

# TIMED AND TARGETED COUNSELLING FOR HEALTH AND NUTRITION

## A TOOLKIT FOR PROGRAMME PLANNERS



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Managed by: Polly Walker. Publishing Coordination: Katie Fike.  
Content Editor: Marina Mafani. Proofreading: Nancy Verrall Warren.

Written by: Polly Walker, Michele Gaudrault and Beulah Jayakumar  
Contributors: Sue England, Tina Monique James, Miriam Yiannakis, Annette Ghee, Fe Garcia, Mesfin Teklu, Dan Irvine, Carmen Tse, Hwa Woo.

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An Ethiopian family who took part in World Vision's "Alive and Thrive" nutrition programme in Chench, Southern Ethiopia in 2012.

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## ABBREVIATIONS

ADAPT	Analysis design and planning tool
ADP	Area development programme
ANC	Antenatal care
ARI	Acute respiratory infection
ART	Antiretroviral therapy
ARV	Antiretroviral
ASHA	Accredited social health activist
CBMNC	Community-based maternal and newborn care
CCC	Community care coalition
CGV	Care group volunteer
CHW/V	Community health worker/volunteer
CMAM	Community-based management of acute malnutrition
CoH	Channels of hope
COMM	Community health committee
CSS	Community systems strengthening
CVA	Citizens voice and action
DADD	Do, assure, don't do
DHS	Demographic and Health Surveys
DME	Data Monitoring and Evaluation
DPA	Development Programme Approach
EBF	Exclusive breast-feeding
EmOC	Emergency obstetric care
EmONC	Emergency obstetric and newborn care
ENC	Essential newborn care
FGD	Focus group discussion
FP	Family planning
GAM	Global acute malnutrition
GBV	Gender-based violence
GC	Global Centre (World Vision International)
GTRN	Global Technical Resource Network
HIV	Human immunodeficiency virus
HMIS	Health Management Information System
H/N	Health and nutrition
HSA	Health surveillance assistant
HSS	Health systems strengthening
HVs	Home visitors
ICCM	Integrated community case management
ICT	Information and communication technologies
IMCI	Integrated management of childhood illnesses
IPM	Integrated Programming Model
IPTp	Intermittent preventive treatment in pregnancy
IYCF	Infant and young child feeding
KMC	Kangaroo mother care
LBW	Low birth weight (baby)

LEAP	Learning Through Evaluation, Assessment and Planning
LLA	Local-level advocacy
LLIN	Long-lasting insecticidal net
MAM	Modern acute malnutrition
MHPSS	Mental health and psychosocial support
MICS	Multiple indicator cluster survey
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
PDH	Positive deviance/Hearth
PHC	Primary health care
PHU	Public health unit
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
SFP	Supplementary feeding programme
SMAG	Safe motherhood action group
SO	Support office
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TA	Technical approach
TBA	Traditional birth attendant
ToF	Training of facilitators
ttC	Timed and Targeted Counselling
ttC-HVs	ttC-home visitors
U5MR	Under-5 mortality rate
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCT	Voluntary counselling and testing
VHC	Village health committee
VHT	Village health team
WASH	Water, sanitation and hygiene
WFP	World Food Programme
WHO	World Health Organization
WV	World Vision

## PURPOSE OF THE GUIDE

World Vision's Timed and Targeted Counselling (ttC) Project Model for community-based volunteers (CBVs), groups and community health workers (CHWs) is now a core model for maternal, newborn and child health (MNCH) programming. It is designed to promote healthy practices at the level of individuals and their immediate families through a scheme of home visits using storytelling, negotiation and dialogue counselling methods, based on the Home-Based Life-Saving Skills<sup>1</sup> method. The ttC was developed to align with World Vision's 7-11 strategy, which seeks to strengthen and consolidate our health programming through a package of high-impact interventions to improve child well-being, including seven interventions during pregnancy and 11 interventions for the child up to 2 years of age, delivered in an integrated lifecycle approach. World Vision's 'Core ttC Curriculum' published alongside this toolkit, offers a starting place for a generic system of training a selected cadre of ttC home visitors or CHWs, which can be adapted to diverse country contexts and local needs.

The ttC model is currently being adapted for use in 20 countries worldwide. We have learnt that there is a gap in the guidance, adaptation and planning as to how to adapt ttC using local materials and how to integrate it into existing community health programming as well as within a country's existing health and community system. 'ttC: A Toolkit for Programme Planners' seeks to bridge that gap by providing an in-depth introduction to the methodology and presenting a range of tools for planning, quality assurance and design.

## WHO IS THE TOOLKIT FOR?

This Toolkit is intended for World Vision national offices (NOs) that are going through the design, adaptation, planning and scale-up of ttC programmes. It can be used by programme planners, health technical specialists, subject matter experts, consultants and regional advisors who support ttC. It can also be used as orientation material for government and stakeholders when conducting national planning workshops to orient them on the methodology of ttC and decision-making processes.

## WHAT IS COVERED IN THIS TOOLKIT?

This document provides a description and strategic framework, background information and justification for the ttC project model, as well as operational guidance for NO-level staff and partners at a country level for decision making related to local context adaptation and scale-up.

- **Situating** the ttC model within the overall health-sector 7-11 programming, and within Area Development Programmes (ADPs) *Development Approach Programming* (Part 1, section 1.1)
- Justify and explain the use of the timed and targeted approach as an alternative to classic health-promotion delivery methods conducted by community home visitors and CHWs, and describe **the core components** of the ttC model and its methodology (Part 1, Section 1.2)
- A **strategic framework** for ttC model implementation including a sample log frame, which may be used for ADP Learning through Evaluation, Assessment and Planning (LEAP) purposes as well as for grant proposal writing (Part 1, Section 1.3)
- Detailing the **core ttC curriculum** and the sources of its technical content. (Part 1, Section 1.4)
- **Minimum standards** applied and evaluated during ttC implementation and design, CHW programming standards and principles that may shape CHW programming (Part 2)

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<sup>1</sup> Home-Based Life Saving Skills (HBLSS): A Manual for Midwives. 4<sup>th</sup> edition 2008. American College of Nurse Midwives. <http://www.midwife.org/ACNM-Publications>

- Outline of the **processes involved in preparing** NOs for ttC implementation (Part 3), adaptation of the model to your country context and building capacity of health technical staff, and to provide practical guidance for the preparation (Parts 4 and 7)
- Outline how ttC integrates with different project models, particularly individual-level models (Part 5).

In Appendix I, you will find the ttC Toolkit itself with links to current online documents and a description of each. These materials can be found on WV internal site [www.wvcentral.org](http://www.wvcentral.org) or are available on request from [sarah.crass@wvi.org](mailto:sarah.crass@wvi.org) or at [health@wvi.org](mailto:health@wvi.org)

# I. OVERVIEW OF TIMED AND TARGETED COUNSELLING

## Purpose of this section

This section provides an overview of the timed and targeted counselling methodology, shows how it is embedded within the World Vision Health 7-11 Strategy and within the ADP *Development Programme Approach*, describes when to implement, and outlines the core components of the project model. These sections are useful for NO-level staff developing NO health strategies (aligned to 7-11), and when guiding ADP staff to understand how ttC fits within overall ADP programming in those ADPs applying the *Development Programme Approach*.

## I.1. WHAT IS ttC?

### ttC IS TIMED, TARGETED AND (BEHAVIOUR CHANGE) COUNSELLING

**Definition of ttC:** ttC is when the key 7-11 practices are promoted to mothers and their supporters through home visits using a timed, targeted and negotiation and dialogue behaviour change counselling approach. Whilst ttC can be applied using diverse *curricula, cadres and job aids*, it is the methodology that defines the ttC approach.

Many countries are currently using a cadre of community-based health workers or volunteers to conduct home visits that seek to promote key practices in the family and community; indeed this is recommended as an activity within the community component of the Integrated Management of Childhood Illnesses Strategy (c-IMCI).<sup>2</sup> Whilst ttC promotes these same practices in the home,<sup>3</sup> several key differences distinguish the ttC approach from more conventional methods of health promotion. Furthermore, we wish to emphasise that whilst ttC can be applied in diverse contexts using different curricula, cadres and job aids, it is not these elements that define a project as ttC. Importantly, the majority of CHW-led health-promotion activities involve CHWs using ‘counselling cards’ to deliver key health messages to individuals or groups; these methods should collectively be described as ‘health promotion’ but are not ttC. There are **three core elements** within the definition of ttC, and all three must be present. As a guide to practitioners, we recommend the following:

### ttC is ‘timed’

Selected messages for maternal, newborn and child health are delivered at appropriate times for the woman and her family to be of most value to them at that time. They are delivered prior to the time she needs to take action and have significant consequences to her or her child’s health during her pregnancy or her child’s first two years of life. The messages should be delivered not too soon that they be forgotten, nor too late for her and her family to have time

<sup>2</sup> Improving family and community practices: A component of the IMCI strategy, World Health Organization; UNICEF 1998.

<sup>3</sup> Key practices include exclusive breastfeeding, complementary feeding from 6 months, Vitamin A supplementation, safe disposal of faeces, vaccination, ITN usage, appropriate home treatment and improved feeding during illness, recognition of illness and referral, promotion of mental and social development of the child.



to change behaviours and take action. To be consistent with the *timed* approach, they should be delivered according to a schedule of visits across the first crucial 1,000 days of life – ie from pregnancy to when a child reaches 2 years of age. **Combined group-based approaches that involve combining target groups across life cycle stages: pregnancy, newborn, infant (1-6m), older infants and toddlers (6-24m), are not ttC.**

### ttC is ‘targeted’

ttC is a home-visiting methodology that reaches women and their supporters including male partners, mothers in law and grandmothers who may be the key decision makers in the home. It is targeted in time (when it is needed), in space (by visiting in the home), and in individualised approaches (messages and barriers focus on the circumstances of a specific family). **Generic health promotion messaging is not ttC. If the counselling includes mothers but excludes key decision makers, then it is not ttC.**

### ttC is ‘counselling’

Current thinking in behaviour change communication (BCC) is based on the evidence that generic health-promotion messaging has a limited impact on behaviour, especially where there are key personal, cultural, financial and geographic barriers to adopting a healthy practice. In ttC, a home visitor engages the family in discussions about their current health practices compared to the messages provided, identifies barriers to the preferred practice through dialogue, and then negotiates a feasible change to current practice based on their individual circumstances. **Importantly, as per many CHW programmes, when a CHW presents a flip chart of messages and uses them to instruct the family about key health practices without engaging in a dialogue, this is not ttC.**

## ttC’S FIT WITH THE 7-11 STRATEGY

### World Vision’s 7-11 health strategy

ttC is one of the core approaches of World Vision’s Global Health and Nutrition Strategy known as 7-11. This strategy is built around evidence-based, cost-effective key interventions for pregnant women and children under age 2 which, when taken together, can significantly reduce maternal and infant/young child morbidity and mortality. The key interventions are summarised in Table 1 below.

**Table 1. 7-11 Interventions for maternal, newborn and child health**

7 Interventions for Pregnant Women	11 Interventions for Children under 2
<ol style="list-style-type: none"> <li>1. Adequate diet</li> <li>2. Iron/folate supplements</li> <li>3. Tetanus toxoid immunisation</li> <li>4. Malaria prevention, and intermittent preventive treatment</li> <li>5. Health timing and spacing of pregnancy</li> <li>6. Deworming*</li> <li>7. Facilitate access to maternal health service: antenatal and postnatal care, skilled birth attendants, prevention of mother-to-child transmission of HIV, HIV/TB/sexually transmitted infections screening</li> </ol>	<ol style="list-style-type: none"> <li>1. Appropriate breastfeeding</li> <li>2. Essential newborn care</li> <li>3. Hand washing with soap</li> <li>4. Appropriate complementary feeding (6-24 months)</li> <li>5. Adequate iron</li> <li>6. Vitamin A supplementation</li> <li>7. Oral rehydration therapy/zinc</li> <li>8. Prevention and care seeking for malaria</li> <li>9. Full immunisation for age</li> <li>10. Prevention and care seeking for Acute Respiratory Infection</li> <li>11. Deworming (+12 months)</li> </ol>

\*At the time of publication, a review of the 7-11 strategy was under way.

For a complete description of the 7-11 strategy and the core and additional approaches that make it up – of which ttC is one component – refer to *The Global Health and Nutrition 7-11 Start-Up Field Guide*.

### Three levels of intervention for 7-11

World Vision’s 7-11 strategy for maternal and child health is based on a model of BCC that calls for intervening at the three levels of **individual**, **community** and **environment**, in order to provide pregnant women and caregivers of children under 2 with ‘360 degrees of support’ for the practice of healthy behaviours. Based on this conceptual model, all 7-11 programmes will implement three core approaches, one at each level.

#### Individual level: ttC

At the individual level, the **ttC** approach reaches pregnant women and caregivers of children under 2 with messaging, dialogue and counselling around the full set of 7-11 practices, carried out by CHWs, volunteers or appropriate selected partners through home visits. World Vision’s Timed and Targeted Counselling curriculum or an equivalent MoH or partner-produced package is used for this programming.

#### Community level: **COMM: community systems strengthening**

At the community level, the focus is on **community systems strengthening** for health, working with a community structure that may be referred to for purposes of consistency within WV, as the **COMM**, or community health committee. WV’s Development Programme Approach refers to these structures as working groups. In the field, they may be known under various local names, which will be retained. The COMM is the prerequisite structure for operationalising the 7-11 strategy, and community systems strengthening will take place through, with, and via the COMM. The COMM is a stand-alone model, which is described in detail elsewhere; however, COMM involvement and capacity building are central to the ttC model, ensuring that home-visitor activities are integrated within a community systems strengthening approach. Furthermore, the activities of ttC home visitors (ttC-HVs) and other community health actors

within a project area, such as prevention of mother-to-child transmission of HIV (PMTCT), integrated community case management (ICCM) and nutrition programming) should be integrated through the COMM.

**Environmental level: LLA/CVA**

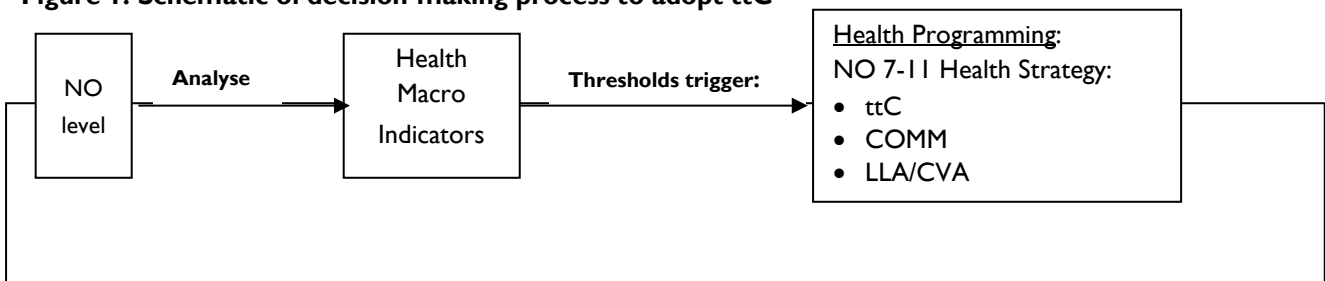
Two core approaches at environmental level aim to improve policies, services and supplies such that the health environment may become enabling and supportive for the pregnant women and caregivers of children under 2, and all those in the community seeking health care. **Local-level advocacy (LLA)** works to identify and address health-system gaps, as appropriate and feasible per World Vision’s organisational strengths and mandate.

Some degree of **health systems strengthening (HSS)** may also be undertaken as per guidance provided elsewhere. However, we wish to emphasise that elements of HSS are incorporated within the core ttC strategic framework in order to ensure that community systems are integrated within functional health systems.

**WHEN IS 7-11 CORE PROGRAMMING IMPLEMENTED?**

**Macro indicator thresholds (Triggers for action)**

**Figure 1. Schematic of decision-making process to adopt ttC**



**ttC AND THE DEVELOPMENT PROGRAMME APPROACH**

At the NO (country) level, a review of macro indicators will determine the need for health (and other sector) programming. When these indicators exceed certain defined ‘trigger’ thresholds, health programming is recommended. In these cases, any NO-level health strategy will include, at minimum, the three core 7-11 models; this is considered the mandatory health programming to be implemented in response to the triggers.

At the area development programme (ADP) level, health programming takes place within the context of overall ADP programming. For certain ADPs, health programming will be implemented within the context of the **development programme approach (DPA)**. It is important for ADP staff to understand how this all fits together. The DPA begins with an assessment, which will trigger the need for health programming. ADP staff, together with community members, will then follow the steps of the ‘critical path’ to determine the specifics of the programming. As part of this process, ADP staff will explain the 7-11 strategy and the three core models that make it up, and will seek to agree with the community on the importance of implementing these models. There are existing guidelines for the adaption of the ttC model within the DPA, however, in order for the ttC model to be used within the context of a single ADP or grant-based project, it is typically a prerequisite that ttC will have been adapted at a national level as part of the NO’s health-sector strategy or technical programming approach, due to the high costs and need for NO-level planning and preparation during the country-readiness process. The choice to proceed with the ttC model will depend on an analysis

of concurrent programming activities amongst community-level actors such as MoH-affiliated CHWs and community groups.

### ttC WITHIN A TECHNICAL PROGRAMMING APPROACH

The **technical programming approach for health**, developed in response to concerns over gaps between strategy and programming, is a process by which a set of technical approaches is clearly defined by the NO for its ministry priorities within a multi-year strategy implementation plan, then applied flexibly during programme design/redesign. A technical approach (TA) will include selection of one or more project models that define how the WV operations in that country will achieve the objective. As well as identifying the project model/s for each strategic objective, a technical approach will also outline other operational elements such as national-level partnerships, advocacy and learning networks at the national level, and the role of NO-level technical staff support required. Health technical programming requires appropriate technical management at multiple levels, and the TA process can identify these staffing requirements with greater precision. The approach is better able to ensure that implementation standards embedded in project models and monitoring/evaluation indicators can be aggregated for management purposes at the NO level, providing a benchmark against which all projects can be compared.

When applying ttC through MoH-affiliated CHW cadres, the TA is particularly conducive to improved programming for several reasons. The CHW curriculum content should be contextualised based on thorough national assessment aligned with national health plans. This assessment is also critical to identify existing implementers and materials so as to avoid duplication. CHW programming design and management cannot be isolated to individual ADPs but requires intensive NO-level partner engagement. WV’s CHW POP<sup>4</sup> requires that our CHW investments be synchronised with partners nationally. That requires an approach guided by national-level strategy, planning and resourcing.

ttC, when selected as part of a technical approach, has the potential to be brought to scale within a country more consistently and cost effectively, clearly leading to a need for stronger technical support across multiple ADPs or geographic zones, and better collaboration with the MoH/local health authorities.

**Table 2. Advantages and risk mitigation for applying the TA for ttC at the national level**

<b>Advantages of the TA for ttC</b>	<b>Risk mitigation of the TA for ttC</b>
<ul style="list-style-type: none"> <li>• Improving scale and consistency and therefore quality of ttC programming through the application of implementation standards;</li> <li>• Pooling the technical expertise efficiently, and relying less on external expertise brought in on a project by project basis;</li> <li>• Saving of time, costs and effort at the ADP level in the adaptation of materials, training events, development and start-up costs;</li> <li>• Saving of time and costs for NO and SO level in the review of programme/project design;</li> </ul>	<ul style="list-style-type: none"> <li>• Ensure that the assessment done for contextualisation of the ttC curriculum enables response to local epidemiology or cultural contexts, and is sufficiently flexible to permit the development of innovative methods;</li> <li>• To avoid the perception that ttC is externally imposed, ensure that local introduction of ttC is developed as part of dialogue with local partners and communities, improving a sense of local ownership through CHWs and COMMs.</li> <li>• If ttC is developed at low quality at the NO</li> </ul>

<sup>4</sup> CHW Principles of Practice. Walker et al., 2013.

[http://www.coregroup.org/storage/Program\\_Learning/Community\\_Health\\_Workers/CHW\\_Principles\\_of\\_Practice\\_Final.pdf](http://www.coregroup.org/storage/Program_Learning/Community_Health_Workers/CHW_Principles_of_Practice_Final.pdf)

<b>Advantages of the TA for ttC</b>	<b>Risk mitigation of the TA for ttC</b>
<ul style="list-style-type: none"> <li>• Unified monitoring and evaluation systems across diverse project sites;</li> <li>• Ensuring that all ttC project designs are agreed in partnership agreements with relevant national government bodies and other key stakeholders;</li> <li>• Ensuring that ADPs within a single health authority catchment area are aligned;</li> <li>• Enabling ttC programmes to come into alignment with WV's CHW POP.</li> </ul>	<p>level and taken to scale, this undermines impact across all programmes.</p>

### ttC CONTRIBUTES TO CHILD WELL-BEING OUTCOMES

ttC contributes to the Child Well-being Aspiration 'Children enjoy good health', by improving the following Child Well-being Outcomes (see Table 3):

- Children are well-nourished
- Children are protected from infection, disease and injury
- Children and their caregivers access essential health services.

#### Child Well-being Outcomes

National offices may also decide to implement health programming as a means of achieving Child Well-being Outcomes, regardless of the levels of health macro indicators at the national level. This is, in fact, recommended for most NOs. The minimum health programming in these cases should also include the three 7-11 core models.

**Table 3. ttC contributions to Child Well-being Outcomes**

<b>Child Well-being Outcome</b>	<b>Contribution</b>
Children are well-nourished	<ul style="list-style-type: none"> <li>• Increases household practices promoting adequate nutrition for children under 2 including appropriate breastfeeding and complementary feeding.</li> <li>• Promotes nutrition in pregnancy, leading to better nourished infants in utero and at birth.</li> <li>• Establishes community capacity to recognise and address malnutrition, through access to knowledge and commodities.</li> </ul>
Children are protected from infection, disease and injury	<ul style="list-style-type: none"> <li>• Promotes practices that prevent disease and injuries in children and pregnant women.</li> <li>• Emphasises practices for protection against infections, including complete immunisation, protection from malaria, and nutritional supplementation in pregnancy and early childhood.</li> <li>• Promotes recognition of danger signs and prompt care seeking during pregnancy and in children.</li> <li>• Addresses vulnerabilities to illness caused by malnutrition.</li> </ul>
Children and their caregivers access essential health services	<ul style="list-style-type: none"> <li>• Increases household-level demand for essential health services.</li> <li>• Creates community-level linkages to health facilities and commodities.</li> <li>• Emphasises behaviours that reduce the need and cost for urgent health services.</li> </ul>

	<ul style="list-style-type: none"><li>• Strengthens local capacity to address maternal and child health issues.</li></ul>
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Also, ttC is aligned with WV's Global Health and Nutrition Strategy's 'Do, Assure and Don't Do (DADD) guidance, shown below.

**Table 4. Alignment of ttC to H/N DADD**

<b>DADD</b>	<b>ttC Alignment</b>
<p><b>Do</b></p> <ul style="list-style-type: none"> <li>• Assess health system performance, including community and primary health care (PHC) systems.</li> <li>• Build capacity of PHC-level workforce.</li> <li>• Mobilise and build capacity of community-level maternal child health and nutrition (MCHN) stakeholders.</li> <li>• Monitor core indicators in the areas in which we work.</li> </ul>	<ul style="list-style-type: none"> <li>• Community health systems are evaluated using the CHW functionality assessment tool, including referral systems and linkage to PHC services.</li> <li>• ttC can be used to build capacity of PHC staff in supervision methodology, health information management systems and MNCH.</li> <li>• ttC is a community-based programme designed to build the capacity of local MCHN stakeholders, and a sustainable PHC-level workforce.</li> <li>• ttC monitors household practice of each of the selected indicators (recommended behaviours).</li> </ul>
<p><b>Assure</b></p> <ul style="list-style-type: none"> <li>• Facilitate and promote equitable access to health care and ensure quality of PHC services for families and communities.</li> <li>• Ensure access to essential H/N commodities.</li> <li>• Empower sustainable community-level MCHN-facing groups/structures.</li> </ul>	<ul style="list-style-type: none"> <li>• ttC seeks to ensure equitable access to H/N benefits for all children, pregnant and lactating women in the community within the same programme focus area (ie, not just sponsored children).</li> <li>• Through monitoring of barriers and access ttC HVs identify the availability of key commodities at community and health facility levels.</li> <li>• ttC focuses on empowerment of the community to keep families healthy.</li> </ul>
<p><b>Don't Do</b></p> <ul style="list-style-type: none"> <li>• Provide health benefits only to sponsored children, excluding children of similar status within the same programme focus area.</li> <li>• Provide reproductive health interventions abortive in nature: contravenes WV reproductive health policy.</li> </ul>	<ul style="list-style-type: none"> <li>• ttC focuses on early identification of pregnant women and ensures that follow up is conducted for all eligible women and children throughout the lifecycles until 2 years of age, and therefore normally targets non-sponsored children.</li> <li>• Family planning is promoted as a part of healthy and timely spacing in of pregnancy in which women are advised and supported to access modern contraceptive methods through public health systems that are non-abortive in nature.</li> </ul>

## 1.2 THE ttC METHODOLOGY

### Purpose of this section

This section provides a detailed description of the ttC methodology and its various components. Included is a rationale for using the home visiting approach, information on why to use 'timed and targeted' visits, and the importance of the storytelling and dialogue technique for interacting with families, specifically demonstrating how this differs from the conventional health-promotion techniques employed by CHWs.

### Overview of Timed and Targeted Counselling

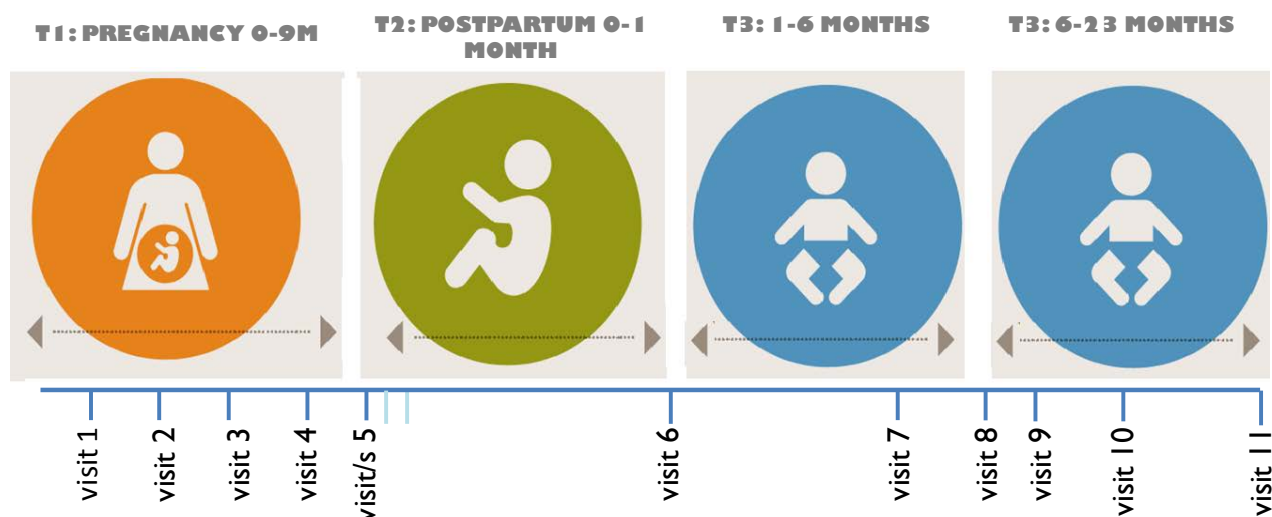
ttC is an individual-level BCC method aimed at pregnant women and caregivers of children under 2 around the full range of 7-11 life-saving interventions for MCHN. The special nuance of the ttC approach that distinguishes it from other, more traditional ways of delivering community outreach services is its '**timed**' and '**targeted**' feature.

When behaviour change approaches are built around the calendar year or around the providers' work weeks, messages often reach the 'doers' either too late or too early. This aspect of timing of communicating messages is critical for outcomes such as initiation of breastfeeding or measles immunisation that require precise timing. Therefore, ttC is designed to enable messages to be appropriately **timed**: neither too early, lest they be forgotten, nor too late for the behaviour to be practiced. Between pregnancy and the child's first two years of life, a series of 11 or more home visits are made during which the 7-11 health topics are organised into sets of appropriately timed messages, delivered using storytelling with pictures and counselling cards to stimulate discussion. The negotiation and dialogue process identifies individual barriers to healthy practices and the counsellor engages the family to identify solutions. The ttC model is intended for household-level delivery, enabling messages to be appropriately **targeted** to those who may practice these behaviours, as well as to members of the household who influence decisions to adopt these behaviours, such as husbands, grandmothers, mothers-in-law and others.

During follow-up visits, they directly monitor the uptake of healthy practices over time. The ttC methodology can be applied using the official World Vision ttC curricula based on WHO and UNICEF guidelines, but also locally available curricula and materials can be adapted for use with the ttC methodology, provided adequate coverage of the appropriate 7-11 topics and fidelity to the method are ensured.

ttC can be delivered by any **appropriate cadre of volunteers or health workers** at a community level, which should be individuals selected by the community, and approved for this work by the Ministries of Health and local Health authorities. We refer throughout this document to the cadres implementing ttC, to be **ttC-Home Visitors**, or ttC-HVs, to reflect the diversity in cadre selection amongst countries, as well as to prevent confusion where these ttC-HVs may be working alongside CHWs.



**Figure 2. Timing of the ttC pregnancy visits across the lifecycle**

### Why are visits made to individual households?

The home setting enables open communication. In the secure environment of their own homes, family members are able to engage in dialogue without hesitation or reservation around the issues that concern, preoccupy or confuse them with regard to the practices recommended. They can ask questions and take all the time they need to come to a full understanding of the recommendations.

The setting also enables engagement of *all the members of the household*. This is important because the ability of the primary caregiver to practice recommended behaviours is often circumscribed by the opinions and decisions of *other* members of the household. It is critically important to involve these 'influencers of behaviour' or the key decision makers.

Finally, this one-on-one approach allows for the tailoring of recommendations to each household's specific situation and needs, after identifying specific constraints and barriers the household might face.

### Why use ttC?

The ttC project model is an effective approach for addressing maternal, newborn and child health and is inclusive of those interventions that are likely to have the most impact in improving H/N from pregnancy to 2 years of age. The model is indicated in areas of high maternal, newborn or child mortality where health-seeking behaviour and health practices in the home are a key limitation to health. It is especially appropriate to consider in contexts where a comprehensive methodology for home-based health promotion and behaviour change counselling by CHWs or volunteers is not already in place. The ttC model replaces old thinking about community health promotion through group-based or consensus approaches, which fail to take into account the social determinants underlying why communities and individuals don't practice or adopt recommended behaviours. Behaviour change counselling is about one-to-one dialogue in which the counsellor and the woman and her family discuss and identify barriers to adopting healthy behaviours. This model is therefore indicated in many diverse contexts where previous health-promotion efforts might have failed to result in behaviour change and where healthy practices are low.

Specific health issues and problems the project was developed to address include:

- **Poor health seeking behaviour** - for illness in pregnant women or young children, which may be indicated by high maternal and child mortality, low knowledge of danger signs or preference for traditional practices or medicines.
- **Low access to health services** - for maternal and child health such as skilled birth attendance, immunisation coverage, antenatal care coverage.
- **Poor health practices in the home** - such as malaria control measures, hygiene and hand washing, newborn cord care, breastfeeding and infant feeding practices.

ttC is appropriate in the following cultural contexts:

- Previous health promotion efforts have had limited impact - possibly because they have failed to uncover barriers to health in those communities.
- Cultural considerations limit the adoption of healthy practices.
- Mothers are not decision makers for health.
- Vulnerable or isolated households are not being reached.
- Group-based methods fail to be inclusive.

In many contexts, mothers have limited decision-making power in the household. Those who hold financial responsibility or positions of authority in the home need to be engaged through counselling in order to ensure that mothers have support in the home. This is highly contextual; often, male involvement may be a key limitation of programme success. In polygamous families, often the eldest wife will be a key decision maker on issues related to family H/N. Mothers-in-law and grandmothers may have a strong influence as they pass on their own experiences to younger women and new mothers. For these reasons, extracting women from the context of their families in order to conduct health promotion can have limited effect in a variety of contexts.

### **World Vision and the Ministry of Health partnership**

In keeping with the principle of partnership, it will always be preferable to institutionalise ttC programming within the Ministry of Health (MoH), wherever possible. A full treatment of considerations that will determine whether or not the MoH in a particular country can take full responsibility for the ttC component of the 7-11 strategy is provided in the *Field Guide*.

### **What is the story-based dialogue-based household counselling process?**

The ttC counselling process is based on principles of learning and behaviour change wherein it is recognised that ‘traditional’ top-down, unidirectional transmission of information leads neither to effective learning and retention, nor to changes in behaviour. From a learning standpoint, it is acknowledged that adults must be actively engaged in their own learning process, building on what they already know and incorporating new information and ideas into existing mental frameworks. From a behaviour change standpoint, it is recognised that information and awareness in and of themselves are not sufficient to change behaviour but, rather, that a more lengthy process of consideration of new practices, attention to barriers and constraints, and trial practice with support and encouragement are all stages through which an individual will frequently proceed before fully maintaining a new practice or behaviour.

### Use of stories

During each household visit, ttC-HVs will present at least one illustrated ‘problem’ story, followed by guiding questions, and one ‘positive’ story followed by guiding questions. The use of illustrated stories enables a process of ‘conscientisation’, which states that humans, being ‘embedded’ as they are in their life situations, are not always able to objectively analyse and assess these situations. To the extent that situations are problematic, however, there is a need precisely to recognise the causes of the problems for what they are and to effectively assess and analyse potential solutions. As long as individuals are embedded in their situations, this necessary objectivity and perspective is not always possible or easy to see.

The process involves a first step of ‘codification’ of reality. This means that the problematic situation in which the individual is embedded is presented to the individual in the form of a ‘code’; normally either an illustration or a dramatisation of the problem situation (here, though the ‘problem’ story). By presenting the situation in this way, individuals have the opportunity to view their situation as outsiders; as if the situation were happening to someone else; ie, the character(s) in the illustrations or dramas. By ‘stepping outside’ of the situation and viewing it objectively, individuals are often better able to recognise the problem for what it is, becoming conscious or objectively aware of a problematic situation. As this ‘awakening’ occurs, individuals are better able to assess the causes of the problem, and to assess the potential benefits of ‘solutions’ presented to them. They are assessing from a vantage point of knowledge and awareness, as opposed to simply accepting what the ‘expert’ has to say. Lastly, the guiding questions help the family to make the link between the situation ‘happening to the character in the story’, and their own realities, a process termed ‘personalisation’. It will not always be the case that the families face the same problems as portrayed in the stories: the guiding questions aim to ascertain the extent to which the problem scenario is relevant to each individual household. These questions help ‘awaken’ the family to the existence of the situation in their own lives, better positioning them to take effective action.

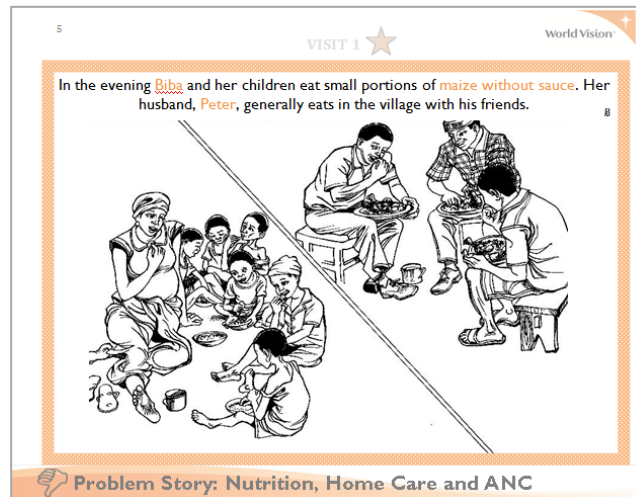
### Presenting new information

The ttC-HVs then present new information to households in the form of a ‘positive’ story. This avoids ‘top-down’, expert presentation of facts but repeats the process of enabling the household member to see the results of the new (positive) actions in the other person’s situation. This also enables the ‘clumping’ of information into the overall ‘category’ of the story, which facilitates learner retention. (Indeed, given the very large number of messages transmitted through 7-11, presenting these messages as isolates should be avoided as far as possible.) The counsellor works through a series of guiding questions to ascertain the extent to which the messages are new or, conversely, already familiar to household members.

Figure 3. Examples of ‘problem’ and ‘positive’ story images



Figure 4. Example of guiding questions for dialogue counselling



#### A. Problem Story: Nutrition: Home Care and ANC Guiding Questions

1. What nutrition behaviours / practices did they see in the story (positive or negative)?

##### Possible answers:

- Biba had too much work. She was pushing her body too much. Her husband didn't help her at all
- She was lifting heavy things
- She was not eating enough food
- She wasn't eating a variety of foods
- She didn't go to the clinic for pre-natal care, to check on her and her unborn baby
- She didn't understand that the bleeding was dangerous, or tell anyone.
- Her husband didn't have a plan for transportation if there was an emergency
- She doesn't wash her hands, which might cause infections or diseases
- Her husband is spending money on himself that could be used for his wife and children instead.

2. Do similar things happen in your community?

3. Do any of these happen in your own experience/family/ home?

## Dialogue

Following codification, conscientisation, personalisation and presentation of new information that takes place through the storytelling, the counselling process moves on to open dialogue between the ttC-HV and the household members, facilitated by the guiding questions. The dialogue begins by identifying those positive practices that the family already performs; acknowledging, affirming and praising these positive behaviours, thereby bringing an element of the 'appreciative' into the counselling approach. The dialogue moves on to discussion of those messages and practices in the positive story that are new to the family members. Although the dialogue is structured insofar as there are guiding questions to work with, ttC allows ample opportunity for open, unscripted discussion, in order that family members may ask questions, raise concerns and fully clarify any doubts or confusion they might have regarding the new practices.

## Negotiation and 'barrier analysis'

The counselling process then moves on to negotiation, in which the ttC-HV asks the family whether or not they feel they will be able to put the new behaviours into practice. An integral part of this negotiation step is an informal type of 'barrier analysis' of potential constraints or hindrances that they might identify in putting the behaviours into practice.

The ttC-HVs will have already thought of some of these constraints in their own contexts and will have already prepared some possible responses to assist family members in thinking through how such constraints might be overcome. It is understood that not all potential constraints will always be resolvable at the level of the ttC-HV together with the family; in such cases, the ttC-HV will refer issues up to either the community committee or the local MoH, as appropriate and as possible. This step concludes with the ttC-HV and the household members agreeing together on those new practices that the household will commit to attempting.

**Use of the Household Handbook:** the process of negotiation is carried out through use of the Household Handbook, which contains illustrations for all of the recommended practices and, as such, can be used as a tool to review and agree on these practices. Symbols beneath each illustration will enable tracking of the family’s adoption of practices. Those behaviours already practiced by the family will use a checkmark symbol. If a family feels unable to carry out a practice, this is represented by an X symbol. If the ttC-HV and family negotiate together that the family will agree to try a new behaviour, there is a space for initials or a fingerprint underneath the corresponding illustration, serving to formalise the negotiated agreement. These agreements can be revisited in subsequent visits, and the process of behaviour change thereby tracked.

**Figure 5. Example of Household Handbook negotiation**



### 1.3 A STRATEGIC FRAMEWORK FOR ttC

**Purpose of this section**

This section presents a strategic framework, including a sample log frame, for the ttC model, which can be used by NO-level health and Design, Monitoring and Evaluation (DME) staff. The strategic framework can be used for grant proposal writing alongside sections of the narrative, which explain the objectives of each component of ttC. This can also be used by ADPs when undergoing redesign following the LEAP process. Sample indicators for the ttC model are provided along with an exhaustive illustrative log frame, which is available in the toolkit.

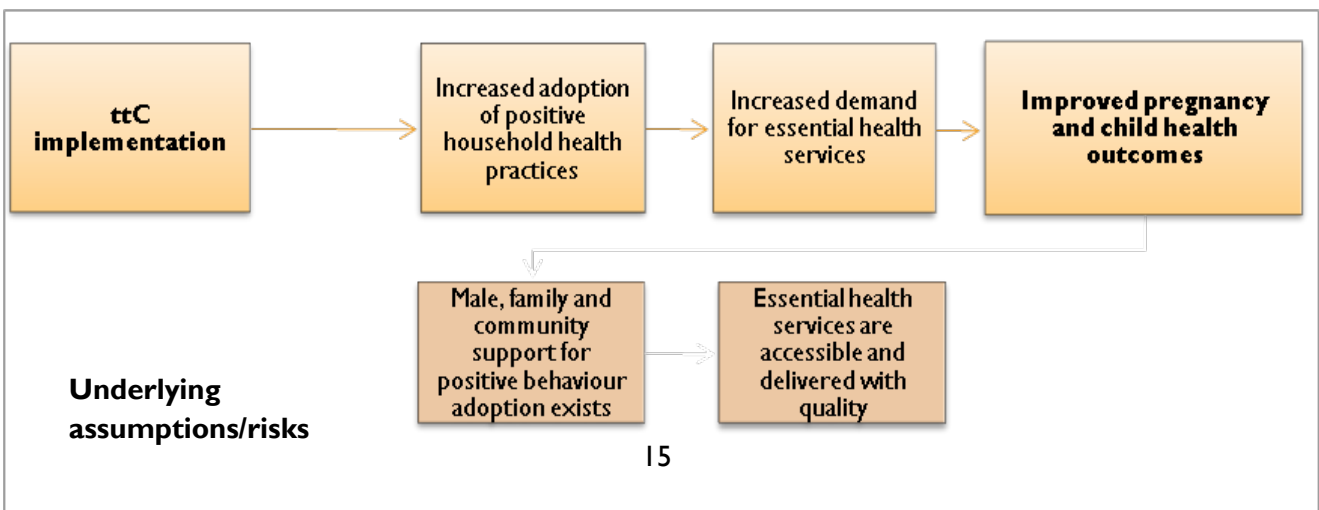
This section begins with a theory of change for ttC, a description of the core programmatic activities, followed by the strategic framework that shows how the project model activities and outcomes contribute to **behaviour, access, community systems strengthening (CSS) and health systems strengthening (HSS)**.

#### A CONCEPTUAL FRAMEWORK FOR ttC

The ttC project model can influence child health outcomes in two possible ways: firstly, that families receiving counselling adopt practices in the household such as hygiene and nutrition, and disease-prevention measures. Secondly, ttC seeks to increase uptake and demand for essential health services by promoting awareness and benefits of those health services at the household level, and supporting families to overcome barriers to service access where possible.

An underlying limitation of health promotion is that male involvement and family members or cultural factors may limit the uptake of new practices, but these influencers are a major target of ttC programming. If CHWs/ttC-HVs neglect to involve key household decision makers such as husbands and grandmothers, this puts the success of the project at risk. A second underlying assumption is that essential services are available in those communities and that they are delivered with quality. Risks associated with this are that health centres will be under-resourced, experience stock outs, lack important skills or have poor community relations. For this reason, it is highly recommended that ttC be implemented alongside the COMM, which contributes to strengthening community health structures and services, and CVA, which seeks to influence decision makers in the local authorities and service providers to improve services. However, where possible, elements of CSS and HSS should be built into the project activities, and therefore follow the strategic framework that has the potential to minimise those underlying risks.

**Figure 6. Process map of ttC steps to behaviour change and risks**



## PROGRAMMATIC ACTIVITIES IN THE ttC MODEL

Although ttC is an adaptable model, certain activities are central to all contexts (see Table 5).

**Table 5. Main activities in ttC model implementation**

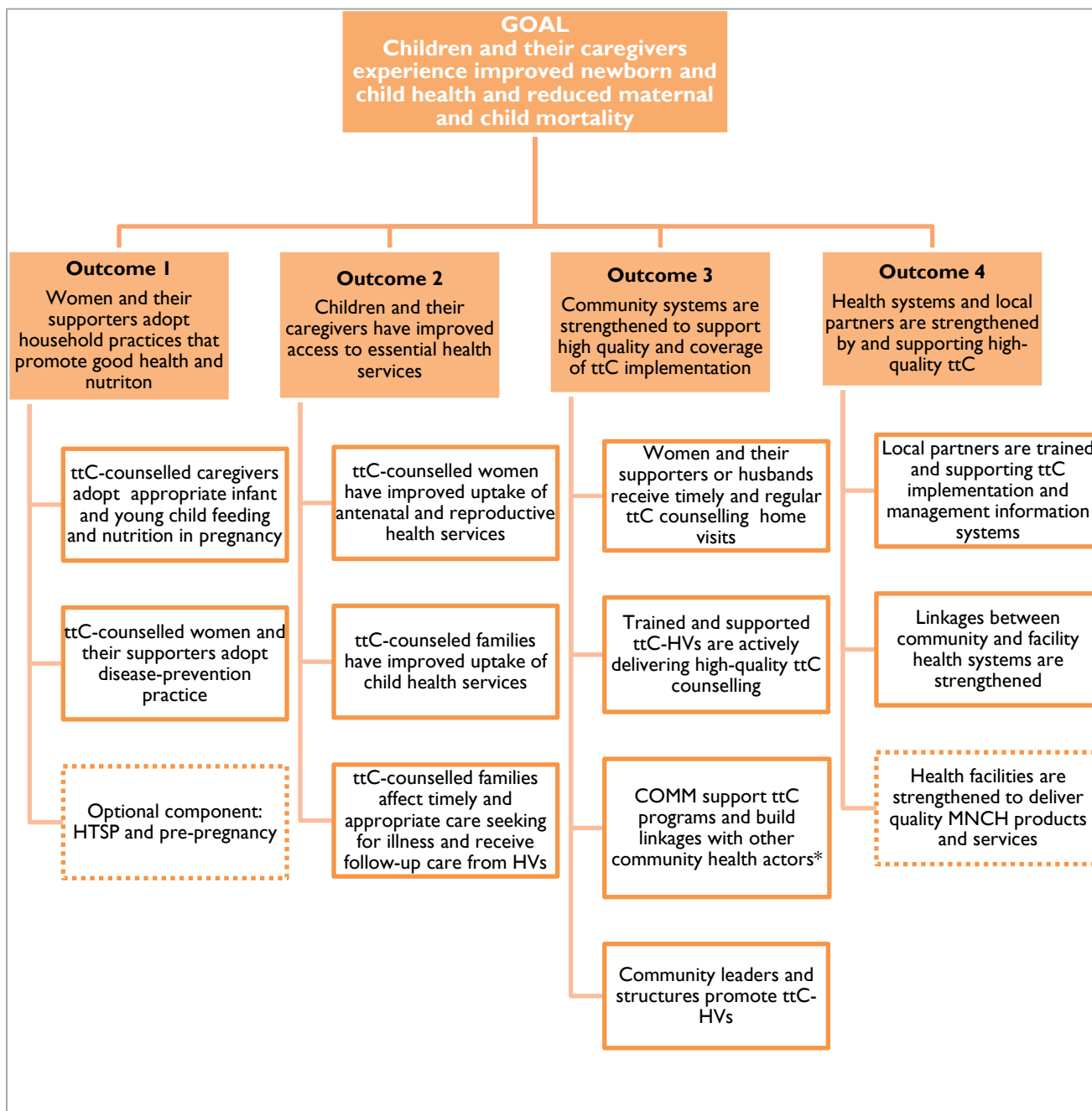
Activity	Description
Country readiness process and MoH dialogue	The country readiness process (Section 4) ensures that MoH and stakeholder collaboration at the national level promotes sustainability and country ownership by: <ul style="list-style-type: none"> <li>analysing existing CHW and home visitors policy and gaps</li> <li>aligning to national health plans and strategies</li> <li>selecting appropriate resources/curriculum and contextualisation as needed</li> <li>determining WV-MoH implementation and supervisory responsibilities</li> <li>reviewing/ensuring minimum standards for ttC implementation</li> <li>designing strategies and methods to ensure good integration in CSS and HSS of ttC.<sup>5</sup></li> </ul>
Training of Facilitators (ToF)	Takes place at national level, ensuring that appropriate facilitators from project areas are included. In the interest of sustainability by key national and regional stakeholders, the model should take a hierarchical approach to scaling up training. Facilitators then train ttC-HVs and supervisors so that transfer of methodologies becomes 'owned' by those engaged in scale-up.
Community engagement and selection of CHW/ttC-HVs	Community members should be engaged at every level including planning, selection of ttC-HVs, and feedback on the ttC-HVs efforts. Programmes are accountable to communities in that activities are reported and grievances are dealt with transparently, ensuring that CHW/ttC-HVs engage positively with the community, enhancing trust and improving performance.
Training of CHW/ttC-HVs	ttC training requires classroom and practical training elements employing multiple methods. Ongoing refresher trainings planned throughout the project ensure the replacement of any drop-outs, contributing to performance improvement, motivation and advancement of ttC-HVs.
Link to and build capacity of COMM if possible	Existing community structures such as COMM should be leveraged or created to provide oversight of the ttC-HVs' work. These groups should be trained and supported to monitor performance, review data collection and coordinate with other health-related programmes. ttC-HVs must meet regularly with other community health actors, including those under MoH and other non-governmental organisations (NGOs), to ensure that they are working compatibly, which may be mediated by COMM.
Ongoing support supervision and data monitoring	Ongoing support supervision is built into the project, given the human resources available at the primary health centre and according to the agreements made on the roles of supervisors. Support supervision can include technical support/assessment and debriefing meetings.
Community integration and programming promotion	Faith leaders, community groups and leaders should be engaged in direct sensitisation and carry out ongoing activities to increase awareness of ttC and related health messaging, addressing any existing negative practices. Seek to engage traditional practitioners and other community health providers where possible.

<sup>5</sup> 'Embeddedness' - a phrase coined by the CHW USAID evidence summit referring to the extent to which communities are engaged in decision making, accountability and support of CHWs, which enhances usage and trust of the cadre. <http://www.usaid.gov/what-we-do/global-health/chw-summit>

## STRATEGIC FRAMEWORK

The strategic framework for ttC is organised into four outcomes that reflect the 7-11 approach from the individual to household, community, and health-systems environment, which should be familiar to project staff. This structure, both as a logic model and monitoring framework, makes it easier to assimilate other core models within this plan. COMM, for example, can be assimilated under the community outcome, and CVA under HSS. C-PMTCT and ICCM, whilst these have stronger emphases on programme technical quality-assurance elements, also group outcomes according to individual, community and environmental levels. Thus, whatever project modes are being integrated with ttC, this framework is ‘expandable’ or ‘reducible’ to accommodate them.

Figure 7. ttC Logic Model/ Strategic Framework



\*where COMM is being deployed alongside ttC.



**Goal:** Children and their caregivers experience improved newborn and child health and reduced maternal and child mortality

### Description of Strategic Objectives

#### **Outcome 1. Women and their supporters adopt household practices that promote good health and nutrition**

In ttC nutrition and health practices are promoted by counselling activities. Importantly ttC data monitoring reports the immediate 'outcomes' of the counselling, i.e. reported uptake of practices by counselled women. At outcome levels, household surveys monitor the extent to which these activities have change the practices at the population level regardless of whether the household have enrolled in ttC. The Illustrative logframe includes all optional practices, but the 'core' monitoring and evaluation indicators should not be omitted. Key outputs pertain to the adoption of household-level practices (or household *uptake*) related to child feeding and the prevention of diseases.

#### **Outcome 2 Children and their caregivers have improved access to essential health services**

Access to essential health services can be separated from the household practices outcomes under the model, because while they are promoted alongside home based care, they may be limited by different factors than household practices such as service availability, cost and quality of care issues. There are three outputs under this outcome including women accessing the full range of reproductive (antenatal, delivery, family planning and post-partum) services available to them; children's access to preventive care services (vaccination, supplementation, de-worming and growth monitoring and promotion), and that in the event of a health problem the household are able to access appropriate services in a timely manner. The ttC-HVs may not always be person to make a referral, if they refer after a home visit, it is recommended they ensure the referral was followed and make a follow up visit to check on the client. deaths. There is an option for project to include here counselling on birth spacing and family planning amongst women and girls pre-pregnancy rather than post partum, although the ttC-core curriculum does not capture this, it may be considered as a local adaptation.

#### **Outcome 3 Community systems are strengthened to support high quality and coverage of ttC implementation**

Community systems strengthening is an integral part of ttC and this outcome aim to ensure projects prioritise ttC community support in terms of programme reach, participation, and quality. All activities related to training, supervision, integration of community health activities, community participation, sensitization of communities and links to COMMs can be covered under this outcome.

The first output under this outcome relates to programme reach, which in turn has three elements – early enrolment during pregnancy, completion of planned visits, husband / partner or family participation, which are key performance indicators for assessing ttC-HVs. The option of registration of eligible women and girls may increase likelihood that women are identified earlier, and promote the programme amongst those at risk or planning a pregnancy. The second output encompasses the various efforts to train, equip, support and motivate the community actors to do their work. The third output relates to linkages and support provided by COMM, their supervision and their active involvement in promoting ttC.

#### **Outcome 4 Health systems and local partners have increased operational structures to support ttC and MNCH**

The ttC model should be implemented alongside appropriate primary health system strengthening activities, to ensure adequate support within the local health authorities. ttC programming should foster linkages with health services through communication, transport and supervision, as well as the sharing of data

(contribution to HMIS of the ttC data). However, in some but not all contexts including fragile contexts and very isolated regions, structuring outcomes this way creates the space for deeper HSS activities to be included. Many pilot ttC projects, especially those developed within a grant system have undertaken specific HSS training activities as they start up ttC, for example, refresher trainings for IMCI and EmOC, Baby Friendly Hospital Initiative, improved support supervision, and HMIS or data management. A full list of HSS activities is provided in the TTC Toolkit. There are core indicators for health systems to be collected (e.g. stocks, patient uptake and satisfaction) which may underlie ttC programme success, therefore collecting this data is highly recommended.

**Table 6. HSS activities relevant to the ttC model**

Health systems strengthening activities	How might these be assessed?	Indicators of success
<p><i>Indirect</i></p> <ul style="list-style-type: none"> <li>• Training staff at facilities</li> <li>• Improved systems and management of community health workers and volunteers</li> <li>• Improved accountability and patient care through community follow-up</li> </ul> <p><i>Direct</i></p> <ul style="list-style-type: none"> <li>• Improvements to emergency referral services*</li> <li>• Strengthening maternal and obstetric services*</li> <li>• Equipment and resources*</li> <li>• Supply chain strengthening*</li> <li>• Distribution of MNCH commodities where supported (eg, ITNs, misoprostol, birth kits, chlorhexidine)</li> <li>•</li> </ul> <p><i>Related facility-based initiatives:</i></p> <ul style="list-style-type: none"> <li>• IMNCI (Integrated Management of Neonatal and Childhood Illness)</li> <li>• Baby friendly hospital initiative</li> <li>• IMPAC (Integrated Management of Pregnancy and Childbirth)/Emergency Obstetric Carer (EmOC)</li> <li>• Family planning</li> <li>• Neonatal intensive care and Kangaroo Mother Care (KMC)</li> <li>• Blood transfusion services</li> </ul>	<ul style="list-style-type: none"> <li>• Rapid health facility assessment</li> <li>• Community follow-up by CHWs post-referral/facility delivery</li> <li>• Maternity unit assessment†</li> <li>• Clinical audit using deaths or near miss cases†</li> </ul>	<ul style="list-style-type: none"> <li>• Staff attrition rates</li> <li>• Staff training rates</li> <li>• Quality performance in support supervision</li> <li>• Referral and follow-up rates</li> <li>• Client satisfaction</li> <li>• Waiting times</li> <li>• Stock outs</li> <li>• Inpatient beds</li> <li>• Maternity services</li> <li>• Antenatal care (ANC) coverage</li> <li>• Family planning uptake</li> </ul>

\*Activities only typically considered under weak health systems/fragile contexts; †activities conducted under research contexts or projects but not mainstreamed.

However, we also strongly recommend that certain indicators for health systems be collected (eg, stocks, patient uptake and satisfaction), as these may be key underlying reasons that ttC programmes are unsuccessful, therefore not collecting this data would lead to poor understanding of where and how to strengthen.

## 1.4 OVERVIEW OF THE ttC CORE CURRICULUM

### Purpose of this section

This section describes the contents of the core ttC curriculum. It provides useful information for initiating a **country dialogue**, considering whether to use the global curriculum, or to source local materials for the technical content of your training. There are four sections: in the first we describe the sources that have contributed to create this curriculum, demonstrating that it is in alignment with current WHO processes and technical content. In the next sections we describe an overview of the **content** and its alignment to 7-11, and the **pedagogy** ie, teaching methodologies, and lastly we describe the different **resources** and how they are used. This familiarity with the content, pedagogy and curriculum will be essential in understanding Part 3 on adapting to a country context.

### TECHNICAL CONTENT

Much of the content comes directly from three training manuals from UNICEF and WHO (Caring for the Newborn at Home: A training course for community health workers, 2009, Draft, Counsel the Family on Feeding, 2009, Draft and Caring for Sick Children in the Community, 2010) as acknowledged in the ttC manuals. It is not the case that World Vision is introducing a newly authored curriculum; rather, it is more accurate to say that World Vision is collaborating with UNICEF and WHO in bringing forward training materials and primary health-care counselling in households that, while tailored to suit WV's specific 7-11 framework, derives fundamentally from the materials and global recommendations of these two primary organisations. The counselling methodology is based on the American College of Nurse-Midwives home-based life saving skills (HBLSS) technique which applies a family-focused, story-based, dialogue and negotiation approach to helping women and their supporters to engage with health recommendations for their own circumstances.<sup>6</sup> World Vision India developed the ttC approach, summarised as 'the right message, to the right people, at the right time',<sup>7</sup> which means that messages are delivered at appropriate times according to a woman's stage of pregnancy, age of infant and fertility intentions of the couple. The ttC methodology also makes use of the *Rapid Assessment of Community Health Worker Programs in USAID Priority MCH Countries*, 2009, developed by the USAID Health Care Improvement Project.

It is important to note that whilst the ttC programme is adaptable for the context of alternative cadres such as mother group volunteers, mother guides and traditional birth attendants, the principles and standards in the USAID CHW AIM framework remains an excellent working practice to be applied to cadres of community volunteers as much as is possible or reasonable within context.

### ttC CORE CURRICULUM

#### A. Facilitator's Manual for Timed and Targeted Counselling

The Facilitator's Manual is made up of three modules. Module 1 provides background information and training in skills important for ttC delivery, and prepares ttC-HVs for the first three visits during pregnancy. Modules 2 and 3 continue with preparation for the household counselling visits through training in the relevant content. Module 2 covers the fourth visit during pregnancy, the first-week visits and the one-month

<sup>6</sup> Life Saving Skills: Manual for Midwives, 4th Edition, 2008. ACNM Publications. <http://www.midwife.org/ACNM-Publications>

<sup>7</sup> Toth, C. (2008). 'The Right Messages - to the Right People - at the Right Time' World Vision United States and India. [http://www.flexfund.org/resources/technical\\_updates/wv\\_india.pdf](http://www.flexfund.org/resources/technical_updates/wv_india.pdf)

visit, and Module 3 covers the remaining visits (from the 6 month to the 24 month visit, ie. all the 7-11 recommended messages and behaviours), and practice with the counselling approach.

**Table 7. Structure of modules in ttC core curriculum**

Module 1 (Continued)	Module 2	Module 3
Visit 1: Early pregnancy Visit 2: Mid-pregnancy Visit 3: Mid-pregnancy	Visit 4: Late pregnancy Visit 5a,b,c: First week of life Visit 6: 1 month	Visit 7: 6 months Visit 8: 9 months Visit 9: 12 months Visit 10: 18 months Visit 11: 24 months
Additional content: <ul style="list-style-type: none"> <li>Country-specific health and nutrition issues</li> <li>Behaviour change communication</li> <li>Communication skills and psychological first aid (2<sup>nd</sup> edition)</li> <li>The dialogue counselling approach</li> <li>Monitoring system</li> <li>Referral system</li> </ul>	Additional content: <ul style="list-style-type: none"> <li>Monitoring system</li> <li>Referral system</li> <li>High-risk strategies (2<sup>nd</sup> edition)</li> </ul>	Additional content: <ul style="list-style-type: none"> <li>Monitoring system</li> <li>Referral system</li> <li>High-risk strategies (2<sup>nd</sup> edition)</li> </ul>

Module 1 covers much of the ttC methodology, including all the ‘soft skills’-based training (such as ‘Interacting with Families’), and therefore **it is recommended that in all adaptations, this section of the curriculum is used** unless there is a more suitable in country curriculum **based in the same methodology** for this aspect. The three modules also cover the monitoring and referral systems relevant to the respective ttC visits.

- **Introduction to country-specific health and nutrition issues:** Relevant statistics from pre-project assessment or baseline surveys are used to orient ttC-HVs to gain a general understanding of the most important H/N problems and issues in their country and community.
- **Communication skills and psychological first aid:** ttC-HVs are introduced to, and begin to develop communication skills and ways of talking to families that will help increase the chances that family members will carry out the behaviours they will be talking about. It also includes basic techniques for dealing with a woman in a distressing situation, whilst treating her with dignity, respect and nurturing a trusting relationship through basic Psychological First Aid (PFA) methods.<sup>8</sup>
- **Behaviour change communication:** In the first module, emphasis is given to introducing the basic principles of BCC as well as techniques for negotiating change with mothers and key decision makers.
- **The dialogue counselling approach:** ttC-HVs are introduced to the standardised approach to be followed during all household counselling visits, and will understand why this approach is more likely to

<sup>8</sup> World Health Organization, War Trauma Foundation and World Vision International (2011). Psychological first aid: Guide for field workers. WHO: Geneva [http://whqlibdoc.who.int/publications/2011/9789241548205\\_eng.pdf?ua=1](http://whqlibdoc.who.int/publications/2011/9789241548205_eng.pdf?ua=1)

facilitate behaviour change among household members than simple, unidirectional presentation of information would. A full description of the dialogue counselling approach is provided in Section 4.

- **The monitoring system:** ttC-HVs will be trained to fill out the forms required to track both the work they are doing (the household visits they are making), as well as the practice of a selection of the recommended behaviours by household members.

In these modules, ttC-HVs are trained in the content/messages related to the household visits, and carry out simulated household counselling sessions under the supervision of the facilitators. A total of between 10 and 12 discrete learning sessions, carried out over a period of 10 days for Module 1 and 5 days each for Modules 2 and 3, will prepare the ttC-HVs to carry out these visits.

### **B. Participants' Manual for Timed and Targeted Counselling**

This component is a companion piece to the Facilitator's Manual, and is given to all **literate** CHWs or HVs during training. While the Facilitator's Manual provides step-by-step guidance to facilitators for carrying out the training, the Participants' Manual provides encapsulated summaries of all of the **technical content** presented in the training. As such, it is meant to serve as a reference of the H/N information that they need to know and remember in order to effectively work with families in the community. Blank tables are included for sessions for note taking, especially on 'barriers to health' households in their communities might face in carrying out the recommended practices, and how to respond. This provides an opportunity during the training to discover any myths, misconceptions, beliefs, non-availability of foodstuffs/ materials/health commodities, and other such barriers that can only be contextualised to each locality. **Note:** The Participants' Manual would not normally be given where the ttC-HVs are not literate. Given that the household counselling approach is built around visual materials (illustrated storybooks), ttC can be carried out by non-literate CHWs and volunteers. In these cases, the source of reference material will be the illustrated storybooks.

### **C. Illustrated Storybooks**

The storybooks are the core of household counselling. There is one storybook for each visit containing 'problem' and 'positive' stories. The problem stories illustrate the types of scenarios common in communities in developing countries and that lead to high levels of maternal and child morbidity and mortality, while the positive stories contain all of the essential messages central to the 7-11 strategy, embedded in the story line. The story narratives are written alongside the illustrations to remind about the key messages covered. Black and white drawings are used rather than photographs, to keep things simple and reduce production costs while aiming to use non-specific or generic depictions. An NO may choose to redo some or all of the drawings as desired. Since ttC has been rolled out, new art has been generated in Cambodia, Guatemala, Jerusalem West Bank and Gaza and Afghanistan.<sup>9</sup>

### **D. Household Handbooks**

The Household Handbook is given to each household, and is kept by them to serve as a reminder of all the new information to which they are being exposed, and as a record of the negotiated outcome. It is organised by subject or by visits (danger signs during labour and delivery, antenatal care, essential newborn care, etc.), with one or two pages given over to each visit. The Household Handbook taken as a whole contains all of the key 7-11 messages and behaviours, focusing on those that are negotiated.

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<sup>9</sup> Art and materials may be available from individual country offices upon request.

## E. Trainer's Guide and CD

The Trainer's Guide is a companion piece to the Facilitator's Manual for ttC and is targeted at those trainers who will train CHW supervisors and ttC facilitators from World Vision, ministries of health and/or partner organisations when conducting ToF or of ttC-HVs. The Trainer's Guide contains all additional information required to plan, design and conduct ttC training, including pre- and post-training assessments, homework/background reading, and handouts to be used during classroom training. The accompanying CD contains a copy of the full curriculum, the ttC Toolkit, the visual aids, as well as supporting materials.

**Handouts** – to be used during the training, as homework tests and for participants to take away.

**Presentations** – provided in MS PowerPoint, the basic presentations can be used as a basis for the orientation to ttC, CHW AIM, the toolkit and the methodology.

**Photo food cards** – contain photographs of approximately 35 foods representing all food groups and many of the various sources of micronutrients. These photographs are reproduced to index card size and laminated, such that they can be used like a deck of playing cards, mixing and sorting them appropriately as per the objective of the learning activity to reinforce messages around food groups, sources of micronutrients, nutrition for the pregnant woman, complementary feeding for infants from 6-24 months and the like. **Note:** Individual NOs will likely want to supplement the core set of photo food cards with additional photos of locally specific foods. This will be a simple matter of taking a set of digital photographs and reproducing them together with the core set.

## Guide to Monitoring and Supervision of ttC

This guide accompanies the Facilitator's and Participants' Manuals. Data-collection instructions for the proposed monitoring system are included in both manuals, however instructions on how to verify, tally, report and use these data are provided in a separate resource. Supervisors for the programme may be selected from amongst COMM members, health facility staff or World Vision staff, although ideally should be fully trained in the methodology. The provision of a separate resource for supervisors enables easier contextualisation of the resource that each country will need to adjust to its own context, methods of supervision and indicators being used. This guide covers the purpose and methodology of supportive supervision, core competencies and how to assess them, the role of COMM and the 'debriefing meetings'. It also can be used to train on tallying and reporting of data using World Vision's ttC monitoring system, or on collection of data using group-based methods.

## PEDAGOGY

### What methodology is used in the Facilitator's Manual?

Facilitators will use interactive and participatory approaches to train on ttC, with the Facilitator's Manual providing guidance and steps to help achieve this. A mix of activities ensures that all learning styles are catered to (ie, visual, oral, aural, kinaesthetic). The methodologies employed respect adult learning, recognising that adults come to the learning task with a host of experiences and hence are not 'blank slates' onto which new information is merely posted. All learning sessions begin by surfacing and tapping into participants' existing knowledge, building from this as the foundation upon which to present new information. Opportunity is given to the participants in every learning session to practice with job aids they will use during household visits, as they carry out simulated counselling sessions under supervision by facilitators.

Various activities throughout the training are designed to engage participants dynamically in the material and discussions, and to promote understanding through putting participants in the position of the mothers and families. Certain video materials are available online and on DVD from WHO/UNICEF sources, which are recommended for key technical elements that are difficult to show non-visually, eg, demonstrating good breastfeeding practice. NOs are encouraged to source video and visual materials from the MoH in their countries to support multimedia inclusion in the training.

Most lessons follow a similar sequence aimed at eliciting participant knowledge, presenting and reinforcing new information, practising the delivery of the messages to households (through simulations), and summarising. Time is also given over in each session to guide discussion around the potential constraints that household members may have in practising the recommended behaviours, and the ways in which ttC-HVs – and the community at large – may respond to these issues.

The general sequence of each learning session is as follows:

- Present the objectives of the session.
- Determine what participants already know.
- Present new information/reinforce the information: various activities.
- Discuss potential constraints in practising recommended behaviours.
- Practise with the visuals/practise a household counselling visit.
- Summarise the main points of the lesson.



## 2. QUALITY STANDARDS

### Purpose of this section

This section presents quality standards in the implementation of ttC programmes. Applying quality standards is essential to mitigate the risks of low impact or loss of fidelity during local adaptation. We present the **ttC implementation standards**, **CHW programming standards** and discuss the relevance of the **CHW principle of practice**. This section is for NOs to review prior to adaptation of ttC, and the standards can be used to assess ttC in design and field implementation.

### 2.1 ttC PROGRAMMING STANDARDS

If working with CHWs, the programming standards need to be considered. In addition, when engaging CHWs to carry out ttC, 13 quality standards need to be considered in the adaptation and implementation of ttC, five of which relate to design decisions and start-up, and 8 standards for implementation at the ADP level.

#### Implementation Standards

##### A. ttC Methodology standards

1. Counselling: Behaviour Change Methodology (negotiation and dialogue counselling)
2. Targeting (a) – household delivery method
3. Targeting (b) – male partner and family involvement
4. Timing: through the life cycle

##### B. ttC Curriculum, training and supervision standards

5. Curriculum content (comprehensive of 7-11 in context)
6. Package of training material
7. Training of facilitators
8. Training of ttC-HVs
9. Supportive supervision systems

##### C. ttC Community and health systems standards

10. Community health systems are strengthened
11. Strengthen referral and counter-referral systems and access to essential services
12. Community sensitisation
13. Appropriate health system strengthening approaches

##### D. ttC Monitoring systems

14. Monitoring and evaluation

## Household Visit Schedule

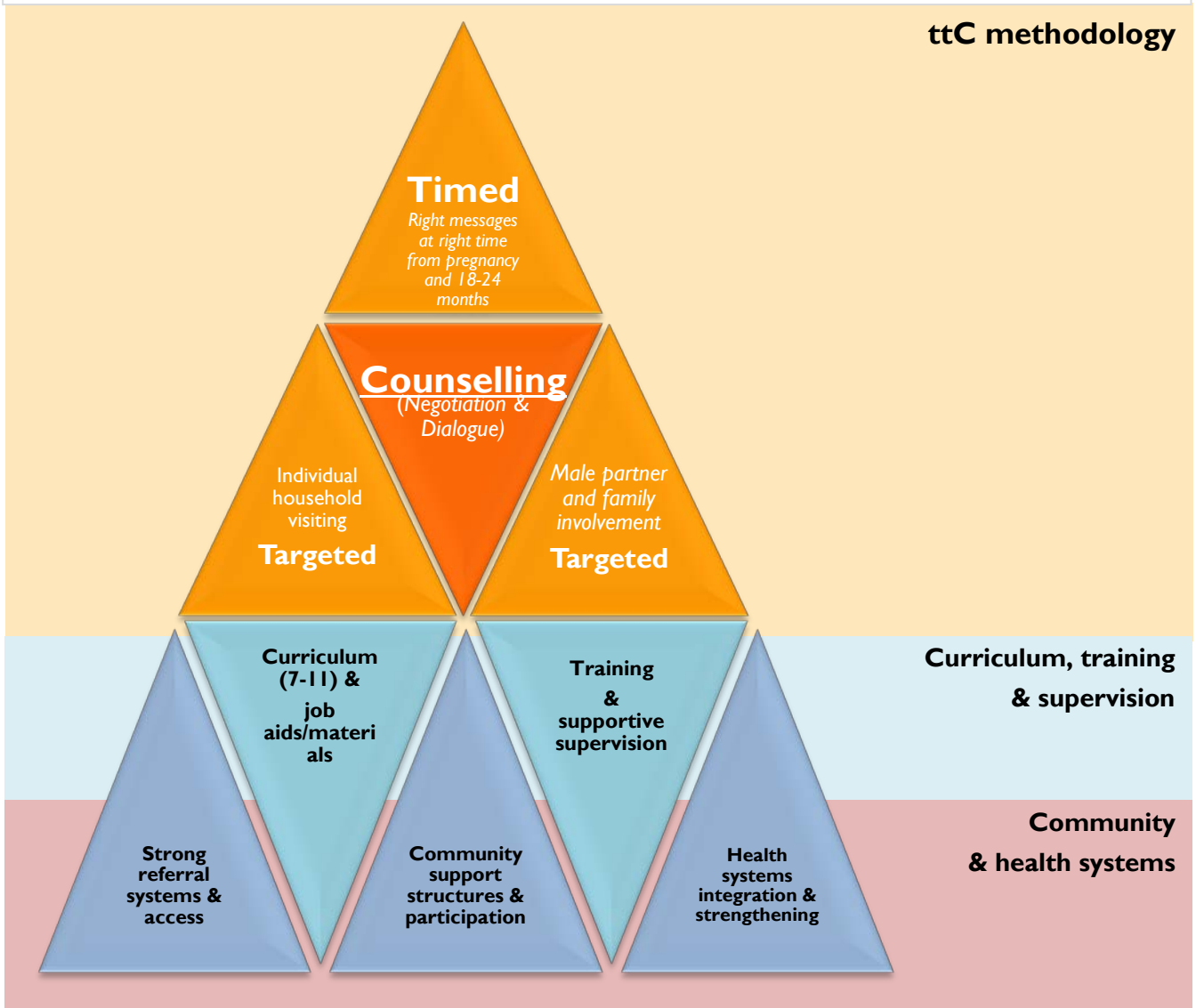
The integrity of the ttC methodology must be retained through the household-delivery methodology, the timing and targeting of messages and negotiation/dialogue counselling technique, which includes a minimum of 10 points of contact delivered at the household level:

**Table 8. Minimum standard visiting schedule**

Minimum standard	Phase	Number of visits
At least three visits in pregnancy (recommended four in high HIV contexts)	<b>Early pregnancy phase</b> (first to second trimester)	at least one household visit
	<b>Late pregnancy phase</b> (third trimester)	at least two household visits
At least seven visits for the child of which two are in the first week of life	<b>First week of life</b> (0 to 1 month)	At least two visits but three if birth was at home*
	<b>Infant care phase</b> (1 week to 6 months)	At least two visits – 1 month, 5 months
	<b>Child care phase</b> (6 to 24 months)	at least three visits (9, 12, 18 months)

\*In contexts where expected facility rates are high (>75 per cent) 2 visits in first week of life is acceptable

**Figure 1. ttC Essential elements: Quality standards as building blocks of ttC programming**



A. ttC Methodology standards	
<b>Essential element 1: Counselling: ttC is delivered using a behaviour change methodology based on negotiation, dialogue and individual barrier analysis.</b>	
<p><i>Recommended practices:</i></p> <p>The behaviour change methodology is central to ttC success and is based on evidence-based adult learning methods used in the home-based life saving skills (HBLSS) method. Ensure open-ended dialogue with individuals and households; making good use of visual aids to deliver health messages; include discussion to uncover individual barriers to recommended behaviours. The use of stories for negotiation and barrier analysis is highly effective.</p>	<p><i>Minimum standards</i></p> <ul style="list-style-type: none"> <li>• Negotiation and dialogue steps are included.</li> <li>• During counselling approach, steps are taken to identify and discuss individual barriers to access/adopting practice.</li> <li>• <b>Stories and not just health-promotion counselling cards are developed, in contexts of low literacy.</b></li> </ul>
<b>Essential element 2: Targeting: ttC is delivered through a targeted approach through individual household visits.</b>	
<p><i>Recommended practices:</i></p> <p>The home-based visiting methodology enables the individualised approach and permits the possibility of a strategy for targeting those most at risk within the community for support.</p>	<p><i>Minimum standards</i></p> <ul style="list-style-type: none"> <li>• ttC targets individuals most in need by being conducted as a home-visiting methodology with the purpose of engaging family members in discussions; and cannot be delivered through group-based methodologies,</li> </ul>
<b>Essential element 3: Targeting: Ensure male partner and birth supporter involvement at the household and community level.</b>	
<p><i>Recommended practices:</i></p> <p>Home-based visiting methods need to ensure that key decision makers in the family also participate. If this is a home-based visit, ensure negotiation and dialogue steps include female supporters such as mother in law/grandmother or co-wife, and the male supporter (husband).</p>	<p><i>Minimum standards</i></p> <ul style="list-style-type: none"> <li>• A system for measuring male/birth partner accompaniment is in place.</li> <li>• ttC aims for a minimum of 10 contacts with women, of which at least three include the involvement of a selected birth partner/family supporter.</li> </ul>
<b>Essential element 4: Timing: ttC home visits and messages are timed appropriately from pregnancy to 2 years of life.</b>	
<p><i>Recommended practices</i></p> <p>To deliver on all 7-11 messages, ttC should encompass messages from pregnancy to the 2<sup>nd</sup> year of life through a system of planned visits. The minimum number of visits recommended in pregnancy is three, with 7 for the child, accepting that adaptation to context may mean that the comprehensive 7-11 ttC model is not being practised.</p>	<p><i>Minimum standards</i></p> <p><b>A minimum of ten (10) points of contact take place</b></p> <p><b>3 visits in pregnancy:</b></p> <ul style="list-style-type: none"> <li>○ Early pregnancy phase (0-2nd trimester) <i>at least 1 visit</i></li> <li>○ Late pregnancy phase (3rd trimester) – <i>at least 2 visits</i></li> </ul> <p><b>7 visits for the child</b></p> <ul style="list-style-type: none"> <li>○ First week of Life (0-7 days) –at least 2 visits (3 recommended.)</li> <li>○ Infant care phase (1-6 months) - <i>at least 2 visits</i></li> <li>○ Child care phase (6-24 months) – <i>at least 3 visits.</i></li> </ul>

**B. Standards for ttC Curriculum, capacity building and support**

**Essential element 5: Selected curriculum is comprehensive/inclusive of 7-11 messaging, context-relevant and agreed with MoH.**

*Recommended practices:*

• **IF LOCAL MoH OR NEW CURRICULA ARE USED**

Curricula/IEC materials existing in the country should be reviewed: all curricula must include a comprehensive training on counselling methodology of ttC. Module 1 ttC methodology section should be used unless national curriculum applies identical methods. If the technical content of the curriculum covers all 7-11 interventions and is ethnographically accurate, then they should be used in preference to new methods. Exclusion of key 7-11 messages should only be considered if they are not relevant to the context, given epidemiology or current health practices. WV ttC curriculum should be shared with MoH, and discussed as a possible alternative. Review the curricula against the 7-11 essential interventions to assure alignment and add the missing aspects. Additional topics relevant to local culture and practices should be included where appropriate.

• **IF THE WORLD VISION ttC CURRICULUM IS USED**

In cases where the ttC curriculum is selected for use, the content should still be considered during contextualisation. Exclusion of key 7-11 messages should only be considered if they are not relevant to the context, given epidemiology or current health practices. Additional topics relevant to local culture and practices should be included where relevant.

*Minimum standards*

- All selected curricula include ttC methodology and counselling skills covered in core curricula module 1 (unless a local equivalent is preferable).
- Technical content is comprehensive of all 7-11 interventions and is covered in the final selected curricula, **relevant to the context** and epidemiology (consider malaria, HIV).
- Technical review of the curriculum is carried out to ensure alignment with MoH messaging, policies and protocols.
- All materials are to have undergone field testing in ethnographically equivalent communities.

<b>Essential element 6: Package of training materials and job aids is complete, suitable to level and capacity available to all participants.</b>	
<p><i>Recommended practices:</i></p> <p>Ensure that the training methods and tools available are consistent across programmes and are inclusive of diverse training methodologies. Household-level materials with key messages that stay in the house after the home visit are highly recommended. Provide ttC materials that they can use for revision and field-level trainings and facilitator’s manuals that guide the trainer through the correct steps, and encourage multi-method training techniques. Household and job-aid materials must be appropriate for non-literate users, and any written materials given in first language.</p>	<p><i>Minimum standards</i></p> <ul style="list-style-type: none"> <li>• Facilitator’s Manual is available to enable the trainers to deliver training.</li> <li>• Manuals or job aids are available for every ttC-HV.</li> <li>• Training package is appropriate for non-literate participants and appropriate translations provided for all materials.</li> <li>• All materials are to have undergone field testing and are ethnographically appropriate.</li> </ul>
<b>Essential element 7: Appropriate supportive supervision systems are designed and in place and include four contacts per year.</b>	
<p><i>Recommended practices:</i></p> <p>Work with MoH staff to consider human-resource capacity for training and supervising ttC HVs. They should be able to provide commitments on the number and frequency of supervision events in each community. Supervisor to ttCHVs, who the supervisors are (COMM member, PHC staff, WV) and modality/location of supervisions might also vary between contexts. All supervisors should be trained in ttC methods and supervision. All above conditions also apply to those WV staff supervisors.</p>	<p><i>Minimum standards</i></p> <ul style="list-style-type: none"> <li>• Supervisions are set up to ensure a minimum of four supervision contacts per year, in which two of these include COMM debriefing exercises and observational field assessments and/or case reviews. These contacts may be individual or in groups.</li> <li>• Supervisors have undergone facilitator’s training or CHW training plus additional two days of support training on supervision methodology.</li> </ul>
<b>Essential element 8: ttC facilitators are well trained over a minimum of 10 days, including practicum and certification process.</b>	
<p><i>Recommended practices:</i></p> <p>For the new curricula, 10 days training for the ToF are needed, although this may take longer under some circumstances. The training must involve practical experiences of delivering the methods and learning the monitoring tools in the field. Only qualified trainers can be used and facilitators should become certified facilitators during this process. Facilitators become certified through a process of evaluation given following the training.</p>	<p><i>Minimum standards</i></p> <ul style="list-style-type: none"> <li>• Minimum of 10 total days of training are met, including five days of field practicum experience.</li> <li>• Certified facilitators must be assessed following training to approve their standards.</li> <li>• Only qualified trainers are used to deliver training to facilitators.</li> </ul>

<b>Essential element 9: Training of ttC-HV in ttC new curricula is at least 10 days with field practicum, conducted by certified facilitators.</b>	
<p><i>Recommended practices:</i></p> <p>For the ttC curricula 20 days total is recommended, although this may take longer under some circumstances. Typically it is better to conduct the training as a modular progressive approach (where ttC technical curricula is used), with approximately 5-10 days for each training element. Modular trainings present better quality coverage of the material and opportunity for a sense of advancement during progression. Classroom sizes should be kept low, ideally ratios should be 12-14 per trainer and not exceed 30 in a class.</p>	<p><i>Minimum standards</i></p> <ul style="list-style-type: none"> <li>• Minimum number of ten days is met for the face to face training, including 5 days field level practical exercises.</li> <li>• Class size for training not more than 30 participants per class</li> <li>• Only certified facilitators training CHW/HVs</li> <li>• Records of individual training progress should be maintained. (see ttC HV training record)</li> </ul>
<b>C. ttC Community and health systems standards</b>	
<b>Essential element 10: Strengthen referral and counter-referral systems installed and monitored by ttC-CHW/HVs.</b>	
<p><i>Recommended practices:</i></p> <p>Evacuations and referral follow-up should be measured during visits. Programmes should strengthen timely and appropriate care seeking, and also ensure that ttC-HVs conduct post-referral follow-up care where possible in order to support mothers with care guidance during illness for themselves or a sick child.</p>	<p><i>Minimum standards</i></p> <ul style="list-style-type: none"> <li>• A system of facilitated referral is in place appropriate to CHW/HV capacity.</li> <li>• A system is in place for conducting and recording home visits following the discharge of a patient from the health centre.</li> </ul>
<b>Essential element 11: COMM are strengthened to support, oversee, promote ttC, and ensure integration with health activities.</b>	
<p><i>Recommended practices:</i></p> <p>Community health management structures (COMMs/CHCs) or equivalent are needed in all proposed project areas that oversee CHW functioning and provide support, oversight and promotion of ttC programmes. Community health activities running in parallel to the programme such as positive deviance hearth (PDH), PMTCT and CCM, community health actors should create regular meetings 1-6 monthly not necessarily facilitated by WV, to ensure that ttC-integration is taking place with other health projects and activities.</p>	<p><i>Minimum standards</i></p> <ul style="list-style-type: none"> <li>• All COMM receive an orientation training within one to two months of start-up, including key programme elements, health messages, overview of data reporting and practical training on CHW debriefing process enabling them to oversee the CHWs' work.</li> <li>• COMM run in ttC debriefings at least once per six months. A system to measure COMM involvement is in place.</li> <li>• ttC-HVs have regular interaction with other community health actors at least once per six months.</li> </ul>

<b>Essential element 12: Community sensitisation activities are conducted regularly and include targeting community/faith leaders and groups.</b>	
<p><i>Recommended practices:</i></p> <p>All cultural religious and community leaders should be identified in a community and also sensitised with respect to the planned programme and 7-11 interventions.</p>	<p><i>Minimum standards</i></p> <ul style="list-style-type: none"> <li>Community-sensitisation activities promoting ttC should take place at least once per year during the project. These should seek to be inclusive of all groups and faith leaders in the community.</li> </ul>
<b>Essential element 13: Appropriate health-systems strengthening and integration approaches are included to support ttC and MNCH.</b>	
<p><i>Recommended practices:</i></p> <p>Activities to strengthen and support the delivery of MNCH activities should be taken into consideration for ttC. Employ partnership approaches ensuring that trainings are sustainable and updated (consider staff attrition rates at public health units – PHUs). Health facilities are strengthened to deliver quality MNCH products and services, including family planning, obstetric and newborn emergency care and IMCI. Evaluate all facilities, and ensure that basic services at referral centres are adequate. Support data management for ttC at district and local health levels to ensure country ownership and accountability.</p>	<p><i>Minimum standards</i></p> <ul style="list-style-type: none"> <li>Training and refresher training should be planned within the project at least once per year, ensure that all PHC staff overseeing CHW/HVs undergo all necessary trainings, including focus on HMIS training, to ensure adequate management of data at health centre.</li> <li>All communities should have at least one phone available to link to the health centre and ambulance services.</li> </ul>

#### **D. ttC Monitoring and Evaluation standards**

##### **Essential element 14: Monitoring and evaluation standards**

<p><i>Recommended practices:</i></p> <p>NO conducts standard, mandatory review of indicators selecting those relevant to ttC programming. Registers and spreadsheets may be adapted to context or HMIS systems are to be utilised where appropriate. Additional information should be gathered by the project.</p>	<p><i>Minimum standards</i></p> <ul style="list-style-type: none"> <li>Core Indicators for ttC are collected annually per community and per programme</li> <li>DME methods are aligned to HMIS and integrated during data flow</li> <li>Data tallying and reporting is done at least every quarter.</li> </ul>
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## 2.2 CHW PRINCIPLES OF PRACTICE

ttC is primarily designed for implementation by CHWs, whether formally or informally recognised and integrated by a country's health systems and policies. Where CHWs are used, especially those formally linked with the MoH, the CHW Principles of Practice<sup>10</sup> and CHW programming standards<sup>11</sup> should apply. In some contexts, though, the adaptation of ttC may involve the selection of a cadre of community health volunteers who are not the official CHW according to country policy, such as mother's group volunteers, mother's guides, or care group volunteers (CGVs). However, the original project model was designed to target CHWs, and as such we recommend that some basic principles of CHW programming be carried over into the ttC model as a best practice. Where care groups or similar civil-society volunteers are the selected cadre, elements of the CHW PoP and programming standards are less feasible to apply, such as unified reporting, training, supervision systems, and integration with health services.

### CHW Principles of Practice

#### The seven guiding principles:

NGOs working in CHW programming should endeavour to work with national and regional health authorities and all collaborating partners, understanding that each country will vary in its approach to CHWs, in order to:

1. **Advocate for the legitimization** and recognition of appropriate CHW cadres within the formal health system through country policies and initiatives that support registration, accreditation and minimum standards for the role and performance of different cadres.
  -
2. **Enable and support country leadership** including national or regional coordination bodies developed under a multi-stakeholder approach, empowered to provide oversight in CHW programme implementation across partner organizations, health authorities and communities.
  -
3. Work with and through **existing local health services and mechanisms** where possible to strengthen them, avoiding the creation of parallel services, methods and supply chains or competitive working practices, while reinforcing the supportive role played by communities.
  -
4. **Establish standards and methods for the motivation and support** of CHWs that are ethical, non-competitive, sustainable and locally relevant under a unified country policy.
  -
5. **Develop minimum standards of needs- and resource-based training** and continuing education of specific cadres of CHWs, as well as necessary minimal tools, under an agreed unified system linked to accreditation.
  -
6. **Support unified mechanisms for reporting** and management of CHW data that promote consistent quality monitoring and accountability to existing health structures and communities reinforcing local use of data for decision making.
  -
7. Maximise the NGOs roles in supporting CHW **research, developing appropriate low-tech innovations**, and judiciously taking to scale **evidence-based cost-effective solutions** made available in **the public domain** through partnership approaches.

<sup>10</sup> Walker, P. et al., CHW Principles of Practice: Guiding principles for non-governmental organizations and their partners for coordinated national scale-up of community health worker programmes.

[http://www.coregroup.org/storage/Program\\_Learning/Community\\_Health\\_Workers/CHW\\_Principles\\_of\\_Practice\\_Final.pdf](http://www.coregroup.org/storage/Program_Learning/Community_Health_Workers/CHW_Principles_of_Practice_Final.pdf)

<sup>11</sup> See Appendix 3 for CHW Programming standards [or \[EMBED LINK\]](#)

## 2.3 CHW PROGRAMMING STANDARDS

The Health Care Improvement Project within USAID has developed a tool to assess the functionality of CHW programmes. This tool serves not only for assessment, but also provides excellent guidance for precisely those programming elements that will result in a functioning and effective CHW programme. World Vision has made the decision to consider these programming elements as mandatory prerequisites to rolling out ttC programming. That is to say, before CHWs are trained in ttC and sent out into the community to carry out household counselling, all of the supportive structures and standards needed to ensure the effectiveness and functionality of the CHWs' work must either be in place, or the project must show solid plans for ensuring these as part of start-up and implementation. The CHW AIM matrix describes 16 components required for strong CHW programme functionality, as shown below:

<b>Considerations/Standards for CHW Programme Functionality</b>	
CHW AIM assessment	Incentives
CHW recruitment process	Community involvement
CHW role clarity	Referral system
Initial training	Opportunity for advancement
Ongoing training	Documentation, information management
Equipment and supplies	Linkages to health system
Supervision	Programme performance evaluation
Individual performance evaluation	Country ownership

Field offices preparing to launch ttC programming should make sure they use this toolkit in order to work through these programmatic considerations. **In Appendix 3**, the programming standards for the design of all CHW programming are outlined in detail.

### APPLYING CHW PROGRAMMING STANDARDS FOR ttC

#### 1. Conducting the CHW AIM assessment at baseline

If ttC-HVs are CHWs then the CHW AIM assessment should be conducted at baseline. Engage local and national health authority representatives in this process from design to analysis, and share the results widely with community and stakeholders, as previously identified as a best practice.<sup>12</sup>

#### 2. Recruitment

The ttC-HVs are the backbone of the home-based counselling system and the critical link between communities and facility providers. If ttC-HVs are CHWs, applying this standard means that recruitment of CHWs ensures volunteers are *selected by* and from the communities in which they work, answerable to the communities for their activities, and supported by a health system where possible. The profile of community volunteers is very diverse. While there are some broad trends, volunteers can be men or women, young or old, literate or illiterate, depending on what is appropriate and acceptable in context. If existing CHWs are already in place then apply the principle of working with existing structures: do not establish new cadres of CHWs unless guided by the MoH. See Section 3.1 for more details and examples of cadre selection amongst countries.

<sup>12</sup> Improving the Health and Nutrition Status of Women and Children: Promising Practices from East Africa. East Africa Regional Learning Center, 2013. <http://www.wvi.org/publication/improving-health-and-nutrition-status-women-and-children-promising-practices-east-africa>.

### 3. CHW role

CHWs, by virtue of the role they are playing in reaching out to households, are almost the 'extension' of facility service providers and need to be supported by a health system but not necessarily a part of its organisation. The role and expectations of the CHWs must be clear to the CHW and to the community in the delivery of ttC. In keeping with the Principles of Practice, roles for CHW are determined in the national policies of the countries, and therefore these should be defined nationally. If ttC-HVs are not CHWs, ensure that roles are defined in collaboration with communities and stakeholders.

### 4. Initial training

The content of this training may vary between countries depending on the decisions made regarding the respective mix of WV versus MoH curricula and materials. Projects should schedule the first training shortly after their recruitment, and ensure that at least one day of field practical is done. If ttC is being delivered in addition to basic CHW training, ensure that all participants have fully completed the basic competency training required by MoH before ttC. Maintain a database or record of all training.

### 5. Ongoing training

Ongoing training reinforces initial training, updates new skills and ensures that they are practising the skills learnt. Training events and participants should be tracked, and training opportunities must be offered in a fair and consistent manner to all CHWs/HVs delivering ttC. Projects will need to build ongoing CHW training into their implementation plans. It is recommended that projects institute a system of meetings involving some reinforcement of the training, every one to three months.

### 6. Equipment and supplies

CHWs should be provided with all necessary supplies for ttC household counselling, requiring a complete set of the ttC visual story flip-books, household handbooks sufficient to provide one to each household visited, and any supplemental MoH IEC materials, as per agreements made with MoH.

### 7. Supervisors

Projects must ensure that a supervisory structure is in place for ttC programming. As discussed, either the MoH or COMM will take responsibility for supervising CHWs, and in exceptional cases World Vision staff will support. Supervisors should aim to organise at least four face-to-face supervision contacts per year, in the community if possible, but at the facility or in a group if not.

### 8. Supervision activities for ttC

See the ttC supervision standards for more details on what to include in ttC supervision.

### 9. Individual performance evaluation

Projects should set up systems to ensure that CHW/HVs evaluations are carried out at least once a year, including individual performance and evaluation of coverage or monitoring data. The community should be asked to provide feedback on performance, and COMM should play a role in providing any rewards.

### 10. Incentives

If financial or non-financial incentive schemes are in place, make sure the CHW PoP principle 4 is applied (ethical, sustainable and established through stakeholder consultation and harmonised with local NGOs and partners). These incentives should be balanced, and in line with the workload expectations. Examples of non-financial incentives might include advancement, recognition or certification processes. In accordance with the standards, avoid payment of services or short-term incentive schemes that cannot be sustained, and ensure that COMM are engaged.

### **11. Community involvement**

Projects should ensure that the community plays an active role in all support areas, such as the development of their roles, providing feedback, solving problems, providing incentives, and helping to establish CHWs as leaders in the community. Monthly meetings and periodic ‘debriefing’ meetings will serve as forums where the information ‘feedback loop’ can be closed, with either WV or MoH representatives presenting aggregated results to the COMM members and the CHWs. These results should be used for problem solving and action planning.

### **12. Referral system**

CHW/HVs must be equipped to refer household members by being trained to recognise danger signs and how to complete and facilitate a referral. CHWs and the community should know where to refer and have a logistics plan for emergencies, including transport and funds. Ideally, projects should support facilitated written referral, and information flows back to the CHW through discharge (counter-referral) forms where available. The referral facility should know to accept these referrals from CHWs, and how to communicate with CHWs regarding difficult cases.

### **13. Opportunity for advancement**

Projects should consider how to offer CHWs opportunities for professional advancement, such as training on new skills, accreditation, or place them on a path to enter the formal sector.

### **14. Documentation and information management**

Projects will need to set up a system of data collection, and ensure that information is fed through appropriate channels. Simple monitoring forms are provided with the ttC curriculum and can be adapted for context. CHWs can be trained to fill them out, but comparison between these forms and the data-collection requirements of the MoH should be made prior to finalising the data-collection system. Supervisors routinely monitor the data quality before they are passed on to WV or MoH. Data collection should aim to be quarterly and shared with COMM at least twice a year.

### **15. Community-health facility linkages**

CHWs and their communities should be linked to the larger health system through involvement in recruitment, training, incentives, supervision, evaluation, equipment and supplier, use of data and referral. The health system should be involved in all the fundamental aspects of CHW programming, although the division of responsibility between MoH and WV or partner organisations will vary by programme. If using CHWs, ensure that they maintain direct reporting relationships with health facilities, and encourage face-to-face contact or via mobile communications.

### **16. Programme performance evaluation**

Projects should aim to have an evaluation of performance against targets, overall programme objectives and indicators. Assessment should include quality as well as quantity of service delivery provided by CHWs, and community/COMM should be asked to provide feedback on ttC performance. Health-facility workers should also be asked to provide feedback based on data received. Share evaluation findings at the community, local and national levels. According to CHW programming standards, evaluation should happen 12 months initially and after that every 18 months.

### **17. Country ownership**

For ttC scale-up, the MoH should be engaged throughout the country-readiness steps, preferably via any national-level committee that coordinates CHW programming if such a thing exists, and also involving key stakeholders, regional MoH and partners. Ensure that all plans to scale up ttC in the country are in alignment with existing MoH national strategies for a) MNCH, b) role-optimisation or health workforce initiatives, and c) health-system strengthening strategic plans. The MoH should be involved in all stages of ttC adaptation to context, including piloting, curricula choice and adaptation, incentives, data systems and evaluation, as well as in delivering the training.

### 3. ADAPTING ttC TO COUNTRY CONTEXTS

#### Purpose of this section

This section looks at specific adaptations to country context, taking into consideration the flexibility related to **cadres, curriculum selection and materials adaptation, and COMM**. We provide country examples of adaptations made and present tools that can be used in programme design to ensure that ttC materials are being adapted with quality, and that the integrity of the key messages is maintained across programmes.

#### 3.1 CADRES AND DELIVERY APPROACHES

The selection of volunteers will differ based on country contexts, and is a key decision to be made during MoH dialogue and country preparedness at the national level. When the ttC model was initially conceived at the global level, it was designed to leverage existing WHO/UNICEF materials, yet bridge them across the lifecycle – ie, from pregnancy through to 2 years of life, and enable CHW cadres delivering health-promotion activities to do so with greater depth and quality. Such an integrated approach is strongly recommended, and the ttC curriculum was recently commended in the recent review of CHW curricula conducted by the WHO.<sup>13</sup> However, over the last five years the CHW policy landscape in the countries in which World Vision is working is shifting towards greater formalisation of the roles of CHW, and greater country leadership in the determining activities, training and approaches. Nevertheless, alongside these activities, the ttC model has much to offer women and their families. Therefore we recommend a selective approach to cadre and delivery method choice developed in consultation with partners, designed for the existing CHW landscape of the country. In existing countries delivering ttC, there are three common scenarios, although they are not exclusive:

**Table 9. Cadre selection scenarios and considerations**

Scenario I	<b>'MoH-CHW model'</b> <i>ttC is conducted by CHWs officially linked to the MoH</i>
Examples:	Community health workers Health surveillance agents (HSAs) Accredited social health activists (ASHAs) Village health teams (VHTs)
Description	For WV to carry out ttC through CHWs in a particular country, MoH approval is required, enabling CHWs to add this responsibility to the work that they may already be doing. By 'linked to the MoH' we are referring to those whose roles and activities are defined in a country's CHW policy and whose work is recognised and affiliated with the local health services.
When is this model appropriate?	This will likely be the choice when: ttC is selected by the MoH, to be rolled out nationally with MoH CHWs. The ministry decides to use ttC for in-service training of CHWs and agrees that these CHWs can carry out the schedule of home visitation. WV agrees to use the existing ministry-produced materials, supporting existing programming through existing MoH CHWs.

<sup>13</sup> Tran NT, Portela A, de Bernis L, Beek K (2014) Developing Capacities of Community Health Workers in Sexual and Reproductive, Maternal, Newborn, Child, and Adolescent Health: A Mapping and Review of Training Resources. PLoS ONE 9(4): e94948. doi:10.1371/journal.pone.0094948

	<p>OR Work through a subset of ministry-linked CHWs, using the ttC materials. This may be the choice when:</p> <p>The MoH wants to <i>begin to use ttC</i> but existing cadres of CHWs already have job descriptions and tasks, with no space in their workloads to take on the ttC visitation responsibilities. As such, the MoH agrees to segregate amongst CHW cadres into a sub-group responsible for ttC. MoH and WV have agreed to <i>pilot ttC</i> in some areas, with select groups of MoH CHWs.</p> <p>This scenario is recommended in the following contexts:</p> <p>The ratio of CHW to households is low. Existing workloads are low. Multiple cadres exist, including a cadre focused on preventive care/health promotion. MoH agrees to scheduled post-partum visits up to two years.</p>
When not to consider this model?	<p>This scenario should not be considered in the following contexts:</p> <p>Ratios of CHW to households are greater than 1:50 and the MoH has not agreed to increase this ratio. The selected cadre has a workload of greater than 15 hours per week. The selected cadre is already conducting ICCM services (they would have much higher workloads). The MoH has already and nationalised strategy for BCC that reaches individual households comprehensively, and/or is proven to be successful.</p>
Advantages	<p>Official CHWs will normally already have some technical background and skill sets with regard to many of the 7-11 promoted practices and will be very well positioned to add household counselling to what they are already doing in the community. They should also have a pre-existing support system with accountability, and their activities ought to be well integrated into existing health services.</p>
Disadvantages	<p>World Vision might have limited freedom to determine the distribution of CHWs per household, there may be workload restrictions, limits to supervision feasibility and training capacity. It may be harder to establish the quality standards in country, although the CHW AIM process is designed to assist this.</p>
Considerations for this model	<p><i>Programming principles and standards</i></p> <p>How to apply the CHW principle of practice and the programming standards for the ttC curriculum where it is not the selected standard will need to be negotiated.</p>
Country examples	<p><i>Swaziland</i> – National CHW programme. <i>Sierra Leone</i> – MoH affiliated CHWs, subset</p>

<b>Scenario 2</b>	<p><b>‘Community group volunteers model’</b>  <i>ttC is conducted by existing community group volunteers using the home visiting approach (N.B. delivery approach is not via group methods but individuals)</i></p>
Examples:	<p>Volunteers linked to COMM          Mother’s support groups          Community care coalitions (CCCs)          Care groups          Safe motherhood action groups (SMAGs)</p>
Description	<p>As of FY09, WV is working with close to 70,000 community volunteers linked to CCCs around the world. Programmes that are unable to work through official ministry-linked CHWs (either because of MoH reluctance to take on the ttC curriculum, or because of an inability on the part of CHWs to add new responsibilities to their existing workloads, or because of the absence of CHWs in the project area) may find a ready cadre of volunteers already mobilised and partially trained through the CCCs, and operational in their areas. Existing health groups may exist established by World Vision, MoH or other partners, which could include CCCs, care groups and SMAGs.</p>
When is this model appropriate?	<p>This may be the choice when:</p> <ol style="list-style-type: none"> <li>MoH is interested in ttC but the MoH CHWs have existing job descriptions that do not enable new responsibilities.</li> <li>MoH agrees to use ttC for in-service training of CHWs to upgrade their skills, but given the CHWs existing job descriptions they cannot take on the responsibility of the ttC home visits.</li> <li>MoH continues to work with its own set of materials to train existing CHWs. WV is not satisfied with the quality of these materials and programme, and chooses to carry out ttC in project areas, mobilising a separate cadre of volunteers.</li> </ol> <p>This scenario is recommended in the following contexts:</p> <ul style="list-style-type: none"> <li>CHW are already overloaded due to CCM and other activities.</li> <li>The geographic distribution or population ratio means the CHWs are unable to reach all households and with quality.</li> <li>Behaviours around health are particular poor, despite active CHWs.</li> <li>There are existing groups with appropriate responsibilities who are targeting mothers in the home.</li> </ul> <p>This scenario should not be considered:</p> <ul style="list-style-type: none"> <li>When existing CHWs are sufficient as per scenario 1.</li> </ul>
Advantages	<p>Working through existing groups has the advantage of enabling rapid scale-up of 7-11 programming, as they are already mobilised in the communities. Within existing groups, the most motivated and active volunteers will already have been identified. There is greater flexibility to adopt the model given less strict limitations related to training, supervisions, and workloads by not using CHWs. Group volunteers may enable us to reach a more optimal household-to-home visitor ratio such as 1:20.</p> <p>This is a good way to engage women in ttC deployment – especially traditional birth attendants (TBAs) and mother’s support volunteers who might not meet the requirements of the government CHW programme in terms of literacy.</p>

	If existing CHWs are working alongside these groups, they may also provide some form of supportive/supervisory role for the groups, ensuring better integration with services in the community. CHWs can also be involved in the training for ttC. CGV approaches could mean that volunteers take a team-based approach and support one another to ensure good coverage and data-collection quality.
Disadvantages	This cadre of volunteers may have less technical experience, and perhaps lower levels of schooling and literacy, than CHWs. The activities of the group may be more highly determined at the local or community level and therefore extensive community liaison is required. Numbers of group volunteers may be much higher and therefore involving a greater start-up cost. Supervision of groups will be harder to reach with quality. The volunteers may have a number of other tasks to perform as members of the group and the workload to add ttC-HV could compromise their other roles in the groups or result in ttC-HV failure.
Considerations for this model	<i>Programming principles and standards</i> Programming standards for ttC take precedence, alongside the NO guidance for working with community volunteers <a href="#">(embed link)</a> , although the CHW programming standards also provide useful guidance for consideration.
Country examples	Zambia – SMAGs Cambodia – Mother’s support group volunteers Malawi – Care group volunteers
<b>Scenario 3</b>	<b>‘Community-elected volunteer model’</b>
<b>Examples:</b>	Traditional birth attendants Guide mothers
<b>Description</b>	In this scenario there is no existing community group as such from which volunteers can be drawn, and CHWs are not the appropriate cadre. Programmes may find other cadres of community volunteers mobilised and trained through different government ministries, other WV programmes, other NGOs or local organisations in the project area, and may choose to work with these volunteers. In some cases, COMM will need to recruit volunteers ‘from scratch’, although in some cases there may be women the community identifies as appropriate for this role.
<b>When is this model appropriate?</b>	This may be the choice when: (a) MoH is interested in ttC but the MoH CHWs have existing job descriptions that do not leave time for new responsibilities. (b) No existing appropriate community group is already mobilised towards household visiting, or existing community groups are overloaded with other activities. (c) A cadre of women/volunteers is already in place who are not currently working through the MoH systems – for example TBAs, who may in certain contexts be promoting poor health practices. . This model should not be considered: <ul style="list-style-type: none"> <li>• Where scenarios 1 and 2 are preferable approaches.</li> <li>• Comprehensive health-promotion approaches already exist through groups or CHWs.</li> </ul>
<b>Country</b>	Jerusalem West Bank and Gaza (JWBG) – newly identified community health volunteers

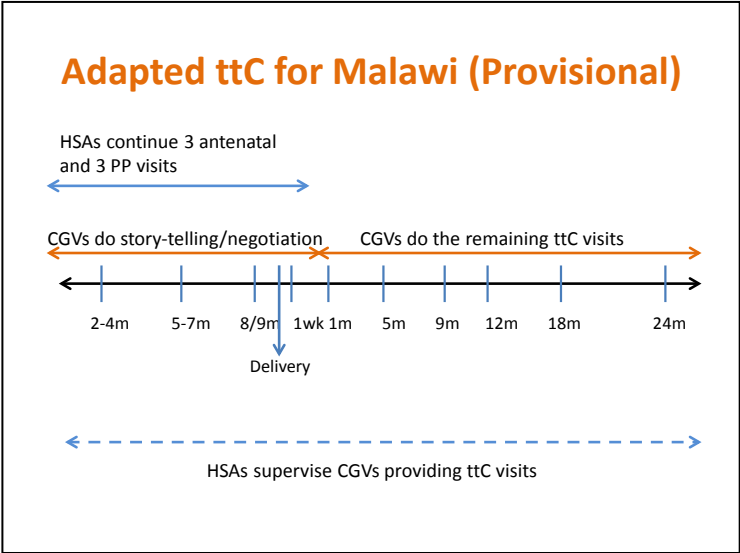


examples	Papua New Guinea (PNG) – TBAs
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### Adapting Existing Home Visits to ttC Example – Malawi

Another scenario encountered is that CHWs are already conducting home visits as in Malawi. HSAs carry out three visits during pregnancy and three during the first week after birth for all pregnant women/mothers, and thereafter continue visits only for HIV-positive mothers. HSAs are trained in the use of MoH tools that are part of its community-based maternal and newborn care (CBMNC) package. They also carry out a range of other activities spanning community case management, counselling/distribution of birth-spacing methods and water, sanitation and hygiene (WASH), and supervising the activities of CGVs where they are present. The household: HSAs ratio per MoH norms was 200 and lower in many locations. The high workload led to HSAs covering only about a third of pregnant women, as found in a recent study.

Considering these factors, MoH, WV Malawi and other partners deliberated on three possible scenarios using a blend of HSAs and CGVs: 1) HSAs continue the pregnancy and post-partum visits and MoH and CGVs the remaining visits, both groups using ttC, and HSAs supervise CGVs in their post-newborn visits. Concerns were the break in continuity, not addressing the poor coverage by HSAs and further increases in HSAs' workloads. 2) HSAs continue current visits without ttC and CGVs the remaining, using ttC and HSAs to supervise CGVs providing post-newborn visits. Here, the value addition of ttC during pregnancy will be lacking, as the HSAs' curriculum does not include storytelling and negotiation. 3) HSAs continue current visits as is, CGVs supplement these visits with ttC methodology, and CGVs continue the remaining visits using ttC. HSAs will supervise the work of CGVs. This third scenario was selected as carrying least risk of failure and tapping into all the benefits of ttC (depicted in graphic above). HSAs will receive orientation on ttC and its supervision tools. The CGV:HSA ratio is about 1:15.



### Care Group Volunteers Model

The CGV model was developed by World Relief in 1995 for community nutrition programming and has since been adopted by various countries and projects in Africa and Asia. The approach helps to rapidly disseminate nutrition/health information and improved practices in low-literate communities. CGVs are selected by the households they represent (10 to 12 households in the neighbourhood), trained as community volunteers by health promoters (NGO-hired staff or government CHWs). Each volunteer works individually with a group of 10 to 15 households and each group forms a 'block' within its own village or area called 'care groups'. Volunteers meet with their groups every two weeks to lead a group education session facilitated by a promoter or CHW, and visit each household in between those meetings. Here are two options for implementing ttC through CGVs, in addition to those considered in the Malawi example above:

**Option 1:** Select a few CGVs from each care group that a CHW supervises or manages (each CHW on average supervises 10 care groups) and assign them to do the ttC for their group with support from the CHW. A similar approach has been used to roll out of IMCI within the care groups. That will help to pick the most brilliant and active CGV from among all CGVs and train a sufficient number of CGVs that can roll out IMCI within the catchment area of their respective CG. This minimises the workload for the CHW, and facilitates a way for CGVs to reach out to pregnant women and children under 2 with ttC materials.

**Option 2:** Care group meetings alternate the routine CG group learning session with ttC home visits every two weeks. The advantage of this option is that both models will run in the same community without over burdening the CHW or the CGVs. The challenge is mainly the number of CGVs that need to be trained in ttC.

## 3.2 CURRICULUM SELECTION AND ADAPTATION

In this section we talk about the ttC curriculum, which is to be determined at the NO level. During negotiations with the MoH, it will need to present a variety of options, and a full review of the existing curriculum would need to be conducted. The decision-making process is the same regardless of whether working with CHWs, groups or other volunteers. There are four possible scenarios for curriculum selection:

### Curriculum choice and applying the ttC methodology

NOs must first enter into discussion with national-level MoH officials to understand the types of ministry-led and sanctioned household-outreach programming, if any, that may already be ongoing in the country, and review the corresponding manuals and IEC materials developed around such programmes. It is always preferable to work with, and help to scale up, MoH-led household outreach programmes than to introduce parallel, WV-developed models and curricula in keeping with the principles of MoH partnership. If suitable ministry-produced household-counselling materials are available, these should be reviewed to ascertain alignment with 7-11 messages. Ongoing dialogue will be needed to decide if these materials would benefit from additions to fill potential message gaps, or adaptations – especially with regard to organising such materials into message sets to enable the timed delivery that the ttC approach recommends.

It is important to understand that this package of materials comprises the six components of **World Vision's ttC package**. This package is provided to field offices as a **source of materials**, but it must always be compared side-by-side with potentially similar materials and curricula produced by the MoH and decisions made as to which of the above three options to select. This exercise with the MoH and selection of materials should always take place before ttC programming commences.

**Scenario 1: World Vision ttC curriculum in full** - MoH decides to take on the **ttC materials in full**, for purposes of institutionalising within the MoH and training for the selected cadres.

**Note:** Often in this scenario, the MoH will wish to first **pilot** ttC in a limited area to gather evidence as to its effectiveness, prior to scaling up and institutionalising the programme.

This scenario will most likely be the case where the existing curricula does not span the life cycle or is not comprehensive of the 7-11 messages, or the curriculum is not suitable for training the level of the selected cadre.

**Scenario 2: World Vision ttC as a supplement to MoH training** - MoH decides to take on **the ttC materials as a supplement** to the training process that CHWs currently undergo. CHWs may be trained in ttC as a part of their in-service training, for example, thereby upgrading their skills.

This scenario is likely where a strong national CHW programme exists, and covers some elements but has large gaps in the 7-11 messaging or in the ttC approach. This is also suitable where ttC is supplemental to ongoing health activities.

**Scenario 3: World Vision/MoH Hybrid curriculum created (or locally produced ttC)** - MoH and WV decide to **create a hybrid of the ttC materials** with MoH materials (mixing the two sets of materials to produce a 'new' package drawing from both.)

**Note:** A merge or 'hybrid' of two or more curricula is not likely to be a straightforward process and the NO may need to seek technical assistance from an experienced trainer, capacity-building specialist, or materials-development specialist.

This scenario is most likely in the case that existing technical content for the CHW or other cadres exist and are of good quality, but lack certain aspects covered in the ttC curriculum. This is especially the case if the BCC and storytelling methodology is lacking in the MoH materials, then these elements would be pulled from ttC.

**Scenario 4: MoH Curriculum only (no ttC done)** - MoH decides **not to make use of the ttC materials** but, rather, to use existing ministry-produced materials.  
This will likely be the case when:

- A. WV decides to also use the ministry-produced materials for 7-11 programming, thereby supporting existing MoH programmes and materials, as opposed to introducing something new or parallel. In this case, WV will **not** implement ttC programming.
- B. WV decides to continue to use ttC materials even while the ministry is using its own materials. (Not ideal, but may be necessary in instances where WV is not satisfied with the quality of MoH materials, but MoH does not agree to take on ttC.)

**Note:** In this latter case it may or may not be possible to work with cadres of ministry-linked CHWs. A separate cadre of volunteers may need to be identified.

**Cadre Selection**

**Scenario 1: CHWs are the ttC cadre, fully led by MoH**

WV H/N technical staff carries out a ToF with MoH staff in the ttC approach. The MoH staff then facilitate trainings with, and supervise, ministry-linked CHWs carrying out the household-level counselling. Either MoH-sanctioned or the World Vision ttC curriculum provided with this package may be used.

**Scenario 2: MoH-affiliated CHWs are the ttC cadre, support is WV led**

In this scenario, the MoH does not have adequate staff availability to enable MoH staff to take responsibility for the training and supervision of CHWs. In this case, WV H/N technical staff carry out a ToF with WV sub-national H/N staff, who then go on to train ministry-linked CHWs in the ttC approach. The COMM handles the supervision. Either MoH-sanctioned or World Vision ttC curriculum may be used.

**Scenario 3: ttC-HVs are not-MoH CHW, support is WV led**

In this scenario, the MoH does not have adequate staff availability to enable MoH staff to take responsibility for the training and supervision of CHWs, nor is there an available cadre of ministry-linked CHWs able to carry out the household-level counselling. There may be CHWs in fact but their workloads are too heavy. In this case, WV will train COMM-recruited and COMM-linked community volunteers in the ttC approach. Again, the COMM supervises the volunteers. Either MoH-sanctioned or WV ttC curriculum may be used.

The table below summarises the three possible combinations of cadre, curriculum selections and implementation:

**Table 10. Scenarios for WV-MoH partnership in implementation ttC**

Scenario	ToF carried out by	Training and supervision of CHWs	MoH CHWs or other volunteers	Curriculum	Desirability
1	WV Technical	MoH	MoH CHWs	MoH/WV	Most favourable
2	WV Technical	WV and COMMs	MoH CHWs	MoH/WV	More favourable
3	WV Technical	WV and COMMs	Other volunteers	MoH/WV	Less favourable

## CURRICULUM REVIEW PROCESS

If considering the use of a set of materials other than ttC, a complete review of the potential alternative curriculum must be carried out. This applies to MoH-produced curricula, curricula produced by other local organisations/partners, and to WV locally produced curricula to be used in place of ttC. Two tools are provided for this purpose, distributed together with this document. The tools aim to assess the degree to which alternative packages include the proven effective aspects of ttC, as described below.

- Alternative curriculum review: WV-produced version
- Alternative curriculum review: MoH version
- Comparative curricula review tool (Excel file), which provides a checklist of 7-11 messages to be used to check MoH curricula against the ttC core curriculum.<sup>14</sup>

**Note:** While programmes may choose to work with a curriculum that does not demonstrate all of the desired elements as found in ttC, it must be understood that there may be a trade-off in such a case, in terms of reduced quality of message delivery and counselling to households. This must be weighed against the desirability of working within the MoH system, using MoH materials. If the alternative materials are not deemed to be of reasonable quality, then ttC should be selected, even if this means a departure from MoH programming.

## CURRICULUM CONTEXTUALIZATION – USING ttC CURRICULUM

### Ensuring coverage and quality in alternative/hybrid curricula

#### a. Comprehensive of 7-11 Messages

A review process using the checklist provided in the *Alternative Curriculum Review* tool must take place to ensure that the selected curriculum is comprehensive of the 7-11 messages. It is likely that some additions to an existing curriculum will be needed to include missing messages.

#### b. Timing of messages and storybook adaptation

One of the unique features of the ttC curriculum is its organisation of all 7-11 messages into **appropriately timed message sets**. If an NO opts to use an alternate existing curriculum, a review process should take place to determine whether a similar timing structure can be accomplished via the selected curriculum, and make appropriate adaptations to the materials, as possible. Where locally adapting materials – see the *ttC Message Visit Checklist*, to ensure that key messages are given at the right time. This checklist can also be used during field implementations to ensure the quality of message transmission during household visits – provided the messages are covered in the curriculum and accompanying storybooks.

#### c. Methodology: Dialogue and negotiation

While a NO may identify alternative existing materials in country, the review of these materials should encompass not only their content, but also the delivery methodology. Although an existing curriculum may be comprehensive of 7-11 messages, if the methodology is one in which these messages are delivered in an antiquated, ‘top-down’ way, this will not align with WV’s household outreach and behaviour change objectives, and corresponding changes

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<sup>14</sup> All tools can be found in the TTC toolkit site on wvcentral <https://www.wvcentral.org/community/health/Pages/TimedandTargetedCounselling.aspx> Or can be accessed by contacting [health@wvi.org](mailto:health@wvi.org)

should thus be made to the materials as possible. If a hybrid curriculum is being developed using storybooks that are developed locally, an additional tool is available to check that all the correct messages are covered within the visits.

#### **d. Data collection and monitoring**

The ttC curriculum includes a data-collection and monitoring system that enables the tracking of a selection of the 7-11 practices among beneficiaries. A good data-collection and monitoring system is needed as it enables a project to understand where its efforts are leading to success (ie, uptake of recommended behaviours), and which practices are lagging behind. In this way, projects can make adjustments to their activities as they go along. If the selected curriculum does not incorporate a data-collection and monitoring system, one will need to be created. **Note:** It is expected that a MoH-produced package will include a data-collection and monitoring system.

### **Contextualisation of the World Vision ttC curricula**

Even when an NO selects the WV ttC curriculum, the ttC core curriculum may not be used 'off the shelf', as-is. Contextualisation is mandatory. Curriculum contextualisation takes place at various levels, as outlined below.

#### **Types of changes**

##### **NO-Level: Mandatory changes: Extractions, as appropriate**

- All countries must go through a mandatory process of **extracting** sessions related to epidemiology not present in their locations, as appropriate. Examples may include malaria, iron-supplementation (recommended only in certain, specific contexts, as prompted in the curriculum), and emphasis given to HIV and TB.

##### **NO-Level: Mandatory changes: Other local issues**

- In addition to extracting non-relevant epidemiology, all countries must review every 'contextual change' prompt in the curriculum and make the necessary changes based on local context. Examples include the use of local foods for food-related exercises, the descriptions of available health services per the context, and the like. These prompts are easily located in the curriculum.

##### **NO-Level: Mandatory changes: Job aids**

- These mandatory changes extend to the **story narratives** as well, wherein NOs must review all **orange text** in the story narratives and change these words or sections as appropriate. Examples of story narrative changes include the choice of **names** for the story characters, the **foods** they are eating, and the like. In addition, every country should review the **photo food cards** and add or remove food examples for their context.

##### **NO-Level: Optional additions**

- In rare cases, an NO may **add** one or more sessions on a highly relevant health issue not included in 7-11 table or the ttC curriculum. An example might be a highly prevalent 'neglected tropical disease' that the NO assesses as important to address. In such a case, a **complete process of session development** must take place.

##### **NO-Level: Optional other changes**

- Finally, an NO may choose to remove sessions related to 7-11 practices that are assessed to be already widespread in project areas (in other words, the assessment shows that the practice is not a problem in the area). There is no harm, however, in leaving these messages in the curriculum, as it provides an opportunity to review with families, and reinforce and praise what they are already doing.

**Locations of changes to curriculum**

The process of making changes to the ttC curriculum must be undertaken in a **careful, detailed and methodical way**. When a change is made to a session in the Facilitator's Manual, a careful review must be made of the additional pieces of the overall package, to determine if corresponding changes are needed in these other locations as well.

- Facilitator's Manual
- Participants' Manual
- Storybooks
- Household Handbook
  
- Data collection and monitoring system
  - List of indicators
  - Reporting spreadsheet
  - ttC registers
  - Supervision tool

**Working with non-literate ttC-HVs**

Although the materials in this package have been developed taking into consideration the various profiles of ttC-HVs that projects may encounter in different country contexts, some adjustments will be needed when working with non-literate CHWs. Field testing of all adapted tools and materials is advised if new materials have been developed.

**Carry out all activities through discussions – do not write on the flip chart:** In the Facilitator's Manual where instructed to 'write the answers on the flip chart', they will not, in fact, write, but handle this discussion instead. Some degree of repetition may be needed to ensure that the ttC-HVs are remembering the main points, as these points will not be posted in written form.

**Do not distribute the CHW Manual:** The Participants' Manual is meant to serve as a reference source only for those ttC-HVs who are literate. Reference material for non-literate ttC-HVs is limited to the illustrated job aids.

**Rely on the visual job aids for content retention and content reference:** While the Participants' Manual serves as a reference for literate ttC-HVs, it is nevertheless the case that those who do not read and write will have a source of reference if they are successful in remembering the story narratives. The illustrations provide clear depictions of **all 7-11** key messages. Thus, the story narratives and illustrations, taken together, provide all of the reference to key content. Facilitators should place a great deal of emphasis on reviewing these job aids and practising with them during training. All other activities outlined in the Facilitator's Manual should still be carried out, but the consolidation of information will happen through extensive and repetitive use of the job aids.

**Assess the extent to which the ttC-HVs are successful in remembering the stories:** It is assumed the ttC-HVs will be able to accurately transmit the stories to families, but facilitators should observe the degree to which non-literate ttC-HVs are, in fact, remembering the story narratives and transmitting them accurately. It may be necessary to provide a tape-recording of the story narratives, or look for additional support from COMM to revise stories. Otherwise, facilitators will need to build in repetition to assist in remembering the story narratives.

### 3.3 COMMUNITY HEALTH STRUCTURES (COMM)

#### The COMM model and its relationship to ttC

As described elsewhere, World Vision's '7-11' strategy for maternal and child health is based on a model of BCC that calls for intervening at the three levels of individual, community and environment. The **COMM** model is the core approach at the community level, and is the name given to a health-focused community group empowered to coordinate and manage activities leading to improved overall community health, and strengthened civil society. COMM programming should be taking place regardless of the nature of CHW or ttC-HV programming. As such, the purpose of this section is to provide a description of the COMM model, and explain the relationship and integration between COMM and ttC.

#### ttC-HV links to COMM

In an ideal scenario, COMM programming start-up would run alongside ttC, which is why COMM is emphasised within the strategic framework. However, this may not always be the case, and a lag may occur between the start-up of each model. The first step in COMM programming is to identify the appropriate community-level group to play the role of the COMM, which is the group with which ttC-HVs will be linked. The COMM Model: Description and Guidance for Design<sup>15</sup> document provides instruction for making this selection, depending on the scenarios that project staff may encounter on the ground. It is recognised that community groups are normally already operating in WV areas; these may be either pre-existing formal national government structures, or mobilised through other types of WV programming such as the Integrated Programming Model (IPM) or CCCs. Staff should follow the guidance in the tool to make the appropriate selection. Following are some of the possibilities that staff might encounter, and the implications for ttC programming.

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<sup>15</sup> Available on wvcentral or on request from [health@wvi.org](mailto:health@wvi.org).



**Table 11. Scenarios for the selection of COMMs**

Scenario 1	Existing government-sponsored village health committee (VHC)
<p>If such a group exists, WV should work with it for COMM programming, strengthening its capacity per assessed need (see below).</p> <ul style="list-style-type: none"> <li>In such cases it is likely that the MoH-supported CHWs are already officially linked to the VHC. If they are not, however – or if the ttC programme is working with a different cadre of volunteers not linked to the COMM – then this link should be fostered.</li> </ul>	
Scenario 2	Other existing government structure(s)
<p>In some cases there may not be an existing health-focused community group as such, but there may be a government-sponsored multi-sectoral or holistic development-type group. In such a case it may be appropriate to work with this group, strengthening its health-related capacity and thereby enabling the group to play the role of the COMM. It may be the case in this scenario that CHWs are not already linked to the group; rather, CHWs may only be reporting to local MoH staff with no formal community accountability.</p> <ul style="list-style-type: none"> <li>In terms of ttC programming, in such cases the ttC-HV – COMM link should be fostered.</li> </ul>	
Scenario 3	No existing government-sponsored group, but community groups mobilised/ supported through other types of WV programming
<p>It is sometimes the case that government-supported structures are non-existent at the community level, but that WV has been active in IPM programming, CCC programming or other types of community mobilisation. The <i>COMM Model: Description and Guidance for Design</i> document provides guidance on how to select the appropriate group to work with in these cases.</p> <ul style="list-style-type: none"> <li>ttC-HVs may or may not already be linked to the group: if they are not, this link should be fostered.</li> </ul>	
Scenario 4	No existing community groups
<p>In rare cases WV may be working in a very weak civil-society context where no community groups yet exist. In these cases, project staff should refer to <i>The CCC Guide</i> for guidance on mobilising a new group, and then refer to <i>COMM Model: Description and Guidance for Design</i> for guidance on the next steps in capacity building.</p> <ul style="list-style-type: none"> <li>This group's link with ttC-HVs will need to be actively fostered.</li> </ul>	

## THE NATURE OF THE ttC-HV- COMM LINK

The type of relationship that ttC-HVs have with COMM will depend on whether the ttC-HVs are supervised by the MoH.

- Scenario 1: MoH supervision of ttC-HVs:** Ideally, the ttC-HVs will be supervised by MoH local staff, and be linked to an official, government-sponsored village health committee (VHC) or the COMM. If MoH staff are the official supervisors of the ttC-HVs, the COMM will not play a formal supervisory role. This does not mean, however, that the ttC-HVs should not have some type of accountability to a community group – they should. Official decision making will continue to rest with the MoH, but the ttC-HVs should also report on

their work to the COMM. At the same time, ttC-HVs may be able to receive supportive assistance from COMM if their MoH supervisors are not always available. If WV is working with ttC-HVs not already linked to a community group, discussions should begin with the MoH, the ttC-HVs themselves, and the appropriate community group, to develop this link and to determine the appropriate roles for each party to play.

- **Scenario 2: CHW/Vs (community health worker/volunteers) not supervised by MoH:** If ttC is carried through a different cadre of volunteers rather than through official MoH-linked CHWs, the community should be involved in the selection of the volunteers, and the volunteers should be linked to the COMM, who will supervise them. This is a very different scenario from the above, in that the COMM will take on formal supervisory responsibilities vis-à-vis the CHW/Vs. The supervisory responsibilities of the COMM in this case are described elsewhere. This is the case for both existing groups and newly identified volunteers for ttC.

## COMM CAPACITY BUILDING

- **Appreciative assessment:** The *Facilitator's Manual for COMM Assessment and Technical Capacity Building* [\(embed link\)](#) begins with carrying out an appreciative assessment with COMM to determine what types of training and capacity building the group has received to date from MoH or other partners, the group's existing strengths and current activities, and the gaps that require additional capacity-building support.
- **Technical capacity building:** Following the appreciative assessment, the *Facilitator's Manual* offers eight sessions aimed at building the COMM's technical capacity. Of particular interest to the ttC programme is *Session 6: Supporting Community Health Workers* (ie, the ttC-HVs). This section is relevant even for all ttC-HV cadres.
  - ttC programmers will want to ensure that COMMs are adequately trained in this area, and that the nature of the support provided is tailored to the context and modalities of ttC. The individuals responsible for ttC should actively participate in the planning and implementation of this part of the COMM training.
- **Organisational capacity building.** The appreciative assessment will likely reveal additional areas needing group strengthening that are not technical in nature but, rather, relate to the group's own internal functioning. *World Vision's Facilitator's Manual for Organisational Capacity Building* can be used to address these identified gaps.

Ideally, the above steps take place prior to ttC implementation, as part of the 'country readiness' process. The COMM should be identified, ttC-HVs should be linked to the COMM, and the COMM should be prepared for its roles through appropriate capacity-building support. This is the best community foundation from which ttC programming should be launched. It may sometimes be the case, that some of these actions will take place concurrently with ttC implementation.

## ROLES OF THE COMM IN SUPPORTING ttC

The COMM is to provide support and oversight to CHWs, whether they are involved in ttC or other health-related activities.<sup>16</sup> All programmes will begin with a process to ensure that necessary systems and structures are in place to support the ttC-HVs, prior to any training and implementation. Projects will use the CHW programming standards, which provide minimum standards against 15 essential elements. The general roles of the COMM with regard to ttC support and oversight may be situated within these programming standards.

### Recommended Roles of COMMs in ttC Programming

- **Recruitment of ttC-HVs:** Engage COMM in identifying selection criteria and recruitment whenever necessary.
- **Roles of the ttC-HVs:** COMMs ensure that roles are clearly communicated to the community so as to avoid misunderstandings.
- **ttC-HV incentives.** COMM and community may not always determine what these incentives are, but should be engaged in their distribution and in ensuring that the HVs are recognised and appreciated in their communities.
- **Community involvement.** COMM quarterly debriefing meetings with ttC-HVs and community members serve as forums for feedback for the community voices to be heard.
- **Individual performance evaluation.** COMMs organize the process of gathering community feedback on individual performance.
- **Referral systems and commodities management:** COMMs support referral procedures as needed, they may also develop an emergency fund to assist with transport and other costs in case of a health emergency. If ttC-HVs are also distributing commodities this would be overseen by the COMM.
- **Documentation and information management:** If COMMs supervise ttC-HVs they might also do data aggregation. Ensure access to and use of data during COMM ttC debriefing meetings.
- **Programme performance evaluation.** COMM and the community at large will be asked to provide feedback during evaluations.
- **Community-health facility linkages:** COMM has a role to play in creating linkages between the various health stakeholders in the community and surroundings.
- **Directly supervising ttC-HVs:** Countries moving to a system of 'lead CHWs' to play the supervisory role, these ttC supervisors are selected from the most competent and should be participants in the COMM.

## 3.4 ttC: 'A HIGH-RISK TARGETING STRATEGY'

In communities, some individuals are of higher than average risk, and these can be identified by ttC-HV during home visits. The specific recommendations for how the ttC-HVs address specific medical needs of these at-risk individuals is a contextual adaptation that depends on country recommendations and availability of other services and local facilities. Encouraging ttC-HVs to identify the risks listed in Table 12 below and taking actions to provide any additional support is an opportunity to enable integration of ttC with other health models such as PMTCT and community-based management of acute malnutrition (CMAM) (see Part 5).

<sup>16</sup> In many areas WV support other CHW-related activities apart from ttC, such as CMAM, iCCM and cPMTCT. The principles articulated here also apply in the COMM support, oversight and promotion of those specialised project models.

**Table 12. Examples of risk and actions to provide additional support by ttC-HVs**

Life cycle stages	Pregnancy (-9m)	Newborn (0-1m)	Breastfed Infant (1-6m)	Child (6-24m)
Examples of high-risk individuals	<ul style="list-style-type: none"> <li>- HIV-positive pregnancies</li> <li>- High obstetric risk pregnancies</li> <li>- Pregnant mothers with medical conditions (hypertension, diabetes, other)</li> </ul>	<ul style="list-style-type: none"> <li>- Low birth weight/premature</li> <li>- HIV exposed</li> <li>- Congenital malformation</li> </ul>	<ul style="list-style-type: none"> <li>- HIV exposed</li> <li>- HIV positive</li> <li>- Low birth weight</li> <li>- Malnourished infant</li> </ul>	<ul style="list-style-type: none"> <li>- HIV positive</li> <li>- Malnourished infant</li> </ul>
	<ul style="list-style-type: none"> <li>- Other (eg, adolescent pregnancy, disabled)</li> </ul>	<ul style="list-style-type: none"> <li>- Other (eg, adolescent mother, maternal orphan, twins etc)*</li> </ul>		
Potential actions	Additional household visits Treatment support Clinic follow-up	Additional household visits Treatment support Clinic follow-up	Additional household visits Treatment support Refer to community services Clinic follow-up	Additional household visits Treatment support Refer to community services Clinic follow-up (HIV and CMAM)

\*A full list of risk factors linked to increased child death at household level is presented within the ttC curriculum.

### 3.5 MONITORING AND EVALUATION OF ttC

Various monitoring tools have been developed to support the design of DME tools for ttC. The ttC model encompasses the ongoing monitoring of the uptake of many household behaviours, as described in Section 1.3. Appendix 1 provides a description and link to the current versions of existing monitoring tools that can be accessed through wvcentral. In principle, the tools provided are intended as **samples that need to be adapted to local context** and during the adaptation process the MoH will need to be consulted and alternative data-collection tools compared side by side before deciding on the best option for the country.

#### Available tools

The **illustrative log frame** for ttC provides an exhaustive list of the core and optional indicators that can be used for monitoring (output level) and evaluation (outcome level) indicators. This can be used during the planning process to plan activities relevant to each outcome. Appendix 2 provides a list of selected core and optional indicators. The **eligible women and girls register** can be used at project start-up to identify all women aged 15 to 49 years covered by an individual home visitor. The **referral/counter-referral** form is a sample that can be used to transmit information between health facilities and ttC-HVs or CHWs and is especially useful if there are integrated high-risk strategies (see Section 3.4).

The sample monitoring tools '**ttC register**' give the option of collecting household outcome data at four points in the life cycle and provides a simple column structure for data collection at each visit. A back-end **ttC tracker Excel spreadsheet** is under preparation/piloting, which can be used for reporting purposes. For supervision purposes a modular sample **ttC supervision tool** is provided, which has various modules that capture the different components of supervision, such as case assessments (spot check), observation assessment checklists, health-knowledge checklists and a basic data module.

#### Steps in adaptation

##### a) Selection of project activities and tools

During this process there should be a review of any existing tools used for data collection at the community level used by the existing cadres/programmes. Use existing versions where possible, and if there are gaps, negotiate adjustments within those tools. If the gaps are substantial consider using the World Vision -provided tools, ensuring that the adjustments are made to ensure HMIS alignment.

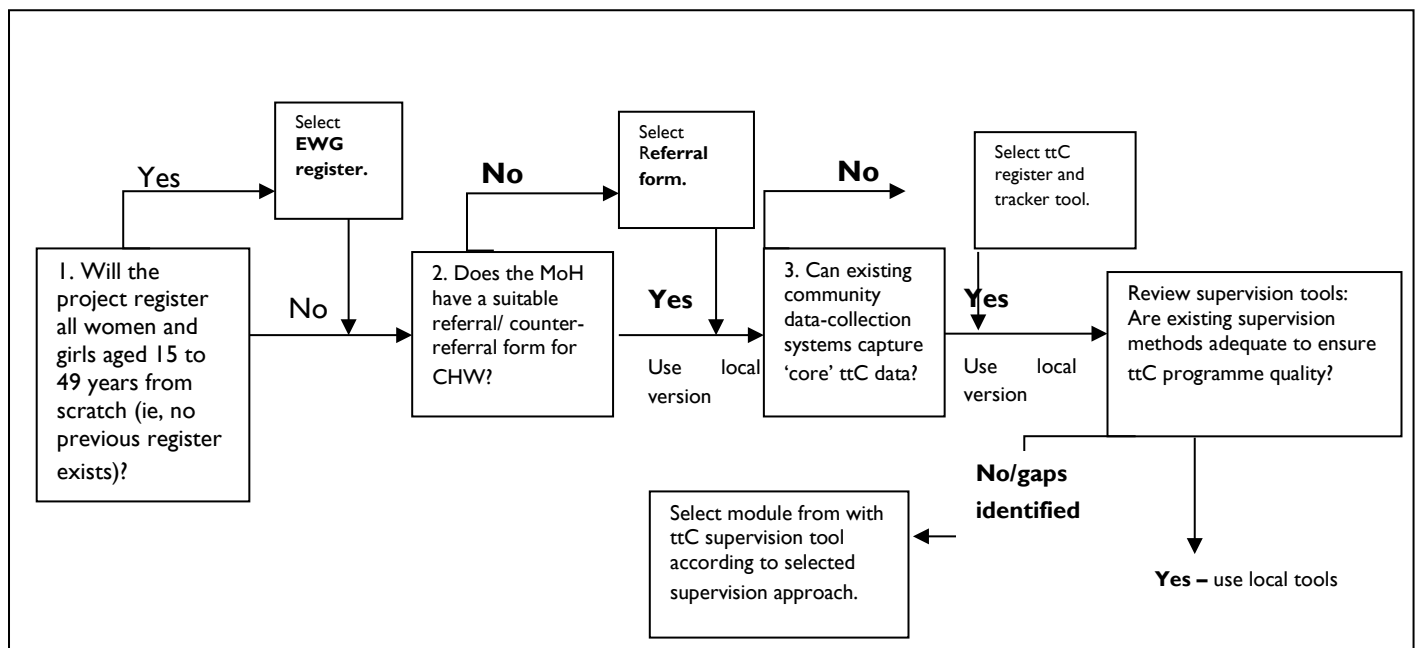
**b) Selection of indicators**

During NO adaptation of the tools, key household outcomes should be selected that will enable the best monitoring of the programme. The ‘core’ indicators to be selected by all offices include those that are health target monitoring indicators, as well as certain aspects that are key to the programme methodology. ‘Optional’ indicators incorporate those that are specific to epidemiological context or the requirement of the programme to integrate with other activities. It is recommended that selection of indicators limits the number of data points to those most informative (ie, those that have high variance), or that are required by HMIS systems. Remember to follow the principle of not collecting data that is unlikely to be used to improve programming.

**c) Adjustment of tools**

Once indicator selection is done, complete the adjustment of tools, which may involve adding indicators to local MoH forms, or if using WV forms, deleting rows from the ttC registers. This should be a straightforward process, and should be done only once during a project. Any HMIS-required indicators not listed on the GC sample ttC registers can be added in the ‘optional indicators’ rows and given suitable icons. For adapting the back-end database, this process will involve selecting and ‘de-selecting’ indicators required by your project. More information is given in the user guide.

**Figure 8. Process flow for monitoring and supervision tools**



**MOBILE ttC**

Currently under development and being deployed in several pilot sites through the world, mobile-ttC has been developed to enable real time data-collection and monitoring. Several modules exist and can be selected and adapted for use in context. Current versions deployed in Sierra Leone and Uganda, amongst others, use a recorded voice with an image and therefore require minimal literacy.

Various modules now exist, including:

- Participant registration
- Closed user group calling
- Audio visual content
- Live referrals and follow-up
- Monitoring of ttC practices uptake

Modules in development

- Automated reporting systems
- Alerts and notifications systems (reminders for ttC-HVs)
- Health messages (for SMS or IVR)
- ttC supervision systems

### 3.6 COUNTRY EXAMPLES OF ADAPTATIONS

Table 13. Country examples of cadre selection and relationships with MoH

Country	Cadre selected for ttC	Curriculum selection and changes	Who are the COMM?	Supervisors of the ttC-HV	Relationship with MoH
Guatemala	<p><b>‘Mother guides’</b> Leaders from communities, typically women and mostly mothers. One MG per 30 households.</p> <p>Roles are defined by World Vision. Some also act as CHWs who are part of MoH activities.</p>	<p>WV ttC core curriculum</p> <p>Changes: No deworming for pregnant mothers or children under 2 years.</p> <p>Locally developed materials artwork and stories.</p>	Community leaders, members of the COCODE (community development council), mother guides, municipality staff and MoH local staff (if available).	Project facilitators (World Vision staff) at ratio of ~15:1.	<p>No MoH trainers or supervisors for ttC.</p> <p>An MoU framework agreement in process with local health facility staff, includes providing health training for project staff.</p>
Cambodia	VHSG = Village Health Support Group. Selected by communities and trained by MoH staff, and are formally recognised by MoH.	Blend of WV ttC core curriculum and MoH/MoH-approved other curricula. Excludes malaria.	Health Centre Management Committee.	MoH local health staff leading group-based supervision with selected individual follow-up strategy.	MoH staff will train VHSG members in the adapted ttC curriculum and supervise.

Sierra Leone	CHWs recognised by MoH policy. Affiliated with local health facilities through training and supervision	WV ttC core curriculum.	COMMs set up by project to include local leaders, CHWs and health actors.	Supervised by the local health facility staff through individual approaches and meetings.	CHWs are selected by communities using MoH policy guidelines. CHWs will continue to be supervised by health-facility staff who are oriented on ttC.  MoH adopted the ttC data-collection and reporting system.
Zambia	SMAGs (MoH-recognised groups, selected by communities, supervised by health-facility staff). SMAGs are not the same as CHWs but some individuals may have multiple roles such as CHWs, Child Health Promoters (CHP), malaria agents, Trained Traditional Birth Attendants (TTBA).	WV ttC core curriculum contextualised to align with MoH policy.  TB screening not included.  ttC extends the mandate of SMAGs from home visiting up to the end of the newborn period (MoH policy) to 2 years of life.	NHCs (Neighbourhood health committee) an umbrella body that is mandated to supervise, plan and coordinate all community health activities and cadres in their communities.	NHCs, with support from the rural health centre (RHC) staff and WV project staff.	Rural health facilities supervise the COMM and train the SMAGs and COMMS in the project areas.  An MoH - technical working group has been convened to review ttC pilot results and lessons.



Malawi	<p>CGVs, selected and supported by communities. No formal MoH policy* recognising this cadre yet <i>but</i> CGs are shown as an integral part of the govt.'s Nutrition Education and Communication Strategy (NECS)</p> <p>*MoH has plans to draft a policy pertaining to CHVs. Consultations with partners already under way.</p>	<p>WV ttC core curriculum, contextualised to reinforce the CMNC home visits conducted by paid MoH HSAs, ie, three pregnancy visits instead of four; and to align with MoH policy such as mandatory HIV testing through ANC, three doses of intermittent preventive treatment in pregnancy (IPTp) instead of two.</p>	<p>VHCs, recognised by MoH. Dialogue with MoH on clarifying their roles as oversight rather than implementation body.</p>	<p>Joint supervision by project facilitators (WV staff) and HSAs (MoH).</p>	<p>The ttC consultative group proposed that CGVs be supervised by HSAs who are MoH-appointed CHWs.</p>
JWBG	<p>CHWs</p>	<p>A contextualised curriculum that combines parts of WV ttC core curriculum and MoH policy.</p> <p>7-11 exclusions: Malaria, PMTCT and TB, deworming in mother and child</p> <p>7-11 inclusions: Newborn harmful cultural practices.</p>	<p>COMM committees: One per ADP with three to five representatives from each village, these committees support the CHWs, needs assessments, create links to MoH, facilitate MoH activities and lead groups such as mother support groups.</p>	<p>WV staff</p>	<p>CHWs are selected by communities and WV Staff-trained by WV staff and MoH and followed by both. Data are monitored, analysed by WV and shared with MoH.</p>

## 4. COUNTRY-READINESS PROCESSES

### Purpose of this section:

This section provides generic and practical guidance for NOs in preparing to implement ttC, including **high-level dialogue with MoH** on critical decisions related to adapting ttC to the country context. Other key steps are related to **contextualising the curriculum**, assessing CHWs, **identifying COMMs** and carrying out **ADAPT**. This is a step-by-step guide, which will also serve as a checklist for ensuring that the office is fully prepared to implement.

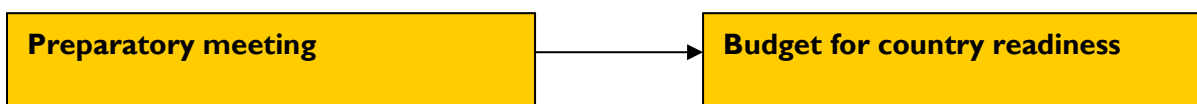
### 4.1 INTRODUCTION

As World Vision gains experience in ttC, it has become apparent that solid preparation is needed before good programming can move forward. The specific details of this preparation will vary by country, but the steps outlined here will generally cover most scenarios. It is not necessary to follow the steps in sequence, although some are natural precursors to others. The staff responsible for the programming should read through the complete document and determine the best way forward for their office and context. The accompanying ‘Country Readiness Tool’ can be used to as a plan or calendar for the activities.

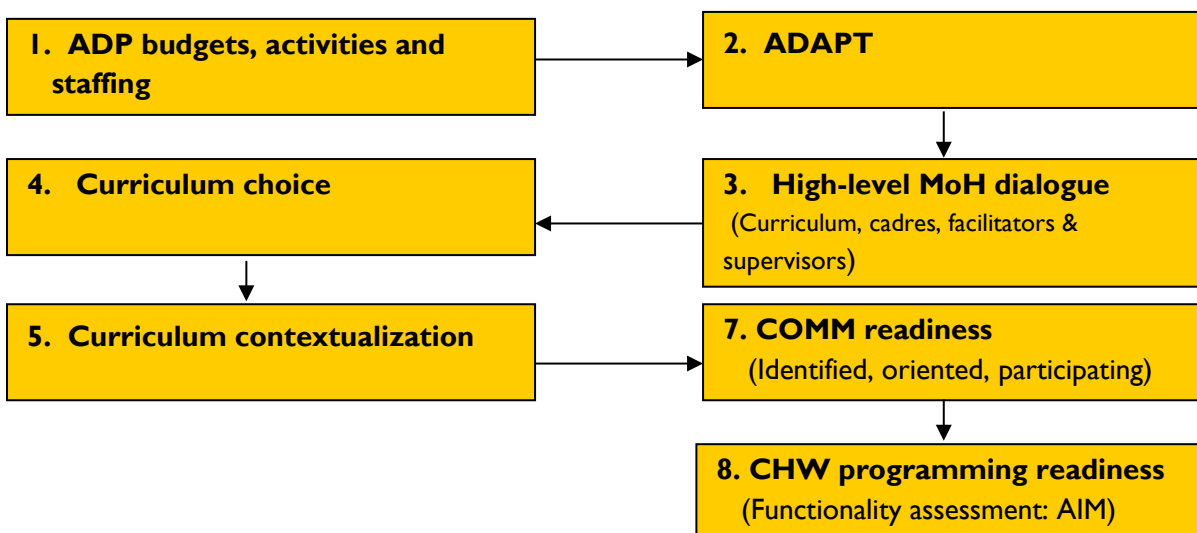
If your NO is moving forward with a curriculum for individual-level BCC through CHWs that is not ttC, it may be the case that not all of the steps will be relevant to your situation. Many will, however, and you should follow the guidance to the full extent that it is applicable, prior to training. Readers can refer to a blog that follows the experience of the WV Swaziland office as it moves through the country-readiness process, as much of these details may prove helpful (<http://wvchw.wordpress.com/>).

#### Overview: Country-Readiness Steps for ttC

##### Preliminary steps



##### Country-readiness steps



## 4.2 PRELIMINARY STEPS: THE PREPARATORY MEETING

### I. Participants

Staff may carry out the preparatory meeting, or a facilitator may be enlisted for this purpose. The following individuals should attend the meeting:

- National health/nutrition coordinator
- National HIV/AIDS coordinator (if different)
- Representative from DME; the individual most indicated to assist in ADAPT process
- Operations manager
- National director (optional, may be briefed after the meeting)
- One or more ADP development facilitators responsible for HN programming (desirable, but optional).

### 2. Information to consolidate

The information to be consolidated during the preparatory meeting should include those listed in Table

**Table 14. Information to be consolidated in the preparatory meeting.**

Programming Areas	Information to be presented
Overview of current H/N programming	<ul style="list-style-type: none"> <li>○ Grant programming: donors, amounts, duration, activities</li> <li>○ Sponsorship programming: ADPs, budgets, activities</li> <li>○ HN models/approaches in use, supporting materials in use</li> <li>○ Data collection already undertaken, describe.</li> </ul>
Staffing to support H/N programming, to include ttC: Overview and needs assessment	<ul style="list-style-type: none"> <li>○ National level</li> <li>○ Sub-national level</li> <li>○ ADP level.</li> </ul>
Administrative structure of the country	<ul style="list-style-type: none"> <li>○ CHW management structures from district to national levels</li> </ul>
Overview of ADPs	<ul style="list-style-type: none"> <li>○ Number</li> <li>○ Support offices</li> <li>○ Phase in LEAP cycle</li> <li>○ Budget</li> <li>○ H/N activities</li> </ul>
Description of MoH CHWs or other cadre of volunteers	<ul style="list-style-type: none"> <li>○ Coverage</li> <li>○ Training received, curriculum used</li> <li>○ Incentives (stipend?)</li> <li>○ Relationship to MoH, to WV</li> <li>○ Any other pertinent issues.</li> </ul>
Community and government structures	<ul style="list-style-type: none"> <li>○ Overview of MoH structures at sub-national, community levels (eg, VHCs)</li> <li>○ Other community groups with current engagement with WV.</li> </ul>
Planning for country-readiness steps	<ul style="list-style-type: none"> <li>○ Using the country-readiness tool.</li> </ul>

## Decisions and Action Items in the Preparatory Meetings

### Step 1: ADAPT

- Set date for ADAPT orientation, communicate with GC as appropriate.
- Ensure that relevant NO DME staff available to participate in ADAPT process.
- Preliminary identification of existing data that can feed into the ADAPT tool (ie, completed H/N-related baseline surveys), government-sponsored surveys such as Demographic and Health Surveys (DHS), etc.)

### Step 2: High-level MoH dialogue

- Arrange a meeting with relevant national level MoH staff (half day or full day) to:
  - Present ttC programming
  - Review the ttC curriculum, discuss its relevance vis-à-vis any similar MoH curricula
  - Discuss the possibility of working through MoH-linked CHWs
  - Other issues
- The WV staff should prepare for the meeting

### Step 3: Decisions re: WV staffing

- If staffing changes or new hires are needed in order to move forward with ttC programming, these processes should get under way soon following the preliminary meeting, budgets/funding permitting.

### Step 4: ADP Planning and budgets

- Identify potential ADPs for ttC implementation, recognising that new programming can most easily be brought in when an ADP is in the design/redesign phase of the LEAP cycle.
- Budget considerations should begin. Funding may be sought.

## 4.3 PRELIMINARY STEPS: BUDGET FOR COUNTRY READINESS

1. Review current H/N grant funding, and
2. Allocate budget for country-readiness steps

**Introduction:** The basic parameters of H/N funding in the NO need to be understood. This includes the important consideration of funding the National Health/Nutrition Coordinator. Once the funding situation is understood, a small budget should be identified, created or reserved to fund country-readiness steps.

### 1. Review H/N grant funding

Before looking at individual ADP budgets, you should find out if there are any **grants** supporting H/N programming.

List the following:

- Donors
- Amounts
- Duration
- Activities.

### 2. Determine funding source for national-level H/N coordinator

It is important to identify the funding source(s) for key H/N staff. A country preparing to undertake ttC programming should have, at minimum, one NO-level H/N coordinator (variably known as H/N director, H/N coordinator or H/N manager, based on context). The funding possibilities include:

- Partly or fully funded through grant funding;
- Partly or fully funded through NO OOC budget
- Partly or fully funded through pooled ADP funds
- A combination of the above.

If the source for long-term funding of the H/N coordinator position is not secure, this is an issue that will need to be addressed. H/N coordinators funded solely through Jump Start funds will require new sources of funding to ensure the ongoing continuation of their position. This is true not only for the national-level H/N coordinator, but for any sub-national H/N staff deemed key to scaling up H/N programming.

**ttC programming requires a fully funded, securely positioned H/N coordinator at the national level. Funding for this position should be identified long term. Additional sub-regional H/N staff may also be required, based on the projected scale of H/N programming.**

### 3. Allocate budget for ‘country-readiness steps’

Once the overall scope of H/N funding has been identified, some reallocation of budget to support the ttC country-readiness steps should be made. **Jump start** funding is a highly appropriate source from which to draw this budget. Alternatively, national-level funds or pooled ADP funds may be used. For a comparative cost analysis of ttC projects in diverse contexts, see the health costing analysis in Appendix 1. Table 15 lists suggested items for a preliminary country-readiness budget.

**Table 15. Budget: Country readiness for ttC**

Budget item	No. of Units	Amount (Estimate! Actuals will vary by setting)
1. Curriculum/a review workshop with MoH	3-5 days	\$3,000-\$5,000
2. Technical support for curriculum contextualisation		\$5,000-\$10,000
3. Illustrator to contextualise <b>some</b> job aid illustrations		\$1,000-\$3,000
4. CHW functionality assessment workshop, 2 days	25 pax	\$2,500
5. CHW functionality assessment field visit (vehicle, snack, etc.)		\$1,000
6. Monitoring contextualisation workshop with MoH	3-5 days	\$3,000-\$5,000
7. ADAPT data-collection field work		\$1,000-\$3,000
<b>Total</b>		<b>\$10,000-\$30,000</b>

## 4.4 COUNTRY-READINESS STEPS

### Country Readiness Step 1: ADP budgets, activities and staffing

**Introduction:** The purpose of this step is to ensure that ADPs have reflected ttC programming in their activity plans and budgets, and that the necessary staff exists at the ADP level to carry out this programming. If these conditions are not met, it will not be possible to move forward with ttC programming unless there is dedicated grant funding available for this purpose.

#### ➤ Collect documentation

You will want to know what kinds of H/N activities are taking place in ADPs, and the budgets for these activities, in preparation for mainstreaming ttC programming. A foundational knowledge of current programming and budgets is essential. Collect the following documents:

- List of ADPs: ADP manager, support office, timeframe, phase in LEAP cycle (with a particular view to ADPs in or approaching redesign)
- Current year and five-year activity plans for each ADP
- Current year budget for each ADP.

➤ **Review documentation and extract H/N activities/budgets**

Be sure to review the activities falling under **all categories** of programming, to include sponsorship management, water Sanitation and hygiene), health and HIV, food security and others. You may find H/N-related activities falling under various categories:

- Verify if medical checkups of registered children are still occurring under sponsorship management. If so, the budgets for these should be reallocated, and may be applied to ttC programming.
- Check for nutrition-related activities under food security. Make sure they are appropriately coded P19 for nutrition or P15 for health.
- Check for health-related/hygiene activities under WATSAN. Make sure they are appropriately coded P15 for health.
- Determine the extent to which 7-11-related programming is taking place under any of the categories, most specifically health and HIV.

You may want to consolidate this exercise in the form of a table of H/N activities per ADP, with respective budgets, in order to see at a glance the full picture of H/N-related programming in the ADPs. As appropriate, you may want to include columns in the table to indicate any reallocations that are necessary, and obtain totals for the budget available for ttC.

➤ **Look ahead to the mechanisms of mainstreaming ttC programming in ADPs**

With a fuller understanding of current ADP-level H/N programming, you should now begin to think through the mechanisms for mainstreaming ttC initiatives in the ADPs, in discussion with the NO. You may consider the following questions in your discussion:

- Where are the ADPs in the LEAP cycle – ie, how many are coming up for redesign?
- What types of negotiations with support offices will be needed to enable the introduction of ttC programming into those ADPs not up for redesign? How feasible will it be to modify the five-year plans, understanding that this will be necessary if ttC is to be mainstreamed?
- Do all or some ADPs have a dedicated HIV or health facilitator? If not, what is the potential for getting a dedicated staff at the ADP level to support H/N programming?
- How will budget reallocations be handled to support ttC programming?
- Can some existing ADP health activities be consolidated under the umbrella of ttC? For example, if training of women in breastfeeding is planned, this activity can be cancelled and covered through ttC instead. How many currently planned activities can be consolidated into ttC in this way?

Some follow-up may be required to inform ADPs and educate them about ttC to enable any changes to activity plans and budgets.

## Country Readiness Step 2: ADAPT

**Introduction:** The H/N Analysis, Design and Planning tool (ADAPT) takes users through a four-stage process of preparation, data collection, analysis and design to ensure that all H/N programming is appropriately contextualised to the local setting. This process will serve to both validate ttC or equivalent implementation (in most cases) as well as to identify areas in 7-11 messaging in the ttC package that may require changes or adaptations.

### I. ADAPT Stage One: Preparation

In order to prepare for data collection, analysis and design, preparation is the first stage in the ADAPT process. This includes ensuring that adequate staffing, budget and knowledge exist (see the ADAPT tool for detailed recommendations for each of these domains), as well as conducting an ADAPT orientation with key implementing staff and national leadership. Invite the following staff, at minimum, to the orientation:

- National H/N coordinator
- National RDME coordinator
- National HIV coordinator
- If desired, you may also invite the national director, operations staff, and select ADP staff. During the orientation, all stakeholders should become familiar with *what* data should be prioritised, *why* the data is important, and the *methods* of collecting the data. Once everyone is familiar with the ADAPT process, you can work together to complete the *Data Collection Work Plan* (Form A). The Work Plan will help with organising the collective effort, and determining who will collect the information and how it is collected. It will also help you to establish a realistic timetable for completing the ADAPT process, and the selection of ADPs where should take place. In many contexts, a representative sample of ADPs will be sufficient, rather than conducting ADAPT for in every ADP in the country.

### 2. ADAPT Stages 2-4: Carrying out the Work Plan

- The ADAPT tool provides several forms (Form A-D) which provide guidance on the collection of appropriate national and sub-national data for important health and nutrition indicators. During Stage 2-4 suitable data sources will be identified from existing sources and input into the provided spreadsheets for analysis.
- **National-level macro indicators assessment** - is completed using data drawn from appropriate secondary data sources such as epidemiological studies and population level surveys such as the Demographic Health Surveys (DHS) and the Multiple Indicator Cluster Survey (MICS). Some of the data used in this process may contain sub-national information as well, if not then additional sources of data will need to be identified for the subnational level. This process is done only once for each ADP level analysis. In obtaining this data it may be necessary to collaborate with the Ministries of Health, WHO offices or UN agencies in order to collect all of the national-level information required.
- **ADP-level data / Sub-national level macro indicators assessment** - is completed using appropriate subnational data sources, if there are **pre-existing data** available for these indicators at the ADP level (for example, previously completed baseline surveys, reports from other organisations in the area, etc.).
- If suitable ADP level data is **not already available**, then it will be necessary to collect this information at the ADP level using Focus Group Discussions (FGDs) to complete the required forms for the subnational level. FGDs will be required for ADAPT Stage 3, to identify the underlying H/N factors at household and community levels. A sample FGD guide for interviewing pregnant women and caregivers of children under 2 is provided and will need to be revised for your context, and FGD tools pre-tested in **one ADP** if needed.

- FGDs will be carried out (as needed) with (a) pregnant women and caregivers of children under 2 (b) ADP staff and (c) health-facility staff. This requires logistics planning, providing advance notice of FGD participants, transport, scheduling. The information gathered will be used to complete the forms (C-E) for use in the analysis for design and planning in Stage Four.

### 3. Presenting the data

The team should utilize the ADAPT reporting template to capture the most relevant data summaries and prepare them for presentation which includes:

- **National-level indicators** inserted each into the pre-defined ‘trigger ranges’ to enable quick analysis of the main critical H/N issues in the country.
- **Health policies and services** examined through a similar trigger range analysis, to clearly identify and highlight the health systems issues in need of most urgent address.

### Country Readiness Step 3: Dialogue with MoH

**Introduction:** In the ideal, ttC programming will be implemented within the MoH system, through MoH CHWs. Numerous decisions around the parameters of this programming must be taken together with the ministry. A long process of dialogue and negotiation at high levels may be required for this.

#### Presentation of ttC materials and discussion

The NO H/N coordinator should have well-established contacts with key individuals in the MoH. The H/N coordinator should set up a meeting with these individuals with the purpose of mutual information sharing.

- MoH to provide an overview of ministry-supported CHW programming and training materials used.
- World Vision to introduce the ttC materials and programming.

#### One of the purposes of this meeting is to dialogue around the applicability of ttC materials for use and scale-up by the MoH.

This must be a mutual dialogue, with no pre-set conclusions. In some settings, it is likely that MoH will find the ttC materials to be highly useful for filling gaps, while in others it is possible that existing MoH programmes and curricula are adequate for fulfilling 7-11 CHW and household-level objectives, and the ttC materials are not needed. In carrying out this dialogue, the following steps may be pursued:

- World Vision should present the PowerPoint distributed together with this document. A good presentation of the background, development, curriculum and methodology of ttC will take about an hour, and should not be rushed. In addition, it is useful to have materials to distribute, as follows:
  - A complete set of the Facilitator’s Manual (three modules), printed and bound, to give to the individual responsible for CHW programmes to thoroughly review.
  - One or more storybooks, and a copy of the Household Handbook, for purposes of illustrating the methodology.
- The MoH representatives, in turn, should provide information about ministry-supported CHW programming. If possible, MoH should provide WV with a copy of the materials/curriculum used to train CHWs, if any.



- Numbers of CHWs, coverage areas
- Materials used to train CHWs
- Future training plans

**Note:** Further details around CHW support will be explored in future steps of the country-readiness process.

### Country Readiness Step 3a: Curriculum choice

WV and MoH should discuss the potential for introducing the ttC materials at the national level, within the MoH. There are various possible scenario outcomes, as follows:

- It will likely be necessary to hold **more than one meeting** to arrive at these decisions, in order to reach all key stakeholders and decision makers within the ministry. This may be a lengthy and protracted process.
- It may also be necessary to carry out a **curriculum review workshop** together with the key MoH individuals in order to arrive at final decisions concerning CHW materials. If so, this workshop should be arranged by the NO, and **should be funded through the ‘country readiness’ budget**. (See step 6 for more information on curriculum selection).

### Country Readiness Step 3b: Select Cadre of ttC- Home Visitors

This part of the MoH dialogue follows logically from the previous choice of scenario. Just as there are various scenarios for curriculum choice

### Country-readiness step 3c: Determine MoH involvement as Facilitators and Supervisors

This stage of the MoH dialogue follows logically from the preceding one. It is important that World Vision determine the extent to which programming will be handled **by** the MoH, as opposed to by WV, as this will then determine the needed WV staffing structure. Again, there are various scenarios:

- **Scenario 1:** All training and supervising is handled by MoH staff. When WV carries out a ttC ToF, all participants (ie, the facilitators, who then train the ttC-HVs) will come from the MoH. This may happen when ttC is the curriculum chosen for use with CHWs **and** the MoH has sufficient manpower to institutionalise the programming within the ministry without further participation from WV. In this case, WV will limit itself to an advisory and mentoring role.
- **Scenario 2:** MoH staff will carry out the training of ttC-HVs, but do not have enough capacity on the ground to supervise them. In this case, WV will assist in identifying field-level supervisory mechanisms. ttC-HV supervisors may be (a) WV ADP staff (b) lead CHW / ttC-HVs (c) members of a ‘community committee’ (ie, VHC or the equivalent). This may happen when:
  - (a) ttC is the curriculum chosen for use either in full, or as in-service training.
  - (b) The decision is made to work with existing MoH materials and programming, but assessment reveals weak MoH supervisory capacity due to workforce issues.
- **Scenario 3:** MoH staff and WV will share the training and supervisory responsibilities, in any of the possible combinations (eg, MoH trainers and WV supervisors, MoH and WV trainers and supervisors, WV trainers and MoH supervisors, etc.). This may happen when:
  - (a) ttC is the curriculum chosen, either in full, or as in-service training.

- (b) MoH materials are chosen, per existing programming, but the MoH welcomes WV assistance with implementation.
- **Scenario 4:** World Vision (and partners) take on the full training and supervisory responsibilities. This may happen when:
  - (a) ttC is the curriculum chosen, but MoH does not have the manpower to either train or adequately supervise the ttC-HVs.
  - (b) WV implements ttC through a different cadre of volunteers (not MoH CHWs) with no involvement of the ministry.

**Table 16. Summary of scenarios**

**Note:** Scenarios do not align vertically; that is to say, a selection of scenario 1 for curriculum does not necessarily imply a selection of scenario 1 for cadre and trainers/supervisors. Various combinations of scenarios are possible.

Item	Scenario 1	Scenario 2	Scenario 3	Scenario 4
<b>Curriculum</b>	MoH uses ttC in full, or for in-service training	A hybrid of MoH materials and ttC	MoH and WV use MoH materials	MoH uses MoH materials, but WV implements ttC
<b>Cadre</b>	MoH CHWs (all) or subset of MoH CHWs	Existing community groups	Other volunteers	
<b>Trainers and supervisors</b>	MoH trainers and supervisors	MoH trainers, but not supervisors	MoH and WV share training and supervising	WV trainers and supervisors

**Note:** It will likely take a series of meetings with the MoH to arrive at all of these decisions. Other country-readiness steps can be moving forward concurrently.

#### Country-Readiness Step 4: Curriculum Review/Choice

Step 3 outlined the various scenarios for curriculum selection. While this selection process is partly based on dialogue and negotiations with the MoH, it must also be based on responsible materials assessment, against defined criteria.

## Country Readiness Step 5: Curriculum Contextualization/Development

1. If the ttC curriculum is going to be taken on by the **MoH**, the ministry should participate in the review and contextualisation process. They may request, for example, that representatives of various departments review sections of relevance for alignment, and approve. Some additional changes (beyond those listed above) may be needed in order to fully align with MoH policies, protocols and priorities.
2. WV may wish to hold a **ttC review and adaptation workshop** together with MoH and other stakeholders, as relevant, to carry out the work outlined here. If so, the funds should be taken from the 'country readiness' budget, identified or created in the preparatory steps.
3. It is possible that the contextualisation process will be **lengthy** in some areas, as the materials are brought into line for use in countries and regions outside of Africa. A complete replacing of all illustrations, for example, might conceivably take as long as nine months to a year to accomplish.
4. When all changes are complete, the NO should **translate** the materials, as needed.

## Country Readiness step 6: COMM Selection and readiness

**Introduction:** Global good practice recognises that CHWs should be accountable not only to local MoH structures, but also to the communities that they serve. As part of overall 7-11 programming, WV will work to strengthen community groups to play the role of VHCs, overseeing community health-related activities. Internally within WV these groups will be referred to as 'COMMs', although programmes may use other local titles. The choice of COMM will vary by context, but in all cases it is important the ttC-HVs are appropriately linked to this group. This step intends to ensure that COMM has been identified, links have been established, and the group is ready to play its important community-level roles. See section 3.3 for more details.

### Processes:

- **COMM selection** - Identify the appropriate community-level group in your country context.
- **COMM capacity building** - If the COMM is a MoH-sponsored VHC, WV should meet with the MoH to understand the types of training and capacity-building support that the VHC has received through government programmes to date. WV and MoH staff will ideally work together in carrying out this capacity building, using **the COMM tool**.
- If the COMM is not linked to the MoH, the above MoH discussions will not take place, although WV staff may identify other sectors or organisations with whom they should meet, if others have been involved in the creation and training of the COMM. What training or other support does this group need to be able to effectively oversee both the CHW/Vs, and any identified appropriate community action? What are the next steps needed to bring this group up to the necessary level of functioning? In a similar manner as above, decisions should be made as to what new capacity building and support the COMM may need, and programming should move forward using **the COMM tool** as a guide.

## Country Readiness Step 7: CHW Functionality Assessment

The purpose of the CHW functionality assessment is to ensure that the cadre of CHWs or other volunteers through whom the programme will be working are adequately supported to carry out their work. It is important to put the necessary systems and structures into place before moving forward with training. The CHW functionality assessment enables programmes to identify areas of weakness in CHW programming and to come up with an action plan to bring these areas up to acceptable levels of functioning.

### MoH Agreement

- If the programme will be working with ministry-linked CHWs it will be necessary to obtain MoH approval to carry out an assessment of their CHW programme. This may happen during the overall dialogue process with the MoH.
- A dedicated meeting should be held with key WV and MoH representatives to introduce and review the functionality-assessment process, and preliminary decisions made in terms of the **sample of CHWs** to cover in the assessment.

### Preparing for the functionality assessment

- Staff should read through *The Community Health Worker Assessment and Improvement Matrix (CHW-AIM) tool*, distributed together with this document. This document outlines the steps in carrying out the CHW functionality assessment.
- Following the guidance in the CHW-AIM tool, WV staff, perhaps together with MoH, will **adapt the tools to the programme context**. This enables the programme to identify the scope of work of the CHWs; that is to say, the types of interventions and activities that the CHWs are involved with. This is necessary to ensure that the CHW programme is only assessed in terms of activities that the CHWs actually do.
- Per the guidance in the tool, WV staff will then **prepare the assessment workshop**. This is normally a one- or two-day workshop that will be attended by an array of stakeholders, as outlined in the tool. Participants will review and score the CHW programme in 15 categories over the one- or two-day period, identifying both the strengths of the programme as well as those areas needing improvement.
- The workshop is normally followed by a one-day field verification visit to interview CHWs, as explained in the CHW-AIM document.
- WV staff should determine the **budget** needed for the workshop and the field visit. All logistics should be arranged accordingly.

### Carrying out the functionality assessment

- Follow the instructions in the CHW-AIM tool for the assessment workshop, field visit, scoring, and action planning.

### Follow-up: Action plan

- The main output of the CHW functionality assessment will be an **action plan** developed during the workshop to bring those areas of CHW programming assessed as weak up to an acceptable level of functioning. The action plan may entail **significant change, significant work** and **significant budget**, based on the scope of the

improvements needed. It is likely that many of these changes will be the responsibility of the MoH, but WV should also determine its role in contributing to the action plan.

- It may be necessary to hold one or more meetings with WV senior staff to identify the source of funding to enable carrying out the action plan and to potentially adjust some staff work plans to reflect these activities.

**Important:** No ttC programme should get under way until the CHW Functionality Assessment has been carried out, and the action plan completed. This is necessary to ensure that the CHWs who will be implementing ttC are sufficiently supported in their roles. Without this, the ttC programme will run a real risk of under-performance and limited success.

## 5. INTEGRATION WITH OTHER 7-11 MODELS

### Purpose of this section

In this section we address issues related to integrating multiple project models including those specialised models for **individual-level** through CHW programming such as **ICCM, PMTCT, ECCD** and **nutrition models** and also those that operate at the community level such as **CVA**. This section is useful for national and ADP-level staff as it encompasses integration at the level of community, and actions to be the community health actors themselves.

The ttC model offers us a 'backbone' for 7-11 message promotion at the individual level, but much of this document to this point assumes that ttC and COMM with accompanying HSS activities will be the only activities happening in a project, which is rarely the case. Depending on context, epidemiology, and CHW policy environment, ttC will be one of a package of models delivered at the community level by community health actors.

According to context, there will be interest in adaptation of the ttC model to deliver additional community-based approaches, and we present some considerations that should be taken into account when considering integrated approaches with the same cadres. This is particularly the case where ttC is conducted by CHWs rather than by civil society groups, as the MoH may require additional roles to be concurrent.

Certain project models such as ICCM, PMTCT and nutrition approaches may be considered specialised approaches, and therefore perhaps a ttC cadre will not be the ideal cadre to conduct those services, due to workload issues. However, the way that ttC 'speaks to' other components of the community health system is of central importance. A second issue is therefore the functional relationships that occur at the community level, which lead to better-integrated activities of community health actors conducting ttC and specialised models. In the second part of this section we will consider how individual community health actors interact through ttC implementation to ensure that good cross-model linkages are established and that community services are person-centred.

In the last section we look at the citizen voice and action model (CVA) and how this is to be integrated with ttC programming as part of the core 7-11 approach.

### 5.1 INTEGRATED APPROACHES

In various NOs there has been interest in including certain approaches alongside the work of the ttC cadre. This depends on the dialogue with government and the specific needs of the country, or its epidemiology. For example, countries with a low infectious disease burden may be more interested in exploring increased emphasis on maternal mental health and psychosocial support and early child development by ttC-HVs. Countries with chronic under-nutrition may wish to see the ttC-HVs undertaking growth monitoring and promotion, or other nutrition interventions. In high HIV prevalence contexts it may be preferable to integrate HIV support activities into the ttC-HVs tasks, in which case these elements in the ttC curriculum may need strengthening.

Integration of additional interventions within the ttC framework may be relevant where ttC is conducted by a formally recognised MoH-affiliated cadre of CHWs who are focused on sexual, reproductive, maternal and newborn health (SR/MNH). Recently, a review process of CHW interventions for SRMNH took place led by the WHO (WHO Optimise<sup>17</sup>), which identified several roles for a cadre of CHWs that are not currently included in the ttC approach. Specifically, this includes promotion of HTSP in pre-pregnancy, misoprostol administration, birth-partner

<sup>17</sup> World Health Organization, 2012. WHO recommendations: optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting. [http://apps.who.int/iris/bitstream/10665/77764/1/9789241504843\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/77764/1/9789241504843_eng.pdf)

support and distribution of oral supplements. World Vision’s ttC model has excluded these activities due to high workload (see Table 17).

**Table 17. Alignment of the ttC strategy to the WHO Optimise recommendations**

Intervention recommended for CHW by WHO	Covered in ttC	Recommendation
Promotion of appropriate care-seeking behaviour and appropriate antenatal care during pregnancy	Y	
Promotion of adequate nutrition, iron and folate supplementation, HIV/AIDS testing, and sleeping under insecticide-treated nets during pregnancy	Y	Ensure integration with HIV care provider CHW and supporters (volunteers groups)
Promotion of birth preparedness, companionship during labour, and skilled care for childbirth	Y	
Promotion of immunisation according to national guidelines	Y	
Promotion of reproductive health and family planning	Partially	Post-partum family planning included, HTSP for all women of reproductive age would only be included as per MoH-led adaptation.
Promotion of basic newborn care, exclusive breastfeeding, post-partum care, and KMC for low-birth-weight infants	X	Enhance existing ttC on newborn care.
Administration of misoprostol to prevent post-partum haemorrhage - where a well-functioning lay health worker programme already exists, skilled birth attendants are not present and oxytocin is not available	X	To be part of the role of the person providing support at time of delivery.
Providing continuous social support during labour (in the presence of a skilled birth attendant)	X	Encourage a family member or friend to be there for support, ttC-HVs don't provide support.
The use of lay health workers should be considered for the following interventions, but with targeted monitoring and evaluation: Oral supplement distribution to pregnant women	X	ttC-HVs only support/check mothers take supplements/not providers

**General recommendations for the introduction of additional materials to ttC:**

There are multiple considerations to bear in mind for any additions/adaptations of the ttC model, and these should be addressed with a plan to mitigate any risks integration might present.

- The current ttC curriculum intentionally limited itself to 7-11 alignment, and many consider this already to be too heavy for the cadres identified. It is recommended that the 7-11 framework continue to be the basis for ttC adaptations, and as the 7-11 framework is updated, so too should ttC.

- Additional core curriculum modifications should be made on a country-level basis, with policy consideration. It may be the case that where ttC is implemented by MoH-affiliated CHWs, there may be a need to integrate elements outside of the 7-11.
- Good CHW support practice calls for regular in-service training. Consider gradual integration of any new material through modular approaches, implemented over time, such as WV nutrition modules,<sup>18</sup> or additional MoH training modules.
- Consider at length the possible loss of quality by integration.

**Table 18. Advantages and disadvantages of integration of other health project models**

Advantages	Disadvantages
<ul style="list-style-type: none"> <li>• Fewer opportunities missed to deliver interventions, more person-centred care</li> <li>• Increased coverage of 7-11 interventions in the ttC target group</li> <li>• Fewer contacts with mother and baby required</li> <li>• ICCM services can be delivered during ttC home visits</li> <li>• Convenience for the mother and family</li> <li>• Cheaper – trainings and supervision can be delivered together</li> <li>• Integrated services may be more acceptable, for example in the context of HIV, specialised HIV cadres may increase stigma</li> </ul>	<ul style="list-style-type: none"> <li>• ttC workload is already very high</li> <li>• Increased demand for payment</li> <li>• Diminished quality of care</li> <li>• Too many interventions per visit = some will be forgotten</li> <li>• MoH may not accept additional roles/activities</li> <li>• Generalist CHW may not have good knowledge or personal experience (eg, of HIV, newborn care)</li> </ul>

Some MNCH components can be more easily assimilated into the ttC workload than others, and for these areas we recommend integration with the same cadre of CHW/HV where that appears to be the most appropriate solution. The following subject areas are recommended for integration:

- Healthy timing and spacing of pregnancy (HTSP) and pre-pregnancy
- Essential newborn care
- Maternal mental health and psychosocial support (MHPSS)
- Early child care and development (for under 2s)
- Birth registration
- PMTCT support in HIV-endemic areas

**HTSP and pre-pregnancy** - ttC-HVs could be deployed to provide counselling and guidance on family planning for women not in the ttC target group, especially those under the age of 18. In some contexts, advanced training might

<sup>18</sup> In-service trainings for nutritional modules developed by the NCoE for community development workers (including health) are available <http://www.wvi.org/nutrition> :

1. Reducing Maternal Anaemia (15 hour course /5 weeks, or 2 day F2F training)
2. Reducing Childhood Anaemia (27 hour course/9 weeks or 3 day F2F training)
3. Reducing Childhood Stunting (36 hour course/12 weeks or 4 day F2F training)



be considered for this group where family planning (FP) commodities are distributed by CHWs and the ttC cadre are the same cadre providing FP commodities as an MoH-led activity only, as WV does not currently have a pre-pregnancy HTSP approach.

**Essential newborn care (if birth occurs at home)** – The components of early newborn care are promoted through the ttC approach, but this is strengthened in the ttC second edition, with additional elements on prevention, detection and referral of sepsis, chlorhexidine cord cleaning and hygiene, and detection and referral of low-birth-weight babies being prioritised. Due to the close relationship of the ttC-HV to the families around the time of birth, and the three home visits in the first week of life, this integration is highly recommended. Where KMC is being promoted in the community, ttC cadres might support this through intensified visiting schemes; however this would involve advanced training.

**Maternal mental health and psychosocial support (MHPSS)** – Skills building for psychological first aid, and the promotion of family support for preventing post-partum depression are included in the second edition of the ttC curriculum. In contexts with very high gender-based violence, adaptations could include more specialised training.

**Early child care and development (for under 2s)** – ECCD programming will largely be addressed through alternative structures such as education groups. However, in the second edition of the ttC curriculum, the promotion of stimulation and playing with the baby – as well as encouraging language development through talking and singing – will be addressed alongside complementary feeding promotion in the 1-18 month visits. A specialised contextualisation might include using local health cards to check development milestones. This area is of high interest as current CHW curricula have identified this as a gap.

**Birth Registration** – Whilst not to be considered a health model as such, birth registration can be encouraged through the ttC model. ttC-HVs in the current method promote birth registration and track its uptake. If contextual adaptation supported this, ttC-HVs might be able to refer to CHWs, COMMs or other structures that act as civil registries, or use mobile technology to enable registration.

**PMTCT support in a HIV-endemic context** – The ttC basic curriculum covers the elements of HIV/PMTCT relevant to most contexts. For example, ttC-HVs are taught to promote HIV testing in pregnancy, along with the partner and family, to ensure early testing for HIV-exposed babies, and to promote exclusive breastfeeding, nutrition and uptake of services for HIV-positive children. In HIV-endemic contexts such as East and Southern Africa region, contextual adaptation of ttC might be considered to increase coverage of PMTCT in ttC target groups, although this might increase the workload, it might be counter-balanced by lowering the ratio of ttC-HVs per household. In such contexts, ttC-HVs would require additional training to cover advanced roles in PMTCT such as:

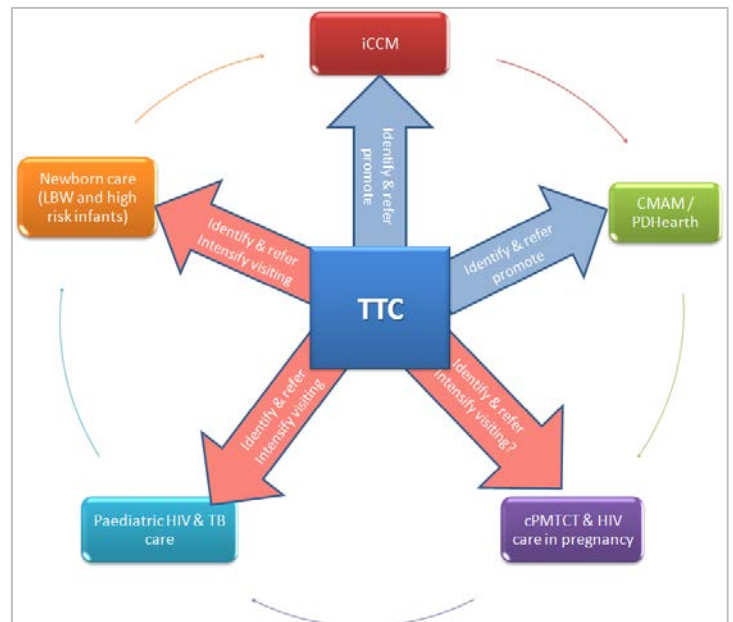
- Community-based treatment support – ART adherence monitoring and treatment failure detection
- Clinic access follow-up
- Psychosocial support for HIV-positive families
- Promotion of self care for mother and baby.

**Growth Monitoring and Promotion** – Given the regularity of the visiting scheme during ttC, integration of GMP through the interpretation and counselling of child growth cards, or the use of MUAC screening and referral (where health facility-management or community-based management of acute malnutrition exists), might be easily integrated with ttC activities.

**Integrating HIV, high-risk newborn care and paediatric care in ttC: High risk targeting strategy**

In Figure 9 below we show a figurative representation of where HIV and high-risk newborn care are integrated with ttC, but where ICCM and nutrition interventions are performed by a separate cadre. Throughout the ttC data-monitoring tools in the World Vision core set, there is a place to mark if a pregnant mother, newborn, infant or child is considered to be ‘high risk’. In the ttC paper-based monitoring system (ttC tracker), and also in the mobile ttC application this high-risk tag can be considered a ‘placeholder’ for interactions with other health models for the patient in question. In the revised ttC curriculum, high-risk categories are discussed at each life cycle stage and the participants are invited to discuss what specific actions they might take to meet the additional care needs of this group, as described in Section 1.2.

The referral/counter-referral forms provided in the ttC toolkit also enable communication between the health facilities and the ttC-HVs – giving additional instructions for the patient on discharge. The referral model includes a place for medicine adherence checking, when to follow-up at the clinic, any counselling messages needed and potential danger signs to look for. If the ttC-HVs are doing referral follow-ups this is a good way to integrate care for specific medical complications, such as management of hypertension in pregnancy. The mobile systems are not yet adapted to perform this function, but clinics should be able to SMS additional care instructions for clients if this is adapted for context.



**Figure 9. Integrated care for HIV, LBW and high-risk children in ttC**

## 5.2 ttC INTEGRATION WITH SPECIALISED MODELS

### Specialised models

- ICCM
- cPMTCT and paediatric HIV
- Paediatric DOT/TB
- CMAM/PDH (therapeutic nutrition interventions)

In most contexts, curative models for child health including ICCM, paediatric TB-DOT (paediatric and adult), and nutrition treatment models (PDH, CMAM), are considered ‘specialised models’, which naturally cluster together given the potential for overlapping treatment needs of the child (eg, TB/DOT with ICCM, and malnutrition with ICCM). It is not recommended ttC-HVs perform these roles themselves as workloads would potentially exceed 15 hours per week, resulting in diminishing returns in terms of quality for each intervention added, which has been observed in studies.<sup>19</sup> In low HIV-endemic contexts such as APR, LACR, West and Central Africa it may be more appropriate for PMTCT and paediatric HIV care to be delivered by non-ttC cadres.

For the most part, where ttC is being conducted by a cadre that is not the official MoH CHW (ttC support group’s model or ttC-volunteers model), ttC-HVs working alongside these services in the community act as intermediaries, providing a sign-posting function to direct families to the services they need. For this reason, the link to the COMM and the integration meetings with other community health providers are an essential element to the ttC model.<sup>20</sup> Our recommendation for integrating these models is that team-based approaches are designed to share workloads amongst different cadres of CHWs as shown in the scenarios below.

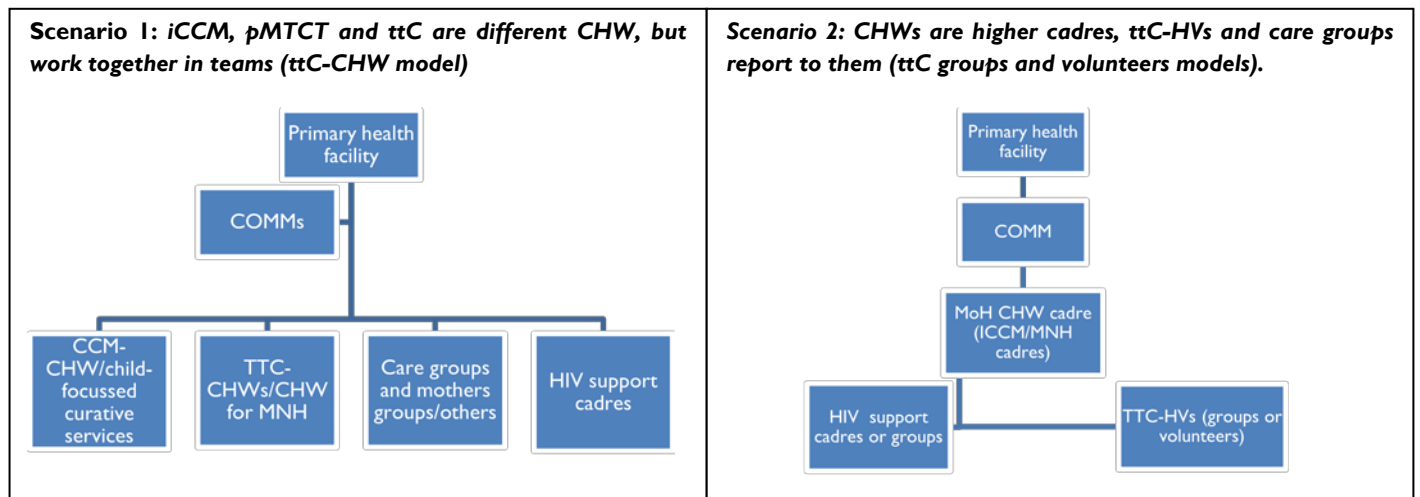


Figure 10. Team approaches in CHW and group ttC models

In team approaches, where the ttC cadre may be linking families to other services, there are several ways ttC-HVs can provide this additional support and referral, as shown in Figure 10 above. In this figure we show that ttC-HVs **promote and refer to** ICCM services, CMAM/PDH, paediatric HIV and DOT cadres in the community. In addition

<sup>19</sup> Rowe et al., 2007. Effect of multiple interventions on community health workers’ adherence to clinical guidelines in Siaya district, Kenya. *Trans. Royal Soc. Trop. Med. and Hygiene* 101(2):188-202.

<sup>20</sup> See ttC minimum standards ‘Essential Elements’.

to this sign-posting function, the 'integration meeting' of teams should enable the discussion of specific difficult cases and ensure that where referrals have been made they are being provided services.

**Integrated community case management** – ICCM is a process that is largely MoH driven, and provides less flexibility in terms of operational procedure. It is typically being done by an increasingly formalised cadre of CHWs. As a medical model, it necessitates strong linkage with and accountability to the formal health system, for technical guidance and supply chain management. In CHW-ttC this would mean two cadres working alongside one another, or a single cadre with a higher workload. In the ttC support group and volunteers model, this would mean another cadre working in a team approach.

**PMTCT and HIV care and support** – Engaging separate cadres for HIV and ttC may be the recommended approach for certain areas, for example where low HIV-endemic areas, where HIV-specialised CHWs are facility-based, where there are special at-risk populations, or where multiple cadres for HIV support exist such as HIV expert clients and special HIV support groups (OVC and CCC groups), and HIV prevention activities amongst different target groups. This includes Asia, Western and Central Africa, MEER, LACR regions. Table 18 describes some of the different roles that would be taken on by the specialist cadres in this context.

Specialised cadre activities include:

- Primary and secondary HIV prevention
- Group-based psychosocial, livelihood support activities
- Community-based treatment support
- Cotrimoxazole preventive therapy and ART
- Psychosocial support
- Clinic access follow-up
- Monitor for signs of treatment failure

**Nutrition treatment models** – In areas where CMAM with ttC, ttC volunteers may be trained with additional skills to assess MUAC and refer moderate and severe acutely malnourished children to the programme. This is only appropriate if MUAC is accepted within MoH protocol for identification of acutely malnourished children. A similar role is possible for areas where PDH overlaps with ttC, as ttC volunteers could refer moderate and severely acutely malnourished children (red and yellow cases) with no complications to local hearth groups in areas where no management of acute malnutrition exists within the health facility or community. ttC volunteers can also promote participation in regular GMP, hearth sessions (if their household are participants) and mobilisation of the community for various PDH events like the nutritional assessments or community feedback sessions.

ICCM CHWs can be integrated with CMAM either as part of the referral chain for CMAM, or using the same cadres for both activities. This process is under way in several offices launching ICCM programmes. PDH can integrate with ICCM in referring children who are sick or who do not respond to rehabilitation (ie, by gaining weight).

## Summary

Table 19 provides a useful overview of integration of project models within ttC. Using this as matrix framework allows WV to consider what needs to be strengthened or integrated with ttC. Basic ttC refers to the World Vision 7-11 package and what it covers, ttC-advanced is where additional component by MoH or other partners, or World Vision are added to ttC, and specialised models involve different cadres.

**Table 19: Matrix of integration**

Intervention	Integrated approach		Specialised approach	Additional community-based approaches
	ttC Basic 7-11 package	ttC Adapted package <i>for specific contexts only</i>	models MoH-affiliated CHWs Specialised volunteers or CHW cadres	eg, community groups, CSS, HSS and advocacy
<b>Models in which integration within the ttC cadre workload could be considered in context</b>				
<b>HTSP and Pre-pregnancy</b>	Post-partum family planning in ttC target group (pregnant women and mothers of children under 2 years)	Registration of women of childbearing age (15 to 49 yrs), in context  Counselling on HTSP messages for pre-pregnancy FP uptake monitoring	FP promotion and uptake measurement  Distribution of FP commodities in context  Promote and refer to folate uptake pre-pregnancy	Health promotion via group-based approaches CVA and health systems strengthening approaches
<b>Essential newborn care (ENC)</b>	ttC basic version includes:  Wiping and wrapping Early breastfeeding Warmth and hygiene  ttC version 2 includes:  Detection/referral of danger signs  Detection/referral of low birth weight  Chlorhexidine cord cleaning	Advanced training could include: KMC Helping babies breathe Enhanced detection and referral of sepsis	Enhanced detection/referral of sepsis ICCM for neonatal sepsis  Helping babies breathe for TBA	COMM demand creation, and potentially tracking of behaviour practice
<b>Maternal mental health and psychosocial support (MHPSS)</b>	Revised ttC curriculum to include:  Basic psychological first aid skills  Promote family support to prevent post-partum depression	Under research contexts only:  Detect signs of post-partum depression  Promote family support to prevent post-partum depression	Psychological first aid skills for dealing with GBV <i>*in certain contexts</i>	Encourage supportive family environment for PPD  Consider support groups for the prevention of post-partum depression
<b>Early child care &amp; development</b>	ttC basic version includes: Promote stimulation, play and language development	For consideration in context Monitor development milestones using local health cards	Assessment of developmental milestones	Provide environment for mothers to learn about ECCD through groups or COMM

<b>Birth registration</b>	Promote and monitor birth registration in centre	SMS birth notification if appropriate (context specific)	If possible: CHWs may complete birth notification record and send to civil registry	<p>COMM: Awareness raising, demand creation</p> <p>HSS: Encourage civil registration through health services; Promote monitoring through HMIS</p> <p>Advocacy: Public health campaigns, engage community health officers as civil registrars</p>
<b>Models where Specialised or alternative cadres to ttC-HVs is the preferred approach</b>				
<b>cPMTCT and HIV testing*</b>	<p>Revised ttC curriculum</p> <p>Promote HIV testing of mother and child</p>	<p>Integrated approach:</p> <p>Promotion of HIV testing</p> <p>Community-based monitoring</p>	<p>Providing ongoing community-based treatment support cPMTCT through facility-based and community-based cadres</p> <p>HIV expert clients</p>	<p>HIV care support groups, CCCs /OVC groups</p> <p>HSS: promote access and availability of PMTCT</p> <p>CSS: strengthen cPMTCT cadres through COMM</p> <p>COMM demand creation, tracking of behavioural practice, and link to HIV support groups, if any</p>
<b>iCCM</b>	<p>Not recommended that ttC-HVs do this role – workload too high</p> <p>Promote CCM demand and uptake through referral to specialised cadres</p>	<p>In exceptional cases where ttC-HV is a formal MoH CHW and &gt;15 hours per week are acceptable</p>	<p>CCM-CHW are MoH cadres</p> <p>Support/promote access quality</p> <p>Integrate paediatric HIV and CMAM in ICCM</p>	<p>Promote and integrate</p>
<b>Nutritional models: PDH, CMAM, GMP</b>	<p>ttC includes Complementary feeding Breastfeeding practices</p>	<p>ttC-HVs could support follow-up counselling and participation of GMP programmes with adequate training; screening using MUAC may be an additional role when volunteers are appropriately trained *contextual adaptation</p>	<p>It is recommended that specialised cadres to do CMAM – ICCM where possible.</p>	<p>Support PDH through promoting/mobilising community to attend regular GMP, hearth sessions and PDH activities, eg. nutritional assessment (weighing of all children under 5 in community)</p> <p>Provide referrals of red and yellow cases of acute malnutrition without complications to PDH, where no management of acute malnutrition exists in the health facility or community</p>

\*depending on HIV epidemiology and context, consider the integration PMTCT with the ttC cadre, provided workloads are reasonable.

## 5.3 INTEGRATING WITH CVA AND CHN

### How CVA and ttC can help your national office meet its CHN campaign objectives

Citizen Voice and Action (CVA) is a local-level advocacy methodology that transforms the dialogue between communities and government in order to improve services at clinics and hospitals. Since 2005, hundreds of local government services have been transformed by the hard work of communities implementing CVA. At the local level, the clinics targeted by CVA have ultimately delivered better services that impact maternal and child health. Although CVA operates primarily at the local level, the methodology can also be used to identify patterns of government failure that are ripe advocacy targets for systemic reform at the provincial, national, or even global levels. CVA is also an approach that can help an NO learn about what kinds of advocacy methods are appropriate or useful to be used in a given context.

This section briefly describes how the CVA and ttC methodologies are synergetic, and how they contribute to your national office Child Health Now (CHN) campaign design. For CVA, it is important to note that the CVA Guidance Notes serve as the primary resource for practitioners.

### How ttC contributes to local-level advocacy

ttC-HV activities at the household level provide accurate, preventive and care-seeking information and support, which leads to knowledge building, awareness raising, creation of demand for services and positive behaviour change within the household. ttC is all about empowering families and communities to know how to keep themselves and their children healthy. In relation to advocacy it is the first step in the process by creating demand for rights and services from the household level.

#### Step 1. Mobilising families: Creating household demand for rights and services

ttC and advocacy will usually operate side by side, as LLA is another core approach that projects will include in H/N and 7-11 programming. The ttC activities will feed issues into advocacy efforts, as it aims to create demand for health services among households, so attention must always be paid to whether or not the supply is there to meet that demand. Since ttC is carried out through a dialogue-based approach, home visitors will be learning about the barriers to good-quality health services (accessible and acceptable services) that families may be facing as they attempt to practise new behaviours. As they learn, the types of things that can be fed into advocacy agendas potentially include:

- Supply of health services and commodities that are needed for each message (eg, vitamin A availability, PMTCT services, early infant diagnosis services, deworming, immunisation coverage, etc.). If there are gaps, this becomes part of an advocacy agenda.
- Quality of health services – ttC-HVs may hear from families about poor attitudes of health staff, unfair treatment, confidentiality issues, etc., which can also be included in advocacy agendas.
- Cultural practises that surface during dialogue between CHWs and individuals. Some of these may prove to be barriers for adoption of the recommended behaviours. If such practises are sanctioned by cultural leaders due to tradition, for example, but in reality are harmful to the health and well-being of children in the community, then that information feeds into the advocacy agenda.
- Post-referral follow-up – when the ttC-HV has made a referral to a facility, it is recommended that they follow-up and check that the patient was seen at the clinic, that they accessed the services and commodities they needed and were treated well. At this point the ttC-HV can note any adverse experiences or reported stock out, and report this to the COMM or to the CVA committee.

**CVA: the approved CHN LLA approach**

CVA brings together citizens, service providers, local government, and civil-society partners in a collaborative, facilitated group process designed to improve the quality of health services at the local level. CVA includes three components: Enabling Citizen Engagement, Engagement via Community Gathering and Improving Services and Influencing Policy. As the first step is creating household demand, the CVA components are then steps two, three and four of this process.

**Step 2. Mobilising communities: Enabling citizen engagement**

This phase builds the capacity of citizens to understand and engage in issues related to health-service delivery. It involves a series of processes that raise awareness on the meaning of citizenship, accountability, good governance, and human rights. Importantly, citizens learn about these abstract human rights translated into concrete commitments by government to provide specific health services under national law. For example, the 'Right to Health' (Article 25 of the Universal Declaration of Human Rights) in a particular country might include a child's right to receive vaccinations at the local clinic, or the community's right to have two midwives assigned to the local clinic, as stated under national law. CVA lays the groundwork for staff to mobilise communities towards ensuring that these rights are respected. As a result of this phase, communities should be ready to engage governments in a constructive, productive and well-informed manner.

**Step 3. Engaging decision makers: Engagement via community gathering**

The 'community gathering' describes a series of linked participatory processes that focus on assessing the quality of health-care services in the community. Community members (especially women and children), community groups (such as CCCs or COMMs), clinic or hospital staff, and local government officials (especially MoH personnel) are all encouraged to participate. The process is collaborative, not confrontational. Simply put, nobody wants an underperforming school or clinic in their community, and local authorities are often eager to work with citizens to improve these essential facilities. Four types of sessions should be held as part of the community gathering:

**The initial meeting** – At this meeting, citizens, clinic or hospital staff, and local government representatives learn about the CVA process, its objectives, and what they can expect moving forward.

**Monitoring standards meeting** – At this meeting, stakeholders recall what they have learnt during the enabling citizen engagement phase of CVA about their health entitlements under national law (such as the hours the doctor is supposed to work, what drugs should be available at the local clinic, or how many beds a maternity ward should have.) With this information in hand, community representatives actually visit the clinic or hospital and compare reality with the stated government commitments. Communities use a simple quantitative method to record what they discover. Importantly, CHN staff should identify some standard indicators for all communities to measure. The results of this process will allow advocacy staff to identify patterns of government failure in health-delivery systems.

**Score-card process** – This process provides both citizens and clinic staff with a simple qualitative method of assessing the performance of health-service delivery. The score-card process asks citizens and clinic staff what an ideal clinic might look like, and compares reality with the ideal. Communities develop proposals for improving the clinic at this stage. Importantly, CHN staff should identify some criteria for all communities to measure. The results of this process will allow advocacy staff to identify patterns of government failure in health-delivery systems.



**Interface meeting** – At this meeting, stakeholders share the information from the monitoring standards and score-card processes with a broader community group. Based on this information, the community, government, and clinic staff create an advocacy action plan to improve the services monitored.

#### **Step 4. Local-level action' Improving services and influencing policy**

In this fourth step, communities begin to implement the action plan that they created as a result of the community-gathering process. During this phase, it is essential that communities benefit from the expertise of advocacy and CHN staff to ensure that they pursue SMART objectives and design a local-level campaign that is likely to succeed.

#### **How the local level ttC and CVA approaches fit with CHN**

With the ttC approach, mothers and their families are empowered to do what they can to keep themselves and their children healthy, and also to know their rights that they should demand to be upheld. If there are further behaviour change issues at a household or community level that need to be addressed, then there are many WV tools and approaches available through IPM such as CoH, community conversations, etc. With the CVA approach, communities are empowered with a wealth of information about what government has promised to do, and what exists in reality. Communities also build essential relationships that strengthen civil society, and create action plans that will allow them to change the condition of the clinic that they have monitored.

To link the local to higher CHN campaign level, we add a fifth step:

#### **Step 5. Higher-level action: Identifying patterns of health service-delivery failure and translating local success into systemic reform**

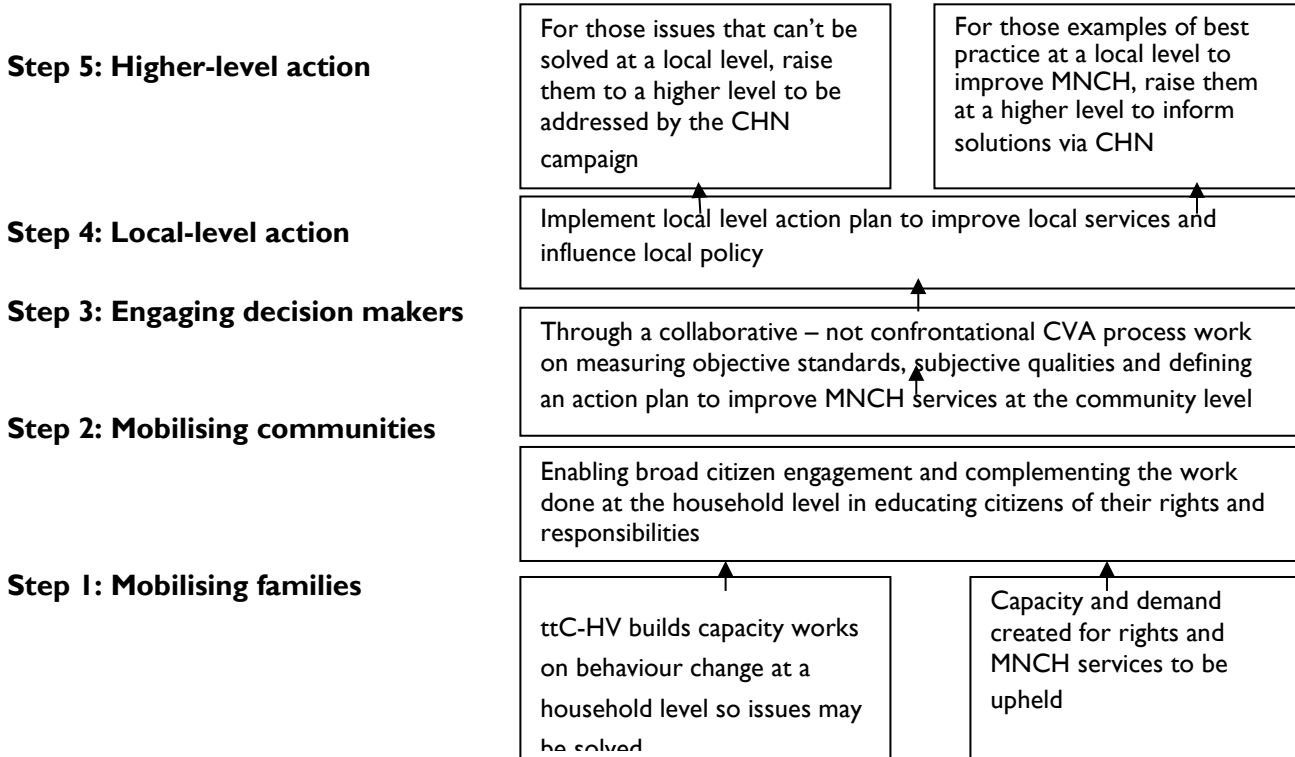
Often, communities find that some of the problems at area health facilities cannot be solved at the local level. Many times, the blockages in health-service delivery occur at the provincial, regional or national level. Campaign staff should work with other communities and partners to identify patterns of government failure across communities. Often, NOs and partners maintain a simple database to collect information about the performance of health services in all communities that are implementing CVA. The CHN team is currently working with health teams and CVA teams on a system to help collect this type of data. In order to prepare for this broader campaign, CHN staff will ensure that communities are all measuring similar indicators in addition to those that the community itself generates. Five key CVA-CHN indicators are currently being developed for this purpose.

Further, while the CVA process is designed to produce quantitative data about health-service delivery, rich anecdotal stories often emerge from the process. These stories can often speak volumes about how service-delivery failure is inhibiting the well-being of mothers and children. CHN staff should work with local staff to ensure that these stories are also captured for campaign purposes. The CHN team is also developing a process to gather qualitative stories. The patterns of health service-delivery failure serve as especially ripe advocacy targets because they are based on the concrete evidence generated by the communities themselves. Child well-being data complement CVA data so that we can illustrate not just 'how' children's health is suffering, but also 'why'. National-level CHN and advocacy staff can then use this information as the evidence base for their broader CHN campaign cycle.

Finally, there may be many good things going on at the local level. It is important that through the CVA work, when a particularly good example of a methodology or approach to improve maternal and child health is identified, it is also transferred to the CHN campaigner in your NO. This approach allows gaps in the system to be identified, but also draws from rich experience to provide solutions that can be included within policy at a higher level.

#### **Summary diagram of the five steps**

In summary the five steps to combine ttC, CVA and CHN are outlined in the diagram below.



### Mobile ttC and real-time data availability

As mobile ttC is currently being developed and piloted in a range of countries, there are opportunities for real-time data about access, quality and acceptability of health services to be made available directly to the decision makers through mobile applications. Specifically under consideration are visits made during follow-up of a referral, and follow-up of a facility birth. Modules for CHWs/ttC-HVs to capture regarding the experience of the families in the facilities and any stock out reported are already integrated into the mobile application, and can be modified as per the country context or the data required by the CVA. The availability of data to duty bearers and to the CVA groups can be developed locally through reporting systems.

## 6. TRAINING AND EXPERTISE

### Country-readiness process technical support

While adaptation to the local context is required, some external support and guidance may be required to ensure that during adaptation, the essential components of the ttC method are maintained, and minimum standards for implementation are met. It is recommended that **high-level technical assistance** be provided in the form of a **registered global technical resource network (GTRN) subject matter expert<sup>21</sup> for ttC**, especially for:

- Orientation to the CHW functionality assessment
- Data system spreadsheet modifications following data system contextualisation
- Development of hybrid curriculum for ttC (ensuring quality in adaptation).

### Project-level technical support during project implementation

During implementation, ongoing technical assistance of a national-level H/N coordinator is required, who supports the programme during start-up and evaluation phases. At the project or ADP level, it is necessary to have ttC-qualified supervisors, who are trained in supervision and data-monitoring methods and who are qualified ttC trainers.

### Staffing at the ADP level

- A project coordinator at the programme level is recommended. This person must have a solid and comprehensive understanding of the project's concepts and principles in order to provide adequate oversight.
- Health development facilitator for each implementing programme: H/N background not required, but this individual should be exclusively dedicated to H/N programming. They should be trained in the programme methodology and therefore this should become standardised as part of staff inductions. xxxx

## Scheduling and Preparing for ttC Trainings

**Table 20. Recommended schedule of trainings in a project area**

Module	No. Days	Comments
<b>Classroom training: Module 1</b>	<b>10</b>	Two weeks of classroom training needed at start-up, to include all background training, and preparation for pregnancy visits 1-3
<b>Four- to six-month interval</b>		
Following the introductory training in Module 1 and the training to prepare for pregnancy visits 1-3, the ttC-HVs will identify a cohort of women in early pregnancy and carry out visits 1-3 with them over a period of four to six months, with support and assistance provided by the ttC-HVs' supervisors. When the first three visits have been successfully completed with all women in the cohort, and before these women deliver, the ttC-HVs will return for Module 3 classroom training.		
<b>Classroom training: Module 2</b>	<b>5</b>	One week of classroom training to prepare ttC-HVs to carry out pregnancy visit 4, one-week visit and one-month visit (visits 4-6)
<b>Three-month interval</b>		
ttC-HVs carry out the final pregnancy visits, the visits during the first week of life, and the one-month visit during this time interval. Three months are allowed to cater to staggered deliveries among the cohort of pregnant women.		
<b>Classroom training: Module 3</b>	<b>5</b>	One week of classroom training to prepare ttC-HVs to carry out visits 7-11 (6, 9, 12, 18 and 24 months)
ttC-HVs complete the last series of visits over a period of 18 months. They may also bring new cohorts of pregnant women into their caseloads at this time.		

<sup>21</sup> You can register to be, or request a subject matter expert for ttC on the GTRN system [www.gtrn.wvcentral.org](http://www.gtrn.wvcentral.org)

## 7. ttC LITERATURE SOURCES

#	Reference
<b>l.</b>	<b>Literature supporting CHW programming</b>
a	<i>Community Health Workers – Key Messages: Global Consultation of Community Health Workers, Montreaux, Switzerland, April 29-30, 2010</i>
b	<i>An Analytical Report on National Survey of Female Community Health Volunteers of Nepal, USAID, undated</i>
c	<i>WHO/UNICEF Joint Statement: Home visits for the newborn child: a strategy to improve survival, WHO, UNICEF, 2009</i>
d	Travis, Phyllida et al., <i>Overcoming health-systems constraints to achieve the Millennium Development Goals, The Lancet, Vol. 364, September 4, 2004</i>
e	Darmstadt, Gary L., et al., <i>Neonatal Survival 2: Evidence-based, cost-effective interventions: how many newborn babies can we save? The Lancet, March 2005</i>
f	Knippenberg, Rudolph, et al., <i>Neonatal Survival 3: Systematic scaling up of neonatal care in countries, The Lancet, March 2005</i>
g	Haines, andy, et al., <i>Achieving child survival goals: potential contribution of community health workers, The Lancet, Vol. 369, June 23, 2007</i>
h	Webster, Paul C., <i>Uganda registers successes with child-health volunteers, The Lancet, Vol. 374, November 21, 2009</i>
i	Freeman, P., et al. <i>Accelerating progress in achieving the millennium development goal for children through community-based approaches, Global Public Health, November 3, 2009</i>
j	Perry, Henry, et al., <i>How Effective is Community-Based Primary Health Care in Improving the Health of Children? A Review of the Evidence, Community-Based Primary Health Care Working Group, International Health Section, American Public Health Association, 7 July 2009</i>
k	<i>CDG Brief: Millions Saved: Proven Successes in Global Health 2007 Edition, Center for Global Development, May 2007.</i>
l	<i>Community Health Workers in Africa, Health systems reporter, 27 February 2008, IDS Health and Development Information Team</i>
m	Prasad BM and VR Muraleedharan, <i>Community Health Workers: a review of concepts, practice and policy concerns, International Consortium for Research on Equitable Health Systems (CREHS), August 2007</i>
n	J.S. Mukherjee and Fr. E. Eustache, <i>Community health workers as a cornerstone for integrating HIV and primary healthcare, AIDS Care 2007; 19 (Supplement 1) S73-S82</i>
o	Hall, Sarah, <i>People First: African solutions to the health worker crisis, AMREF (The African Medical and Research Foundation), undated</i>
p	<i>Bold Solutions to Africa's Health Worker Shortage, Physicians for Human Rights, August 2006</i>
q	<i>Community health workers: What do we know about them? The state of the evidence on programmes, activities, costs and impact on health outcomes of using community health workers, WHO, January 2007</i>
r	Amare, Yared. <i>Non-Financial Incentives for Voluntary Community Health Workers: A Qualitative Study. Working Paper No. 1, The Last Ten Kilometers Project, JSI Research and Training Institute, Inc., Addis Ababa, Ethiopia, 2009</i>

	<b>Literature supporting ttC approach and methodology</b>
<b>2.</b>	<b>HBLSS findings (the dialogue counselling approach, black and white illustrations, non-literate volunteers)</b>
a.	Sibley, Lynn et al., <i>Home-Based Life Saving Skills in Ethiopia: An Update on the Second Phase of Field Testing, Journal of Midwifery and Women's Health, Volume 51, No. 4, July/August 2006</i>
b.	Dynes, Michelle, et al., <i>Home-based life saving skills in Matlab, Bangladesh: a process evaluation of a community-based maternal child health programme, Midwifery (2009), doi: 10.1016/j.midw.2009.07.009</i>
c.	Lori, Jody R., et al., <i>Home-Based Life Saving Skills in Liberia: Acquisition and Retention of Skills and Knowledge, Midwifery (2009), doi:10.1016/j.mwh.2009.09.016</i>

d.	Fullerton, Judith, et al., <i>Outcomes of a Community-and Home-Based Intervention for Safe Motherhood and Newborn Care</i> , Health Care for Women International, 26:561-576, 2005
3.	<b>HCI findings</b> (attention to structural considerations improves CHW programming performance)
	Crigler, L. and K. Hill. 2010. Assessing and Improving Programs Extending Health Services to Communities: The Community Health Worker Programme Assessment and Improvement Matrix (CHW AIM). Draft for Beta Testing. Published by the USAID Health Care Improvement Project. Bethesda, MD: University Research Co., LLC (URC)
4.*	<b>World Vision literature review</b> (sources to draw from when developing ttC curriculum)
	Global Health and Nutrition, Literature Review: Training Resources for the 7-11 Strategy, September 2009
5.	<b>HCI matrix</b>
6.	<b>From World Vision India</b> (support for the timed and targeted concept and approach)
a.	Pragati Child Survival Project in India: October 2003-January 2008: Lessons Learnt; USAID, World Vision India
b.	The Right Messages – to the Right People – at the Right Time, USAID India
7.	<b>Literature on TIPS</b> (additional support to dialogue counselling and negotiation for behaviour change)
	Trials of Improved Practices (TIPs): Giving Participants a Voice in Programme Design, The Manoff Group
8.	<b>Field test of ttC curriculum: Swaziland and Ghana</b>
	Field Test One-Pager

## 8. APPENDIXES

### Appendix I: Toolkit Resource Guide

A number of tools are available both externally and [internally](#) that support ttC programme design and implementation. Links and descriptions of each of these are provided in the table below, or in the appendixes. (For all internal resources, please visit

<https://www.wvcentral.org/community/health/Pages/TimedandTargetedCounseling.aspx>.)

Clickable tools	Description	Embedded tool or link
<b>External Resources and references</b>		
<b>CHW AIM Toolkit</b> Community Health Worker Assessment and Improvement Matrix	A qualitative tool for conducting assessment and improvement for Improving Community Health Worker Programs and Services, applied during baseline and ADAPT processes. This tool helps identify weaknesses and gaps in CHW programming that need strengthening in programme design. <i>Crigler L, Hill K, Furth R, Bjerregaard D. - Published by the USAID Health Care Improvement - Project. Bethesda, MD: University Research Co., LLC (URC).</i>	<a href="#">CHW AIM Toolkit (September 2013)</a>
<b>Preparatory tools</b>		
CHW principles of practice	Seven principles for the planning and implementation of CHW programmes through sustainable and ethical partnership approaches, addressing for systems, incentives.	<a href="#">CHW Principles of Practice</a>
Implementation standards introduction	Description of how to use quality standards in design, implementation and evaluation phases.	See <a href="http://wvcentral.org">wvcentral.org</a>
ttC curriculum checklist and household visit messages checklist	<ul style="list-style-type: none"> <li>Alternative Curriculum Review: WV-produced version</li> <li>Alternative Curriculum Review: MoH version</li> <li>Comparative Curricula Review Tool (excel file)</li> <li>Key messages by household visit checklist</li> </ul>	See <a href="http://wvcentral.org">wvcentral.org</a>
ttC costing model	Excel-based tool in which start up and scale up costs can be estimated alongside several country examples of costs,	See <a href="http://wvcentral.org">wvcentral.org</a>
Samples forms for ttC programmes start up	Excel-based tools for various activities within ttC <ol style="list-style-type: none"> <li>CHW recruitment and training and allocation matrix for recruitment of volunteers for ttC</li> <li>A sample ttC-HV registration spreadsheet</li> <li>A sample ttC Home Visitor Training Record Card</li> </ol>	See <a href="http://wvcentral.org">wvcentral.org</a>
Health facilities assessment tool	For examining readiness for cIMNCI support at the rural health facilities during design phase of ttC programmes.	See <a href="http://wvcentral.org">wvcentral.org</a>
<b>Monitoring and supervision tools</b>		
Guidelines for monitoring and supervision of ttC programmes	A brief guideline for CHW supervisors on how to conduct a ttC supervision. Targeting COMM-level or low-level facility staff or experienced CHWs.	TBD
Illustrative log frame	An Excel version of the ttC generic log frame, including a complete list of possible indicators for use alongside the strategic framework.	See <a href="http://wvcentral.org">wvcentral.org</a>
Core competencies for ttC-HV	<i>Core competencies for ttC</i>	See <a href="http://wvcentral.org">wvcentral.org</a>

	A list of skills and competencies which can be used during assessment, performance evaluation and design of supervision models for ttC	
Qualitative supervision tools	A modular supervision tool, which can be selectively used to create country specific supervision tools. This includes: <ol style="list-style-type: none"> <li>1. Basic data collection</li> <li>2. Case evaluation checklist</li> <li>3. Observation assessment checklist</li> <li>4. Health knowledge assessment checklist</li> <li>5. Core competencies evaluation</li> </ol>	See wvcentral.org
Eligible women and girl register	A simple Excel tool for CHWs to identify all eligible women and girls in their coverage areas and regularly track women for new pregnancies, births and deaths.	See wvcentral.org
CHW referral/counter-referral tool	An excel-based version of a simple double-sided form that enables information to be sent with the mother to the clinic and the other side completed by the clinic and returned with the patient after discharge. This is to be adapted locally.	See wvcentral.org
<b>ttC Core curriculum package</b>		
<b>Name</b>	<b>Description</b>	<b>Link</b>
Facilitator's Manual	The three manuals for each of the modules of ttC, designed to orient those who will conduct the training of CHWs/ttC-HVs.	See wvcentral.org
Participants' Manual	Companion material for participants engaged in ttC training including CHWs/ttC-HVs who have basic literacy.	See wvcentral.org
Storybooks	A package of 11 storybooks, 1 per visit.	See wvcentral.org
Household Handbooks		See wvcentral.org
Trainer's Guide and CD	Additional material and guidance for those organising training workshops on ttC, includes additional materials for planning, pre- and post-tests and handouts. CD also includes a copy of this ttC toolkit.	See wvcentral.org

**Appendix 2. Illustrative log frame for ttC**

<b>Outcome 1. Women and their supporters adopt household practices that promote good H/N</b>	<b>Outcome 2. Children and their caregivers have improved access to essential health services</b>	<b>Outcome 3. Community systems are strengthened to support high-quality coverage of ttC implementation</b>	<b>Outcome 4. Health systems and local partners have increased operational structures to support ttC and MNCH</b>
<p><i>Core indicators include:</i></p> <ul style="list-style-type: none"> <li>- Early initiation of breastfeeding (within one hour of birth)</li> <li>- Exclusively breastfed for the first 6 months of life</li> <li>- Children aged 6-24 months receiving continued breastfeeding</li> <li>- Children age 0-23 months who received all three components of essential newborn care</li> <li>- Proportion of parents or caregivers with appropriate hand-washing behaviour (evaluation only)</li> </ul>	<p><i>Core indicators include:</i></p> <ul style="list-style-type: none"> <li>- % skilled birth attendance</li> <li>- % women four or more antenatal visits in pregnancy</li> <li>- % registered mothers of children 0 to 23 months using a modern contraceptive method</li> <li>- % pregnant women counselled tested for HIV and received their test results during pregnancy</li> <li>- % of pregnancies in the last six months who experienced a complication and were referred to a health facility</li> <li>- # /% maternal deaths</li> <li>- #/% still birth or newborn deaths</li> <li>- Coverage of essential vaccines among registered children 12 to 23 months</li> <li>- Deaths of post-neonatal registered infants and children</li> <li>- % children who experienced a danger sign and were referred to a facility or appropriate care provider</li> </ul>	<p><i>Core indicators include:</i></p> <ul style="list-style-type: none"> <li>- # of COMMs that are functional and supporting ttC activities in the last six months</li> <li>- #/% of ttC-HVs undergoing a - COMMs supervision events (ttC-HVs debriefings)</li> <li>- # and % of ttC-HVs who have completed a competency-based trained course using a standardised curriculum by gender (including initial and continuing training events within the last 12 months)</li> <li>- Ratio of active ttC home visitors per registered mother infant pair in the last six months</li> <li>- #/ % of ttC-HVs who participated in and passed a support supervision or technical observation activity at least once within the last three months</li> <li>- #/ % of registered pregnancies who received 1st home-based counselling visit within 16 weeks of pregnancy</li> <li>- % of registered caregivers who received the minimum number of planned visits by stage</li> <li>- #/% of registered women accompanied by husband or birth partner in household counselling in the last visit.</li> </ul>	<p><i>Core indicators include:</i></p> <ul style="list-style-type: none"> <li>- Proportion of health facilities reporting that at least two thirds of communities under their jurisdiction are currently being served by active CHW/ttC-HV programmes that have been supervised within the last six months (outcome)</li> <li>- # of ttC-HV referrals received at health facilities (output)</li> <li>- # ttC supervisors trained and ratio to ttC-HVs (output )</li> <li>- Health facilities report that they have used ttC/community health data to inform service improvements or planning (output)</li> </ul>



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<p><i>Optional indicators include:</i></p> <ul style="list-style-type: none"> <li>- Proportion of young children receiving minimum dietary diversity</li> <li>- Proportion of women who increased food consumption during most recent pregnancy</li> <li>- Proportion of young children receiving at least minimum meal frequency</li> <li>- Proportion of children given appropriate feeding during illness</li> <li>- Proportion of children consuming (daily) consuming of iron-rich or iron-fortified foods</li> <li>- Proportion of parents or caregivers who know at least two post-partum danger signs and at least two neonatal danger signs</li> <li>- Proportion of pregnant women who slept under an insecticide treated net in the previous night</li> <li>- Proportion of households where all children under 5 years slept under an insecticide-treated net in the previous night</li> </ul>	<p><i>Optional indicators include</i></p> <ul style="list-style-type: none"> <li>- % pregnant registered women accessing antenatal care in the first 16 weeks of pregnancy</li> <li>- % registered women who took iron/folate during previous pregnancy (100 X IFA)</li> <li>- #% of registered women who had a birth plan prior to delivery</li> <li>- #/% Low birth weight among registered live births</li> <li>- % children who received an antihelminthic (deworming treatment) in the past six months</li> <li>- Proportion of registered children receiving Vitamin A supplements</li> <li>- Referrals made and completed by disease (diarrhoea, malaria/fever, pneumonia)</li> <li>- % referrals who received follow-up</li> </ul>	<p><i>Optional indicators</i></p> <ul style="list-style-type: none"> <li>- #/% of ttC-HVs who have received an individual performance-based evaluation including time series assessment within the last year</li> <li>- # of formal interactions between ttC HVs and other community health actors (via COMM meetings or other meeting amongst care providers)</li> <li>- # % of ttC-HVs who have adequate functional supplies and equipment for delivering services (ttC support materials)</li> <li>- # and % of ttC-HVs trained in ttC who have dropped out permanently of the ttC programme o the last 12 months (attrition rates)</li> <li>•</li> </ul>	<p><i>Optional indicators include</i></p> <p>For evaluation/outcome:</p> <ul style="list-style-type: none"> <li>- Proportion of households who used facility service who report satisfaction with the health services they received</li> <li>- Proportion of pregnant women and women with children under five who report stock out of any key primary health care commodities</li> <li>- Proportion of health facilities providing basic and/or comprehensive emergency obstetric care (EmOC)</li> <li>- #/% of health facilities that report no stock outs of key relevant essential drugs and commodities in the past six months</li> </ul> <p><i>Monitoring/output level only</i></p> <ul style="list-style-type: none"> <li>- # of improved communications and directing reporting events between CHWs and health facilities</li> <li>- # for which follow-up care guidance was given to community health providers (counter-referrals)</li> <li>- # of health facilities and local partners with improved operational structures to deliver quality MNCH services</li> <li>- #/% of CHWs supervised by health facility staff</li> <li>- Proportion of health facilities that have complete and timely health data from ttC programmes</li> </ul>
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### Appendix 3. Quality Standards for CHW Programming

• Essential elements and recommended practices	Minimum standards for implementation
<b>1. CHW functionality assessment is carried out prior/during project planning phase</b>	
<p><i>Recommended practices:</i> Functionality assessment conducted at a national level assessing policy environment and guidelines during country-readiness process for model expansion, (ttC/CCM). CHW-AIM tool along with CHW demographic and educational profile information is captured during planning or baselines. The NO should coordinate assessment of current functioning of existing CHW programmes for 15 programme components preferably in collaboration with district health partners.</p>	<ul style="list-style-type: none"> <li>• CHW functionality assessment conducted as part of project baseline activities (or has been conducted <i>at least once</i> by the local or district health authority within the last two years).</li> <li>• Health authorities engaged in design, implementation and analysis.</li> <li>• Results shared with CHWs, COMM, local health authorities and MoH.</li> </ul>
<b>CHW recruitment process is community-driven, transparent and engages all existing cadres without the creation of new ones.</b>	
<p><i>Recommended practices:</i> Community members and target beneficiaries are directly involved in recruitment through democratic process, and empowered to remove and re-elect CHW if deemed unfit. Selection criteria and core competencies are available and transparent to all those involved, and appropriate for country context (culture, language, literacy, gender).</p>	<ul style="list-style-type: none"> <li>• A minimum CHW-AIM score of 2 or above</li> <li>• CHW is selected from the chosen community and currently resident there.</li> <li>• Community is directly involved in the recruitment of the CHWs, including women.</li> </ul>
<b>2. CHW role is designed with clarity, including competencies with agreement of community, CHW, and health system.</b>	
<p><i>Recommended practices:</i> Process for discussion and update to CHW role is in place. Expectations of CHW regarding time, role, protocol, incentives, supervision and training are clearly documented. Guidelines are aligned to national policies and are available to CHW, health staff, community.</p>	<ul style="list-style-type: none"> <li>• A minimum CHW-AIM score of 2 or above</li> </ul>
<b>3. Initial CHW training is sufficient to prepare them for their role with appropriate time, trainers and practical training.</b>	
<p><i>Recommended practices:</i> If required by the MoH, standardised basic training modules are to be completed prior to any subsequent training modules. Training is consistent with health facility guidelines and existing policies and local health staff conduct or are involved in training. All records of training should be maintained. Practical skills training and support are included in all trainings.</p>	<ul style="list-style-type: none"> <li>• All new training modules only introduced once basic competency-based training required by MoH is completed.</li> <li>• Field practical skills training during at least one day.</li> <li>• Programme maintains a record of trainings per individual.</li> </ul>
<b>4. Ongoing training is planned to ensure necessary revision, skills-building and considering estimated attrition rates.</b>	
<p><i>Recommended practices:</i> Ongoing training provided to update CHW on new skills, reinforce initial training, and ensure protocol compliance. Replacement rates can be as high as 40% per year and need estimating prior to project. Training is tracked and opportunities offered in a consistent and fair manner to all CHWs. The health facilities are involved in all training events.</p>	<ul style="list-style-type: none"> <li>• Refresher training plans for at least <i>four days per year</i> throughout the project cycle.</li> <li>• Reselection and attrition rates are predicted at least 10%, and budgeted for 10% retraining of new volunteers per year.</li> </ul>
<b>5. Equipment and supplies are available and sufficient to deliver services including medicines, supplies, and job aids.</b>	
<p><i>Recommended practices:</i> Medicines and materials are channelled through existing supply chains where possible, assure functionality avoiding parallel systems. Medicine supply is linked to supervisory mechanisms, and</p>	<ul style="list-style-type: none"> <li>• Existing supply chains are utilised and strengthened during project.</li> <li>• Stocks and job aids quality assessed at supervision at <i>least twice per year</i></li> </ul>

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<p>technically competent staff check and update stocks including expiration dates, quality and inventory to ensure no substantial stock-outs.</p>	<p>(as part of supervision).</p>
<p><b>6. CHW supervisors are trained, equipped and supported to conduct regular supportive supervision with at least four contacts per year</b></p>	
<p><i>Recommended practices:</i> Supervisors are trained in supportive supervision methods and have basic super-vision tools (checklists) to aid them, and sound technical knowledge. Community, CHW and PHU have clear guidance on supervisor role. <b>Frequency:</b> A suitable time frame is established for supervision, with face-to-face contact regularly planned. Include more supervision in year 1. <b>Ratio:</b> An appropriate supervision ratio of CHWs: supervisor is established- eg, <b>30 CHW per supervisor</b>. Supervision data are available to community members and community health structures.</p>	<ul style="list-style-type: none"> <li>• Supervisors have completed basic competence training on the programme model and are selected as those with a background in the technical area of implementation.</li> <li>• <i>At least four</i> face-to-face contacts with supervisor per year.</li> </ul>
<p><b>7. Supervision activities are designed and implemented to identify and resolve individual performance quality.</b></p>	
<p><i>Recommended Practice</i> Supervision, typical one of the weakest areas of programming, is essential for the learning progress of CHWs. Individual mentoring may have more impact on skills and quality than classroom training alone. Clinical models such as CCM/cPMTCT do require adequately trained clinical mentors.</p> <p><i>Highly recommended</i></p> <ul style="list-style-type: none"> <li>• <b>Qualitative data review</b> - use of CHW diaries to review information on barriers to service access</li> <li>• <b>Troubleshooting</b> (technical advice) offered during supervision</li> <li>• <b>Problem solving</b> (non technical) offered during supervision</li> <li>• <b>Refresher training:</b> Knowledge checking, revision exercises or additional training using the CHW manuals during supervision as required by CHW</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Case assessment:</b> Home-visit/case assessment of recorded cases to ensure service quality, focusing on adverse events, referrals and follow-up (at least three cases) for quality monitoring four times per year, especially important in CCM and treatment programmes.</li> <li>• <b>Observation of service delivery:</b> home visits done with CHW, providing skills coaching through observation. At least twice, as soon as possible following training as part of practical CHW training.</li> <li>• <b>Record review and data collection/reporting:</b> Data gathered is used for problem solving and coaching, conduct at every supervision (4 times per year).</li> </ul>
<p><b>8. Individual Performance Evaluation occurs at least annually and is designed to fairly assess work and improve quality</b></p>	
<p><i>Recommended Practice</i> Individual performance is evaluated using using time-series data and supervision is in place and is widely known by supervisors, PHC staff and CHWs, incorporates community involvement including beneficiary feedback, and is linked to rewards (financial or other).</p>	<ul style="list-style-type: none"> <li>• At least once per year, a minimum of 4 goal indicators of programme coverage are tracked through time-series at the individual CHW level.</li> <li>• Community inputs are incorporated and performance is rewarded/recognised.</li> </ul>
<p><b>9. Incentives - Standards and methods for performance-based incentives are ethical, non-competitive, sustainable, and under a unified country policy.</b> ♦(see CHW Principles of Practice)</p>	
<p><i>Recommended practices</i></p> <ul style="list-style-type: none"> <li>• <b>One country one policy</b> - Where a national policy is not in existence, investigate the incentives paid by MoH and NGOs in the surrounding areas, convene meetings to achieve an agreement in which incentives will not vary widely or be competitive, at district or regional level if not national. MoH should sign off on the agreed rates.</li> <li>• <b>Community Participation and Accountability</b> - Community involvement, transparency and accountability are very important in the determination of the incentives. To avoid conflict the incentives schemes need to be explained, agreed and</li> </ul>	<ul style="list-style-type: none"> <li>• Incentives are developed in collaboration with MoH and partners in line with local or national policies/practices.</li> <li>• Community involved in incentives and provide feedback on performance that is taken into consideration.</li> <li>• No payment for services is applied.</li> <li>• Incentive scheme is comparable and sustainable across all project types in the area.</li> </ul>

<p>documented in a transparent manner.</p> <ul style="list-style-type: none"> <li>• <b>Non-payment of services</b> - CHWs should <i>not</i> receive financial incentives from families via sale of services that may result in service inequality to poorest households.</li> <li>• <b>Sustainability</b> - Financial incentives paid for activities including both short term and long term projects, an agreed stipend should be applied to all circumstances that can be recreated in an ADP budget or similar.</li> <li>• <b>Reasonable compensation</b> - Incentives provided in line with expectations placed on CHW, based on the estimated number of work hours applied.</li> </ul> <p><i>Suggested practices:</i></p> <ul style="list-style-type: none"> <li>• <b>Performance-based application</b> - Linked to successful supervision or performance evaluation, subject to provision of expected services; not given for non-activity and reported misconduct.</li> <li>• <b>Non-financial incentives and advancement</b> – eg training, certification, advancement opportunities, uniforms, medicines, bicycles et, are awarded in accordance with project needs with agreement with MoH and communities.</li> </ul>	<ul style="list-style-type: none"> <li>• Incentives in line with expectations placed on CHW in time and opportunity cost.</li> <li>• Incentives given are linked to performance-based assessment and not given in cases where CHW is not active.</li> <li>• Job tools (eg, phones, bicycles) for exclusive use of CHW and are documented and transparent. They should not be given by beneficiaries as 'service in kind' payment.</li> </ul>
<p><b>10. Communities are continuously engaged in the support of CHW's work at all levels, and kept informed.</b></p>	
<p><i>Recommended practices:</i> Community including the beneficiaries should be involved in project from planning, feedback, review and incentives to the CHW. Community leader/s or existing health committees have ongoing dialogue with CHW regarding health issues in village using data gathered. Community provide feedback during supervision visits to resolve issues.</p>	<ul style="list-style-type: none"> <li>• Community-wide meetings to discuss and sensitise on CHW initiatives should take place at least <i>once per year</i>.</li> <li>• COMMS/CHCs should be involved in feedback review of CHW supervision at least twice per year (CHW debriefing sessions).</li> </ul>
<p><b>11. Referral system for emergency evacuations of cases is in place and referrals documented</b></p>	
<p><i>Recommended practices:</i> CHW has a logistic plan for referral and current knowledge of emergency transport and funds if available. CHW records all emergency referrals recommended and then follows up in the home at least once to ensure referral compliance and care. CHWs to report/record the result of the referral and experience of client (client discharge guidance). Counter-referral is encouraged to enable increased communication on specific cases to the CHW and to improve case management.</p>	<ul style="list-style-type: none"> <li>• A facilitated referral system is in place and referrals and evacuations are recorded.</li> <li>• Post-referral follow-up visits by CHWs are conducted for all emergency evacuations.</li> <li>• Counter-referral system is available to the health centre for severe/chronic cases.</li> </ul>
<p><b>12. Opportunity for advancement, growth, promotion and retirement for CHW is considered</b></p>	
<p><i>Recommended practices:</i> Advancement (promotion) offered to CHWs who perform well and express interest in advancement if opportunity exists (formal accrediting/role change). Advancement rewards good performance or achievement, based on fair evaluation.</p>	<ul style="list-style-type: none"> <li>• A <i>minimum CHW-AIM score of 2 or above</i></li> </ul>
<p><b>13. Documentation, Information Management is in place which is consistent, transparent and used for service improvements</b></p>	
<p><i>Recommended practices:</i> CHWs document activities consistently using appropriate job aids. Supervisors monitor quality</p>	<ul style="list-style-type: none"> <li>• A <i>minimum CHW-AIM score of 3</i></li> <li>• Data submitted to health facility/authority on a quarterly basis.</li> </ul>

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<p>of documents and provide help when needed. CHWs work with supervisor or facility to use data in problem solving at the community. Health staff are involved in reviewing data, and systems are aligned to HMIS.</p>	<ul style="list-style-type: none"> <li>• Data made available to COMM twice per year.</li> </ul>
<p><b>14. Linkage to Health System</b></p>	
<p><i>Recommended practices:</i> CHWs are formally recognised by the health authority in a direct relationship and not solely to the project. Links between the community health structures managing CHWs are the district health authorities are built through regular communication, contact, meetings and training events. Two-way reporting and sharing of information and data are supported throughout the project cycle. Each CHW is assigned to a PHC technical staff member with a personal mentoring relationship and direct contact.</p>	<ul style="list-style-type: none"> <li>• A minimum CHW-AIM score of 2 or above</li> <li>• CHW has a direct reporting relationship to the local health facility/authorities.</li> <li>• CHW community management structures and district health teams should interact at least twice yearly.</li> </ul>
<p><b>15. Programme Performance Evaluation</b></p>	
<p><i>Recommended practices:</i> General programme evaluation of performance against targets, overall programme objectives, and indicators that is carried out on a regular basis <b>Yearly evaluation</b> conducted of CHW activities (may be sample) assessing achievements in relation to programme outcomes and targets. Includes evaluation of the quality and coverage of service delivery and community feedback. Health staff also provide feedback based on data received from CHW. Feedback given to CHWs on programme indicators and targets and against standards.</p>	<ul style="list-style-type: none"> <li>• Programme evaluation should aim to occur after 12 months in the first instance, then 18 monthly.</li> <li>• Includes CHW functionality assessment and time-series programmatic data.</li> <li>• Report findings summary shared at local, regional and national levels with partners.</li> </ul>
<p><b>16. Country ownership - National level MoH partners have a direct involvement, oversight and decision-making powers over programme methodology and implementation and review processes.</b></p>	
<p><i>Recommended practices:</i> Ideally we should look to work through partners as much as possible, ensuring that all trainings and skills we support are building capacity of these state actors to continue the project in our absence. A National level committee coordinates CHW programming involving key stakeholders, MoH and partners. WV activities promote legitimisation of CHWs and task shifting within the national health service and are in alignment with existing MoH strategies. MoH partners are involved in training at national and regional levels and retain rights to review methods. MoH involved in all stages of including piloting, curricula choice and adaptation, incentives, data systems and evaluation. Adequate accompanying activities contributing to health systems strengthening are applied.</p>	<ul style="list-style-type: none"> <li>• A minimum CHW-AIM score of 2 or above</li> </ul>

**Appendix 4. ttC for MNCH Curricula Checklist**

Message code	7-11 Strategy: Target behaviors	ttC	Curriculum under review
<b>Mother: 7 Interventions</b>			
<b>M1. Adequate diet</b>			
M1.1	Additional meal	X	
M1.2	Nutritious snack	X	
M1.3	Iodised salt	X	
<b>M2. IFA Supplementation and safe pregnancy</b>			
M2.1	Iron-rich foods	X	
M2.2	IFA supplements per national guidelines	X	
M2.3	Avoiding alcohol, drugs, smoking, heavy workload	X	
<b>M3. TT2</b>			
M.3	TT2 vaccination	X	
<b>M4. Malaria prevention/treatment</b>			
M4.1	Sleeping under bednet	X	
M4.2	IPTp (2 doses)	X	
M4.3	ACT for malaria	X	
<b>M5. BP/HTSP</b>			
M5.1	Birth plan	X	
M5.2	Facility birth	X	
M5.3	Knowing danger signs	X	
M5.4	Arranging finances	X	
M5.5	HIV testing	X	
M5.6	FP method use	X	
<b>M6. Deworming</b>			
M6.1	Deworming medicine through ANC	X	
M6.2	Wearing shoes	X	
<b>M7. Access to maternal services</b>			
M7.1	Four antenatal care visits	X	
M7.2	Facility birth	X	
M7.3	HIV testing for mother	X	
M7.4	Postnatal care	X	
M7.5	ART for HIV-exposed infants	X	
M7.6	Early testing for infants	X	
M7.7	Condom use during pregnancy/breastfeeding	X	
M7.8	Timely diagnosis of TB and DOT	X	
		<b>26</b>	
<b>Child: 11 interventions</b>			
<b>C1. Appropriate Breastfeeding</b>			
C1.1	Exclusive breastfeeding * 6 months	X	
C1.2	Continued breastfeeding * 23 months	X	
C1.3	Positioning and attachment	X	
C1.4	No bottles	X	
C1.5	Continued breastfeeding during illness	X	
C1.6	Switching after emptying breast	X	
<b>C2. Essential Newborn Care</b>			
C2.1	Wiping, covering	X	
C2.2	Clearing airway	X	
C2.3	Timely initiation of breastfeeding	X	
C2.4	Feeding colostrum	X	
C2.5	No prelacteals	X	
C2.6	Skin-to-skin care for LBW	X	
C2.7	Care of eyes and cord stump	X	
C2.8	Exclusive breastfeeding	X	
C2.9	Expressing breastmilk	X	
C2.10	Positioning and attachment	X	
C2.11	PMTCT; feeding options for HIV-positive mother	X	

	<b>C3. Handwashing</b>		
C3.1	Handwashing with soap and running water	X	
C3.2	When to wash hands	X	
	<b>C4. Appropriate complementary feeding</b>		
C4.1	Initiate at 6 months	X	
C4.2	Responsive feeding	X	
C4.3	Minimum frequency	X	
C4.4	Diverse diet	X	
C4.5	Density of foods	X	
C4.6	Recipes	X	
C4.7	Continued breastfeeding	X	
C4.8	Growth monitoring	X	
	<b>C5. Adequate Iron</b>		
C5.1	Iron-rich foods	X	
C5.2	Iron-fortified foods	X	
C5.3	Iron supplements (per malaria context)	X	
C5.4	Iron for LBW infants	X	
	<b>C6. Vitamin A supplementation</b>		
C6.1	Twice-yearly vitamin A doses 6-24 months	X	
C6.2	Vitamin A-rich foods	X	
C6.3	Post-partum high dose vitamin A	X	
	<b>C7. ORT/Zinc</b>		
C7.1	ORT	X	
C7.2	Zinc	X	
C7.3	Sugar salt solution when ORS unavailable	X	
C7.4	Continued breastfeeding/comp feeding	X	
C7.5	Knowing signs of severe dehydration	X	
C7.6	Prevention of diarrhea	X	
	<b>C8. Prevention and care seeking for malaria</b>		
C8.1	Sleeping under bednet	X	
C8.2	Timely care from appropriate provider for fever	X	
	<b>C9. Full immunisation</b>		
C9.1	Seeking timely vaccinations	X	
C9.2	Keeping card safe	X	
	<b>C10. Prevention and care for ARI</b>		
C10.1	Recognising fast breathing/chest indrawing	X	
C10.2	Timely care from appropriate provider	X	
	<b>C11. Deworming</b>		
C11.1	Deworming medication	X	
C11.2	Wearing shoes	X	
<b>TOTAL KEY MESSAGES</b>		74	