ttC-HVs may still do the cooking.

e. Once the various foods and recipes have been demonstrated, everyone should sample everything prepared. Participants must wash their hands again before eating.

Suggestions for food demonstrations appropriate for children aged 6–9 months

Mashed fruits and vegetables	Enriched porridge
banana mango papaya melon cooked, mashed sweet potato cooked, mashed orange-fleshed sweet potato rich in vitamin A	Some sample recipes for enriched porridge follow.

Note: The preference for the consistency of porridge will vary according to country. It is therefore not possible to indicate exact amounts of water to use. Nevertheless, the porridge should not be too thin or runny. It should be of a consistency that stays on the spoon when the spoon is tilted, as in the illustration below.



Recipes for enriched porridge

Note: It is important to emphasise boiling water to safeguard against use of water that isn't safe. Include boiled water in all the preparation steps as they are cooking (have access to fire). Review each recipe before you start and ask the participants to identify which of the foods are from which foods group. Point out that a good recipe will contain all of these, together with a small quantity of oil/butter.

- 'Go' foods/carbohydrates/energy foods (according to your definitions used)
- 'Grow' foods/proteins/body building foods
- 'Glow' foods/fruit and vegetables/protector foods

RECIPE 1	RECIPE 2
Ingredients 3 tablespoons of flour (maize, rice, cassava, sorghum, millet) Mashed fruit (or 1 teaspoon of sugar to sweeten) 1 teaspoon oil, or 4 teaspoons coconut milk 4 teaspoons of ground roasted groundnut Boiled water **Preparation** Prepare the porridge in a pan with boiled water. If adding oil or coconut milk, add at the time of cooking the porridge. If adding groundnut, add at the end of cooking. At the end, add mashed fruit or sugar and stir.	**Ingredients** 3 tablespoons of flour (maize, rice, cassava, sorghum, millet) 1 teaspoon oil, or 4 teaspoons coconut milk 1 egg, beaten Salt to taste (iodised) Boiled water **Preparation** Cook the porridge in a pan with boiled water, adding the oil or coconut milk. Before removing pan from heat, add the previously beaten egg. Add salt at end and stir.
RECIPE 3	**RECIPE 4**
Ingredients 3 tablespoons flour (maize, rice, cassava, sorghum, millet) 3 tablespoons beans (any kind), cooked and mashed 3 tablespoons greens (any kind) 1 teaspoon oil or 4 teaspoons coconut milk, or the seeds of sunflower, sesame, pumpkin or watermelon, toasted and ground Boiled water **Preparation** Cook the flour with boiled water to make porridge. If using oil or coconut milk, add at the time of cooking, together with the greens, if these are fast-cooking greens such as pumpkin leaves, or sweet potato leaves. If cassava leaves, these must be cooked beforehand. If using the seeds of sunflower, sesame, pumpkin or watermelon, add these at the end of cooking. The beans must be cooked separately, mashed and added at the end of cooking.	**Ingredients** 3 tablespoons flour (maize, rice, cassava, sorghum, millet) 3 tablespoons fish (any kind), cooked and mashed or smoked and pounded 3 tablespoons greens (any kind) 1 teaspoon of oil, or 4 teaspoons coconut milk, or the seeds of sunflower, sesame, watermelon or pumpkin, toasted and ground. **Preparation** Cook the flour with boiled water to make porridge. If using oil or coconut milk, add at the time of cooking, together with the greens, if these are fast-cooking greens such as pumpkin leaves or sweet potato leaves. If cassava leaves, these must be cooked beforehand. If using the seeds of sunflower, sesame, pumpkin or watermelon, add these at the end of cooking. The fish must be cooked separately and mashed. If the fish is dried fish, it should be toasted and ground /pounded and added at the end.

RECIPE 5

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

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

Activity 3: Water treatment: Demonstration

Ask: Why is it important for children to always drink clean (purified) water?

Ask: How can we be sure that water is clean?

Explain that if a family is not sure about the purity of their water source, they should always boil or treat the water. Explain that you will demonstrate how to treat water with chlorine, as an alternative to boiling.

1. **Use** the water purification solution most commonly found in the area and follow instructions on the label. You will normally **add** two drops of chlorine to one litre of water, and **let stand** for 15 minutes. The water is then safe to drink.
2. Using clean cups, **give** each ttC-HV some water to taste. **Ask** the ttC-HVs if there is any noticeable difference in the taste of the water.

Activity 4: Barriers and enablers for complementary feeding and follow-up care

Working in groups: review the negotiated practices for complementary feeding and hygiene in the Household Handbook. Discuss barriers and enablers for the mother adopting and maintaining the practice, making notes in the *ttC Participant's Manuals* in the table.

Key messages and additional information	**Barriers** *What makes it difficult to do?*	**Enablers** *What would make it easier to do?*	**Counselling response or solution**
Preparation of complementary foods for a 6- to 9-month child: give 2 to 3 meals a day - Feed in response to child's hunger. (responsive feeding). - Give food on a separate plate.			
Hand washing with soap, hygiene during food preparation (preventing diarrhoea).			
From six months, give water to drink – should be boiled or purified water.			

Summarise the main points of the session

- Prepare complementary foods for a child aged 6 to12 months:
  - Wash hands with soap or ash before preparing and feeding; use clean utensils, plates. Cook thoroughly and serve straight away, as mashed or pureed food.
  - For children under 2, give them their own plate of food in order to know how much is being consumed.
  - Don't prepare watery or runny food as the baby will not receive enough nutrition for healthy growth.
- Wash hands with soap after defecation and before preparing food, eating and feeding.

Summarise the recipes they learnt again.

Session 3: The Major Killers and Feeding During Illness

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: Diarrhoea Activity 3: Diarrhoea: Preparing and giving ORS and zinc Activity 4: Review relevant information: Malaria and pneumonia Activity 5: Give relevant information: General danger signs Activity 6: Give relevant information: Feeding during illness Activity 7: Barriers and misconceptions: Feeding during illness	 **Time: 2h 00**
Learning objectives	At the end of this session, participants will be able to: • counsel families on the correct actions and treatment of the major killers, including when to seek care from a trained health worker • explain the importance of oral rehydration solution (ORS) and zinc for the treatment of diarrhoea and where to locate and how to prepare it • counsel families on continued feeding of sick infants.	
Key messages 	• Most deaths of infants under 2 years are due to pneumonia, malaria or diarrhoea, which are diseases that are preventable or can be treated. • Diarrhoea can be treated at home by the family using ORS and continued feeding. • Pneumonia and malaria need to be treated by a trained health worker. • From 6 months until 2 years, continue to breastfeed the baby every day, whenever the baby is hungry. Breastfeed longer and more frequently than usual during and after illness. • A child will need to eat and drink more than usual during and especially after any illness. Encourage mothers to patiently feed children small, frequent meals during illness until they are better. • If a child is unable to drink or breastfeed at all, this is a danger sign for urgent referral.	
Preparation and materials 	*Materials* • Flipchart, paper and markers • Household Handbooks • Pack of ORS and zinc tablets, if available • IMCI demonstration DVD if available (Danger signs in children) *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 families on the correct actions and treatment of the major killers, including when to seek care from a trained health worker
- explain the importance of oral rehydration solution (ORS) and zinc for the treatment of diarrhoea and where to locate and how to prepare it
- counsel families on continued feeding of sick infants.

Activity 1: Determine what they already know

Ask: What are the main causes of death in children under 2 years of age?

Ask: Have any of your children had diarrhoea? When? How did you treat it? What happened?

Ask: Have any of your children had pneumonia or malaria? What happened? How did you treat it?

Write important answers on the flipchart, one page for each disease, and refer to these during the session.

Activity 2: Give relevant information: Diarrhoea

DIARRHOEA

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

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

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

  Danger signs (needs to be referred)
  - The child has blood in the stools.

Activity 3: Diarrhoea: Preparing and giving ORS and zinc[1]

Demonstrate how to prepare ORS, ideally using the conditions that the community members would also use, such as using a charcoal stove and filtering water. **Explain** that it is useful for ttC-HVs to know how to do this so they can show the mother how to prepare it.

MAKING ORS

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

GIVING ORS

ORS should be given after every loose stool:

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

How to give ORS:

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

GIVING ZINC

Dose:

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

Giving zinc:

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

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

Activity 4: Review relevant information: Malaria and pneumonia (revision of module 2)

Ask: What is malaria? How is it transmitted? How do we test and treat a child for malaria?

Ask: What is pneumonia and why is it dangerous for children? How is it treated?

INFORMATION ABOUT MALARIA

- Malaria is an infectious disease that is transmitted through mosquito bites. Sleeping under an insecticide-treated mosquito net is the best way to prevent mosquito bites.
- A child with a fever should be examined immediately by a trained health worker within 24 hours in case it is malaria, which can be very serious. They will test the child for malaria using a diagnostic test. If malaria is diagnosed, treat the child using anti-malarial treatment.

ACUTE RESPIRATORY ILLNESS/PNEUMONIA

- Pneumonia is a chest infection whereby the lungs fill with fluid and the baby cannot breathe. It is life-threatening illness needing immediate treatment at a health facility. An infant or child who is breathing rapidly or with difficulty might have pneumonia. Many children die of pneumonia at home because their caregivers do not realise the seriousness of the illness and the need for immediate medical care.
- A child with a cough may have pneumonia and should be referred immediately if they have danger signs:
- Chest indrawing (this is a sign of severe pneumonia)
- fast breathing and noisy breathing (grunting, wheezing/stridor)

Activity 5: Give relevant information: General danger signs

Ask: What are the most serious danger signs in children? How do we assess for urgent signs?

GENERAL DANGER SIGNS (URGENT MEDICAL CARE)

If the child has one of these signs they must be referred urgently to a facility for care.

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

DANGER SIGNS (NEEDS TO BE REFERRED OR SEEK NEAREST MEDICAL CARE)

- The child has a fever.
- The child has fast or difficult breathing and/or an indrawn chest.
- The child has a cough together with an indrawn chest.
- The child has three or more watery stools in a day.
- The child has blood in the stools.

- The child has pus in the eyes.
- The child has pus in the ears.
- The child has swelling in both feet.
- The child has body blisters/rash.

ASSESS AND OBSERVE THE SICK CHILD AGED 2 TO 59 MONTHS DURING A HOME VISIT

- Ask: Is the child able to drink or breastfeed?
- Ask: Does the child vomit everything?
- Ask: Has the child had fits or convulsions?
- Look: Is the child very sleepy or unconscious?

IF THE CHILD HAS ANY OF THESE SIGNS, REFER IMMEDIATELY.

Check for all other danger signs. Refer to an appropriate care provider if danger signs are observed.

Activity 6: Give relevant information: Feeding during illness

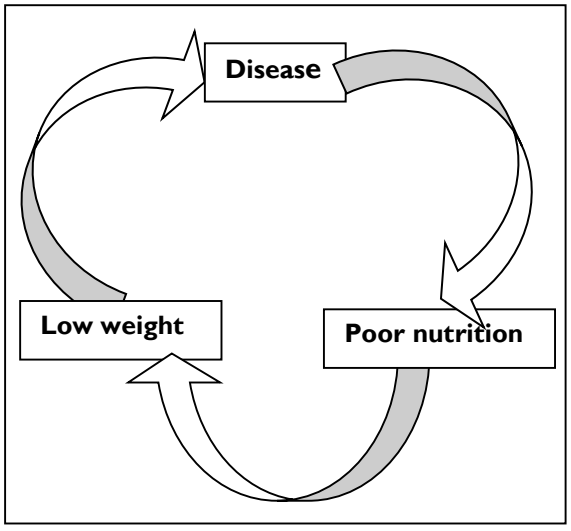
Ask: How does illness affect the breastfeeding a young child? Do they feed more or less than usual? What should they be doing?

Ask: What are the community's beliefs about children breastfeeding during illness?

Ask: from your experience of caring for a sick child, how did he or she eat, how do parents encourage the child to eat and drink more than usual?

Reinforce the information: Malnutrition and illness

Draw the diagram (opposite) on the flipchart (without the arrows). Ask the following questions and then ask them to draw relationships between them.



How does illness affect a child's appetite and eating? *Answer:* The child eats less.

What happens to a child's weight if they eat less? *Answer:* The child may lose weight.

If a child is low weight are they able to fight off infections? *Answer:* The child is less able to fight infections.

What might happen then?

Answer: The child can get sick again and lose weight again.

Explain: This vicious cycle of malnutrition and disease is why feeding during and after illness is so important.

FEEDING DURING ILLNESS FOR THE CHILD OVER 6 MONTHS

- **Breastfeeding:** Tell the mother to breastfeed more frequently and for longer at each feed, especially if the child is exclusively breastfed. Breastfed children under 6 months of age should first be offered a breastfeed then given ORS and no other fluids.
- **For children not breastfed or over 6 months, give additional fluids:** Give as much fluid as the child will take, as soon as the diarrhoea starts. This is to replace the fluid lost in diarrhoea and prevent dehydration. Give one or more of the following:
- ORS solution (for diarrhoea only)
- Food-based fluids (soups, rice water and yoghurt drinks)
- Clean water (preferably given along with food).
- **Give additional foods:** When sick, children may be less inclined to eat solids. Mothers should breastfeed as much as possible and encourage the child to eat small snacks or soft liquid foods. Give small quantities frequently rather than a large meal if this is easier. If the child vomits, wait some time and try again. If the child vomits everything ingested, this is an urgent danger sign.
- **Active feeding:** It is important to actively feed the child, encouraging the child to eat. The child should not have to compete with older brothers and sisters for food from a common plate, but should have his/her own serving. Until the child can feed him/herself, the mother or caretaker should help the child to feed. This is especially important during illness when the child may need more encouragement or help than usual to feed adequately.

Give relevant information: WHO recommendations: Feeding during illness

Contextualisation: replace the box below with that adapted for your context from national guidelines

Under 6 months	6 months to 12 months	12 months to 2 years	2 years and older
Breastfeed as often as the child wants, day and night. Feed at least 8 times in 24 hours. Do not give other foods or fluids. 	 Continue to breastfeed as often as the child wants. Give 3 servings of nutritious complementary foods. Always mix margarine, fat, oil, peanut butter or groundnuts with porridge. Also add chicken, egg, beans, fish, full cream milk or mashed fruit and vegetables at least once each day. If baby is not breastfed, give 3 cups (3 x 200 ml) of full cream milk as well.	 Continue to breastfeed as often as the child wants, and also give nutritious complementary foods. Give at least 5 adequate nutritious feeds. Increase variety and quantity of family foods: Mix margarine, fat, oil, peanut butter or groundnuts in porridge. Give egg, meat, fish or beans daily. Give fruit or vegetables twice every day.	 Continue to breastfeed as often as the child wants. Give at least 5 adequate nutritious feeds. Increase variety and quantity of family foods: Mix margarine, fat, oil, peanut butter or ground nuts with porridge. Give egg, meat, fish or beans daily. Give fruit/ vegetables twice every day.

	If baby gets no milk, give 6 complementary feeds a day.	Give milk every day, especially if no longer breastfeeding. Feed actively with baby's own serving.	Give milk every day, especially if no longer breastfeeding. Feed actively with baby's own serving.

Activity 7: Barriers and misconceptions: Feeding during illness

Play this game by forming two lines or by having participants raise their hands. Read the statement and ask if it is 'true or false' Then ask the participants about other common beliefs in their areas.

- A child who is vomiting they should not be given any food or drink until the vomiting stops (False)
- If a child has diarrhoea, giving less water to drink will stop the diarrhoea. (False)
- A child with pneumonia or a cold should eat and drink more than usual for at least two weeks (True)
- If a child under 2 has malaria, the mother should continue to breastfeed. (True)
- If the child does not have an appetite during an illness, it's okay to give the child only fluids. (False)
- If an exclusively breastfed baby has diarrhoea, then this is because the mother's breast milk is bad and she should stop breastfeeding until the child is better. (False)

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

		more than usual and for longer, and if the child is over 6 months, give other fluids.

Summarise the main points of the session

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

Session 4: Counselling the Family on Care for Child Development

Session plan	*Session should be organised in two parts with a break.* <u>Part 1: Play and communication for early child development (ECD).</u> Activity 1: Determine what they already know Activity 2: Give relevant information: what can a baby do? Activity 3: Review of the child health record Activity 4: Give relevant information: interactions and communication Activity 5: Video: Still face experiment followed by group discussion Activity 6: Reinforcing the information: the brain activity Activity 7: Language, communication and play through the lifecycle Activity 8: The role of fathers Activity 9: Barriers and enablers for child development in the home <u>Part 2: Assess and counsel the family on child development.</u> Activity 10: Demonstration: assess and counsel the family on care for child development Activity 11: Counsel the family on problems in caring for the child's development Activity 12: Giving information: barriers to child development Activity 13: Vulnerable children and the need for extra care and stimulation	 **Time: Part 1: 3-4 hrs** **Part 2: add 3-4 hours if included**
Learning objectives	At the end of this session participants should be able to: • Understand and explain the importance of parents' interactions with their young children through age-appropriate play and communication to support early child development, and why attending to this is just as important as providing good health and nutrition. • Explain how to counsel the family on age-appropriate play and communication activities to strengthen the relationship between the child and caregiver. • Describe how family practices, behaviours and psychosocial dynamics in the home can influence early child development. • Identify potential areas for improvement in the caregivers' interactions with the child and counsel on how to improve these. • If needed, apply Psychological First Aid (PFA) action principles[2] and link family to other supports if signs of family stress are suspected.	
Key messages	• Each child is unique at birth and grows and develops at an individual rate, but there are some key milestones that will help identify if a child is developing appropriately. • If a child cannot yet do something at a particular age, it does not necessarily mean there is a problem, as most likely he or she will 'catch up' in time with attentive and supportive family care for development. Any concerns the family or ttC-HV have about development should be referred to a health facility. • Babies' growth and development, especially the brain, is most rapid *in utero* and during the first two years of life, and it is largely influenced by the babies' environment and their interactions with mother/caregivers.	

[2] PFA principles are outlined in the ttC methodology module and can be found for reference throughout this session in the ttC *Participant's Manual* (Methodology).

	• Babies develop deep emotional attachment to their primary caregivers, which provides them with the security they need to actively learn and build foundational life skills (e.g. intellect/cognitive, motor/physical, language/communication, social, emotional[3]). • Babies who are sensitively cared for by their mothers, fathers and family members, with consistent love, responsive attention, stimulation, protection and minimal stress, have significantly better adult outcomes (in health, education, employment and society). • Babies who are born prematurely or with low birth weight, or who are sick, malnourished, orphaned, HIV-positive or have a disability will need extra love, stimulation and attention from caregivers and from the ttC-HV. • As primary caregiver, the mother's state of well-being is critical to her ability to interact with her child, recognise and respond to their needs and support their development.
Preparation and materials	*Materials* • LCD projector; links to video clips • Flip chart and pens or colour pencils for drawing • WHO Counselling cards • Printed pictures of lifecycle stages (below) • Dolls (4-5 dolls) for role play activities • Large ball of wool and scissors • Local child health cards, if developmental milestones are displayed • Sample toys for demonstration: shaker rattle, ring on a string, containers with lids, metal pot and spoon, doll with face, nesting and stacking objects, container and clothes clips *Preparation* • Set up the projector and materials in advance. • Place pictures or names of lifecycle stages [Newborn, 1 week to 6 months, 6 to 9 months, 9 to 12 months , 12 to 24 months] on flipchart sheets around the training room on the walls or the floor.

Contextualisation:

Inclusion of Part 1: Play and communication for early child development:

This section comprises the universal component of ECD added in to ttC 2nd edition. This section includes a general overview of early child development concepts, the role of positive caregiver interactions and how age-appropriate play and communication can be promoted to mothers *and fathers* or other family members. The terminal objective of this section is that ttC-HVs promote age-appropriate play and communication from birth during home visits.

Inclusion of Part 2: Assess and counsel the family on child development:

This section is derived from the WHO Care for Child Development[4], and includes a discussion of barriers to child development, as well as an assessment in the home of potential barriers, including observation of

[3] Use language appropriate to the educational level of the group.

[4] World Health Organization, UNICEF (2012). Care for child development: improving the care for young children. ISBN: 9789241548403

caregiver interactions with the child. This section would be included depending on a. supporting country policy environment, b. cadre selection and c. in-country support by accredited ECD training body which may be MoH, WHO and/or UNICEF.

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- Understand and explain the importance of parents' interactions with their young children through age-appropriate play and communication to support early child development, and why attending to this is just as important as providing good health and nutrition.
- Explain how to counsel the family on age-appropriate play and communication activities to strengthen the relationship between the child and caregiver.
- Describe how family practices, behaviours and psychosocial dynamics in the home can influence early child development.
- Identify potential areas for improvement in the caregivers' interactions with the child and counsel on how to improve these.
- If needed, apply Psychological First Aid (PFA) action principles[5] and link family to other supports if signs of family stress are suspected.

PART 1: PLAY AND COMMUNICATION FOR EARLY CHILD DEVELOPMENT

Activity 1: Determine what they already know

Ask: <u>How</u> do parents play and communicate with their babies in your communities?

<u>When</u> do parents <u>start</u> to play with their babies through talking, reading, playing games?

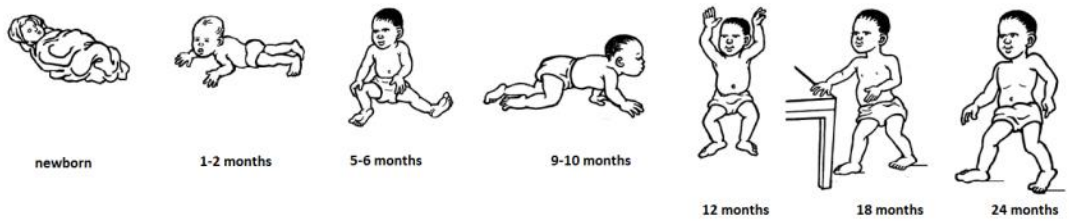
Are there any cultural beliefs that people have about interacting with babies?

Do the fathers also join in?

Activity 2: Give relevant information: what can a baby do?

Lead a discussion about *cultural ideas and beliefs* about a baby's ability to play, interact and learn from birth. **Explain:** in many societies, people believe that a newborn baby cannot see, think or feel emotion and that they cannot communicate with caregivers until they learn to talk. Other societies might believe that a father's role in playing and interacting with the baby isn't important until later.

[5] PFA principles are outlined in the TTC methodology module and can be found for reference throughout this session in the ttC *Participant's Manual* (Methodology).



Working in groups: ask 3-5 participants to stand next to one of the lifecycle stages (during preparation you will have pinned these flipcharts up around the room or on the floor). Ask them to think about each lifecycle stage and discuss the following:

- ***What can a child do at that age?***
- ***Can they see, hear or smell?***
- ***Can they feel fear, excitement or joy?***
- ***Can they recognise voices and faces?***
- ***Can they communicate, and if so, how do they communicate with caregivers?***

They may draw pictures or write ideas on the flipchart and, after discussion, present their ideas in plenary. Use the tool below to explore some of their suggestions. **Note to facilitator:** this tool is not intended for use to assess a baby's abilities in the context of ttC, only to clarify this discussion exercise. It is not included in the Participant's Manual.

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

	Toddler may help caregiver dressing her/him by holding out an arm or foot Toddler can point to some body parts when caregiver says 'where are your eyes? nose? ears?' Toddler tries to jump even if both feet stay on the ground.

Adapted from source: Parent Evaluation of Developmental Status: Developmental Milestones (PEDS:DM): A tool for Surveillance and Screening Professional's Manual (2008) by Glascoe F and Robertshaw N. (Adaptation: removal of some of milestones at each stage to simplify.)

Activity 3: Review of the child health record

Country contextualisation: If your country's child health record has a section on developmental milestones, then include this activity here. If not proceed directly to the discussion questions.

- Show a sample of the health records.
- Point out where milestones are recorded (if they are recorded) on the country child health card.

CHILD DEVELOPMENT AND MILESTONES

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

CHILD DEVELOPMENT

A process of change in which a child learns to handle ever more difficult levels of moving, thinking, speaking, feeling and relating to others. This process takes place continuously and rapidly beginning in utero, and is fully integrated between the areas of physical, mental, social and emotional well-being.

DEVELOPMENTAL MILESTONE

A task that most children can perform at a certain age. Every child is unique in the way that he or she develops, and reaching milestones at different times may not be a problem. These norms help us understand patterns of development, while recognising that there is wide variation between individual children.

Ask: When a child reaches a milestone slower than its peers, what might be the cause?

Causes of delays could be due to medical conditions, prematurity or lack of interactions with caregivers.

Explain: the role of the ttC-HV in early child development is *not* to assess children for developmental delay or problems. Ensure ttC-HV understand that these issues can be sensitive with parents, and suggesting there is a problem may even put the child at risk.

What to do if there is concern?

Refer the child to health facility if you or the parents suspect a developmental delay.

PRINCIPLES OF LEARNING AND DEVELOPMENT

Babies' brains at birth are not fully mature. The 'back & forth' interaction between baby and caregiver helps to build the developing brain and prepare the baby for life. Note these four key principles:[6]

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

Activity 4: Interactions and communication

In plenary: Explain that this activity is actually about *communication and interaction between caregiver and baby*, and the role play between adults is to facilitate experiential understanding of nonverbal communication amongst participants. For each role-play ask for two volunteers, who will hold a conversation as though meeting in the street. Practice this as a normal interaction first, including eye contact and appropriate verbal and facial expressions (tone of voice, smiles, etc.).

Person 1:	Hello (*name),* how are how?
Person 2:	I'm very well, thank you, how are you?
Person 1:	I'm well, thank you. How is your family?
Person 2:	We are all doing fine. It's good to see you again. Have a great day.
Person 1:	You too. Goodbye!

Role play 1: In the first role play, conduct the conversation, but person 2 must respond *without smiling and without looking at person 1*. No eye contact, no smiling.

- ⇨ Ask person 1, how did that interaction go? Did person 2 seem happy to see you? How did that make you feel?
- ⇨ How do you think a baby might feel if the caregivers responded this way?

Role play 2: Repeat the same role play, but now person 2 will make eye contact but speak in a *monotone voice throughout.*

- ⇨ Ask person 1, how did that interaction go? How did that make you feel? Did you feel that person 2 seemed interested and engaged?
- ⇨ How do you think a baby might feel if caregivers spoke this way? How might those feelings affect the baby's development?

Role play 3: Repeat the same role play with new volunteers, now ask person 2 to make good eye contact, use a varied (sing-song) tone of voice. He or she can also embrace person 1 and give them a great big hug! If they like, they can also tickle, play and joke around! (They should have fun with this role play!).

- ⇨ Ask person 1, how did you feel now? Are you feeling good about the interaction you had?
- ⇨ How do you think a baby might feel if caregivers spoke this way?
- ⇨ What have we learnt about interactions from this exercise?

[6] WHO/UNICEF: Counselling the Family on Care for Child Development

Explain: the purpose of this exercise is to show how positive voice and body language signals are important to our *understanding of an interaction.* This is especially true for a baby during a time when brain development is so dependent on interactions, and while verbal language development is underway. Eye contact, smiling, a sing-song engaging tone of voice, hugging and playing all contribute to making a baby feel happy, safe, loved, and build trust with the caregiver, which supports the baby's social and emotional development, as well as cognitive development.

Activity 5: Video - Still face experiment followed by group discussion

Still Face Experiment: Dr. Edward Tronick

Discussion:

- Play the video (3 mins) with or without sound according to language preference. You may stop the video to highlight key points.
- Discuss the participants' reactions to the video, asking:
  - How did the infant react when the mother was responsive and engaged with her child?
  - How did the infant express the need for engagement with the mother?
  - How did the infant respond when the mother stopped reacting and responding to her?
  - What would that child do, eventually, if the mother kept ignoring her?
  - What do you think happens with depressed mothers or those who don't respond and interact with their children? What might that mean for the child's physical, emotional and social development?

Explain: in this video we see the reaction of the child when the mother is engaging positively. Although not using language, the infant uses eye contact, gestures and noises to engage and communicate with the mother. When the mother's facial expression is still, showing no reaction, the infant rapidly becomes distressed, which we can see in the body language, gestures and sounds made by the infant in an attempt to regain the mother's attention. We can see the infant is deeply affected by this change. If the mother continued to ignore the child's cues to communicate, the infant would eventually stop trying and become withdrawn. Eventually this would lead to slower development of the child's brain and impaired emotional and social development.

Ask the participants to refer to their *Participant's Manuals*.

Explain or read aloud:

EARLY CHILD DEVELOPMENT: THE IMPORTANCE OF POSITIVE CAREGIVER INTERACTIONS

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

1. **LOOK/SMILE:** Babies can see between 8 and 12 inches at birth - the distance between the mother's and baby's faces during breastfeeding. The baby loves faces, especially the mother's. Babies love to respond to smiles and sounds, and after 4-6 weeks of age, they begin smiling and making noises to make the mother smile.

2. **TALK/SING:** At birth, babies can hear and learn sounds like the mother, father and family members' voices. Before they understand language, body language like eye contact, facial expressions, cooing and

babbling are important preludes to using words. Talking is critical for the development of babies' language and intellect. Storytelling traditions found in many cultures are also a valuable form of communication with infants and children.

3. **HUG/TOUCH:** The mother's body (her touch, heat, sounds, smell) helps the baby to feel calm and safe, which is the beginning of a baby's *emotional attachment* to her. This early connection between mother and baby is really important because it lays the foundation for good social and emotional relationships and mental health in life. When the caregiver responds with touch and hugs, the baby learns to feel safe and loved.

4. **PLAY:** For their brains to develop, babies also need to explore and play – when they can see, hear, feel, move freely, and experiment – which is a part of learning. Between swaddling, allow the baby to move freely; massage and exercise the baby's arms and legs to make them stronger every day. By one month, many babies can hold their head up briefly, and begin to support their own body weight. Putting the baby with tummy on the bed/surface (tummy time) can help the baby develop stronger muscles. Parents can begin giving the baby age-appropriate toys* and safe objects to explore, touch and play with as part of learning.

5. **READ:** Reading to a child or sharing a book with pictures by pointing and describing a pictorial book stimulates language development through age-appropriate communication, a rich vocabulary and a shared interest with the child. Reading can begin at any age.

**examples of suitable toys are provided in Activity 5.*

Note: Create a mnemonic to remember the above actions, e.g. LTSPR (love, talk, sing, play, read), or use the local language to ensure that all actions are promoted together as actions that promote early child development. This will help them to remember these actions better when counselling the family.

Activity 6: Reinforcing the information: the brain activity

Information for facilitators: This activity introduces the concept of brain development in infants through the formation of 'connections' between 'neurons' or 'cells' in a simple yet effective way. Explain these concepts using simple local language. Ensure and check their understanding throughout.

1. Ask trainees to stand in a circle, with one facilitator (holding a ball of wool/yarn) standing in the centre, and another standing outside the circle who will narrate the story. Explain that the group circle represents the baby's brain, while the wool represents the pathways in a baby's brain that are set up as they grow and develop from experience. The facilitator outside the circle then tells a simple story, shown below (does not need to be verbatim). For each 'action' or 'interaction' described (e.g. suckling, hearing the mother's voice, receiving comfort), the facilitator inside the circle will draw out the wool to participants in the circle at random, eventually forming a complex set of pathways to represent the brain. Note that sometimes you need to place the wool multiple times to the same person in the circle to show how these pathways are strengthened through repetition. Key actions and skills are **bolded below**, to indicate when you pass the wool around the circle, cut a pathway or tie one back together.

FACILITATOR NARRATION: INFLUENCE OF POSITIVE INTERACTIONS

When I am born, I have many neurons in my brain. Most of them are clustered in the centre of the brain, like this ball of wool. But I have some automatic pathways already established so I can survive. I have a ***suckling*** *and* ***swallowing*** *instinct, and each time I am* ***breastfed****, I feel a since of* ***comfort*** *from my mother. When I'm* ***breastfed regularly*** *and my hunger or comfort needs are met, these pathways become stronger (pass the wool*

*multiple times to the same person to demonstrate strengthening of the pathway). When I hear my mother **singing**, I feel a sense of joy and safety. When I **cry**, and my mother sensitively responds, I make the connection that my needs are attended to. When my father **plays** with me, I feel happy and excited. When my grandmother **reads** to me, I feel soothed by the sound of her voice. When people in my community make **cooing noises** and **play** with me, I feel safe. When **I feel unsafe**, I know that my mother or father will be there to **connect back** to and I feel safe again. As I become older, I begin to explore the world around me. I **touch** things and my brain begins to understand softness and hardness. I **throw** things, and my brain begins to understand distance. When I **eat new food**, my taste buds tell my brain what I like and don't like. When I **hear certain sounds**, I begin to connect what they mean, even though I can't say words. For every action and response, the pathways in my brain get stronger and my brain and my skills develop.*

2. At this point in the story, you may summarise what has been observed: positive interactions have led to strengthened pathways in the brain during the time in life when the most rapid amount of brain development is happening. Then proceed to the next part.

FACILITATOR NARRATION: INFLUENCE OF NEGATIVE INTERACTIONS

*But if my mother **stops responding to my cries consistently**, then I learn that my needs may not always get attended to, and the strong neural pathways become weaker (cut one, but not all of the pathways). If my **father yells at my mother**, I feel scared and unsure where to go for safety (cut another piece). If my caregivers **stop making eye contact** with me, then I learn to lose trust in the people that I love (cut a few more pathways). If my mother **scolds me harshly** when I try to explore the world around me with my senses by touching things, or if my father **ignores my attempts to play**, then I become less interested in learning and trying to do new things for myself (cut a few more pieces). If my grandmother **stops reading to me**, then I don't feel the regular sense of joy and comfort from her voice, and my language development slows down (cut another pathway).*

3. At this point summarise what is happening due to negative interactions: important pathways in the brain are not being developed; they are even being cut. The foundation for my future learning, growth and maintaining healthy relationships with others is being weakened. This can cause developmental delay or emotional damage in the growing baby, which becomes more difficult to repair or recover from as the child gets older.

FACILITATOR NARRATION: BALANCING POSITIVE AND NEGATIVE

*But the brain is amazing because it also has the ability to heal itself (called neuroplasticity) as it continues to grow in childhood. Even though I've been through some difficulties and some of my pathways are cut, if my mother **begins responding consistently to my needs again**, I start to reconnect those pathways that used to exist (tie a knot on broken pathways). If my mother and father **start showing love to each other**, my sense of safety slowly returns (tie another knot on another broken pathway). If my aunty takes the place of my grandmother and **reads to me again**, my language and memory development pick back up rapidly (tie another knot in a broken pathway). Although these pathways may be scarred or damaged, they are still functional and I'm still able to grow.*

4. **Summarise the activity**:
   - Every interaction we have with infants is important to their physical (motor), cognitive, emotional and social development. The most important time for this is birth to 3 years.
   - Exposure to stresses such as family violence, sexual abuse, or neglect (physical and/or emotional) can cause a stress reaction in the brain, damaging or limiting neural pathways and development.

- Positive interactions between parent and child strengthen their attachment while simultaneously building the child's brain. The child learns that others can be trusted and are responsive to his or her needs. Such positive interactions with caregivers can counter-balance negative influences and prevent the damaging effect they can have on the child's development.
- In this early phase babies are *learning* how to feel and manage and express their own feelings to others. If parents aren't responsive or respond negatively and the negative interactions dominate, then it can lead to a child's lack of trust and secure attachment with them. This can limit the child's mental and emotional development, which goes on to affect social interactions and relationships throughout the child's life.

5. End with any questions participants might have.

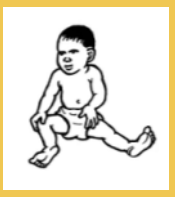
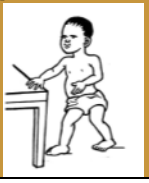
Activity 7: Reinforcing the information: language, communication and play through the lifecycle

Needs contextualisation: for the toys and objects typically used or available in that community. Note that home-made toys can be just as effective as anything store-bought, as long as they are clean and safe.

Working in groups: Divide the participants into five groups. Place five flipcharts on the walls or floor in different parts of the training room, and write the age of room, and write the age of the baby on them according to the table below. Provide if possible, a selection of toys or objects listed from the table below at these locations. If you have enough helpers/facilitators, assign one to each age group to help demonstrate, and given them a doll, which they can pretend is the baby. Explain that each group is going to start at a different stage, and their baby is going to 'grow' a stage each time the facilitator shouts 'grow!' (every 5 mins). As they move around they can discuss and practice these activities with the dolls and use the objects and toys. This will mean that those starting at the older ages will, in fact, return to the newborn. The important aspect is that they cover each of the age groups.



Examples of locally available toys (Uganda 2015) (*See additional visuals for training ttC Trainer DVD*)

Age of young infant	Recommendations for family
Newborn, birth up to 1 week 	Your baby learns from birth. • *Play:* ○ Provide ways for your baby to see, hear, move arms and legs freely, and touch you. ○ Gently soothe, stroke, and hold your child. Skin to skin is good. • *Communicate:* ○ Look into baby's eyes, and talk to your baby. ○ When you are breastfeeding is a good time. Even a newborn baby sees your face and hears your voice. 
1 week up to 6 months 	• *Play:* ○ Provide ways for your child to see, hear, feel, move freely, and touch you. ○ Slowly move colourful things for your child to see and reach for. ○ Sample toys: shaker rattle, ring on a string. • *Communicate:* ○ Smile and laugh with your child. Talk to your child. ○ Get a conversation going by copying your child's sounds or gestures. 
6 months up to 9 months 	• *Play:* ○ Give your child clean, safe household things to handle, bang, and drop. ○ Sample toys: containers with lids, metal pot and spoon. • *Communicate:* ○ Respond to your child's sounds and interests. ○ Call the child's name, and see your child respond. 
9 months up to 12 months 	• *Play:* ○ Hide a child's favourite toy under a cloth or box. See if the child can find it. ○ Play peek-a-boo. • *Communicate:* ○ Tell your child the names of things and people. ○ Show your child how to say things with hands, like 'bye bye'. ○ Sample toy: doll with face. 
12 months up to 2 years 	• *Play:* ○ Give your child things to stack up and to put into containers and take out. ○ Sample toys: Nesting and stacking objects, container and clothes clips. • *Communicate:* ○ Ask your child simple questions. Respond to your child's attempts to talk. ○ Show and talk about nature, pictures and things.

Activity 8: The role of fathers

Ask: In your communities, what are the roles of the mother in caring for and playing with the child? How do they typically interact with the child?

What are the roles of the father, and how do they typically interact with the child?

Write two flipchart sheets: one for fathers and one for mothers, each listing their typical and ideal interactions with the baby. Compare answers, highlighting that while the role of fathers may differ from mothers, they are just as critical to a child's development.

The role of fathers: Watch DVD clip.

Contextualisation: if the MOH have other videos or materials showing paternal interactions using a local examples, use these instead.

Discussion questions:

- How does the father show he is aware of the child's needs?
- How does the father comfort the child and show love?
- How might we further encourage such positive paternal interactions during our home visits?

Activity 9: Barriers and enablers for child development in the home

Ask: What prevents the whole family engaging in child development?

Key message	**Barriers** *'what makes it difficult to do? '*	**Enablers** *'what would make it easier to do?'*	**Counselling response;** ttC-HV actions
Caregivers, including the mother father and other family members, should engage their children through positive interactions play and stimulation *(LTSPR or equivalent mnemonic)*	- Lack of time - Mother depressed or 'feeling low' - Beliefs and culture - Access to toys and learning materials - Poverty - Culture or attitudes of fathers	- Family having knowledge and learning skills for ECD - Having more time - Fathers making time to play with kids - Toy making	*Educate* the family on the importance of play and stimulation for development *Teach:* demonstrate techniques for play and stimulation *Teach:* show family how to make age appropriate toys *Refer:* direct family to appropriate health or social services *Counsel:* apply psychological first aid principles where need and

			refer/link to community or public service support

PART 2: BARRIERS TO CHILD DEVELOPMENT AND ASSESSMENT DURING HOME VISITS

Activity 10: Demonstration: assess and counsel the family on care for child development

Note to facilitator: this activity is the most important in Part 2 as it is what they will carry out in the communities. Ensure sufficient time for practice and feedback.

Facilitators should lead a role play in which they assess and observe the mother and baby (and/or father and baby) interactions. After this, ask for volunteers to come up and role-play the following scenarios

- Mother and child show difficult interaction: the baby doesn't react with her .
- Mother has no problems, baby is very responsive with her. Father is not familiar with child and unable to get the baby to smile. He says he doesn't have time to play.

COUNSELLING FOR CHILD DEVELOPMENT: ASK/OBSERVE

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

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

Activity 11: Counsel the family on problems in caring for the child's development

Ask the participants to review the table in their *Participant's Manuals*.

Problem identified by caregiver	Counselling response

If the caregiver does not know what the child does to play or communicate:	• Remind the caregiver that children play and communicate from birth. • Demonstrate how the child responds to the counsellor's activities.
If the caregiver feels that she is too burdened or stressed to play and communicate with the child:	• Listen to her feelings, and help her identify a key person who can share her feelings and help her with her child. • Build her confidence by demonstrating her ability to carry out a simple activity. • Refer her to a local service and/or social support if needed and available.
If caregivers feel that they do not have time to play and communicate with the child:	• Encourage them to combine play and communication activities with other care for the child. • Ask other family members to help care for the child or help with chores.
If caregiver has no toys for her child to play with:	• Use any household objects that are clean and safe. • Make simple toys. • Play with her child. The child will learn by playing with her and others.
If the child is not responding, or seems 'slow', or the parents report concerns that they think this may be so:	• Encourage family to do extra play and communication activities with child. • Check to see whether the child is able to see and to hear. • Refer the child with difficulties to special services. • Encourage the family to play and communicate with the child through touch and movement.
If the mother or father has to leave the child with someone else for a period of time:	• Identify at least one person who can care for the child regularly, and give the child love and attention. • Get the child used to being with the new person gradually. • Encourage mother and father to spend time with the child when possible.
If it seems that the child is being treated harshly:	• Recommend better ways of dealing with the child. • Encourage family to look for opportunities to praise the child for good behaviour. • Respect the child's feelings. Try to understand why the child is sad or angry. • Give the child choices about what to do, instead of saying 'don't'.

Working in groups: Ask each group to role play a scenario from the table and practice counselling the family. Then, ask them to consider a situation where several risks or problems in the home. How might they deal with that situation with sensitivity, whilst ensuring safety for mother and child?

Activity 12: Giving information: Barriers to child development

Ask: What hinders a child's development?

Brainstorm on the flipchart with the words 'Child development and growth' in the centre. Ask them to list all the aspects of family life that might create negative conditions for the child's development. Write as many as possible, but try to roughly group them together to make them easier to remember. Refer participants to the information in the *Participant's Manual*.

WHAT HINDERS EARLY CHILD DEVELOPMENT?

Important message:

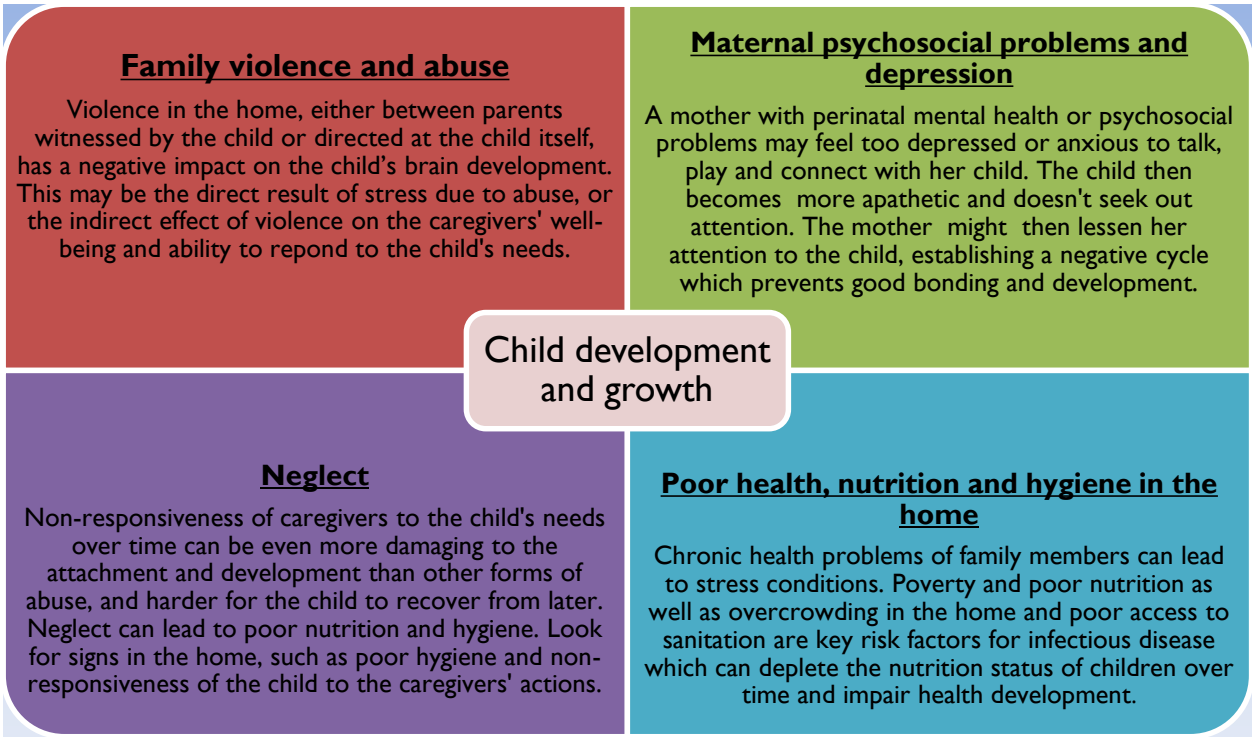
'All families need some support to learn how to develop and apply sensitivity and responsiveness in their childcare practices. There are, however, both *biological and environmental factors that can negatively impact on attachment*. These include low birth weight, malnutrition and infections, poverty and its associations, conflict and domestic violence, and mental health problems such as maternal depression. In these instances, external support for families is particularly important.'[7]

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

Negative conditions for child development

Refer to the figure below in their *Participant's Manual*.

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



Now explain: these conditions often occur in combination. They must consider these issues when counselling families and, where possible, link them to services and groups which might help them further. ttC-HVs are a critical link to support services and community programmes. **Explain:** these issues are sensitive and cannot be addressed explicitly, so during home visits the ttC-HVs should look for key signs.

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

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

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

**Consider referral for undernutrition.*

Activity 13. Vulnerable children and the need for extra care and stimulation

Ask: Which children do you think might need extra care for them to develop well?

SOME MORE VULNERABLE CHILDREN NEED EXTRA CARE AND STIMULATION

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

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

Summarise the main points of the session

- Each child is unique at birth and grows and develops at an individual rate, but there are some key milestones that will help identify if a child is developing appropriately.
- If a child cannot yet do something at a particular age, yet it does not necessarily mean there is a problem, as most likely they will 'catch up' in time. Any concerns the family or ttC-HV have about development should be referred to a health facility.
- Babies' growth and development, especially the brain, is most rapid *in utero* and during the first two years of life and largely influenced by the babies' environment and their interactions with the mother/caregivers.
- Babies develop deep emotional attachment to their primary caregivers, which provides them with the security they need to actively learn and build foundational life skills (e.g. intellect/cognitive, motor/physical, language/communication, social, emotional[8]).
- A baby who is cared for consistently by his/her mother, father and family members – who receives responsive love, attention, stimulation, minimal stress and safety – have significantly better adult outcomes (in health, education, employment and society)
- Babies who are sick, premature, low birth weight or stunted, orphaned, HIV-positive or have a disability will need extra love, stimulation and attention from caregivers and from the ttC-HV.

Further materials and reading

Early Childhood Development Kit: Guideline for Caregivers. ECD Unit/ECD Emergency Task Force Programme Division , UNICEF New York, (2005).
Care for child development: improving the care for young children. (2012) World Health Organization, UNICEF. ISBN: 9789241548403.

[8] Use language appropriate to the educational level of the group.

Early child development: a powerful equalizer: final report for the World Health Organization's Commission on the Social Determinants of Health (2007). A Siddiqi, LG. Irwin, C Hertzman, Human Early Learning Partnership
PEDS: Developmental Milestones – A tool for Surveillance and Screening. France Page Glascoe and Nicholas S. Robertshaw, 2nd Ed. (2010). PEDS- *Parents Evaluation of Developmental Status.*
Psychological first aid: Guide for field workers (2011). WHO, War Trauma Foundation and World Vision International. ISBN: 9789241548205.

Session 5: Conducting Visit 7: 5-months visit

Session plan	Activity 1: Understanding the story and identifying positive and negative practices Activity 2: Give relevant information: Visit 7 (5-months visit) Activity 3: Practise Visit 7	 **Time: 1h00**
Learning objectives	At the end of this session, participants will be able to: • demonstrate how to conduct the 5-months visit (Visit 7) • demonstrate how to use the visuals appropriately during the counselling visit • conduct the household visit and engage effectively and appropriately with household members.	
Key messages 	• Child feeding: 6–9 months • Child feeding for the HIV-positive mother • Complementary foods • Routine health services: growth monitoring and supplements • Major killers – diarrhoea, pneumonia and malaria	
Preparation and materials 	*Materials* • Flipchart, paper and markers • Storybook for Visit 7 and 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 the 5-months visit (Visit 7)
- Demonstrate how to use the visuals appropriately during the counselling visit
- Conduct the HH visit and engage effectively and appropriately with HH members.

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

Distribute copies of Storybook 7. **Working in groups** with one facilitator/helper per table, ask the facilitator to read the story to the group, applying good techniques of storytelling. 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.

Positive story messages	Negative story messages
• Habiba and Uma take their children for growth monitoring. • They bring their growth-monitoring cards with them to the meeting. • They participate in the food demonstration.	• Not happy, not energetic • Skinny

• Mothers are learning how to prepare foods from all the food groups. • The children are receiving iron supplements at 6 months. • Child should continue to breastfeed. • Caregivers wash their hands before preparing food and before feeding the baby. • They should begin to give complementary foods now. • They should feed these foods to the child 2 or 3 times a day, from all the food groups. • They should mash the foods up so the child can easily swallow. • The mothers should be patient when feeding the children. • Make sure the water is purified. • Even HIV-positive mothers should continue to breastfeed, until the child is at least 12 months old. • Three or more watery stools a day is diarrhoea. • Crying with no tears, eyes that look sunken and skin that seems tight are all signs of dehydration. • Diarrhoea is very dangerous for children because the water that their bodies need is lost. • If a child has three or more watery stools in a day, the family should take the child to the clinic right away. • It is okay to vaccinate the child even if the child has diarrhoea or another illness. • The mother should continue to breastfeed even when the child has diarrhoea. • The child was given ORS and zinc to help diarrhoea. • The child was given a vaccine to prevent measles. • The child was given vitamin A for good vision and good protection against diseases. • Mother sings to the baby. • Father hangs the mosquito net.	• Reddish hair • Distended stomach

Activity 2: Give relevant information: Visit 7 – 5-months visit

Review the sequence of Visit 6 with the participants, in the *ttC Participant's Manuals* (brief recap). If they are not literate proceed directly to conduct a demonstration.

SEQUENCE FOR VISIT 7: 5-MONTHS VISIT

Before starting: Greet the family. Ensure that the identified supporters are all present.
Identify and respond to any difficulties: Ask the mother if she has any danger signs, including any emotional distress. Conduct referral if needed. Apply psychological first aid principles if needed.
Assess the child: If the mother reports the child is sick, check for danger signs and refer if any are present.

ttC Counselling process:

a. **Step 1: Review the previous meeting** (Visit 6) and update the Household Handbook for new practices completed.

b. **Step 2: Present and reflect on the problem:** problem scenario: 'Malnutrition' and ask the guiding questions.
c. **Step 3: Present information:** positive story: 'Complementary feeding' and ask the guiding questions.
d. **Step 2: Present and reflect on the problem:** problem scenario: 'Diarrhoea' and ask the guiding questions.
e. **Step 3: Present information:** positive story: 'Diarrhoea' and ask the guiding questions.
f. **Step 4: Negotiate new actions using the Household Handbook.**
g. **Step 5: ttC-HV additional actions:**

- Ask about continuing breastfeeding and provide advice as necessary.
- Ask about family-planning choice.
- Check child health card for growth monitoring and/or immunisations, and remind them about vitamin A.
- Demonstrate water purification.
- Demonstrate enriched porridge (optional).
- Ask and observe: Counsel family on care for child development

Record the results of the meeting: Fill in the *ttC Register* for this visit *(we will do this at the end).*
End the visit: Decide with the family when you will visit again (at 9 months). Thank the family.

Activity 3: Practise Visit 7

Working in groups: Participants should practice the sequence in groups, each taking a different step in the role play. Facilitators may sit with groups or go around the circle giving feedback. The observer participants must give suggestions on how to conduct each step and ensure that the role playing ttC-HV is using good communications, negotiation and counselling skills, using the **counselling skills guide** in the *ttC Participant's Manual* (Methodology). The last step: When counselling the family on care for child development, it may be better to do this in plenary, if participants are not yet fully comfortable with the material.

Summarise the main points of the session

- The seventh home visit happens at the end of the baby's 5th month, preparing the mother and family to appropriately introduce complementary foods. During the seventh home visit you will dialogue, negotiate and encourage mothers and families to appropriately feed their 6-month-old babies, adding complementary foods to breastfeeding. You will also assess the child for danger signs and refer if necessary.
- During the seventh home visit you will show two problem scenarios: 'Malnutrition' and 'Diarrhoea', and tell two stories: positive story: 'Complementary feeding' and positive story: 'Diarrhoea', and ask the corresponding guiding questions.
- Following the negotiation steps, you should carry out several other important actions, including advising on continued breastfeeding to two years and beyond, asking about family planning, checking that the child health card is up to date, and demonstrating water purification and preparation of foods (optional).
- Lastly, you should counsel the family on care for child development, including the 'ask/observe' steps outlined previously, encouraging the whole family to participate. Provide further support or counselling if needed.

Session 6: Completing the Infant Register

Session plan	Activity 1: Review of the forms Activity 2: Sample cases and completing the forms Activity 3: Validating information using the child health record Activity 4: Discussion and practice	 **Time: 2h10**
Learning objectives	At the end of this session, participants will be able to: • complete the *Infant Register* correctly • explain how to validate the birth information using health records/card.	
Key messages 	• The *Infant Register* serves as a record of important information relating to the visits between 1 and 6 months of life, including all vaccinations, breastfeeding and the introduction of complementary foods, which should not happen until 6 months. • For all practices, the ttC-HVs should mark a tick for a positive answer and a cross for a negative answer, aligned to the timing of the home visit.	
Preparation and materials 	*Materials* • Infant registers (three per participant) • Sample registers – printed or projected on screen • Child health record (local examples) *Preparation* • Distribute the *ttC Infant Register*.	

Introduce the session

OBJECTIVES OF THE SESSION

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

- complete the infant register correctly
- explain how to validate information using a child's health records/card.

Activity 1: Review of the forms (similar to previous forms)

Distribute a copy of the *ttC Infant Register* to each participant. Explain that this register serves as a record of information relating to home visits between 1 and 6 months of life, including all vaccinations, breastfeeding and the introduction of complementary foods, which should not happen until 6 months.

Review with participants the structure of the forms, explaining what is required in each section:

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

Column structure and timing: Complete each visit in a vertical column aligned to the time of the visit in terms of the age of the child. The ttC-HVs are required to complete visit at the 5th month.

How to mark planned and completed visits: In the row 'visits planned' write the date of the planned visit. In the row below, literate ttC-HVs can write the date the visit was completed, or mark a tick ✓.

Indicators: Each row corresponds to health practices the ttC-HVs will have promoted using the stories and Household Handbook. Write a tick ✓ for practices done and cross × for those not done/not yet done.

Danger signs and referral: Check for danger signs during each visit. If you recommend referral, write the date of referral (or ✓ if not literate). If there is no danger sign, write a cross ×. Confirm that the family referred the child before marking the referral as completed.

Activity 2: Sample cases and completing the forms

Explain that two examples/storylines will be used to help us learn how to fill out the registers: We are still working with our friends Lara and Sheila used in the previous modules exercises; we are using their stories only during the training.

Contextualisation: Cross-check the story examples below with the final versions of the *ttC Register* you are using. Ensure that the vaccine schedule for your country is properly reflected on the registers.

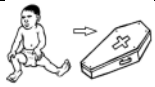
EXAMPLE 1: LARA

- Lara has a 5-month-old baby called Esther who was born on 18 October. You planned to visit her for the 5-months visit on 23 March, and find her and her husband, Hussein, at home.
- Lara reports that Esther was not at any point considered to be high risk.
- She has been to register the birth since 3 months of age and also reports vaccines. You check the vaccine card and find that Esther has received all of the required vaccines.
- Esther was breastfed exclusively until she was 4 months but Lara has been giving her some water and *chima* to eat, as she felt that the baby was not eating enough.
- Lara reports that she is not currently using any family-planning method to prevent pregnancy.
- She reports both her and the baby sleep under a mosquito net every night.
- During the home visit, you observe that both Lara and the baby are well and have no complications.

Ask: What would the register show if she had breastfed until Esther was 6 months of age?

Ask: If Esther were a high-risk child, perhaps additional visits would have been done before 5 months. Where would these be listed on the form?

Worked example: Lara

ttC REGISTER - INFANT				
Instructions: Record information EVERY VISIT		**Infant** 	**DATA CODE**	
Visits planned *(write date)*		**V6** **V7**		
Infant death *(date of death)*		✘	D5	
Home visits		*23/3*	i1	*5-months visit?*
Husband/partner participation in ttC visit		✔	i2	*Husband/partner attend most of ttC visit?*
High-risk infants		✘	i3	*Infant identified as high risk at any time?*
Infant has a birth certificate		✔	i4	*Infant received a birth certificate?*
DTP/PENTA (1-3) vaccines given		✔	i5	*Did the child complete 3 Penta and 3 OPV for this period?*
OPV vaccines given (1-3)		✔		
Exclusively breastfed for 6 months		✘	i6	*Baby breastfed exclusively to 6 months?*
Mother is giving complementary foods or water at this time?		✔		
Mother is currently using contraceptive method?		✘	i7	
Infant is sleeping under a mosquito net every night?		✔	i8	
Infant danger sign identified		✘	E5	*Total events*
Referral completed		✘	E5A	*Total events*
Post-referral home visit completed		✘	E5B	*Total events*

EXAMPLE 2: SHEILA (READ ALOUD OR PROJECT)

Sheila had twins but sadly only one of them survived. As you were concerned about the twin who survived, and she was a high-risk case, you went to check up on the baby at 3 months, and then conducted Visit 7 at the 5th month as planned, on 22 April. Sheila's husband was not present at either of the visits.

3-months visit (control visit only)

- The baby, Matthew, who was high risk, has only had one vaccine so far, and does not have a birth certificate.
- She is breastfeeding Matthew exclusively; she has not introduced any foods yet.
- Sheila is taking the pill to prevent another pregnancy. They are using a mosquito net every night, and the baby is in good health.

5-months visit (Visit 7)

- By now Matthew is 5 months old, and Sheila is still exclusively breastfeeding him.
- She has taken him for vaccines on your recommendation, and has now completed all required. She has also registered the baby's birth, and she is still taking the pill to prevent pregnancy.
- During the visit she reports that Matthew has had sickness and diarrhoea three times a day since yesterday. You observe that Matthew seems quiet and floppy and is not responding when you call his name. You refer him and then follow-up two days later, but Sheila has not yet been to the facility.

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

Ask: In this example, what would happen if the health centre sent a counter-referral showing that Matthew is not growing well, and is 'high risk' because he is underweight?

Ask: What actions might you take to support Sheila?

Activity 3: Validating information using the child health record (literate ttC-HVs)

Contextualisation: Provide examples of the child health record 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:

- vaccines required
- date vaccinations given
- growth curve
- any complications or consultations
- development indicators or milestones.

Activity 4: Discussion and practice with the forms

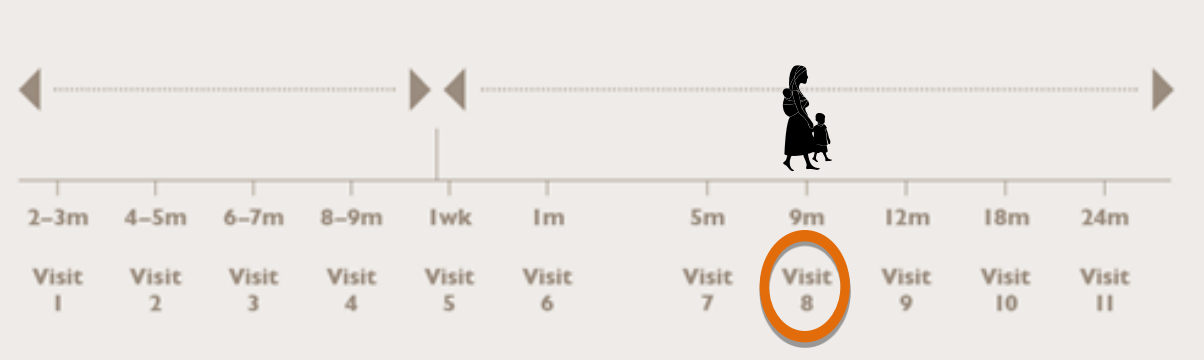
Working in groups: Ask participants to practise filling the register with one of them role-playing as the home visitor and the other as the mother. The one playing the role of the ttC-HV will ask all the needed open-ended questions to fill out the register section pertaining to this visit, and the other will respond to the

questions (making up the responses). Once this is completed, switch roles and repeat the process. You may carry out this activity in the same way regardless of working with literate or non-literate ttC-HVs.

Summarise and check the main points of the session

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

VISIT 8: 9-MONTHS VISIT



Session 7: Child Nutrition and Development at 9 Months

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: Child feeding at 9 months Activity 3: Give relevant information: Micronutrients Activity 4: Reinforcing the information: Card sorting: Micronutrient-rich foods Activity 5: Feeding as an opportunity for holistic child development Activity 6: Give relevant information: Counsel the family on play and communication Activity 7: Barriers and enablers to practising the recommendations	 **Time: 1h 20**
Learning objectives	At the end of this session, participants will be able to: • counsel families on the correct feeding of an infant from 9 to 12 months of age • identify barriers that families may have in practising the feeding recommendations and understand how to respond to these concerns • understand the importance of micronutrients, identify the three important micronutrients and identify the foods that contain them • counsel the family on appropriate care for child development for a child aged 9 to 12 months.	
Key messages 	• At 9 months of age, children need to eat more frequently and in greater amounts. Children should be given complementary foods at least four times per day at this age as well as continue to breastfeed. • It is important that children receive adequate vitamin A, iron and iodine in their diets. Families should understand which foods contain these important micronutrients. • In addition, children will be given vitamin A supplements twice per year from 6 months to 5 years of age. In some situations, children will also be given iron supplements. • Encourage the mother and family members to play and communicate with the child to help him or her feel loved and to grow and develop fully.	
Preparation and materials 	*Materials* • Flipchart, paper and markers • Household Handbooks • Photo food cards *Preparation* • Gather all training materials in advance.	

Contextualisation: As with all sessions concerning foods, you should only use food examples common locally and familiar to the participants. This may mean changing some of the examples provided here.

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- understand and counsel families on the correct feeding of the infant from 9 to 12 months of age
- identify barriers that families may have in practising the feeding recommendations, and understand how to respond to these concerns
- understand the importance of micronutrients, and identify the three important micronutrients and the foods that contain them
- counsel the family on appropriate care for child development for a child aged 9 to 12 months.

Activity 1: Determine what they already know

Ask: Can you name some foods rich in vitamin A and iron?

Write their answers on the flipchart. They may also sort their photo food cards according to foods that contain these two micronutrients.

Activity 2: Give relevant information: Child feeding at 9 months

Ask: By 9 months, what is the child eating? Can it feed itself? How often should it eat?

Explain or read aloud the following information. Answer any questions the ttC-HVs may have.

CHILD FEEDING AT 9 MONTHS

- All 9-month-old babies should continue to breastfeed.
- Children at this age should eat four times per day instead of three times. Food should be given from all three food groups and may be finely chopped or mashed.
- The mother should make sure that the child is eating foods rich in iron and rich in vitamin A.
- The child should eat from a separate plate so the mother can be sure he/she is getting enough food.
- By 9 months, babies will start to try feeding themselves but will continue to need to be actively fed, and the mother or caregiver must ensure that the babies get enough to eat at each meal.
- All family members should wash their hands before preparing food and before eating.
- Continue to take the child to be weighed every month.

Activity 3: Give relevant information: Micronutrients

Contextualisation: Teach the ttC-HVs that they will counsel the family to give the child iron supplements only if they are working in an area where the prevalence of anaemia in children is greater than 40 per cent and it is a non-malarial area, and where this is the policy of the country. If a child is anaemic, he or she should be treated with iron supplements (as prescribed by a health worker).

Find out if iodised salt is readily available in your area and if most families use it. If it is not used, what is the policy of the country in preventing goitre?

Review the information about the three important micronutrients, and **answer** any questions they have.

VITAMIN A

- Until children are 6 months of age, breast milk provides them with all the vitamin A they need, as long as the mother herself has enough vitamin A from her diet or supplements.
- Children older than 6 months need to get vitamin A from other foods or supplements.
- Vitamin A is found in liver, eggs (yolk), some fatty fish, ripe mangoes and papayas, yellow or orange sweet potatoes, dark green leafy vegetables and carrots.
- When children do not have enough vitamin A, they are at risk of night blindness. This is when it is difficult for them to see when the light is dim, such as in the evening or at night. If not treated with vitamin A, this condition can lead to permanent blindness.
- Children also need vitamin A to resist illness. A child who does not have enough vitamin A will become ill more often, and the illness will be more severe, possibly leading to death.
- Children should receive vitamin A capsules twice per year between 6 months and 5 years of age.

IRON

- Children need iron-rich foods to protect their physical and mental abilities. The best sources of iron are liver, lean meats, fish, insects, and dark green leafy vegetables.
- The child may also get iron from iron-fortified foods or iron supplements. The health worker may recommend iron supplements in some situations.
- Anaemia (a lack of iron) can impair physical and mental development. Even mild anaemia in young children can slow mental development. Anaemia is the most common nutritional disorder in the world.
- Malaria and hookworm can cause or worsen anaemia.

IODINE

- Small amounts of iodine are essential for children's growth and development. If a child does not get enough iodine, or if his/her mother is iodine-deficient during pregnancy, the child is likely to be born with a mental, hearing or speech disability, or may have delayed physical or mental development.
- Using iodised salt instead of ordinary salt gives pregnant women and children as much iodine as they need.
- If iodised salt is not available, iodine supplements may be provided by the health facility (according to country policy).

Activity 4: Reinforcing the information: Card sorting: Micronutrient-rich foods

Divide participants into two teams and have the teams stand in lines on opposite sides of the room. **Show** the first member of the first team one of the photo food cards. The team member must first say which food group the card belongs to (Go, Glow or Grow), and then indicate if the food contains vitamin A, iron, neither, or both. If the team member responds correctly, the team gains a point. Carry on in this fashion, alternating teams, until all photo food cards have been displayed.

Activity 5: Feeding as an opportunity for holistic child development

Remind the ttC-HVs that in an earlier training session they learnt that a child's learning and development begins at birth. It is important for family members to promote the baby's development from this early age by talking and interacting with the baby. **Emphasise** the following information:

CHILD DEVELOPMENT

- **Touch:** It is important to give the baby loving affection. Feeding is a time when the baby can be held and his/her arms and legs rubbed gently.
- **Communication:** Feeding is also a good time to communicate with the baby, which will help him or her to keep calm and comforted and learn to speak. Caregivers should talk to the baby about the food, encourage self-feeding, and praise when the child manages it. Feed in response to the child's hunger – it shouldn't be necessary to force-feed the child.

Activity 6: Give relevant information: Counsel the family on play and communication

Refer to the following in the *ttC-HV Participant's Manual,* and discuss the key actions the family can take for this age group. **Remind** participants that all family members, especially the father and older children, can help play and talk with the baby. Use the box below to explain how to play and communicate with the child at this age.

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

Activity 7: Barriers and enablers to practising the recommendations

Ask the ttC-HVs for their opinion as to whether they think families in their community will be able to feed their children foods rich in vitamin A and iron and to prepare food using iodised salt. What are some of the barriers in carrying out these recommendations? Review also the HH steps related to child nutrition at this age group and discuss any new barriers that might emerge not previously discussed, and what might help enable them to overcome the barrier.

Instruct the ttC-HVs to fill in the table in their *ttC Participant's Manuals* with their ideas.

Visit 8: 9 months

Key messages and additional information	**Barriers** What makes it difficult to do?	**Enablers** What would make it easier to do?	**Counselling response or solution**
Continued breastfeeding alongside complementary foods			
Give vitamin A-rich foods			
Micronutrients: Vitamin A supplementation from 6 months.			
Preparation of complementary foods for 9- to 12-month-old child: • Give 3 to 4 meals a day • Feed in response to child's hunger (responsive feeding) • Give food on a separate plate			
Continued growth monitoring at clinic and community (MUAC)			
Holistic child development, communication and play			

Summarise the main points of the session

- At 9 months of age, children need to eat more frequently and in greater amounts. Children should be given complementary foods at least four times a day at this age as well as continue to breastfeed.
- It is important that children receive adequate vitamin A, iron and iodine in their diets. Families should understand which foods contain these important micronutrients.
- In addition, children will be given vitamin A supplements twice a year from 6 months to 5 years of age. In some situations, children will also be given iron supplements.
- Encourage the mother and family members to play and communicate with the child to help him or her feel loved and to grow and develop fully.

Session 8: Detecting and Referring Acute Malnutrition

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: Malnutrition Activity 3: Give relevant information: Signs of severe acute malnutrition Activity 4: Give relevant information: Home-based follow-up of the malnourished child	 **Time: 1h 20**
Learning objectives	At the end of this session, participants will be able to: • understand the types and causes of malnutrition • explain how to recognise and refer a child with severe acute malnutrition • counsel the family on appropriate care for a child with severe acute malnutrition • know and explain when and how to identify and refer a child with severe acute malnutrition.	
Key messages	• Malnutrition is the condition of being undernourished due to multiple factors. There are two key forms of malnutrition: chronic and acute. • A child with severe acute malnutrition is characterized by: • Presence of bilateral pitting oedema of both feet (*kwashiorkor)* • Very low weight for the height resulting in severe visible wasting indicated by 'baggy pants' appearance of the buttocks (*Marasmus)* • A middle upper arm circumference (MUAC) less than 11.5 cm (check for national cut-off). • Severely malnourished children are 9 times more likely to die before the age of 5 than children with good nutrition. • Cases of severe acute malnutrition should be referred urgently to the health facility. • After a child has been treated in a facility for acute malnutrition, the family may need special support in the home to ensure that: • the family adopts improved feeding practices for the child • the child attends growth monitoring and promotion sessions • the child is gaining weight and not experiencing further problems.	
Preparation and materials	*Materials* • Flipchart, paper and markers • IMCI photo cards – malnutrition *Preparation* • Gather all training materials in advance.	

VISIT 8

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- understand the types and causes of malnutrition
- explain how to recognise and refer a child with severe acute malnutrition (SAM)
- counsel the family on appropriate care for a child with severe acute malnutrition
- know and explain when and how to identify and refer a child with acute malnutrition..

Activity 1: Determine what they already know

Ask: What does it mean if we say a child is 'malnourished'?

How does a child become malnourished? Do illness and infection affect malnutrition?

What types of malnutrition exist? What can happen if a child only eat one kind of food?

Write the answers on the flipchart and discuss participants' ideas around malnutrition.

Activity 2: Give relevant information: Malnutrition

MALNUTRITION

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

CHRONIC AND ACUTE MALNUTRITION

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

Note to facilitator: Most ttC-HVs will not have received in-depth training on how to measure child height for age, or weight for height, nor have training on the accurate interpretation of growth charts. The information above is given to introduce key concepts in order to refer severe cases.

Ask: What are the immediate risk factors or causes of malnutrition?

Explain or read aloud:

FACTS ABOUT MALNUTRITION

- Nearly 52 million children under age 5 suffer from severe acute malnutrition worldwide. Every year, 1 million children die from SAM, many of these in Africa and Asia.
- Severe acutely malnourished children are nine times more likely to die before age 5 than children with good nutrition.
- Malnutrition can cause death in children both directly (starvation), or indirectly through increased vulnerability to illness and infection.
- **Vicious cycle of illness and malnutrition:** When children get an infection or illness such as diarrhoea, it weakens their defences and they may lose weight due to poor appetite, and they can lose more weight. The more underweight a child becomes, the more likely they are to catch infections, and so the cycle continues.

Activity 3: Give relevant information: Signs of severe acute malnutrition

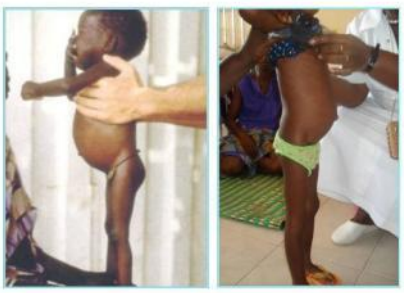
Explain: Presence of these signs suggest the child require urgent referral and medical care..

Observing visible severe wasting (marasmus)

Show or project the images: A child that is severely malnourished is very thin, has no fat, and looks like skin and bones. The skin appears to 'hang off them' like baggy clothing as they have little fat and muscle left to support it. **Also explain** that wasting will typically show on the MUAC (instruction for use are given in Session 9). Hence, this danger sign in the Household Handbook is shown as a picture of a MUAC band.

Point out the following in the pictures:

1. Severe wasting of the shoulders, arms, buttocks and legs.
2. Ribs – can easily be seen protruding from the body.
3. Hips – appear small compared to the chest and abdomen.
4. Buttocks – The fat of the buttocks is missing; folds are seen on the buttocks and thighs. It looks as if the child is wearing baggy trousers.
5. Abdomen – may be large or distended.
6. Compare to normal child – second picture set, bottom right-hand side.

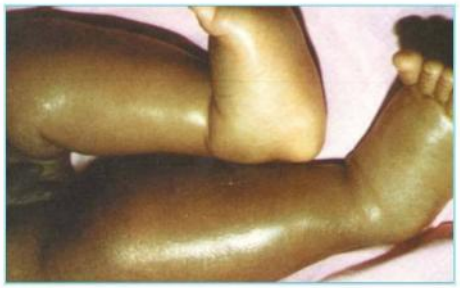
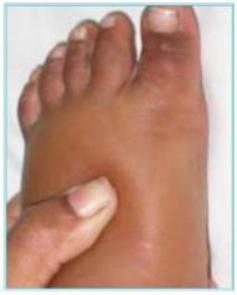
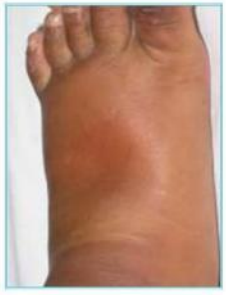


Observing swelling of both feet ('bilateral' pitting oedema), also known as kwashiorkor.

A child with oedema of both feet may have kwashiorkor, another sign of severe acute malnutrition. If the oedema is just one of the feet, it may not be caused by malnutrition. Children with kwashiorkor sometimes have other signs such as thin, sparse and pale hair that easily falls out; dry, scaly skin; or a puffy face.

Show or project the pictures:

Explain: Pitting oedema is caused by fluid gathering in the child's tissues so that they look swollen or puffed up. It is called 'pitting' because if you press your thumb down on the top of the foot, it will leave a 'pit' or thumb impression in the skin. To check for bipedal oedema, use your thumbs to press gently for a few seconds on the top of each foot at the same time. The child has oedema if a pit remains in the child's foot when you press and lift your thumb, even for a few seconds.

Activity 4: Give relevant information: Home-based follow-up of the malnourished child

Ask/recap: When and how might you detect a case of severe acute malnutrition?

- During home visits, check children for signs of severe acute malnutrition using the armband (MUAC) and bilateral pitting oedema, especially those currently or recently ill. If the child qualifies, refer to health facility.
- During a follow-up visit if a child was referred to a health centre.

Contextualisation: if you are doing Community-based Management of Acute Malnutrition (CMAM) or community-based follow-up of acute malnutrition, it is likely that screening of acute malnutrition will be done via an alternative cadre, such as a formal CHW, or the person conducting iCCM, or specialised nutrition cadres or PD hearth, in which case ttC-HVs may refer to this person. If that doesn't exist, ttC-HVs may conduct referrals, then follow up at home to make sure the family is giving the recommended care and attending regular appointments, as well as connecting the family to any other appropriate existing community programmes for nutrition, including growth monitoring and promotion sessions.

HOME-BASED FOLLOW-UP FOR THE MALNOURISHED CHILD

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

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

During the home visit, conduct the following checks:

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

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

Summarise the main points of the session

- Malnutrition is the condition of being undernourished due to multiple factors. The major causes are classified into immediate, underlying causes and underlying factors. There are two forms of malnutrition chronic and acute.
- A child with severe acute malnutrition is characterised by:
- Presence of bilateral swelling of both feet (pitting oedema), also called kwashiorkor
- Very low weight for the height resulting in severe visible wasting indicated by 'baggy pants' appearance of the buttocks (also called Marasmus)
- A middle upper arm circumference for children 6 months to 5 years of less than <11.5 cm. Check this cut-off if it is similar to the national definition of SAM.
- Severely malnourished children are 9 times more likely to die before the age of 5 than children with good nutrition.
- Cases of severe acute malnutrition should be referred urgently to the health facility.
- After a child has been treated in a facility for acute malnutrition, the family may need special support in the home to ensure that:
- the family adopts improved feeding practices for the child
- the child attends growth monitoring and promotion sessions
- the child is gaining weight and not experiencing similar problems.

Optional Session 8b: Screening for Acute Malnutrition Using MUAC

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: MUAC screening for acute malnutrition Activity 3: Demonstrate correct technique of MUAC band Activity 4: Practise taking an MUAC reading	 **Time: 1h 20**
Learning objectives	By the end of this session participants will be able to: • explain MUAC in simple language • explain when it is appropriate to use MUAC to measure nutritional status • demonstrate how to measure a child's MUAC accurately • interpret MUAC readings and explain their implications.	
Key messages 	• MUAC helps us to quickly determine the level of malnutrition in large groups of people. • MUAC is a simple and easy-to-use measurement tool that is often used for screening in emergency situations and is also used in nutrition surveys in development contexts. • It is not appropriate to do an MUAC screening for a child under the age of 6 months. • ttC-HVs can do MUAC screening during or after an acute illness in which the child may have suffered weight loss, and during routine home visits. • Children with an MUAC of below 11.5 cm (yellow or red) should be referred to the nearest facility for nutrition support and medical attention.	
Preparation and materials 	*Materials* • MUAC bands (one for each participant) **Note:** A simple tape measure made of non-stretch material can be used if MUAC bands are not available; however, MUAC bands are always preferable. ***Source material:*** Measuring and Promoting Child Growth Tool. A Module of the Nutrition Toolkit Facilitator's Manual Version 2, August 2011. *Nutrition Centre of Expertise, World Vision International.*	

Contextualisation: Include this session in circumstances where it is considered appropriate that the ttC-HVs are screening for acute malnutrition, especially following illness, or on a regular screening programme in contexts where levels of acute malnutrition are high, or are prone to seasonal fluctuations. Consider including also in contexts where ttC-HVs have a limited role of screening. The ttC-HV cadre may have undergone other training in nutrition, including MUAC, while in other contexts ttC-HVs work alongside nutrition volunteers or formal CHW cadres who do this work, where this training can be applied.

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- explain MUAC in simple language
- explain when it is appropriate to use MUAC to measure nutritional status
- demonstrate how to measure a child's MUAC accurately
- interpret MUAC readings and explain their implications.

Activity 1: Determine what they already know

Ask: What can we do to quickly assess if a child is malnourished?

Ask: Has anyone in the group ever used MUAC tapes before?

Mid-upper arm circumference (or MUAC) is a measure often used in these situations. If they have used this before, **ask** them to briefly describe the experience.

Activity 2: Give relevant information: MUAC screening for acute malnutrition

Explain or read aloud:

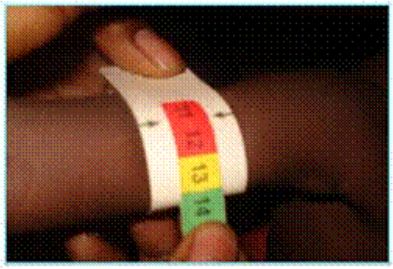
MUAC SCREENING

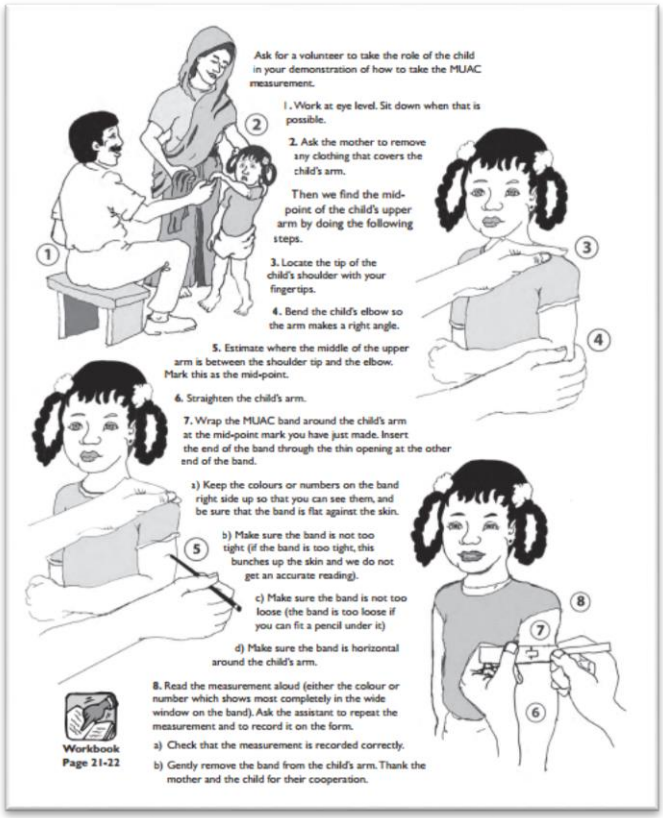
- MUAC is a simple and easy-to-use measurement tool that can be used to quickly assess for malnutrition.
- MUAC is based on the fact that a small or decreasing arm circumference signals the loss of muscle mass. ('Circumference' means 'outside edge of a circle'.) Muscle mass is known to be important in maintaining body functions and in fighting infections.
- MUAC is a good predictor of immediate risk of death, which is why it is often used in emergency situations, for a quick assessment of nutritional status.
- MUAC is not used to measure malnutrition in children under 6 months because we don't have established cut-off levels for this age group.
- For monitoring growth, we use weight and age. To measure stunting, we use height and age. Wasting is measured using weight and height. MUAC can be used as a quick check for malnutrition, but is not as sensitive as growth monitoring, therefore both need to be done and MUAC screening cannot replace other nutrition assessment activities.

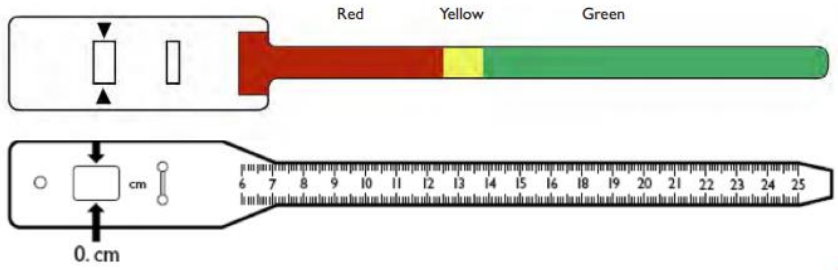
Activity 3: Demonstrate correct technique of MUAC band

We measure upper-arm circumference with special bands or tapes like the one shown.

Different types of MUAC bands are available. Some have numbers, some have numbers and colours, and some have colours only. Use colour-coded bands when available as this makes measuring MUAC simpler. Review the steps in plenary.







Activity 4: Practise taking an MUAC reading

Working in pairs: Ask participants to take the MUAC reading of their partner, then switch so that everyone has the experience of being measured and of measuring. The facilitator should go to each pair and observe. Be encouraging, but correct technique when necessary.

TAKING A MUAC READING

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

Interpreting MUAC

- We use a 'cut-off' point of 11.5 cm to identify severely malnourished children. Any child whose MUAC measurement is below 11.5 cm (red) is considered severely acutely malnourished and at risk of death, and requires immediate medical attention.
- Those children with a MUAC between 11.5 cm and 12.4 cm (yellow) are classified as moderately acutely malnourished. These children are at risk of developing severe form of acute malnutrition. Hence they need to be referred to local supplementary feeding programme if available. If not, they need to participate in community nutrition sessions, such as PD Hearth, to rehabilitate them and equip the family in feeding practices to prevent future malnutrition.
- A child whose MUAC is 12.5 cm or greater (green) is classified as having a normal mid-upper arm circumference.
- This cut-off is based on the global recommendation and it is recommended to check the national cut-off points for MUAC before making the decision for referral.

Summarise the main points of the session

- MUAC is a simple and easy-to-use measurement tool that can be used to quickly assess for malnutrition.
- It is not appropriate to do a MUAC screening for a child under the age of 6 months.
- ttC-HVs can do MUAC screenings during or after an acute illness in which the child may have suffered weight loss, and during routine home visits.

- Children with a MUAC of below 11.5 cm should be referred for nutrition support and medical attention at the nearest facility.

Session 9: Conducting Visit 8: 9-months visit

Session plan	Activity 1: Understanding the story Activity 2: Give relevant information: Visit 8: 9-months visit Activity 3: Practise Visit 8	 **Time: 1h30**
Learning objectives	At the end of this session, participants will be able to: • demonstrate how to conduct the home visit at 9 months (Visit 8) • demonstrate how to use the visuals appropriately during the counselling visit • conduct Visit 8 and engage effectively and appropriately with household members.	
Key messages	• During the eighth home visit you will dialogue, negotiate and encourage mothers and families to appropriately feed their 9-month-old babies, increasing the quantity of complementary foods to include foods rich in iron and vitamin A, and to recognise the danger signs of diarrhoea and seek care when needed. You will also teach the families how to prepare ORS. • During Visit 8 you will show two problem scenarios: (1) vitamin A deficiency and (2) diarrhoea, and tell one story: positive story: 'Diarrhoea, complementary feeding and vitamin A', and ask the corresponding guiding questions. • Following the negotiation steps, you will carry out several other important actions, including advising on continued breastfeeding to two years and beyond, checking that the child health card is up to date, screening for MUAC, and reminding the family about measles vaccination (and yellow fever, if given) at 9 months. • Lastly, you should counsel the family on care for child development, including the 'ask/observe' steps outlined previously, encouraging the whole family to participate. Provide further support or counselling if needed.	
Preparation and materials	*Materials* • Flipchart, paper and markers • Storybook for Visit 8 • Household Handbooks *Preparation* • Gather all training materials in advance.	

VISIT 8

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- demonstrate how to conduct the home visit at 9 months (Visit 8)
- demonstrate how to use the visuals appropriately during the counselling visit

- conduct Visit 8 and engage effectively and appropriately with household members.

Activity 1: Understanding the story

Working in groups: Distribute copies of Storybook 8. With one facilitator/helper per table, ask the facilitator to explain the three pictures to the group, and demonstrate how to discuss with the household to relay the messages.

- Picture 1: Measles – if a child is not vaccinated against measles he/she can develop complications such as blindness, epilepsy and brain damage or even death.
- Picture 2: Night blindness – if a child doesn't get enough Vitamin A.
- Picture 3: Diarrhoea – what can happen if a child does not eat well after having diarrhoea.

Activity 2: Give relevant information: Visit 8 – 9-months visit

Review the sequence of the 8th home visit with the participants in the *ttC Participant's Manual* (brief recap). If they are not literate, proceed directly to conduct a demonstration.

SEQUENCE FOR VISIT 8: 9-MONTHS VISIT

Before starting: Greet the family. Ensure that the identified supporters are all present.
Identify and respond to any difficulties: Ask the mother if she has any danger signs, including any emotional distress. Conduct referral if needed. Apply psychological first aid principles if needed.
Assess the child: If the mother reports that the child is sick, check for danger signs and refer if any are present.

ttC Counselling process: Diarrhoea, complementary feeding, vitamin A

a. **Step 1: Review the previous meeting.**
b. **Step 2a: Present and reflect on the problem:** Problem scenario: 'Vitamin A deficiency', and ask the guiding questions.
c. **Step 2b: Present and reflect on the problem:** Problem scenario: 'Diarrhoea'.
d. **Step 3: Present information:** Positive story: 'Diarrhoea, complementary feeding, vitamin A', and ask the guiding questions.
e. **Step 4: Negotiate new actions** using the Household Handbook.
f. **Step 5: ttC-HV additional actions:**

- Ask about continuing breastfeeding and provide advice as necessary.
- Check child health card for growth monitoring and/or immunisations, and remind about vitamin A and measles vaccine.
- Screen for MUAC (optional/contextual).
- Ask what the child ate in the previous day; check for iron-rich and vitamin A-rich food, and a balanced diet.
- Ask and observe: Counsel family on care for child development.

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

End the visit: Decide with the family when you will visit again (at 12 months). Thank the family.

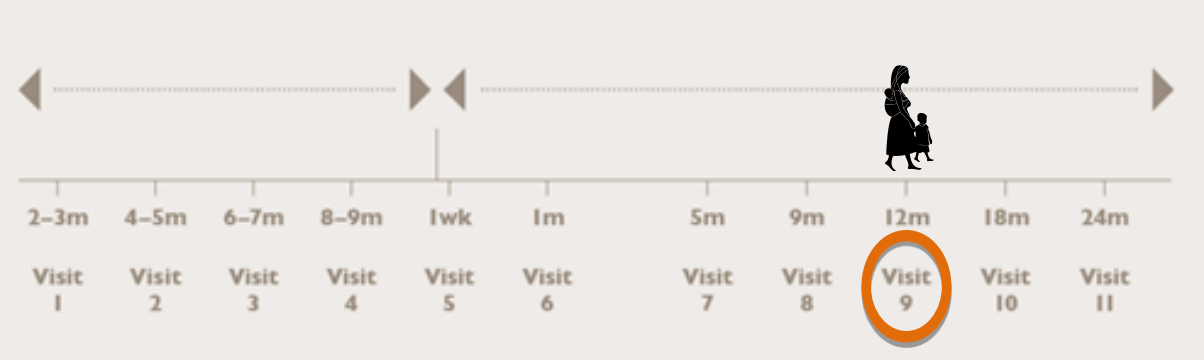
Activity 3: Practise Visit 8

Working in groups: Participants should practice the sequence in groups, each taking a different step in the role play. Facilitators may sit with groups or go around the circle giving feedback. The observer participants must give suggestions on how to conduct each step, and ensure that the role-playing ttC-HV is using good communications, negotiation and counselling skills, using the **counselling skills guide** for reference, found on the last page of the ttC-HV manual. The last step: When counselling the family on care for child development, it may be better to do this in plenary, if participants are not yet fully comfortable with the material.

Summarise the main points of the session

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

VISIT 9: 12-MONTHS VISIT



Session 10: Child Development and Nutrition at One Year

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: Child feeding at 12 months Activity 3: Determine what they already know: Deworming Activity 4: Reinforcing the information: Pictures Activity 5: Give relevant information: Counsel the family on play and communication Activity 6: Review: Vaccination, vitamin A, deworming and growth monitoring Activity 7: Barriers and enablers to practising the recommendations	 **Time: 1h00**
Learning objectives	At the end of this session, participants will be able to: • counsel families on the correct feeding of the child at 12 months of age • recognise barriers that families may have in practising the feeding recommendations, and understand how to respond to these concerns • know that intestinal worms can cause or worsen anaemia, and counsel families to get deworming tablets at the health facility in areas where worms are common • explain the hygiene practices that help prevent intestinal worms • understand that the child should receive a vitamin A capsule at 12 months and communicate this to families.	
Key messages	• Children at this age should eat six times per day. Three or four of these feedings should be from the family food supply, whilst others may be snacks such as fruits, eggs or peanuts. Food should be given from all three food groups and should be finely chopped or mashed. Children should continue to be breastfed. • Growth monitoring and promotion: the child should continue to be weighed every month. • Intestinal worms can lead to anaemia and diarrhoea, which contribute to a child becoming malnourished. Prevent intestinal worms through good hygiene, hand washing, wearing shoes outside, thorough cooking and hygienic handling of raw meat. • Vitamin A: All children over the age of 6 months are given vitamin A supplements once every 6 months until they are 5 years of age, which prevents night blindness and protects from other diseases. The mother can obtain this from the health facility, or during outreach campaigns. • Deworming: All children from the age of 1 year are given a deworming tablet once every 6 months. The mother can access this at the health facility or during outreach campaigns.	
Preparation and materials	*Materials* • Flipchart, paper and markers • Household Handbooks • Collection of pictures: intestinal worms • Sample child health card from a 1-year-old child (ask ttC-HVs to bring) *Preparation* • Gather all training materials in advance.	

VISIT 9

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- counsel families on the correct feeding of the child at 12 months of age
- recognise barriers that families may have in practising the feeding recommendations, and understand how to respond to these concerns
- know that intestinal worms can cause or worsen anaemia, and counsel families to get deworming tablets at the health facility in areas where worms are common
- explain the hygiene practices that help prevent intestinal worms
- understand that the child should receive a vitamin A capsule at 12 months and communicate this to families.

Activity 1: Determine what they already know

Ask: What should a 12-month-old child eat and how often?

Activity 2: Give relevant information: Child feeding at 12 months

Explain or read aloud:

CHILD FEEDING AT 12 MONTHS

- 12-month-old babies should continue to breastfeed.
- Children at this age should eat six times per day. Three or four of these feedings should be from the family food supply, whilst the others may be snacks such as fruits, eggs or peanuts. Food should be given from all three food groups and should be finely chopped or mashed.
- The child should eat from a separate plate so the mother can be sure that he/she is getting enough to eat.
- All family members should wash their hands before preparing food and before eating.
- The child should continue to be monitored for growth every month.

Activity 3: Determine what they already know: Deworming

Contextualisation: Find out what the Ministry of Health policy on deworming is in your country and provide the correct information to ttC-HVs.

Ask: What do you know about intestinal worms? Have any of your children suffered from worms? If so, what did you do? What happened?

Ask: What might be the outcome if you do not treat worms in children under 5 years of age?

Explain or read aloud:

INTESTINAL WORMS

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

Activity 4: Reinforcing the information: Pictures

Show or project the collection of pictures of intestinal worms. Whilst these pictures are unpleasant, it is useful to understand what worms are and the harm they can do. These are worms that live in the gut of an infected person, competing with the body for nutrients in their food. After seeing these pictures it is often easier take the necessary actions and help others to prevent infection, thereby motivating behaviour change.

Activity 5: Give relevant information: Counsel the family on play and communication

Refer to the following in the *ttC Participant's Manual,* and discuss the key actions the family can take for this age group (12 months to 2 years). Remind participants to encourage all family members to engage in play and stimulation of the growing child. Use the box below to explain what the mother and family can do to play and communicate with a child of this age.

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

Activity 6: Review: Vaccination, vitamin A, deworming and growth monitoring

Present the child health card samples brought in. If not possible, project a completed example that facilitators have prepared.

Ask: What vaccines and supplements should a child have completed before 1 year of age?

Ask: What additional preventive services does a child still need after 1 year of age and when?

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

Activity 7: Barriers and enablers to practising the recommendations

Visit 9: 12 months

Key messages and additional information	**Barriers** *What makes it difficult to do?*	**Enablers** *What would make it easier to do?*	**Counselling response or solution**
Continued breastfeeding to 2 years and beyond alongside complementary foods			
Give iron-rich foods			
Routine health services: Growth monitoring and immunisations (immunisations should be complete)			
Deworming from 12 months			
Vitamin A supplement at 12 months			
Growth monitoring and promotion at clinic and the community (MUAC)			
Holistic child development – stimulation and play			

Summarise the main points of the session

- Children at this age should eat six times per day. Three or four of these feedings should be from the family food supply, whilst the others may be snacks such as fruits, eggs or peanuts. Food should be given from all three food groups and should be finely chopped or mashed. Children should continue to be breastfed.
- Growth monitoring and promotion: The child should continue to be weighed every month.
- Intestinal worms can lead to anaemia and diarrhoea, which contribute to a child becoming malnourished. Prevent intestinal worms through good hygiene, hand washing, wearing shoes outside, thorough cooking and hygienic handling of raw meat.
- Vitamin A: All children over the age of 6 months are given vitamin A supplements once every 6 months until they are 5 years of age, which prevents night blindness and protects from other diseases. The mother can obtain this from the health facility, or during outreach campaigns.
- Deworming: All children from the age of 1 year are given a deworming tablet once every 6 months. The mother can access this at the health facility or during outreach campaigns.

Session 11: Conducting Visit 9

Session plan	Activity 1: Understanding the story Activity 2: Give relevant information: Visit 9 – 12-months visit Activity 3: Practise Visit 9	 **Time: 1h00**
Learning objectives	At the end of this session, participants will be able to: • demonstrate how to conduct the 12-months home visit (Visit 9) • demonstrate how to use the visuals appropriately during the visit • conduct the visit and engage effectively and appropriately with household members.	
Key messages 	• Visit 9 takes place when the child is 12 months old. During this home visit, ttC-HVs will dialogue, negotiate and encourage mothers and families to appropriately feed their 12-month-old babies, adding complementary foods to breastfeeding. You will also assess the child for danger signs and refer if necessary. • During Visit 9 you will present only the positive story 'Complementary feeding, deworming and vitamin A', and ask the corresponding guiding questions. • Following the negotiation steps, you will carry out several other important actions, including advising on continued breastfeeding, asking about family planning, checking that the child health card is up to date, reminding about vitamin A, checking if the child has received a deworming tablet and reminding the family to have this at 12 months, and screening any sick or recently sick child for signs of malnutrition. • Lastly, you should counsel the family on care for child development, including the 'ask/observe' steps outlined previously, encouraging the whole family to participate. Provide further support or counselling if needed.	
Preparation and materials 	*Materials* • Flipchart, paper and markers • Flip-book stories for Visit 9 • Household Handbooks *Preparation* • Gather all training materials in advance.	

VISIT 9

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- demonstrate how to conduct the 12-months home visit (Visit 9)
- demonstrate how to use the visuals appropriately during the visit
- conduct the visit and engage effectively and appropriately with household members.

Activity 1: Understanding the story

Distribute copies of Storybook 9. **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 facilitator should go around the circle and identify the key messages.

Positive story messages
• Thomas washes his hands. • Thomas has his own bowl. • Thomas eats fruits and vegetables. • Elizabeth helps Thomas to eat six times a day. • Elizabeth gives Thomas foods that are rich in iron, like liver and dark green leafy vegetables. • They go to the clinic and Thomas gets deworming medicine. • Elizabeth is sure to take Thomas to the clinic every month to monitor his growth. • Thomas gets a vitamin A drop.

Activity 2: Give relevant information: Visit 9 – 12-months visit

Review the sequence of the home visit in the *ttC Participant's Manual*. If the participants are not literate, proceed directly to conduct a demonstration.

SEQUENCE FOR VISIT 9: 12-MONTHS VISIT

Before starting: Greet the family. Ensure that the identified supporters are all present.
Identify and respond to any difficulties: Ask the mother if she has any danger signs, including any emotional distress. Conduct referral if needed. Apply psychological first aid principles if needed.
Assess the child: If the mother reports that the child is sick, check for danger signs and refer if present.

ttC Counselling process:

a. **Step 1: Review the previous meeting** (Visit 8) and update the Household Handbook.
b. **Step 2: Present and reflect on the problem** There is no problem story in this visit.
c. **Step 3: Tell the positive story:** 'Complementary feeding, deworming and vitamin A' using the appropriate flipbook visuals that show the story of Thomas.
d. **Step 4: Negotiate new actions** using the Household Handbook
e. **Step 5: ttC-HV additional actions:**
    - Ask about continuing breastfeeding and provide advice as necessary.
    - Ask what the child has eaten the previous day, checking for iron-rich and vitamin A-rich foods, and a balanced diet.
    - Check child health card for growth monitoring and/or immunisations, and remind about vitamin A.
    - Refer for deworming if the child has not already had it at 12 months.
    - Screen sick or recently sick children for signs of malnutrition.
    - Ask and observe: Counsel family on care for child development.

Record the results of the meeting: Fill in the *ttC Register* for this visit *(we will do this at the end)*.
End the visit: Decide with the family when you will visit again (at 18 months). Thank the family.

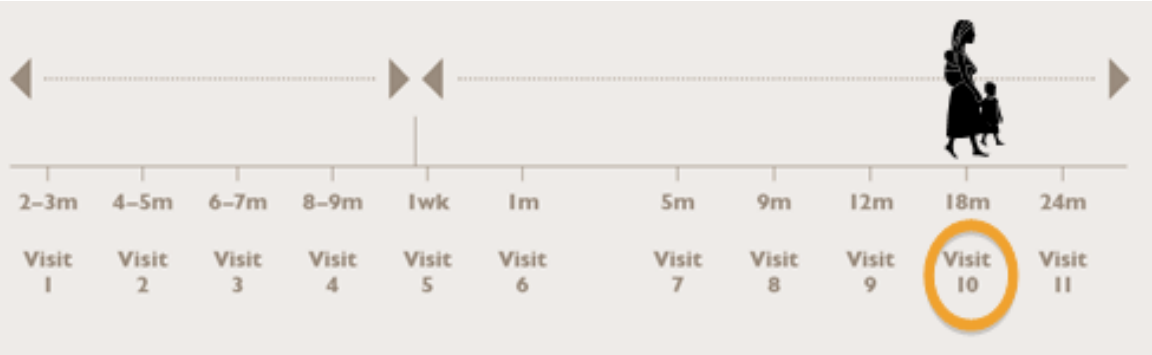
Activity 3: Practise Visit 9

Working in groups: Participants should practise the sequence in groups, each taking a different step in the role play. Facilitators may sit with groups or go around the circle giving feedback. The observer participants must give suggestions on how to conduct each step, and ensure that the role playing ttC-HV is using good communications, negotiation and counselling skills, using the **counselling skills guide** for reference, found on the last page of the *ttC-HV manual*.

Summarise the main points of the session

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

VISIT 10: 18-MONTHS VISIT



Session 12: Child Nutrition and Development at 18 Months

Session plan	Activity 1: Determine what they already know Activity 2: Give relevant information: Promoting health and nutrition at 18 months Activity 3: Give relevant information: Counsel the family on play and communication Activity 4: Barriers and enablers to the 18-month-old's health practices	 **Time: 1h00**
Learning objectives	At the end of this session, participants will be able to: • carry out a complete review of all counselling messages with households • assess levels of knowledge retention and adoption of practices in the household and community • demonstrate how to conduct the 18-months home visit (Visit 10) • demonstrate how to use the visuals appropriately during the counselling visit • conduct the household visit and engage effectively and appropriately with household members.	
Key messages 	• Child feeding at 18 months and beyond: 18-month-old babies should continue to breastfeed. They should eat six times per day. Three or four of these feedings should be from the family food supply, whilst the others may be snacks such as fruits, eggs or peanuts. Food should be given from all three food groups and should be finely chopped or mashed. The child should eat from a separate plate so the mother can be sure he/she is getting enough to eat. • Continued monitoring and promotion of nutrition: The parent should continue to take the child to be weighed on a regular basis, and ensure that the child receives vitamin A supplement and deworming tablet at 18 months. • Continued promotion of hygiene and handwashing: All family members should wash their hands before preparing food and before eating. As children learn to feed themselves, it is even more important that the family ensures that children wash their hands with soap or ash before eating.	
Preparation and materials 	*Materials* • Flipchart, paper and markers • Household Handbooks *Preparation* • Gather all training materials in advance. • Review all previous messages delivered during previous training sessions/HH counselling visits.	

VISIT 10

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- carry out a complete review of all counselling messages with HHs
- assess levels of knowledge retention and adoption of practices in the HH and community
- demonstrate how to conduct the 18-months home visit (Visit 10)
- demonstrate how to use the visuals appropriately during the counselling visit

- conduct the HH visit and engage effectively and appropriately with HH members.

Activity 1: Determine what they already know

Ask: What should an18-month-old child eat and how often?

Ask: What ongoing monitoring is required at the health facility?

Activity 2: Give relevant information: Promoting health and nutrition at 18 months

Explain or read aloud:

CHILD FEEDING AT 18 MONTHS AND BEYOND

- 18-month-old babies should continue to breastfeed.
- Children at this age should eat six times per day. Three or four of these feedings should be from the family food supply, whilst the others may be snacks such as fruits, eggs or peanuts. Food should be given from all three food groups and should be finely chopped or mashed.
- The child should eat from a separate plate so the mother can be sure he/she is getting enough to eat.

CONTINUED MONITORING AND PROMOTION OF NUTRITION

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

CONTINUED PROMOTION OF HYGIENE AND HAND WASHING

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

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

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

Age of young infant	Recommendations for family
2 years and older 	*Play:* • Help your child count, name and compare things. • Make simple toys for your child. • Sample toys: Objects of different colours and shapes to sort, sticks, chalkboard or puzzle. *Communicate:* • Encourage your child to talk; answer your child's questions. • Teach your child stories, songs and games. Talk about pictures or books. • Sample toy: book with pictures.  

Activity 4: Barriers and enablers to the 18-month-old's health practices

Visit 10: The 18-month-old child

Key messages and additional information	Barriers What makes it difficult to do?	Enablers What would make it easier to do?	Counselling response or solution
Preparation of complementary foods for 18-month-old child: - Give 3 to 4 meals a day - Feed in response to child's hunger (responsive feeding) - Give food on a separate plate			
Give iron-rich foods			
Vitamin A and deworming at 18 months			
Child should sleep under a bed net			
Family to consider birth spacing interval (from 2 years)			
Holistic child development – play and stimulation			

VISIT 10

Summarise the main points of the session

- **Child feeding at 18 months and beyond:** 18-month-old babies should continue to breastfeed. They should eat six times per day. Three or four of these feedings should be from the family food supply, whilst the others may be snacks such as fruits, eggs or peanuts. Food should be given from all three food groups and should be finely chopped or mashed. The child should eat from a separate plate so the mother can be sure he/she is getting enough to eat.
- **Continued monitoring and promotion of nutrition:** The parents should continue to take the child to be weighed on a regular basis, and ensure that the child receives vitamin A supplement and deworming tablet at 18 months.
- **Continued promotion of hygiene and hand washing:** All family members should wash their hands before preparing food and before eating. As children learn to feed themselves, it is even more important that the family ensures that children wash their hands with soap or ash before eating.

Session 13: Conducting Visit 10 at 18 Months

Session plan	Activity 1: Understanding the story Activity 2: Give relevant information: Conducting Visit 10 at 18 months	 **Time: 1h00**
Learning objectives	At the end of this session, participants will be able to: • demonstrate how to conduct the 18-months home visit (Visit 10) • demonstrate how to use the visuals appropriately during the counselling visit • conduct the household visit and engage effectively and appropriately with household members.	
Key messages 	• Visit 10 will take place when the child is 18 months of age. During Visit 10 ttC-HVs will dialogue, negotiate and encourage mothers and families to appropriately feed their children by continuing to provide healthy complementary foods in addition to breastfeeding. You will also assess the child for danger signs and refer if necessary. • During Visit 10 you will present only the positive story: 'Complementary feeding, deworming and vitamin A' and ask the corresponding guiding questions. • Following the negotiation steps, you will carry out several other important actions, including advising on continued breastfeeding, asking about family planning, checking to see that the child health card is up to date, reminding about vitamin A, checking if the child has received a deworming tablet and remind them to have this at 18 months, and screening any sick or recently sick child for signs of malnutrition. • ttC-HVs should counsel the family on care for child development, including the 'ask/observe' steps outlined previously, encouraging the whole family to participate. Provide further support or counselling if needed.	
Preparation and materials 	*Materials* • Flipchart, paper and markers • Household Handbooks • Storybook for Visit 10 *Preparation* • Gather all training materials in advance. • Review all previous messages delivered during previous training sessions.	

VISIT 10

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- understand how to carry out a complete review of all counselling messages with households
- assess levels of knowledge retention and adoption of practices in the household and community
- demonstrate how to conduct the 18-months home visit (Visit 10)
- demonstrate how to use the visuals appropriately during the counselling visit

- conduct the HH visit and engage effectively and appropriately with household members.

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

Distribute copies of Storybook 10. **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 facilitator should go around the circle and identify the key messages (there are no negative stories).

Module 3: Storybook messages (Note: only positive stories)

Storybook	Positive story messages
10	• Leila washes her hands. • Leila snacks all day long, and her mother gives her good choices for snacks. • Mother prepares nutritious meals, putting nutritious ingredients into the sauce • Leila sleeps under a bed net. • Leila's parents recognise the danger sign and take her to the clinic right away. • Growth monitoring. • Vitamin A. • Leila still eats as much when she is ill. • Family planning.

Activity 2: Give relevant information: Conducting Visit 10 at 18 months

SEQUENCE FOR VISIT 10: 18 MONTHS

Before starting: Greet the family. Ensure that the identified supporters are all present.
Identify and respond to any difficulties: Ask the mother if she has any danger signs, including any emotional distress. Conduct referral if needed. Apply psychological first aid principles if needed.
Assess the child: If mother reports that the child is sick, check for danger signs and refer if any are present.

ttC Counselling process:

a. **Step 1: Review the previous meeting** (Visit 9) and update the Household Handbook.
b. **Step 2: Present and reflect on the problem** (there is no problem story in this visit).
c. **Step 3: Tell the positive story:** 'Complementary feeding, danger signs, birth spacing' using the appropriate flipbook visuals that show the story of Leila.
d. **Step 4: Negotiate new actions** using the Household Handbook.
e. **Step 5: ttC-HV additional actions:**
   - Ask about continuing breastfeeding and provide advice as necessary.
   - Ask what the child has eaten in the previous day, checking for iron-rich and vitamin A-rich foods, and a balanced diet.
   - Check child health card for growth monitoring and immunisations, and remind about vitamin A.
   - Refer for deworming if the child has not already had it at 18 months.
   - Screen sick or recently sick children for signs of malnutrition.
   - Ask and observe: Counsel family on care for child development

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

End the visit: Decide with the family when you will visit again (at 24 months). Thank the family.

Summarise the main points of the session

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

VISIT 11: 24-MONTHS VISIT

Session 14. Conducting Visit 11- the Exit Interview at 24 Months

Session plan	Activity 1: Give relevant information: Child feeding at 2 years Activity 2: Give relevant information: Family planning Activity 3: Check the family's knowledge: Review health practices and danger signs in children	 **Time: 1h00**
Learning objectives	At the end of this session, participants will be able to: • demonstrate how to conduct the 2-years home visit (Visit 11) • demonstrate how to use the visuals appropriately during the counselling visit • conduct the household visit and engage effectively and appropriately with household members.	
Key messages 	• Complementary feeding: child eats five to six times per day • Danger signs in children • Birth spacing/family planning: may consider another pregnancy	
Preparation and materials 	*Materials* • Flipchart, paper and markers • Flipbook stories for Visit 11 • 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 the 2-years home visit (Visit 11)
- demonstrate how to use the visuals appropriately during the counselling visit
- conduct the HH visit and engage effectively and appropriately with HH members.

Activity 1: Give relevant information: Child feeding at 2 years

CHILD FEEDING AT 2 YEARS

- Two-year-old children may continue breastfeeding for as long as it is agreeable for both the mother and the child. But if the mother wishes to stop breastfeeding now, it is OK for her to do so.
- Two-year-old children should continue to eat five to six times per day. Three or four of these feedings should be from the family food supply, whilst the others may be snacks such as fruits, eggs or peanuts. Food should be given from all three food groups, and the child should eat foods rich in iron and in vitamin A. Children are able to eat solid foods at this age.
- The child should continue to eat from a separate plate so that the mother can be sure that he/she is getting enough to eat.
- All family members, including the child, should wash their hands with soap or ash before preparing food and before eating.

Activity 2: Give relevant information: Family planning

In previous home visits the ttC-HVs have advised the families on the various methods that can be used to avoid pregnancy. The advice has always been that the woman should not try for another pregnancy until the child reaches 2 years of age.

Now that the ttC-HVs will be making Visit 11 at 2 years, they will advise families that if they want to have more children they can begin trying for another pregnancy.

Review the recommendations in the box below with the ttC-HVs. **Answer** any questions they may have.

FAMILY PLANNING

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

Activity 3: Check the family's knowledge: Review health practices and danger signs in children

Explain: There are no *new* messages to communicate to families during Visit 11. Use the visit instead to **review** with the families **all** of the lessons that have come before.

Explain that the ttC-HVs will **review the complete Household Handbook** with the families. This review will have three purposes:

1. to assess **knowledge retention:** that is to say, to see if the families remember and understand the messages represented in each of the pictures
2. to assess **adoption:** that is to say, to learn if the families have been able to put the recommendations into practice

3. to assess their knowledge of the major killers – diarrhoea, malaria and pneumonia – and the danger signs in children. Remind them that these are the key danger signs for children up to aged 5.

Working in pairs: Participants should practise assessing **knowledge in the household. Divide** the participants into pairs and ask them to work with the Household Handbook. Each pair should review the complete handbook to ensure that they, as ttC-HVs, also remember all the messages and will be able to carry out the review with the families. They should carry out the review with each other as if they were carrying it out with the family, alternating roles for each page of the handbook. They should review all the illustrations in the household handbook and explain what each illustration represents.

Summarise the main points of the session

- Visit 11 takes place when the child reaches 24 months of age. There are no new stories or negotiated practices during this visit.
- ttC-HVs will review all of the pages in the Household Handbook with family members during Visit 11. They should be prepared to answer any questions that HH members have regarding messages they do not remember or do not understand.
- Major killers such as diarrhoea, pneumonia or malaria can happen quickly and at any time. Always be aware of the danger signs for these major killers and take the sick child to the health facility. ttC-HVs should check the family's knowledge about danger signs in children and what to do if they observe them.
- The ttC-HVs will also remind the families to take the child to the health clinic for growth monitoring and to receive vitamin A capsules and deworming at 2 years if they have not already done so.
- They should remind families that after the child is 2 years old, it is now safe to try for another baby if they wish and they should discuss with the health-care provider about considering a new pregnancy.
- Two-year-old children should continue to eat six times per day. Three or four of these feedings should be from the family food supply, whilst the others may be snacks, such as fruits, eggs or peanuts. Food should be given from all three food groups. Children are able to eat semi-solid foods at this age.

MONITORING AND REFERRAL FOR CHILDREN AGED 6 TO 24 MONTHS

Session 15: Supportive Care for the High-Risk Child

Session plan	Activity 1: Determine what they already know: Risk factors Activity 2: Give relevant information: Combining risks: Social and vulnerability factors Activity 3: Reinforcing the information: Combining risk factors Activity 4: High-risk case studies: Home-based support Activity 5: Give relevant information: Special care for HIV-positive children	 **Time: 2h30**
Learning objectives	At the end of this session, participants will be able to: • describe which young children may be more vulnerable to illness and need extra care from the ttC-HVs and some of the ways ttC-HVs can support their caregivers. • counsel mothers and caregivers on the special care required for a young child who is HIV-positive • counsel mothers and caregivers on the special care of a high-risk child.	

Key messages 	• A high-risk child is more likely to die before the age of 5, or to suffer complications such as infections and malnutrition.
	• Risk factors common in children: being HIV-positive, experiencing malnutrition, not being breastfed, being a maternal orphan and living with disabilities.
	• Factors in the family home environment can influence or exacerbate risks, such as mother experiencing psychosocial problems, previous child death, neglect or abuse of children, abuse and violence within the family home, caregivers with chronic or serious health problems, extreme poverty and poor living conditions.
	• High-risk children may be targeted to receive additional support, such as:
	  ○ additional home visits, counselling support or breastfeeding support
	  ○ psychosocial support for the mother and family
	  ○ monitoring and supporting medicine adherence and clinic attendance
	  ○ increased vigilance for danger signs and hygiene promotion
	  ○ connection to other community- and facility-based services.
	• Children who have HIV are at much higher risk of dying from other illnesses in the first 2 years of life and are in need of improved nutrition and more access to regular health care than those without HIV.
	• Children with HIV require lifelong antiretroviral (ARV) medicines that need to be taken every day. Families caring for an HIV-positive child must ensure that they give their ARV medicines every day. If they do so, they can be confident that their child will be healthy and go on to live a productive, healthy and long life no different from any other child.	

Preparation and materials 	*Materials* • Flipcharts and pens • Household Handbook • ttC-HV diary (if used) • Provide local examples of a follow-up schedule for an HIV-positive child • Provide local examples of antiretroviral treatment (ART) regimen for an HIV-positive child *Preparation* • Gather all training materials in advance.	

VISIT 11

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- describe which young children may be more vulnerable to illness and need extra care from the ttC-HV and some of the ways the ttC-HV can support their caregivers
- counsel mothers and caregivers on the special care required for a young child who is HIV-positive
- counsel mothers and caregivers on the special care for a high-risk child.

Activity 1: Determine what they already know: Risk factors

Ask: Are some children more vulnerable to infection and disease? Which children?

Ask: What are risks that they might face?

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

Ask: What might be the additional needs of these children be compared to others?

Explain or read aloud:

HIGH-RISK AND VULNERABLE CHILDREN

- A high-risk child is more likely to die before the age of 5 or to suffer complications such as infections and malnutrition.
- Risk factors common in children: being HIV-positive, experiencing malnutrition, not being breastfed, being a maternal orphan and living with disabilities.

Discuss the following cases with the participants. For each case, ask 'What are the risks?', 'What are the home-based care needs?' and 'What are their medical care needs?' Write their answers on a separate flipchart for each case, and add or clarify the comments from the table below.

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

Activity 2: Give relevant information: Combining risks: Social and vulnerability factors

Ask: Consider the context of the family home: what might be happening in the family home that could contribute to making a high-risk child even more vulnerable?

Write all the possible risks they identify on a separate flipchart, and pin it up alongside the previous one.

Children at risk	Social and vulnerability factors – what is going on in their home environment?
• A child who has, or has previously experienced, malnutrition • HIV-positive child • Child with disability • Child who is not breastfed • Maternal orphan	• Mother with psychosocial problems or depression • Previous child deaths • Evidence of neglect or abuse of children • Abuse and violence within the family home • Caregivers with chronic or serious health problems • Extreme poverty • Poor living conditions • Many children • Adolescent or single mother • Others... *discuss*

Activity 3: Reinforcing the information: Combining risk factors

Working in groups: Consider how these risks can combine. Give each group two cases to compare. At the end of their discussion they can report what they think the different outcomes of the cases might be and what the ttC-HV might consider when caring for the child.

Group 1: Compare and contrast the two cases

- Case 1: An HIV-positive child living in safe and clean environment, with access to medical care and family support for special care.
- Case 2: An HIV-positive child living in conditions of poverty, with a mother who is financially, physically or emotionally unable to care for her child.

Group 2: Compare and contrast the two cases

- Case 3: A child who was previously treated for malnutrition whose family is relatively wealthy and has only one child.
- Case 4: A child who was previously treated for malnutrition whose family has serious financial burdens, and five children under the age of 10.

Group 3: Compare and contrast the two cases

- Case 5: A child with a disability whose parents actively seek support and health care and who create a loving and stimulating environment for the child.
- Case 6: A child with a disability in a home where abuse or domestic violence is suspected.

Explain or read aloud:

FAMILY AND HOME ENVIRONMENT CONTRIBUTES TO RISK

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

Activity 4: High-risk case studies: Home-based support

Working in groups: Give each group a case study, and ask each group to discuss what the child'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 report back, and participants note the recommendations in the table.

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

- additional home visits and counselling or feeding support
- psychosocial support for the mother and family
- monitoring and supporting medicine adherence and clinic attendance
- increased vigilance for danger signs and hygiene promotion
- connection to other community- and facility-based services.

Case study	Possible answers
Case 2: An HIV-positive child living in conditions of poverty, with a mother who is financially, physically or emotionally unable to care for her child.	
Case 4: A child who was previously treated for malnutrition whose family have serious financial burdens, and five children under the age of 10.	
Case 6: A child with a disability where there is evidence of abuse and domestic violence in the home.	

Activity 5: Give relevant information: Special care for HIV-positive children

Reminder: In module 1 we talked about HIV in pregnancy and access PMTCT (Module 1, Visit 2). Ask participants if they can remember the key messages for pregnant women. Write these down on a flipchart. Then ask participants if they can remember in Module 2 when we talked about diagnosing HIV and starting children on medication called ARVs or Cotrim (Session 16 in Module 2). Write these down on a flipchart. This session is going to cover how to care for a child who is HIV-positive.

Ask the ttC-HVs to share the experiences they have had with any HIV-positive children in their community. What happened?

Write any important actions on a flipchart. Also consider stigma if this is discussed.

Explain or read aloud:

SPECIAL CARE FOR THE HIV-POSITIVE CHILD

- Children with HIV are more likely to get diarrhoea, pneumonia, TB and malnutrition. When this child becomes sick he/she is at risk of developing severe illness and needs special care for the illness. **Refer a child who has HIV and any other illness.**
- Children with HIV may suffer the usual childhood infections more frequently than uninfected children and are especially susceptible to getting TB or becoming malnourished. Children with HIV therefore need extra nutritious meals and snacks or may be provided with multivitamins to protect them from malnutrition. They need to be taken for more regular growth monitoring and health checks at the clinic than those without HIV.
- Knowing a child's HIV status can help the ttC-HV to best advise the family. However the ttC-HV must keep this knowledge confidential between the family, themselves and health facility staff.
- Children with HIV require lifelong ARV medicines that need to be taken every day. These will protect and improve their health. Mothers and caregivers need encouragement and support to ensure that they adhere to the treatment regime and never miss giving their child the ARVs. These children can reach adolescence without any severe illnesses if they always take their ARVs.

Summarise the main points of the session

- A high-risk child is more likely to die before the age of 5, or to suffer complications such as infections and malnutrition. This may include being HIV-positive, experiencing malnutrition, not being breastfed, being a maternal orphan and living with disabilities.
- Factors in the family home environment can influence or exacerbate risks.
- High-risk children may be targeted to receive additional support, such as:
    - additional home visits, counselling support or breastfeeding support
    - psychosocial support for the mother and family
    - monitoring and supporting medicine adherence and clinic attendance
    - increased vigilance for danger signs and hygiene promotion.
- Children who have HIV are at much higher risk of dying from other illnesses in the first 2 years of life, and are in need of improved nutrition and more access to regular health care than those without HIV. Children with HIV require lifelong ARV medicines that need to be taken every day. Families caring for an HIV-positive child must ensure that they give their ARV medicines every day. If they do so, they can be confident that their child will be healthy and go on to live a productive, healthy and long life no different from any other child.

Session 16: Referral and Follow-up of the Sick Infant and Child

Session plan	Activity 1: Review danger signs in children Activity 2: Care of the sick child during referral Activity 3: Completing the referral forms Activity 4: Discussion: Home-based follow-up Activity 5: Interpreting counter-referral forms	 **Time: 2h30**
Learning objectives	At the end of this session, participants will be able to: • describe considerations for referring a sick infant or child with a complication • describe how to conduct a follow-up home visit after referral • complete a written referral form to the best of their ability and interpret counter-referrals received from the health facility (literate ttC-HVs).	

Key messages 	• When conducting an emergency evacuation of a child, ensure that he/she is accompanied by mother and a family member or CHW, well wrapped and regularly monitored for breathing, continuing to breastfeed as often as possible. Ensure the mother has all medical records or cards/materials needed for a hospital stay.
	• A written counter-referral (facility discharge note) may be written by the facility with the patient's consent and can communicate important information about the care of the sick child, which might be important for the ttC-HV, CHW or family, such as:
	  ○ medical conditions that need extra care (malnutrition, HIV)
	  ○ 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 ttC-HV or CHW should follow-up in the home.
	• During a home-based post-referral visit, a ttC-HV should ensure that the child was seen at the clinic, received the medical care and medicines needed, is fully recovered, and is following treatment and care guidance given. If the child is still sick 48 hours after being treated with no signs of improvement, refer him/her back to the clinic.	

Preparation and materials 	*Materials* • Sample referral forms: three per participant • Sample counter-referral forms, either printed or projected *Preparation* • Distribute referral forms.	

Introduce the session

Explain or read aloud:

OBJECTIVES OF THE SESSION

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

- describe considerations for referring a sick infant or child with a complication
- describe how to conduct a follow-up home visit after referral
- complete a written referral form to the best of their ability and interpret counter-referrals received from the health facility (literate HVs).

Activity 1: Review danger signs in children

Start this session by quickly reviewing the danger signs in the child using the storybooks.

Activity 2: Care of the sick child during referral

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

FOR THE SICK CHILD:

- Ensure that the child is accompanied by the mother.
- Continue breastfeeding as much as possible throughout the journey.
- Give fluids regularly if the child is over 6 months and able to drink.
- Take medical records, cards, money to pay for services and transport, food and water for herself, clothes and materials prepared for an overnight hospital stay.

Activity 3: Completing the referral forms

Contextualisation: Use referral/counter-referral forms available in country as necessary, replacing the system below.

Ask: What are your experiences with using the referral forms? Discuss any concerns. Remind them how to use the form:

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

Training exercise

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

1. Faith Mwembe #1232 has a 12-month-old son called Samson. During the visit you observe that Samson has a bad cough and cold. You notice that his skin is hot to touch and that his breathing is rasping and quick. Faith reports that she gave Samson some Bactrim syrup that she had in the cupboard since last time he was sick (6 months ago), and that he is starting to feel better today. Complete the form and discuss how to counsel Faith for the journey.

2. Laxshmi Gupta, ID number #028472 has an 18-month-old daughter, Bhavana. Bhavana has been suffering from fever for 2 days now, and she has a rash on her body and some mouth ulcers. Laxshmi has been giving her daughter Paracetamol syrup, 5ml 3 times a day for the last two days. Counsel the mother and complete the form.
3. Janet Nyakuzi # 00142 has a daughter Imani, who is 9 months old. Imani has had sickness and diarrhoea for 6 days, and Imani has been treating her at home using a local tea remedy for nausea, and giving water to drink. Imani is very unwell and is no longer able to breastfeed or drink anything since the morning. You also notice during the visit that she currently has oedema in both feet, and her arms look very thin. You confirm in Imani's health card she has been underweight in the last two clinic visits. Complete the form and discuss how to counsel Janet for the referral.

Activity 4: Discussion: Home-based follow-up

Ask: Has anyone had an experience where a child has been treated at a facility and gone on to die at home?

Ask: What might have gone wrong in such a case? Discuss their responses.

Answers could include:

- The child developed another complication.
- The medicines provided were not of good quality.
- There was an underlying condition not detected/treated, such as malnutrition, HIV or TB.
- The mother did not complete the treatments given.
- The clinic considered the case to be less serious and the child was discharged too soon.
- The child did not feed or drink well during illness and became dehydrated/malnourished.

In reality, when a death occurs, it is often the case that families have sought care at the heath centre during the episode, but for some reason, the child does not recover, and the parents delay returning to the clinic.

Ask: What is the purpose of conducting a home visit when a sick child has been seen at the facility?

Discuss their answers and stress:

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

Activity 5: Interpreting counter-referral forms

Recap the purpose of counter-referral from the facility:

- A written counter-referral (facility discharge note), may be written by the facility with the patient's consent and can communicate important information about the care of the patient, which might be important for the ttC-HV, CHW or family. Examples include the following:
    - Conditions identified which need extra care

- When the patient should return for follow-up at the facility
- Medicines the patient should be taking
- Danger signs to look out for and care guidance to follow
- When the ttC-HV or CHW should follow-up in the home.

The trainer should complete copies of the counter-referral with the following cases and distribute to the groups. Ask the ttC-HVs to read and interpret forms. Then read the italics and discuss (with health staff if possible) how to handle the case.

1. Faith Mwembe #1232 and her 12-month-old son, Samson, were seen at the health facility. Samson was treated for acute respiratory infection using antibiotics and discharged the same day. The referral form gives instructions to treat with antibiotics for 5 days, with Paracetamol 3 times daily. The facility discharge notice says they do not need to come back, unless Samson shows no improvement after 48 hours. The form suggests you should visit twice in the next week.

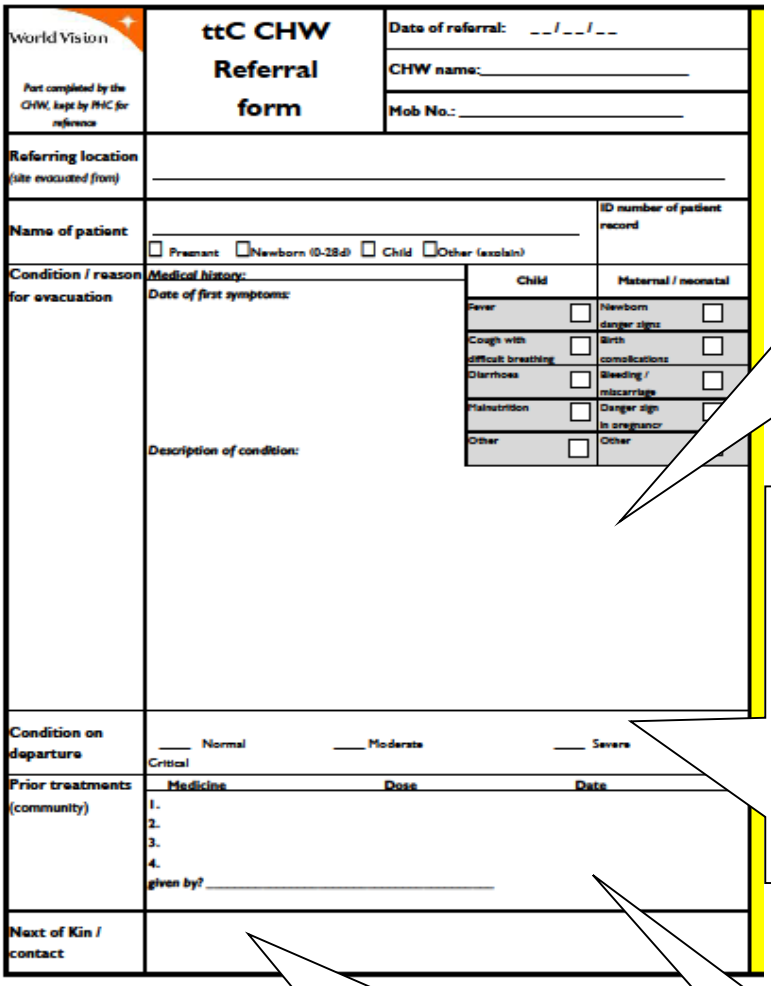
During the 48-hour follow-up visit, Samson is still coughing with rapid breathing, and Faith reports that he has not improved. She is giving the antibiotics as guided. Counsel Faith and her family on what to do.

***Possible answers** = return to the clinic, follow-up as guided.*

2. Laxshmi Gupta, ID number #028472 and her 18-month-old daughter, Bhavana were seen at the facility, and Bhavana was identified as having measles. She has been given Paracetamol syrup and told to continue giving Bhavana 5ml 3 times a day if she has fever. The form says the condition on departure was moderate and that the child should only return if there are danger signs, or if fever continues after 7 days. They recommend follow-up once per week for two weeks.

During the home visit, the ttC-HVs find Bhavana no longer has fever and is starting to recover. Laxshmi confirms that she does not have other concerns.

***Possible answers** = follow-up as guided.*



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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

ID number of patient record

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

Condition / reason for evacuation

Medical history:

Date of first symptoms:

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

Description of condition:

Condition on departure

___ Normal ___ Moderate ___ Severe Critical

Prior treatments (community)

Medicine	Dose	Date
1.		
2.		
3.		
4.		

given by? _____

Next of Kin / contact

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

At the time they left the location were they:

Normal – able to walk, comfortable

Moderate – able to walk with difficulty

Severe – conscious, unable to walk

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

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

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

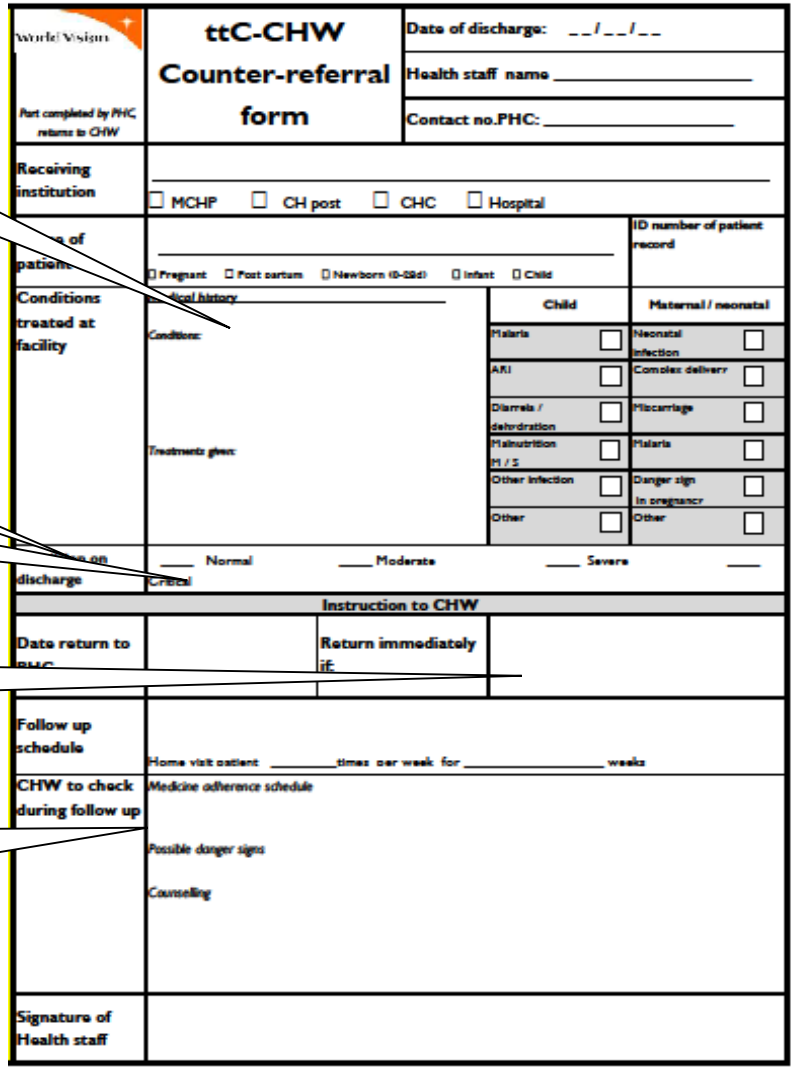
Health staff declare the condition of the patient upon departure – sometimes the family may opt to remove a sick patient from the facility to care for them at home.

Health staff list the date required for follow-up – CHW can ensure that this follow-up clinic appointment is attended.

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

Message to the CHW 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

ID number of patient record

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

Conditions treated at facility

Medical history

Conditions:

Treatments given:

Child		Maternal / neonatal	
Malaria	☐	Neonatal infection	☐
AKI	☐	Complex delivery	☐
Diarrea / dehydration	☐	Miscarriage	☐
Malnutrition M / S	☐	Malaria	☐
Other infection	☐	Danger sign in pregnancy	☐
Other	☐	Other	☐

Condition on discharge

____ Normal ____ Moderate ____ Severe ____

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 17: Completing the Child Register

Session plan	Activity 1: Review the forms Activity 2: Sample cases and completing the forms Activity 3: Validating information using the child health record Activity 4: Discussion and practice	 **Time: 1h30**
Learning objectives	At the end of this session, participants will be able to: • complete the *ttC Register – Child* correctly • explain how to validate the birth information using health records/card.	
Key messages 	• The child register serves as a record of all important information relating to the visits between 6 and 24 months of life, including all vaccinations, continued breastfeeding to 2 years and beyond, complementary feeding, vitamin A and deworming. • For all practices, the ttC-HVs should mark a tick for a positive answer and a cross for a negative answer, aligned to the timing of the home visit.	
Preparation and materials 	*Materials* • Child registers (three per participant) • Sample registers – printed or projected on screen • Child health records (local examples) *Preparation* • Distribute the *ttC Register – Child* 6 to 24 months.	

Introduce the session

Explain or read aloud

OBJECTIVES OF THE SESSION

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

- complete the *ttC Register – Child* correctly
- explain how to validate the birth information using health records/card.

Activity 1: Review the forms

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

- The *ttC Register – Child* serves as a record of information relating to the visits between 6 and 24 months of life including vaccines, continued breastfeeding to 2 years and beyond, complementary feeding, vitamin A and deworming.
- For all practices, the ttC-HVs should mark a tick ✓ for a positive answer and a cross × for a negative answer, aligned to the timing of the home visit.

Review the structure of the forms, or ask participants to explain each section:

- **Universal register information** (*contextual change):* registration information can be transferred from the infant register or deleted if printing of forms is back-to-back.

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- **Column structure and timing:** The register has one column for each of the recommended visits aligned to the age of the child.
- **How to mark planned and completed visits:** In the row 'visits planned' write the date of the planned visit. In the row below, literate ttC-HVs can write the date the visit was completed. If they are not literate, they could mark the visit with a tick ✓ to show they have done the visit.
- **Indicators:** Each row corresponds to health practices the ttC-HVs will have promoted during the visits. Write a tick ✓ for practices done and cross × for not yet done.
- **Danger signs and referral:** In each visit check for danger signs in the child. If you recommend referral write the date of referral (or tick ✓ if not literate). If there is no danger sign write a cross ×. Wait until confirming they went to the health facility before marking a referral as completed.

Activity 2: Sample cases and completing the forms

We are still working with our friend Lara, whose child is now 2 years old. For the first column, read the story. The group should fill in details for the 9-months visit on their blank forms. For the second example, project, or distribute a photocopy of the completed form (without the answers!).

Contextualisation: Cross-check the story examples with the final versions of the *ttC Register* you are using. Ensure that the vaccine schedule for your country is reflected correctly. Ensure that you have deleted any indicators you are not collecting from the sample form below.

WORKED EXAMPLE: LARA: COMPLETE THE BLANK FORM

- Lara's daughter Esther was born on 18 October. You have planned her visits according to the correct schedule. In the 9-months visit you visit them on 19 July. Mother and baby are well, and the husband participates.
- Esther is not considered to be high risk. She has completed her vaccines by 9 months and was given a dose of vitamin A at 6 months. She always sleeps under a mosquito net.
- Lara reports that she is taking the pill to prevent pregnancy, she is washing her hands regularly and breastfeeding is going well.
- She reports that she is feeding the baby complementary foods, but she just gives mashed rice and sauce, usually only twice per day. She has not introduced eggs, meat, fish or green leafy vegetables.

Ask: What do you counsel Lara on complementary feeding?

Ask: Why is the deworming schedule grey for 9 months? *(deworming starts from 12 months)*

Distribute the completed form below, without the answer balloons. Discuss the results in groups and point out anything unusual. Then ask the following questions:

- How does the supervisor know Visit 10 was conducted late?
- When does Lara stop taking contraception?
- When does Lara stop breastfeeding her child?
- Do Lara's complementary feeding practices improve after 12 months? How?
- Has Esther completed all the required vitamin A and deworming doses?

- What happened to Esther during Visit 9?

Activity 3: Validating information using the child health record (literate ttC-HVs)

Contextualisation: Provide examples of the child health record 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:

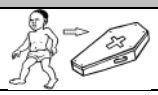
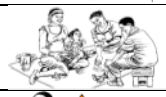
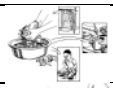
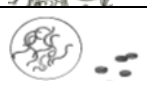
- vaccines, vitamin A and Mebendazole schedule (if marked)
- date of vaccinations/doses given
- growth curve and progress
- any observations
- development indicators or milestones.

Summarise the main points of the session

- The *ttC Register – Child* serves as a record of information relating to the visits between 6 and 24 months of life, including vaccinations, continued breastfeeding to two years and beyond, complementary feeding, vitamin A and deworming.
- For all practices the ttC-HVs should mark a tick ✓ for a positive answer and cross × for a negative answer, aligned to the timing of the home visit.

Worked example: Lara

Gender of child (circle): ♀ ♂ **ttC REGISTER - CHILD**

		CHILD					Totals completed by the supervisor when
		6m 9m	12m	18m	23m	DATA CODE	
Visits planned		V8 18/7	V9 18/10	V10 18/4	0V11 18/10		This visit was conducted late.
Migrations/maternal death *(date of death)*		×	×	×			
Child death *(date of death)*		×	×	×	×	D6	
Home visits *(date of visit)*		19/7	18/10	30/4	18/10	C1 C2	*2 visits before 1 years?* *4 visits 6-24 months?*
Husband/partner participated in ttC visit?		✓	✓	✓			*Did the husband/partner participate in most ttC visits?*
High-risk child?		×	×	×			*Child was considered at risk at any point?*
Mother is using contraceptive method		✓	✓	×			*Mother using a contraceptive method at least 18 months post partum*
Handwashing		✓	✓	✓		C6	*Mother practices hand washing regularly at all visits?*
Continued breastfeeding		✓	✓	×	×	C7	*Child continued to receive breast milk to 23m?*
Complementary feeding from 6 months		✓	✓	✓			*Complementary feeding was introduced from 6 months?*
Minimum meal frequency regularly eaten		×	✓				*Child is receiving minimum meal frequency during all visits?*
Iron-rich foods regularly eaten?		×	×	✓			*Child is consuming iron rich foods regularly at all visits?*
Iron supplements given		×	×	×	×		*required?*
Completed all vaccinations		✓					*child completed all due accines before 12m*
Vitamin A given (6m, 12m, 18m, 24m)		✓	×	✓	✓	C13	*Child received at least two times before 23m?*
Deworming tablets given (12m, 18m 24m)			×	✓	✓		*Child received at least 2 m*
Child is sleeping under a mosquito net every night?		✓	✓	✓	✓		*-23 months onsistently?*
Child with sign of illness?		×	✓	×	×	E6	*Total events*
Child with illness was taken to the health facility		×	✓	×	×	E6A	*Total events*
Post-referral home visit completed		×	✓	×	×	E6B	*Total events*

Lara stops taking the pill after 12 months because she wants to have another child.

Lara stopped breastfeeding at 18 months.

Lara isn't giving enough meals per day in the 12-months visit, but after counselling she begins better practices.

Lara isn't giving chicken meat or eggs until the baby is 12 months. You counsel her and she begins giving iron-rich foods

WHOOPS! Lara missed a vitamin A and deworming dose at 12 months.

Poor Esther was sick at Visit 9. You referred her and followed up later – well done!

VISIT 11

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