MINISTRY OF HEALTH

COMMUNITY BASED MATERNAL AND NEONATAL CARE

TRAINING COURSE FOR COMMUNITY HEALTH WORKERS

PARTICIPANT'S GUIDE
THIRD EDITION
REVISED MARCH,2025

LAST MILE HEALTH

World Health Organization

THE WORLD BANK

Table of Contents

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Anti-Retroviral Therapy
ARV	Anti-retroviral medicine
BCG	Bacille Calmette Guerin
CBFP	Community Based Family Planning
CBMNC	Community Based Maternal and Neonatal Care
CHNM	Community Health Nurse Midwife
CHW	Community Health worker
CMA	Community Midwifery Assistant
COVID	Corona Virus Disease
DMPA	Depot Medroxyprogesterone Acetate
DoDEA	Department of Disability and Elderly Affairs
DPPD	Department of Planning and Policy Development
EBF	Exclusive Breast Feeding
EDD	Expected Date of Delivery
eMTCT	Elimination of Mother to Child Transmission
FP	Family Planning
HIV	Human Immunodeficiency Virus
HSA	Health Surveillance Assistant
IM	Intramuscularly
IPTp	Intermittent Preventive Treatment of malaria in pregnancy
IUCD	Intra-Uterine Contraceptive Device
IUGR	Intra- Uterine Growth Restriction
KMC	Kangaroo Mother Care
LLITN	Long Lasting Insecticide Treated Nets
LNMP	Last Normal Monthly Period
MDHS	Malawi Demographic and Health Survey

MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MNCH	Maternal Newborn and Child Health
MNH	Maternal and Newborn Health
MTCT	Mother to Child Transmission
NGOs	Non-Governmental Organisations
NMR	Neonatal Mortality Rate
PPFP	Postpartum Family Planning
PrEP	Pre-Exposure Prophylaxis
QMD	Quality Management Directorate
RHD	Reproductive Health Directorate
SC	Subcutaneous
SP	Sulfadoxine Pyrimethamine
SRH	Sexual Reproductive Health
SUN	Scaling Up Nutrition
TA	Traditional Authority
TBA	Traditional Birth Attendant
Td	Tetanus diphtheria vaccine
UN	United Nations
WHO	World Health Organization

Foreword

The Government of Malawi through the Reproductive Health Directorate in the Ministry of Health developed a Road Map that outlines various strategies, which will guide policy makers, development partners, training institutions and service providers in supporting government efforts towards the attainment of SDGs related to maternal and neonatal health. This includes community initiatives such as the Community Based Maternal and Neonatal Care (CBMNC) implemented since 2007.

The aim of CBMNC program is to empower individuals, households and communities to take responsibility for their health. The reduction of neonatal mortality and improvement of maternal health at the community level can also be achieved through the provision of essential information pertaining to maternal and neonatal health and the strengthening of the role of community-based health workers.

However, after implementation of this initiative it was deemed necessary to revise the training manual so that other emerging issues could also be taken on board after noting the gaps in service provision at community level. The gaps include; Community Based Family Planning, HIV/AIDS Care and Nutrition, Gender Issues, TB, Malaria, assessment and referral of antenatal mothers, postnatal mothers and neonates with danger signs.

The rationale behind the development of this manual is to empower Community health workers with skills and knowledge necessary for the provision of information, counselling, assessment, and referral of mothers and neonates to a health facility appropriately. The manual will also help Community Health Workers (CHWs) to understand that antenatal and postnatal periods are critical for the survival of mothers and babies.

This 3rd edition of CBMNC training manual was initially adapted from the WHO manual on 'Caring for the Neonates in the Community' and draws lessons and experience from the implementation of the CBMNC in Malawi

My sincere gratitude goes to all stakeholders who have contributed towards the revision of this document.

I wish to urge you all to use this document to the maximum for the benefit of the Malawi Nation.

Dr. Samson Mndolo

SECRETARY FOR HEALTH

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The Ministry of Health would like also to thank the Community Health Section, Department of Planning and Policy Development (DPPD), Department of Nutrition, HIV and AIDS (DNHA), for providing technical support of the review process and printing of this manual. The following individuals are appreciated for their technical contribution and committed expertise in reviewing and finalising this manual:

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Background

Women in low resource settings face so many challenges that expose them to an increased risk of dying during pregnancy, childbirth and in the postpartum period. These challenges include, poor access to health care, gender-based violence, poverty, lack of information on safe motherhood as well as harmful cultural beliefs and practices. It is therefore important that these challenges are adequately addressed both at community and facility level to reduce the alarming numbers of maternal deaths.

Maternal mortality remains unacceptably high with the current global estimate of 211/100,000 live births (WHO, 2019). 86% of these deaths occur in Sub-Saharan Africa. In Malawi MMR is estimated at 439/100,000 live births (MDHS 2015-16). According to WHO, 75% of the maternal deaths are due to: severe bleeding (mostly after birth), infections, high blood pressure during pregnancy, complications from delivery and unsafe abortion. Early recognition of danger signs and provision of comprehensive quality maternal care are key in reducing these deaths.

While countries are still struggling to reduce maternal deaths, improving neonatal health also exists as a prevailing challenge. The first month of life, called the newborn or neonatal period, is the most risky period in the life of an individual. According to WHO, fact sheet 2020; out of 5.2 million deaths in children under five years of age that occurred in 2019, 2.4 million deaths occurred during the first 28 days of life. Globally, Neonatal Mortality Rate (NMR) is at 18/1000 live births (Hug et. al., 2019). This rate is even higher in developing countries and, in Malawi NMR is at 27/1000 live births (MDHS 2015-16). Most of these new-born deaths occur in the first week of life. The risk of mortality is greatest during the first week after birth, during which about 70% of neonatal deaths occur. Many of these new-born deaths can be prevented by simple interventions delivered at the community level. Many newborns fall sick in the first days of life due to complications of childbirth. It is therefore important to have skilled care during pregnancy and at birth so that any complication can be prevented or treated. Furthermore, inside their mother's uterus, babies are safe, warm and well fed. After birth, newborns have to adapt to a different way of feeding, breathing and staying warm. It is very important to help them meet their new needs. At this time, babies can get sick easily and the sickness can become serious very quickly.

Therefore, adequate follow up of mothers during pregnancy and after birth by CHW at community level is essentially important in the improvement of maternal and newborn health.

Aim of CBMNC Program:

- To empower individual households and communities to take responsibility of their health through interaction with community health workers.

Objectives of CBMNC Program

- To develop community health workers' competence in communication skills and building a good relationship with the family when conducting a home visit.
- To develop CHW's competence in counselling the family on the importance of early antenatal care, HIV testing, Family planning TB screening, planning for birth in a health facility, home care for pregnant women, malaria prevention, good nutrition and appropriate newborn care practices after birth.
- To develop CHW's competence in assessing breastfeeding, danger signs and weight of a newborn, when to refer or provide care at home depending on the results of the assessment.
- To equip families with knowledge on optimal care practices for the pregnant woman, birth preparedness and complication readiness, danger signs identification and early health seeking behaviour.
- To develop CHW's competence in assisting families to provide extra care for the small baby.
- To promote community involvement in maternal and neonatal care.
- To promote linkages and referral pathways between hospital care and community based maternal and neonatal care.
- To promote community awareness on maternal and neonatal health issues.

Methodology

Consultative meetings were conducted with all stakeholders implementing and supporting CBMNC activities in the country. Notable ones include UN organisations, NGOs, Government sectors such as Reproductive Health Directorate, Department of Planning and Policy Development (DPPD), Department of Nutrition and HIV/AIDS, Nursing and Midwifery Directorate, Community Health Section, Quality Management Directorate (QMD), Department of Disability and Elderly Affairs (DoDEA) and Ministry of Gender and Child welfare and Media fraternity

During these meetings CBMNC 2015 training package was revised to incorporate emerging issues. The package includes counselling card, registers, reporting tools, supervision checklist, facilitators and participant's manual.

UNIT I

HOME VISITS DURING PREGNANCY

Sessions 1 through 17

SESSION 1

INTRODUCTION TO COMMUNITY BASED MATERNAL AND NEONATAL CARE

Learning Outcomes

By the end of this session, you should be able to:

- Discuss why the mother and baby are particularly vulnerable during pregnancy, birth and the postpartum period.
- Discuss the importance of maternal and newborn care
- Name important elements of community maternal and newborn care
- Describe the materials that are used in CBMNC service provision

Why Mothers and Newborn Babies Need Extra Care.

Women in low resource settings face so many challenges that expose them to an increased risk of dying during pregnancy, childbirth and in the postpartum period. These challenges include, poor access to health care, gender-based violence, poverty, lack of information on safe motherhood as well as harmful cultural beliefs and practices. It is therefore important that these challenges are adequately addressed both at community and facility level to reduce the alarming numbers of maternal deaths.

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While countries are still struggling to reduce maternal deaths, improving neonatal health also exists as a prevailing challenge. The first month of life, called the newborn or neonatal period, is the most risky period in the life of an individual. World-wide, Neonatal Mortality Rate (NMR) is at 18/1000 live births (Hug et. al., 2019) This rate is even higher in developing countries and, in Malawi NMR is at 27/1000 live births (MDHS 2015-16) Most of these newborn deaths occur in the first week of life.

Many newborn babies fall sick in the first days of life due to complications of childbirth. It is therefore important to have skilled care during pregnancy and at birth so that any complication can be prevented or treated. Furthermore, inside their mother's uterus, babies are safe, warm and well fed. After birth, newborn babies have to adapt to a different way of feeding, breathing

and staying warm. It is very important to help them meet their new needs. At this time, babies can get sick easily and the sickness can become serious very quickly.
Therefore, adequate follow up of mothers during pregnancy and after birth by CHW at community level is essentially important in the improvement of maternal and new-born health.

STORY OF DEATH

A woman in a nearby village, Amina, was pregnant with her first child. She was very happy. Amina's family was as poor as others were in the village. She was short and thin. She did not go to get any health care during pregnancy.

When labour started, Amina's husband called the Traditional Birth Attendant (TBA). The baby was born small and weak. Amina did not breastfeed the baby. Her mother-in-law fed the baby sugar water with a dropper because she thought that breast milk should not be given because the baby was too small.

By the end of the second day, the baby stopped accepting sugar water, became cold and died the next morning.

Amina was very sad. She blamed herself for not being able to take care of the baby.

STORY OF A DEATH PREVENTED

A woman in another village, Esther, missed her period so she visited the health facility to confirm the pregnancy. Esther was confirmed pregnant and on the same day, she started her antenatal care. Esther was very happy to be expecting her first child.

Esther's family was as poor as others were in the village. She was short and thin. Esther tested for HIV at the first visit, and was found to have HIV. She was given antiretroviral therapy (ART) for herself and the baby. She also received iron tablets to take every day to prevent Anaemia. She went to the clinic eight times during pregnancy.

The CHW discussed where Esther wanted to give birth and CHW explained the benefits of health facility delivery. Esther and her family agreed to have the birth in the health centre. They discussed how the family could plan for delivery. She also explained how to care for the baby; how to dry the baby immediately after birth, to keep the baby in skin-to-skin contact and to put the baby to the breast soon after the cord was cut.

When labour started, Esther's husband called his neighbour who had an oxcart and had agreed to take them to the health facility. Esther took her ARVs while in labour to protect her baby from HIV. They reached the health centre in time. The baby was born small but crying loudly. The midwife dried her and placed her on Esther's abdomen, covered with a dry cloth. After some minutes, the baby showed signs of wanting to feed, and the midwife helped Esther breastfeed her. The midwife gave the baby ARVs to protect from HIV and advised the mother to be giving the ARVs at home every day for six weeks. The midwife also counselled Esther on family planning and provided a method of her choice. Esther was discharged the next day.

The following day, the CHW visited Esther and checked the baby for signs of illness. Since the baby was small, (she weighed 2100grams. at the health facility) the worker encouraged Esther to feed the baby only her own breast milk every 2 hours and on demand, including at night. The community health worker also showed her how to keep the baby warm by keeping the baby in skin-to-skin contact as much as possible.

The CHW visited Esther two more times in the first week and twice in the second week after discharge. The baby did not have any signs of illness, was breastfeeding exclusively and was always warm. The CHW also checked that Esther and her baby were taking ARVs. Esther was happy that she was taking good care of the baby.

At 6 weeks, Esther took the baby to the health facility for a check-up and vaccinations. The baby also had his first HIV test and was initiated on Cotrimoxazole. He did not have HIV then or at 12 months when he was retested. Esther was very happy. The baby is one-year-old now.

It is clear from this story that community health workers can do a lot to improve newborn health and prevent newborn deaths. However, Community Health Workers need appropriate training to perform their tasks.

Overview of CHW tasks

a) Identify pregnant women in the community
b) Make two home visits to all pregnant women
c) Make 3 home visits after birth
d) Make two extra home visits after birth for small babies
e) Make a follow-up visit for babies or mothers referred to health facility

Community Health Worker materials

- **CBMNC Manual** to provide the CHW with information needed to carry out the work and exercises to complete during training.
- **A set of Counselling Cards,** which will guide the CHW during home visits and will be shown to the families to help them understand the messages.
- **Referral Note** to be used when referring a baby or mother to the health facility
- **Home Visit Register** to use for recording important information on pregnant women, postnatal mothers and newborns during home visits
- **CBMNC reporting booklet** for monitoring progress
- **Assessment tools**- handheld weighing scale, thermometer and time

SESSION 2

COMMUNITY HEALTH WORKER TASKS IN CBMNC

Learning Outcome:

By the end of this session, you should be able to:

- Explain the community health worker tasks in CBMNC.

Community Health Worker Tasks

1. **Identify pregnant women** in the community so that CHW can make home visits during pregnancy and in the first days after birth for the greatest impact

2. **Make two home visits to all pregnant women** in the community:
   First home visit during pregnancy — as early as possible/during the first trimester:
   - To encourage the pregnant woman to go for early antenatal care
   - To encourage her to know her HIV status so that she can take action to best protect her health and protect her baby from HIV
   - To promote birth in a health facility
   - To help in developing a birth plan
   - To teach home care for the pregnant woman.
   - To counsel the pregnant women on healthy timing and spacing of pregnancy

   Second home visit during pregnancy — about 2 months before delivery
   - To review actions discussed during the previous home visit.
   - To encourage the family to follow optimal newborn care practices immediately after birth.
   - If the woman has HIV, to check that she is taking ARVs every day and will continue for life.
   - Check if the woman has selected her FP method of choice and counsel on the method and timing.

3. Make 3 home visits after birth

   First home visit after birth — on Day 1 after discharge:

- To assess the mother and baby for signs of illness, weigh the baby, and help the mother with early and exclusive breastfeeding and keeping the baby warm.
- If the mother has HIV, check that the mother and baby are taking ARVs.
- Check if the mother has accessed the PPFP method of choice, if not counsel and refer if the method cannot be provided by CHW

Second home visit after birth- on Day 3 after discharge.

- To assess for signs of illness, help the mother to sustain breastfeeding and prevent breastfeeding problems, and advise on optimal care for the mother and her baby.
- If the mother has HIV, check that the mother and the baby are taking ARVs
- Check if the mother has accessed the PPFP method of choice, if not counsel and refer if the method cannot be provided by CHW

Third home visit after birth — on Day 8 after discharge from the health facility:

- To assess for signs of illness, and advise on optimal care beyond the first week of life.
- If the mother has HIV, check that the mother and the baby are taking ARVs at the same time every day; and to bring the baby to the health facility when the baby is 6 weeks old, so that the baby can be tested for HIV and started on Cotrimoxazole.

4. **Make two extra home visits after birth for small babies** (birth weight less than 2500 grams): on day 2 and day 14 after discharge from the health facility. During these extra visits, the CHW can provide the extra care that small babies need.
5. **Make a follow-up visit on the following day for a baby or a mother who is referred to a health facility** for illness and after discharge from facility.

SESSION 3

INTERACTING WITH FAMILIES

Learning Outcomes

By the end of this session, you should be able to:

- Explain the stages of behaviour change
- Explain the counselling steps in a home visit
- Explain why it is important to use effective communication skills

Process of behaviour change

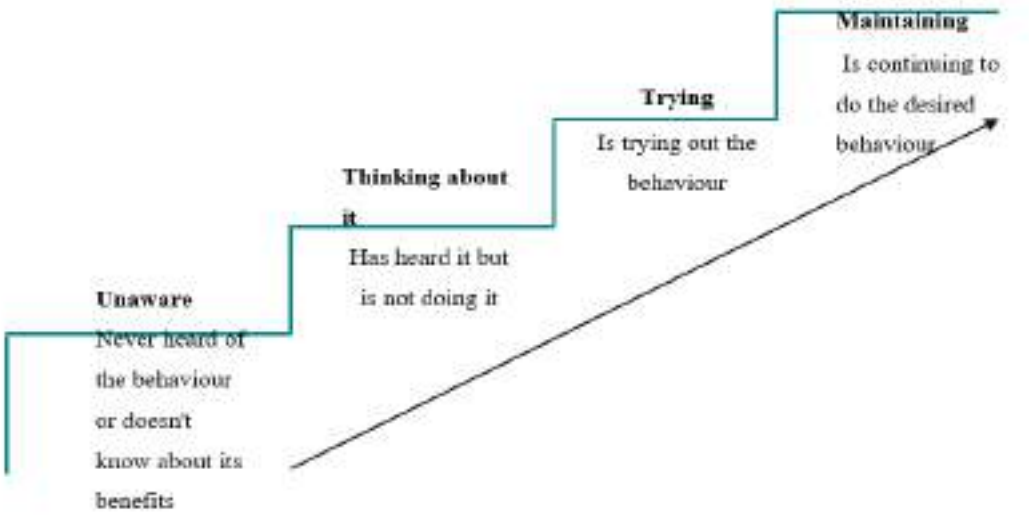
It is important to understand the process of behaviour change before you start visiting and counselling the family.

In order for counselling to be successful, you need to:

- Understand **how people change** the way they do things and adopt a new behaviour,
- Ask questions and listen to **determine where the family is** in terms of adopting the behaviour, and
- **Counsel the family based on their situation**.

Stages of behaviour change

The steps below show the stages people usually go through when they are adopting a new behaviour. When CHW understand the stage that the family is in at the time of the visit, he/she will modify counselling to be more effective.



Examples of the stages below:

Unaware: Sara has heard about washing hands with soap before eating but does not know that it could prevent illness.

Thinking about it: Rita is aware that washing hands with soap before eating prevents illness. She is thinking about adopting this behaviour but does not wash hands every time before eating.

Trying: Janet has just started washing her hands with soap every time before eating, but sometimes it is too inconvenient or there is no soap.

Maintaining: Pamela has been washing her hands with soap every time before eating since last year.

DISCUSSION IN SMALL GROUPS

Decide for each case the stage of behaviour change in which the woman is.

Case 1:

A woman has heard that delivering at a health facility is safer than delivering at home, and her husband and mother-in-law also are talking about it. She is thinking about saving money for a health facility birth because she thinks it will be best for her and her child.

Case 2:

A woman started to breastfeed her last two babies immediately after birth and says this helped make the babies strong and healthy. She is pregnant and plans to do the same for this baby.

Case 3:

A woman has delivered a small baby. She was told by the CHW that feeding small babies every 2 hours is important to make them strong and healthy and she is trying to do this. She is worried that waking the baby up to feed her is making the baby irritable and making the baby take a long time to fall asleep

ANSWERS: Case 1 –

Case 2 –

Case 3 –

The table below shows the kind of information a person or a family needs depending on the stage of adopting a new behaviour they are in:

If the person or family is in this stage of behaviour change:	**Then, to provide effective counselling:**
Unaware	• Give information about the behaviour. • Explain the benefits of the behaviour.
Thinking about it	• Encourage the family to try the behaviour. • Identify the problems the family may have in trying the behaviour and help solve these problems.
Trying	• Encourage continuation of the behaviour through praising. • Identify and solve any problems the family is having in adopting the behaviour.
Maintaining	• Praise the family and encourage them to continue the behaviour.

COUNSELLING STEPS DURING A HOME VISIT

One of the most important tasks of the CHW is to visit families in their homes. To do this well, he/she needs to develop good relations with the families, listen to them, understand the situation, provide relevant information, and encourage them to make their own decisions. **Counselling is a way of interacting with people in which you try to understand how they feel and help them to decide what to do.** In order to counsel effectively, CHWs need to be able to use various communication skills and maintain confidentiality.

A key activity for CHWs is to share important health information with your neighbours, especially pregnant women and caregivers of newborns and young children. Counselling is an effective way to sharing relevant information.

Counselling does not mean simply giving information or messages. It should be a two-way communication between the CHW and the families. Good counselling makes it more likely that the family will listen to the advice. When they are willing to try a new behaviour, counselling includes helping them plan how they can adopt the behaviour.

Steps to be followed during home visit

The CHW uses the following steps during home visits:

1. **Greet and build good relations**
2. **Tell the family that all personal information will be kept confidential**
3. **Ask questions and listen; understand the situation**
4. **Give relevant information**
5. **Check understanding**
6. **Discuss what the woman and family will do**
7. **Together, try to solve any problem**
8. **Thank the family**

As a CHW, you will use counselling cards during each home visit. The cards are labelled for each visit (i.e. First Pregnancy Visit, Second Pregnancy Visit, First Postnatal Visit, etc.) There are two to five cards per visit. The text on all of the cards follows the steps above. Counselling cards are a useful tool to guide CHWs through each home visit.

Communication skills for home visiting

Importance of good communication skills

- It helps to gain the trust of people in the community.
- It helps to ensure that information given to families is provided in a way that is easy to understand, and follow.
- Helps the CHW to talk to people in a way that will make it more likely to listen and accept advice.

NOTE: Using good communication skills, the CHW can talk with families effectively and help them provide best care possible for their newborn babies.

In order to carry out an effective home visit, communication skills are needed:

I. Skills for greeting and building good relations

II. Skills for asking and listening

III. Skills for giving relevant information

IV. Skills for checking understanding and solving problems

I. SKILLS FOR GREETING AND BUILDING GOOD RELATIONS

- Be friendly and respectful
- Speak in a gentle voice
- Talk to the whole family
- Explain why you are visiting
- Maintain confidentiality and build trust

DEMONSTRATION ROLE PLAY: Greeting and building good relations

* * *

ROLE PLAY SCRIPT: Greet the family and build good relations

GREET THE FAMILY

CHW: Hello, Is anyone home?

Pregnant woman: Hello.

CHW: Hello**.** I am Monica, a CHW for this community. I am married to Ishmael. We live near the river. ***(Speaking in a gentle voice)*** How are you and the family? ***(Smiles and looks at her)***

Pregnant woman: We are fine. Yes, we know your family. Welcome. Please have a seat.

EXPLAIN THE VISIT

CHW: Thank you. I am glad to hear you are well.

Pregnant woman: As you can see, I am pregnant for the first time.

HCW: Yes, I see! You are looking very well. ***(Praise)*** Part of my responsibility is to visit pregnant women and discuss what you can do to make sure you and the unborn baby stay healthy ***(Explains the visit)***. Any personal information that we discuss will be kept confidential. Is this a good time for me to visit or should I come back another time?

Pregnant woman: (*Nods).* This is a good time.

CHW: Excellent. Can your husband or mother-in-law join us? ***(Include other family members if possible)***

Pregnant woman: Let me call my mother-in-law…

END OF ROLE PLAY

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II. SKILLS FOR ASKING AND LISTENING

a. Ask open-ended questions
b. Use 'body language' to show that you are listening to the family
c. Show that you are listening by reflecting back
d. Empathize with how the person is feeling
e. Avoid words that sound judging

a. Ask open-ended questions

Asking questions is important to learn about the family's situation so that you provide information based on what the family already knows and is doing or thinking about doing.

Read the following two questions:/

- Are you giving only breast milk to your baby?
- Please tell me how you are feeding your baby.

The first question is answered with a yes or no. Such questions **are called 'closed-ended questions.'** Closed-ended questions are good for getting specific information, such as whether the mother has had any children previously.

The second question is answered with a longer description **and are called 'open-ended questions.' Such** Questions are asked when you want to understand a situation or learn more about something. They usually start with "How do you….", "Please tell me about….", "Please describe…", "What are the….", and "Why do you…".

Open-ended questions are better to explore the family's situation of what they already know and are doing. The CHW can then build on this information while counselling them instead of talking to them as if they did not know anything. Open-ended questions are more likely to identify harmful beliefs than closed- ended questions.

When you ask questions, be aware of the following:

- Disclosure issues amongst the family.
- Sensitive or possibly sensitive topics (for example, anything related to HIV or HIV testing, the female body, sexual behaviour, family problems).
- That the woman may be afraid to answer some questions or discuss some issues in front of others.

b. Use 'body language' to show that you are listening to the family

- Show that you are listening even without saying anything by using 'body language'.
- Sit squarely to the person you are listening to.
- Lean slightly towards the person to demonstrate interest in what they are saying.
- Maintain eye contact as appropriate.
- Look relaxed and open, show you are at ease with them - arms should not

be crossed.

- Do not rush or act as if you are in a hurry
- Use gestures, such as nodding and smiling, or saying ‘mmm’ or ‘ah’

c. Show that you are listening by reflecting back what the woman or family member said

Responding to the woman by reflecting back will encourage the woman to continue to talk to you. When a person states how they are feeling (afraid, worried, happy etc.), let them know that you hear them by **repeating it**. An example would be ‘so you say you are worried’.

For example, if a mother says, "My baby was crying too much last night."

You could say, "He was crying a lot?"

d. Empathize with how the person is feeling

Show that you understand what the person feels by putting yourself in their place and thinking of how they feel in that situation. Empathizing builds trust. If a mother says, “I am tired all the time now,” a response showing empathy would be ‘‘you are feeling tired, that must be difficult for you.’ Another example:

CHW: How is breastfeeding going on?

Mother: He is suckling well and I am happy.

CHW: You must feel pleased that it is going so well.

e. **Avoid words that sound judging**

Judging words are words like: right, wrong, well, badly, good, enough, properly. If you use judging words when you talk to a mother about breastfeeding, especially when you ask questions, you may make her feel that she is wrong, or that there is something wrong with the baby.

For example:

Do not say: "Does the baby sleep enough?"

Instead say: "How is the baby sleeping?" (open-ended question with no judging words).

III. SKILLS FOR GIVING RELEVANT INFORMATION

a) Accept or acknowledge what the woman thinks or feels.
b) Give a little relevant information.
c) Tell a story.
d) Make suggestions instead of commands.
e) Give information in short sentences and use simple language.

a) **Accept or acknowledge what the woman thinks or feels**

Sometimes a mother says something that you do not agree with because of your knowledge about good practices. At times, a mother may feel very upset about something that you know is not a serious problem.

It is important not to disagree with a woman or family member. On the other hand, it is also important not to agree with a mistaken idea. Instead, accept what the woman thinks or feels. Accepting means responding in a neutral way, and not agreeing or disagreeing.

For example

The `mother' says (in tears):

"It is terrible! Mabvuto is having difficulties breastfeeding. He just cries and I don't know what to do!"

Which of the following is the most appropriate response?

(Response 1)"Don't worry -- your baby is doing very well"

(Response 2)"You are upset about Mabvuto, aren't you?"

(Response 3)"Yes, this could be dangerous

Why did you not come to me earlier?"

b. Give a little, relevant information at a time.

By asking questions and listening, you can identify the family's stage of adopting a behaviour: Unaware, thinking about it, trying, or maintaining. Then you can decide the type of information that is relevant for each stage.

c. Tell a story

Tell a story to give information without seeming like you are giving instructions**.** Many of the counselling cards that you will use will ask you to tell a story. By telling a story of how a family was successful in caring for a pregnant mother and a healthy baby, you can describe the behaviours that you want the families to adopt and the benefits.

d. Make suggestions instead of commands: Have you considered….?; Would it be possible…? What about trying….?

For example: A command was phrased, "You better save money to pay for a facility delivery." A suggestion could be phrased, "Would it be possible to put aside a little money each week during your pregnancy, so that you could pay the expenses of a facility delivery?"

e. Give information in short sentences and use simple language

Use short sentences because they are usually easier to follow and understand. Do not use technical words. Use simple words.

An example using suggestions, short sentences and simple language would be:

"You may find that eating more when you are pregnant gives you more energy. It will also help the baby to grow."

IV. SKILLS FOR CHECKING UNDERSTANDING AND SOLVING PROBLEMS

a) Use open-ended questions.
b) Discuss what the family plans to do.
c) Together try to solve any problems.
d) Praise when appropriate.

a) Use open-ended questions

Have the mother or family members repeat what needs to be done in her/their own words. This gives you feedback – **that they understand what you have said and what they remember**. This is very important to ensure that they have understood what needs to be done. If necessary, repeat your advice in a different way.

b. Discuss what the family plans to do

This is perhaps the most important part of the counselling process. Encourage the family to tell you **what they plan to do** about the behaviours you have talked about. (Do not assume they will do what you have said.) Encourage them to tell you if they have any concerns or problems. Praise the family for doing so.

c. Together, try to solve any problem the family has in adopting a behaviour.

Only if they tell you their concerns or problems, discuss what they can be done to arrive at a solution that will be relevant for them.

d. Praise when appropriate

Praise the mother and family if they are doing something well or if they have understood correctly. Praising the family for this will strengthen their confidence to maintain the beneficial behaviour and to adopt other beneficial behaviours. However, be sure that praise is genuine. You can always find something to praise.

Praise can be given throughout the counselling process when appropriate.

Example:

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

CHW: It was very good that you called me so quickly because you were concerned

about the baby.

DEMONSTRATION ROLE PLAY: Using good communication skills

*** * ***

ROLE PLAY SCRIPT:

Using Counselling Cards during pregnancy: Communication skills

(This role-play takes place during the first visit during pregnancy)

GREET AND BUILD GOOD RELATIONS

CHW: Hello Mara. How are you? I can see you are growing.

(Greets, smiles and makes eye contact)

Mara I am fine.

CHW: I have come to visit you since you are pregnant and that is now part of the work I do. ***(Explaining reason for visit)***

Mara: You are welcome.

ASK QUESTIONS AND LISTEN TO UNDERSTAND THE SITUATION

CHW: Mara, have you been to the clinic yet?

Mara: Not yet, I think it is still too early.

CHW: Oh, but it is very important to start early. I have something to show you ***(Brings out First pregnancy Visit Card***

1: Promote Early Antenatal Care,)

What do you see in this picture? ***(Uses visual aids appropriately)***

Mara: Let us see… a pregnant woman is walking towards a clinic. Here she is taking an injection ***(CHW says hmm shows she is listening)*** **….**and here she is taking some pills.

CHW: Yes, that is right. Good.

Mara: But I don't understand why she is getting an injection?

CHW: The injection is to protect the mother and child from tetanus, which can kill. It is important that a pregnant mother gets at least 2 shots during pregnancy. That is why it is important to start early.

Mara: Really? Okay. I remember my sister took those tablets but she was very nauseous.

CHW: That is a very normal reaction ***(Acknowledges feelings)***.

It is best to take the pills with meals before bedtime or with citrus or lemonade. If there are any problems with the tablets, you can always call me and we can discuss it further.

GIVE ADVICE AND CHECK UNDERSTANDING

CHW: If you start these check-ups early, the doctor or midwife can check for any other problems. It is advised that the pregnant mother should have at least 8 check-ups during her pregnancy. In case there is high blood pressure or other problems, the doctor or the nurse can take care of them, because they are dangerous to both the mother and the baby.

Mara: Okay

CHW: Yes, it is very important. Mara, do women in your family go for check-ups during pregnancy? ***(Asks to find out where the family is in adopting the behaviour of going for ANC)***

Mara: Most of them go. I went one or two times with my last pregnancy. Now I know it is important.

CHW: Very, very important. So now that you are pregnant again what will you do? ***(Asks open-ended question to check what she understands and will do now)***

Mara: I will definitely go for the antenatal check-ups…. I will start this week.

CHW: That is really good. ***(Praises)***

CHW: Mara, let me ask you a question…. have you gone for an HIV test? ***(Deals with a sensitive and personal issue carefully)***

Mara: No, not yet.

CHW: Why not? ***(Ask about concerns or problems)***

Mara: I am afraid that if I turn out to have HIV the other women will not talk to me.

CHW: I understand how you are feeling, ***(empathizing)*** there are many women in the same situation as you. But don't be afraid. Our government is encouraging everyone to come out openly and talk about this disease. ***(Body language shows caring)*** If you go for this test, the doctor will be able to take care of both you and the baby. Do you know that the virus can be passed from the mother to the baby during pregnancy, delivery, and breastfeeding?

Mara: Really?

CHW: Yes. So if the test shows that you have HIV, they can give you ARVs to keep you healthy, protect the baby from HIV, and protect your partner. They will also give you advice. So you see it is very important. So Mara, what will you do? ***(Asks open- ended question)***

Mara: So, I will ask my husband and go for an HIV test this week.

CHW: That is excellent Mara! ***(Encourages)*** I will visit you again two months before delivery to

see how you are doing ***(schedules the next visit)***

Mara: You can come as many times as you want. Go well.

END OF ROLE PLAY

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SESSION 4

MAINSTREAMING GENDER IN CBMNC

Learning Outcomes

By the end of the session, you should be able to:

- Define key gender concepts.
- Discuss the effects of gender-based violence in maternal and neonatal health.
- Explain the impact of gender sensitive approaches.
- Explain ways in which gender equality can be integrated in community health work.
- Mention key messages in relation to gender and MNCH.

UNDERSTANDING GENDER CONCEPTS

Gender: refers to the social interpretations and values given to being a woman, man, boy or girl. More specifically, it refers to roles, behaviours, attitudes and responsibilities that are encouraged in males and females by society. Gender is learned through a process called socialization.

Sex: refers to the biological differences between women and men. It mainly refers to the genetic, physiological and biological characteristics that determine whether a person is male or female.

Differences between sex and gender

SEX	GENDER
Biological	Cultural
Given by birth	Learned through socialization process
Universal	Varies from culture to culture

Note: Though sex is given by birth, it can be changed through surgical intervention.

Gender issue: refers to a situation when inequality and differences exist between men and women, boys and girls purely based on being male or female. It is an issue when a grievance is felt by one sex that their needs are not being met or there is unfair treatment

Gender sensitive: to be aware of the differences between men's and women's needs, roles, responsibilities and constraints and being able to take action to address these issues

Gender responsiveness: Being able to respond to perceived needs of women and men. This means taking into consideration the impact of policies, legislation and programs on women, men, girls and boys

Ensuring that gender equity and equality are maintained within the programs and project

Gender Blindness: The inability to perceive that there are different gender roles, responsibilities and gender-based hierarchy

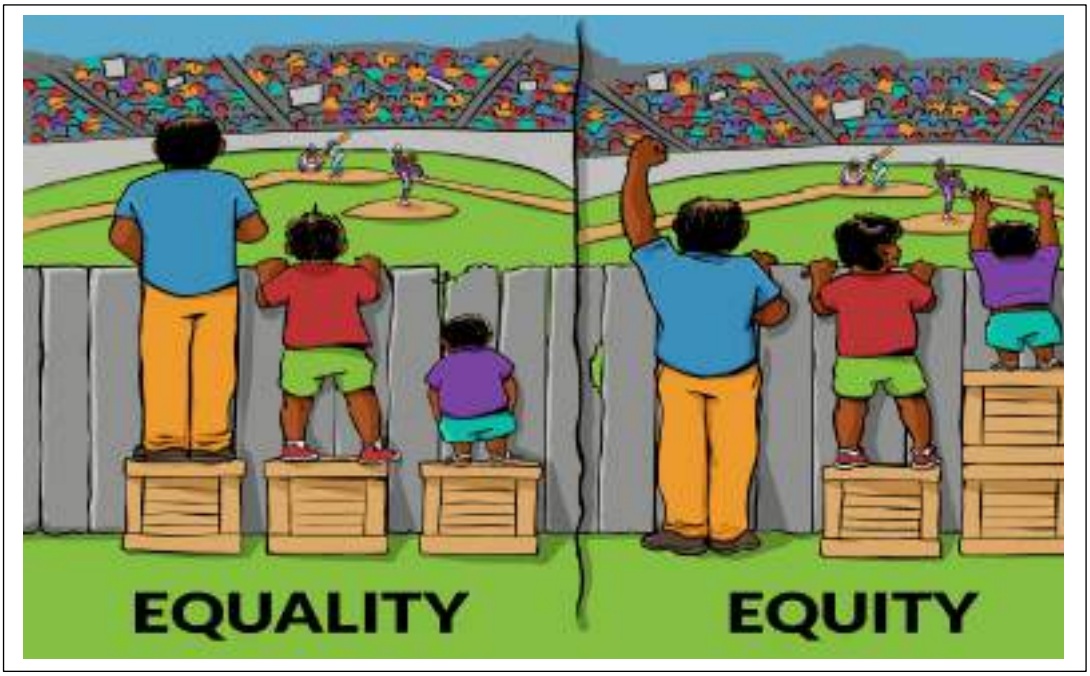
A lack of recognition that gender is an essential determinant of the life choices available to one in society and consequently the failure to realize that policies, programs, budgets and projects can have different impacts on women and men

Empowerment: The process of building capacities to enable women, men, girls and boys to exercise control over their own lives. Gives ability to an individual to gain self- confidence and take control of one's life. It involves giving power, to enable someone do certain things for example, the provision of education, training and provision of loans.

Gender equality: means having equal access to resources, opportunities and services, ownership of and control over assets. This means that having the same status, rights and responsibilities for women, men, girls and boys. It is based on the idea that no individual should be less privileged in opportunities or in human rights. It involves the identification and removal of underlying causes of discrimination in order to give everyone a chance.

Gender equity: It is the process of being fair to women and men. It means being socially just and impartial through fair distribution of benefits and resources. There is need to make processes fair for both men and women (gender equity) to promote gender equality. To ensure fairness, measures must often be available to compensate for historical and social disadvantages that prevent women and men from enjoying the same rights.

Example:



Gender based violence

It refers to any unlawful act perpetrated by a person against another person on the basis of their sex that causes suffering on the part of the victim and results in, among others, physical, psychological and emotional harm and economic deprivation".

Effects of gender-based violence in maternal and newborn health

- Gender based violence leads to poor reproductive maternal and child health outcomes that includes Miscarriage, Late antenatal care, Stillbirth, obstetric fistula, hemorrhage, depression, disability and death.
- Child marriage and early child bearing
- Disproportional distribution of domestic work on women and girls
- High rates of mobility
- Lack of decision-making at the household level to seek MNCH information and services independently this may also result in more children in a household
- Lack of access to and control over financial resources
- Low participation in birth preparedness planning
- Low participation and support to women and girls over the MNCH continuum of care
- Men having large portion of nutritious food
- Restrictions of some nutritious food during pregnancy.

IMPACT OF GENDER SENSITIVE APPROACHES IN CBMNC

- Better health programming & service provision Equitable leadership & governance
- More effective health promotion & prevention
- Empowered communities
- Better health outcome

NOTE: Low educational status, inadequate knowledge of MNCH and inability to access MNCH information has impact on Gender-based Approaches in Community Health

INTEGRATING GENDER EQUALITY IN COMMUNITY HEALTH WORK

There are four categories of integrating gender in programs or activities that are gender unaware, gender neutral, gender aware and gender transformative.

Four Gender Equality Categories

Gender Unaware: do not recognize gender issues, and tend to encourage gender inequalities

Gender Neutral: recognizes gender issues but do not do anything about them, and so tend to reinforce gender inequalities

- **Gender Aware:** seeks to improve the daily condition of women and girls by reducing barriers based on existing role expectations. They do not try to transform gender relations such as engaging men in MNCH
- **Gender Transformative:** involves improving women and girls' access to MNCH services by addressing gender norms that devalue men and boys' sharing of responsibility and partnership in gender equality and MNCH promotion. In other words, also engages with boys and men.

EXERCISE

To which category of **Gender Equality** do these scenarios fall under?

1. A CHW who has been trained in gender responsive CBMNC conducts a home visit and does not enquire about the pregnant woman's male partner and does not engage them during the home visits -
2. A CHW enquires about male partner and engages them during home visit highlighting the importance of joint decision making for mother and father in planning for birth, father taking part in household chores and keeping baby warm
3. CHW discovers that some women are not able to attend awareness meeting they call for because gender norms in the community prevent women from travelling alone. By accounting for this norm, the CHW adjusts when and where to conduct meetings with the women so that they may be able to access and benefit from it

How to integrate gender equality in community health work.

- Striving to be gender aware at the least and gender transformative where possible.
- Consider how gender-related barriers and issues may cause vulnerability, risk and disadvantage for women, adolescent girls, men and adolescent boys, particularly paying attention to the most vulnerable and marginalized. These barriers affect their capacity to seek health care services in MNCH/SRH and their opportunities to access them, including information
- Ensure that whatever actions undertaken as CHW do not bring harm or risks or negative consequences ('Do no harm principle') to women, men, girls and boys in the community
- Be sensitive to the particular barriers women and girls face.
- Consider the differences between women, adolescent girls, men and adolescent boys. They are not all the same. (E.g., there are married and unmarried adolescent girls, first time parents etc.)
- Ensure that home visits, community dialogues and/or information sessions take into account the different needs, priorities and concerns of women and adolescent girls
- Recognize the influence men have over the lives of women and children in families and communities and engage both men and women as productive and supportive partners in promoting health care.
- Recognize the influence of other socially respected male and female leaders such as religious leaders or certain traditional female influencers and engage them as productive and supportive partners in promoting gender equality and MNCH/SRH.
- Challenge prevailing discriminatory attitudes, behaviours and assumptions
- Act as a good role model and lead by example.
- Influence and inform male/female clients on gender equality and gender issues in MNCH.
- Empower men/boys and women/girls to bring about change for equality.

IMPORTANCE OF MALE INVOLVEMENT IN CBMNC

- Increases usage of pre-and post-natal attendance and skilled birth attendants at birth
- Contributes to less physical and emotional distress during labour and delivery
- It increases breastfeeding
- It increases child development outcomes
- Increases household income with increased women's economic participation and increases health and well-being of families
- It improves the health and well-being of men themselves: more productive at work; less likelihood of substance abuses and more satisfaction and happiness.
- It improves quality of care

ENGAGING ADOLESCENTS IN MNH

- Go to where they spend time
- Provide informational material using a language, format and comprehension level appropriate to adolescents.
- Avoid mixing groups of girls and boys when speaking about sensitive topics; only bring them together when they are ready for such dialogue.
- Ensure that adolescents are involved in the development of messaging material and bi laws. Ensure privacy, confidentiality, non-discrimination and non-judgmental attitudes.
- Suspend any gender and or age biases. It is recommended never to mix married and unmarried adolescent girls in one dialogue group, because their issues are not the same

Key Messages in relation to gender and MNH

- Gender-based discrimination, injustice including child marriages, unfair treatment, and loss of opportunities to advance in life just because one is born a female, violate the fundamental and universal right to equality between women/girls and men/boys. Moreover, that families and societies are more productive and prosperous when they reap the full potential and talents of all. The emphasis being that gender equality is not a 'women's concern' but the responsibility of all in society, as all benefit from it.
- Women and girls face additional gender-based barriers, i.e. lack of access and control of financial resources; may be constrained in their mobility by dominant gender norms and this contributes to delays in accessing timely appropriate MNH services for themselves and their babies.
- There is an unavoidable connection between the wellbeing of mothers and their babies. Healthy, empowered women and mothers are essential if we are to realize the rights of women and babies to health.
- Support gender equality and value the rights of women and babies.
- There should be equal responsibility of men and women in family health and MNH, ensuring that the stereotype of MNCH being a women's issue is addressed
- Women and girls with disabilities face significant challenges from family and society in every sphere of reproductive lives including pregnancy, childbirth and motherhood.
- This group of people is often abused in all forms and is missed in sexual reproductive health services.

- There is a need for CHW to raise awareness and improve advocacy to mitigate misconceptions about disability and promote disabled women ‘s sexual and reproductive rights
- CHWs are therefore encouraged to conduct home visits to all disabled women and involve other family members for support during pregnancy, delivery and postnatal period. They should also be assisted to access family planning methods.

SESSION 5

IDENTIFYING PREGNANT WOMEN IN THE COMMUNITY

Learning Outcomes

By the end of this session, you should be able to:

- Explain why it is important to identify pregnant women early in pregnancy.
- Describe ways in which you will identify pregnant women in your community
- Demonstrate ability to compile a list of names of pregnant women in the register.

Importance of identifying all pregnant women in the community during their first trimester

All mothers and newborns are vulnerable and need care. Often, the ones who are missed are the most vulnerable and at risk of illness and death. Therefore, it is important to identify women early in pregnancy because:

- The sooner a woman goes for antenatal care (ANC), the sooner she can be examined and given important medicine and advice.
- Families need time to prepare for birth: to save money for transport and any costs and to gather supplies (cloths for drying and warmth, etc.). The CHW needs to visit the pregnant woman two times during Pregnancy.

THE STORY OF SELINA

Selina is a CHW. One of her tasks is to identify all pregnant women in a catchment area and visit them during pregnancy.

In order to do her work Selina had to know and plan on how she could identify all pregnant women in her catchment area.

To help her decide how to get this information, she called a few people in the catchment area. The team composed of the head teacher, midwife from the health centre, religious leaders and village headmen.

She explained about identification of pregnant women in the community.

The school head teacher suggested that Selina could visit every household every few months and ask if anyone was pregnant. He also said that when he sees a pregnant woman at the school, he would ask if the CHW has already visited, and if not he will inform Selina. The village headman suggested that at the next village meeting, Selina should explain her work, and ask all families to inform her as soon as anyone becomes pregnant. The midwife said that every month when Selina comes to the health centre or when she goes to the community for outreach

activities, they can discuss who is newly pregnant in the catchment area. The religious leaders promised to report to Selina if anyone reports to them about their pregnancy

Selina's plan to identify pregnant women:

1. To visit all the households every three months and update list of women of childbearing age and in the process identify if anyone is pregnant.
2. To work with existing community structures such as community health volunteers, secrete mothers, religious leaders, local leaders and marriage counselors to inform her of any new pregnancies in the community.
3. To work with the midwife or nurse at the health centre to identify all pregnant women in the community early in their pregnancies.
4. To ask other people in the community, such as the school head teacher to let her know if someone is pregnant.
5. To establish a system to encourage self-reporting on new pregnancy to her.

Once the CHW knows someone is pregnant, she/he needs to visit the house of the woman in order to either make the first pregnancy visit or schedule a time to do so. She should also fill in the CBMNC CHW Register.

EXAMPLE: Completing list of pregnant women in the CBMNC Register

Today the CHW learnt that Maria Phiri is pregnant. She is 22 years old, from *Katsekaminga* village near Catholic Church.

Look at the entries written on the list of pregnant women on the next page to see how the CHW listed Maria Phiri and recorded her information.

LIST OF PREGNANT WOMEN

EXERCISE: Completing List of Pregnant Women in CBMNC register

No	Name of pregnant woman	Age	Address
1	Maria Phiri	22	Katsekaminga village, near Catholic Church
2			
3			

LIST OF PREGNANT WOMEN

In your CBMNC Register, write your name.

Enter the information for Maria Phiri on first row in the register.

1. The CHW identified Mary Luo who is pregnant, aged 21, physical address *Madeya* village near *kapalamula* primary school. Enter her information in the register.

2. The CHW learnt that Grace Matumba was pregnant and went to verify with her. She is 24 years old and her physical address is *katsekaminga* Village near mosque. Enter the information in the register.

SESSION 6

PROMOTE EARLY ANTENATAL CARE.

Learning Outcomes

By the end of this session, you should be able to:

- Explain why pregnant women should attend antenatal care early in pregnancy and the care they are expected to receive
- Explain why it is important for the woman to know her HIV status
- Discuss how many antenatal contacts are recommended.
- Explain the reasons why some women do not attend antenatal care
- Help families solve problems in attending antenatal care

Overview of care given during antenatal contacts.

- History taking
- Screening of the pregnant woman (checking blood pressure, weight, etc.)
- Provision of Iron and folic acid tablets to prevent anemia.
- Provision of at least 2 doses of Tetanus Diphtheria Vaccine (TDV) to prevent tetanus.
- Supply of long-lasting insecticide-treated bed nets and intermittent preventive treatment of malaria.
- Provide advice on home care for the pregnant woman to ensure the baby grows well.
- Educate the family about danger signs and the importance of early health care seeking behaviour.
- Testing for infections such as HIV, STIs, and TB, and giving treatment and care if needed
- Checking of blood group and amount of blood
- Educate the family on birth preparedness i.e. facility delivery, companion, transport, blood donor and national identity card, names of babies.

Importance of early antenatal care

- Maintenance of health of mother during pregnancy.
- Promote physical, mental and social wellbeing of mother and baby.
- Early detection of high-risk cases and minimize risks by taking appropriate management.
- Prevent development of complications.
- Screening for conditions and diseases.
- Teach the family about childcare, nutrition, sanitation and hygiene.
- Ensure continued medical surveillance and prophylaxis.
- Advise the family about breast-feeding, post-natal care and immunization.
- Advise on family planning and motivate the couple about the need of family planning.
- Provide information on pregnancy and birth and discuss with the couple about the place, time

and mode of the delivery provisionally and care of the new born.

Importance of a pregnant woman knowing her HIV status

If a woman knows her HIV status, she can receive appropriate advice and counselling to decide how best to care for herself. If she does not have HIV, she can learn how to protect herself from HIV. If she has HIV, she can be given advice and treatment to keep herself healthy and to protect her baby and her partner from HIV.

Antenatal Care Contacts

The number of antenatal care contact recommended is eight. The schedule is as follows:

Contact number	Gestation age
1	Up to 12 weeks
2	20 weeks
3	26 weeks
4	30 weeks
5	34 weeks
6	36 weeks
7	38 weeks
8	40 weeks

NB: for those who started ANC within 12 weeks should have an additional visit at 13 to 16 weeks to receive IPTp-SP dose1.

Reasons for not attending antenatal care.

- Do not see the need to go for antenatal care
- Distance to clinic
- Hidden costs
- Poor attitude of the health care workers
- Medicines, equipment or tests not available at the health facility
- Too much work to do at home
- No one to look after the home
- Cultural and religious beliefs

For each possible reason in your community, try to understand the problem and how you could help overcome the problem. Some solutions are listed below.

- Discuss the importance of attending antenatal care with husband and other family members:
- Have other family members do some of the work on clinic days
- Discussing 'poor attitude of health facility staff with supervisor who may be able to talk to them

NOTE: Although the CHW will be visiting each pregnant woman in her area 2 times during pregnancy, the CHW does not provide antenatal care during the visit. ANC is provided at the health facility or through outreach clinics.

DEMONSTRATION ROLE PLAY: How to use First Home Visit During Pregnancy Card 1: Promote Early Antenatal Care.

Monica, the CHW found out that Taziona was pregnant a few days earlier. She had been visiting all the houses in the village trying to identify pregnant women, and when she got to Taziona's house, she learned she was pregnant. At that time, it was agreed that Monica could return today to visit Taziona and carry out the first home visit during pregnancy.

Observe the interaction. This role-play will not show a complete visit, but only the greeting and using Card 1.

***

ROLE PLAY SCRIPT:

Be prepared to discuss the following after the role-play:

- How did the community health worker greet Taziona?
- How did you know that she was listening?
- How did the CHW use the card?
- How did the CHW use her knowledge of how behaviour changes?

First Pregnancy Home Visit Card 1: Promote Antenatal Care

GREET THE FAMILY

CHW: Hello, Taziona, are you home?

Taziona: Hello Monica. Welcome.

CHW: Thank you. How are you and the family? Feeling alright? ***(Smiles and looks at her)***

Taziona: Oh, yes. I get tired more easily than before I was pregnant but otherwise, I feel fine.

CHW: Yes, that is normal, and I am glad you feel fine otherwise, getting tired more easily can happen when pregnant ***(Reflecting feelings)***.

EXPLAIN THE VISIT

CHW: As I said the other day, part of my responsibility is to visit pregnant women and discuss what you can do to make sure you and the baby are healthy.

Taziona: (*Nods)* I was looking forward to your visit.

CHW: Remember as I said last time, whatever we discuss will be kept confidential.

Taziona: Yes, I remember that.

CHW: (*Opens counselling cards on First Pregnancy*

Home Visit Card 1 and has the illustrations facing Taziona***)***

ASK AND LISTEN TO UNDERSTAND THE SITUATION

CHW: Taziona, do you have other children?

Taziona: Yes, I have two other children.

CHW: Did you attend the clinic with your other pregnancies?

Taziona: Yes, I went once with my last baby, but not with the first one.

CHW: Have you been to antenatal care for this pregnancy?

Taziona: Not with this baby. I plan to go when I am further along.

CHW: I am glad to hear you are planning to go. I suggest you go there early in pregnancy so you can begin receiving the necessary care right away. I am going to tell you a story about a woman named Abena, who had a very healthy baby. First, what do you see in these pictures?

Taziona: I see a clinic and the health worker is examining a pregnant woman. Here she is getting an injection, here there are some tablets, and here she is getting something, I think it may be a bed net. In this picture, it looks like the health worker is pricking her finger.

TELL THE STORY OF ABENA AND ADAPT ADVICE ACCORDINGLY

CHW: Yes, that is right. Abena went to the clinic so she could be checked by the midwife because she knew that check-ups were important to make sure she and the baby were healthy throughout the pregnancy. The first time she went, which was early in her pregnancy, they gave Abena an injection against tetanus, screened her for TB and syphilis, and they checked her for any problems. They gave her iron and folic acid tablets to prevent anaemia.

Taziona: hmmm

CHW: Abena received a long-lasting insecticide-treated bed net. Abena also received SP which she took to prevent her from getting malaria.

Lastly, Abena agreed to get a test for HIV. It is important to test for HIV because if a woman has it, she can receive ARVs to keep her healthy, to prevent HIV from passing to the baby, and to protect her partner.

Taziona: I didn't know that. How many times did you say she went to the clinic?

CHW: Abena went eight times for antenatal care. It is important to go back because in the subsequent visits they check for any problems that may have come up, and help you prepare a birth plan. The 8th visit is usually a few weeks before delivery and includes checking to make sure the baby is in a good position for the delivery. You will be tested again for HIV if you did not have HIV on the first visit.

Taziona: I have learnt a lot from you.

CHECK UNDERSTANDING AND SOLVE ANY PROBLEMS

CHW: Good. Can you tell me what you understood from our discussion?

Taziona: Yes, I should go early for antenatal care because I will be examined and receive medicines and information. I will be tested for HIV, and I should go at least 8 times like Abena.

CHW: That is excellent. Now that you know these things, what are your plans about antenatal care?

Taziona: I will discuss with my husband when he gets back from the fields. I will go to the clinic in the next day or so, because now I know how important it is.

CHW: Very good. Now let us talk about the baby's birth.

END OF ROLE PLAY

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SESSION 7

HUMAN IMMUNODEFICIENCY VIRUS (HIV) AND TUBERCULOSIS (TB)

Learning Outcomes

By the end of this session, you should be able to:

- Explain how HIV is transmitted.
- Explain how HIV can be prevented.
- Explain the benefits of knowing HIV status and taking ARVs for the HIV positive pregnant woman and her baby.
- Explain the HIV testing process.
- Explain how TB is transmitted.
- Explain how TB can be prevented.
- Explain who should be referred to a Health facility for TB screening.
- Explain the roles of a CHW in improving the health and survival of pregnant women and newborns related to HIV and TB.

7.1. HIV

HIV transmission

HIV is a viral infection. Transmission may occur through:

- Unprotected sex with a person who has HIV.
- Sharing of needles or blades (e.g. ear piercing, needle prick injury or between intravenous drug users).
- From a mother who has HIV to her baby during:
  - pregnancy
  - labour and delivery
  - breastfeeding

HIV cannot be transmitted by:

- Touching or hugging a person who has HIV.
- Using the same eating utensils with a person who has HIV.
- Using the same toilet or chair with a person who has HIV.
- Mosquito bite.

Preventing transmission of HIV

- Consistent and correct use of condoms (male or female) will prevent transmission of HIV and other infections during sexual contact. Condoms must be used from pregnancy up until the child stops breast-feeding.
- Women using other Family Planning methods should also practice dual protection by using condoms in addition to the contraceptive.
- ARVs can prevent HIV transmission from mothers to their babies and to their partners. ARVs are available in all certified health facilities.
- Pre-Exposure prophylaxis (PrEP) is defined as the use of antiretroviral drugs by HIV-negative people that are at substantial risk of acquiring HIV before potential exposure to HIV to prevent HIV acquisition
- Pregnant women or breastfeeding woman falls under the category of such high-risk groups of people if she
    - Has Sexually transmitted infections.
    - Is a sero discordant couple. Offer PrEP if HIV negative woman is pregnant or breastfeeding or HIV positive sexually partner is:
        - Not on ART
        - On ART less than 6 months
        - With unsuppressed or high viral load
        - Is none adherent to antiretroviral treatment
- Providing PrEP during pregnancy or breastfeeding period, reduces the risk of HIV transmission to HIV negative pregnant or breastfeeding woman. It also reduces anxiety about HIV transmission at times when couples are not always using condoms to prevent HIV transmission. This will eventually reduce the risk of HIV transmission to the baby during the perinatal or breastfeeding period

Benefits of knowing HIV status

- It is important that every pregnant woman has an HIV test to know her HIV status, so that she can know how best to protect herself and her baby.
- If she has HIV, she should take ARVs every day for life to prevent transmission of HIV to her baby and to improve her own health.

HIV Testing Process

- Trained personnel in maternal and child health services, maternity departments and in the community provide HIV testing and Counseling.
- HIV testing and Counseling:
    - Is done with privacy and confidentiality.
    - Blood is drawn from the finger prick and tested or self-testing using oral specimen.

HIV test results are ready after 15 - 20 minutes and given or read immediately by the woman or couple during post-test Counseling.

NOTE: every pregnant woman should re-test for HIV before delivery, after delivery (before

discharge) and during breastfeeding to check that she still does not have HIV. If at any time the woman tests positive, she should start taking ARVs right away.

7.2. TB

TB Transmission

- TB is spread from person to person through the air.
- If a person has TB of the lung and they cough, sneeze or spit, the TB germs are propelled into the air.
- If a person inhales these germs, they will be infected with TB.

Prevention of TB

- All newborn babies should receive BCG vaccination at birth.
- The exception is when the baby is sick, or the mother has TB or has been taking TB treatment for less than 2 months.
- Ensure proper coverage of mouth during coughing and sneezing inside the elbow and spitting in a bottle and cover it well.
- People who have cough for more than 2 weeks should go to the health facility to be screened for TB. If they have TB, they will be started on TB treatment right away. After 2 weeks on treatment, they will no longer transmit TB germs to their family members and others. However, treatment needs to continue until completed.
- If someone in the household has TB, make sure rooms in the home are well ventilated.
- A person who lives in the same household with someone who has TB is exposed to TB. People who are exposed to TB, especially young children, or people who have HIV, should be referred to the health facility to be screened for TB.
- Children less than 5 years, if they do not have TB, they are given isoniazid preventive therapy (IPT) for 6 months to prevent development of TB disease. IPT can also be given for protection in HIV positive people, irrespective of age.

Risks for transmission of HIV and TB to babies during pregnancy, labour, delivery and while breastfeeding

- Exposed babies are much more likely to get HIV if their mothers are not receiving ARVs.
- A pregnant mother who has HIV and TB has an increased chance of passing HIV to her baby.
- A mother who has HIV and TB has an increased risk of having a small baby or even death of the baby or the mother herself.
- A newborn baby is at risk of contracting TB if the mother has TB.
- Infants who are exposed to TB in the household are at higher risk of becoming seriously

ill and dying from TB than older children and adults.

1. **GIVE RELEVANT INFORMATION:** ***Risks for babies during pregnancy, delivery and while breastfeeding***

Read together:

Roles of a Community Health Worker in HIV or TB settings

During pregnancy home visits
The CHW should: ● Encourage the pregnant woman and her partner to be tested for HIV. They do not have to tell you their HIV status. It is important that they know it, so that they can receive advice, counselling, and if needed, treatment to prevent or treat HIV infection. ● Encourage her to tell her partner her HIV status and encourage him to test for HIV. ● Encourage the mother to have at least eight antenatal contacts at the health facility. ● Encourage the family to give birth at a health facility.

Encourage a pregnant woman **who does <u>not</u> have HIV** to:	Encourage a pregnant woman **who <u>has HIV</u> to:**
• Go for antenatal care and be screened for TB at the health facility. • Practice safe sex by using condoms to protect her and her baby from HIV and other infections during pregnancy and until the baby stops breastfeeding • Test for HIV again before delivery, during labour / before discharge and during breastfeeding.	• Go for antenatal care and be screened for TB at the health facility. • Take ARVs provided by the health facility to keep her well, to protect her baby from HIV, and to protect her partner. She should take the ARVs at the same time every day. • Practice safe sex by using condoms to protect her and her baby from HIV and any STI. • Take her ARVs for life, once initiated. • Take her ARVs with her when she goes to the health facility for birth. • Give the baby ARV prophylaxis immediately after birth.
During postnatal home visits	

If the mother **does <u>not</u> have HIV**, the CHW should encourage her to: ● Go to the postnatal care clinic for a check-up and be screened for TB and other infections after 1 week. ● Practice safe sex by using condoms and use family planning method to prevent unwanted pregnancy. ● Test again for HIV during breastfeeding. ● Take the baby to the health facility at 6 weeks for a check-up and vaccines. If the mother is below 20 years of age, ask her family to give her extra support, especially breastfeeding. **The CHW should also:** ● Check whether the baby was given BCG vaccine after birth. If not, refer to the health facility ● Ask the mother if she had TB while she was pregnant, or lives in the household with anyone on TB treatment. If concerned that the newborn was exposed to TB, refer to health facility ● Ask the mother to take the baby to the health facility anytime that anyone in the household starts treatment for TB. Also ask her to send anyone in the household who has coughed for more than 2 weeks for TB screening	If the mother **has <u>HIV</u>**, the HSA should do all the tasks to the left (except encouraging re-testing for HIV) **and:** ● Check that the mother takes her ARVs at the same time every day. ● The ARVs keep the woman well, protect the baby from HIV, and protect her partner. ● Check that the mother is giving the baby the ARV syrup at the same time every day for 6 weeks to protect the baby from HIV. (, If not, help to solve any problems; refer if necessary. ● If the woman is a teenager who has HIV, ask the family to give her extra support, especially to breastfeed exclusively, go to the postnatal clinic for care, take her ARVs at the same time every day, and give the baby ARV prophylaxis every day for 6 weeks. ● Remind the mother to take the baby to the health facility at 6 weeks for his/her first HIV test and to begin taking cotrimoxazole to prevent pneumonia. ● Explain that if the baby does not have HIV, she should take the baby to the health facility to re-test for HIV at 12 months, 24 months and again 6 months after stopping breastfeeding. ● If, at any time, the baby has HIV, it is important to start the baby on lifelong ARV treatment as soon as possible, so the baby does not get other serious infections such as diarrhea and pneumonia.

Using Counselling Cards

Have a look at the First home visit during Pregnancy **Card 4: Care of the mother in HIV and TB Setting.**

SESSION 8

MALARIA IN PREGNANCY

Learning Outcomes

At the end of this session, you should be able to:

- Define malaria.
- Explain how malaria is transmitted.
- Explain why pregnant women are at a high risk of malaria.
- List the signs and symptoms of malaria.
- Explain the malaria preventive measures in pregnancy.
- Explain complications of malaria.
- Explain the role of CHWs in prevention of malaria in pregnancy.

Definition of Malaria

Malaria is a life-threatening disease caused by the infection of the red blood cells with protozoan parasites called plasmodium.

Transmission of malaria

The disease is transmitted to people through the bites of infected female anopheles' mosquitoes.

Why pregnant women are at high risk of malaria

A pregnant woman's risk of malaria infection increases due to changes in her hormonal levels and immune system.

Signs and symptoms of malaria

- Fever or history of fever
- Chills
- Sweating
- Headache
- Nausea and vomiting
- General body pains
- Diarrhea
- Convulsions/ fits

Prevention of malaria in pregnancy

- Sleeping under long lasting insecticide treated nets (LLITNs).

- Intermittent Preventive Treatment in pregnancy (IPTp).
- Cutting down tall grasses of the surrounding area.
- Draining all stagnant water.
- Use of mosquito repellent.
- Indoor residual spraying (IRS).

Complications of malaria in pregnancy

- Anemia
- Abortion
- Preterm labour
- Still birth
- Intrauterine growth retardation (IUGR)
- Neonatal malaria
- Cerebral malaria
- Maternal deaths

The role of CHWs in preventing Malaria in pregnancy

As you have learnt, Malaria in pregnancy does not only cause long-term effects to the mother and the baby, but it is also fatal, hence the main role of the CHW is to counsel the pregnant woman on the importance of:

- Early attendance of ANC clinic (during the first trimester)
- Taking SP as given at the facility
- Sleeping under LLITNs everyday
- Early health seeking if she has signs and symptoms of malaria
- The CHW should refer the mother or the newborn if she/he suspects them to have malaria.

SESSION 9

FAMILY PLANNING

Learning Outcomes

By the end of the session, you should be able to:

- Define Family Planning.
- Explain the benefits of family planning.
- 0utline Indications of family planning.
- Outline recommended family planning methods and where to access them.
- Explain Consequences of not practicing family planning.
- Describe roles of Community Health Workers in family planning.

FAMILY PLANNING

Family planning is an informed decision to a mother, youth or couple on when to start bearing children, how many, and at what interval.

BENEFITS OF FAMILY PANNING.

It is essential that family planning providers understand the benefits of family planning in order to assist the community in reducing maternal and neonatal death. some of the benefits are listed in the table below;

To the Child	**To the Mother**
• Improved nutrition • Improved mental health • More parental love and guidance • Well provided with basic needs of life i.e. good food, clothing, education, accommodation and better health care • Grows up feeling secure and confident • Healthy child from healthy mother	• Improved quality of health • Prevention of illegal abortions • Better opportunities for education • Enough time to develop and maintain love bond between mother and child • Happier sexual relationship between husband and wife • She has enough time for involvement in income generating projects • Allows time to keep the home and the family clean • Has chance to express love to husband • Reduces maternal morbidity and mortality
To the Father	**To the Family**

• Ability to allocate resources to every member of his family such as sending children to school, enough food, better house • Free mind therefore is more productive • Has chance to express his love to his wife	• It strengthens relationship and love • Improved economic activities • Increased education opportunities
To the Community	**To the Nation**
• Healthier community • More grazing land • Enough land to cultivate • More recreational facilities • Enough schools and hospitals within everyone's reach • Preserved natural resources	• Low birth weight deliveries are less likely to occur • Healthy nation • Educated nation • Improved economy for the nation • Offers time for government to plan and expand health, education and other services • Reduced infant mortality and morbidity

Indications of family planning

- Any woman of reproductive age regardless of age and parity;
- Breast feeding women less than 6 weeks or more. {postpartum period]
- Women who had an abortion
- Nullipara

FAMILY PLANNING METHODS AVAILABLE IN MALAWI

Long term methods	Short term methods	Permanent methods
• Levoplant – 4 years • Jadelle -5 years • Implanon – 3 years • IUD – 5 to 12 years	• Depo subcutaneous – 3 months • Depo intramuscular – 3 months • progestin-only pills - daily • condoms – daily • combined oral contraceptives • Emergency pills	• Tubal ligation / female sterilization • Vasectomy

NOTE
Family planning Methods are provided at both facility and community levels;

- Trained Clinicians provide permanent methods
- Community midwives and community nurses provide all short term and long term methods
- HSAs provide all short-term FP methods
- CBDAs provide Pills and Condoms only

Postpartum Family Planning,
Postpartum FP is the initiation and use of FP methods during the first year after delivery.

List and Schedule for Postpartum family planning methods

- All methods of contraception are recommended during postpartum family planning, what differs is time of initiation.
- Implants, IUD, progestin-only pills, and condoms can all be offered <48 hours after delivery.
- Tubal ligation / female sterilization should be offered within first 7 days or delay until 4 - 6weeks;
- Injectable (DMPA-IM/SC) at 6 weeks;
- Combined oral contraceptives should be used from 6 months after delivery.

NOTE: IUD should not be inserted between 48 hours and 4 weeks after placental delivery because of high rates of IUD expulsion during that period.

CONSEQUENCES OF NOT PRACTICING FAMILY PLANNING

The consequences/effects are divided into three categories namely, too early, too late and too many which can affect both the mother and child;

Category	Effects on the mother	Effects on the child
Too early - birth occurring in women less than 20 years	They are due to the fact that the mother herself is still growing ● Pregnancy related hypertension ● Obstructed labor ● Traumatic deliveries ● Death	● Still births ● Prematurity
Too late: birth occurring in women of 35 years or older	● Obstructed labor/Ruptured uterus ● Bleeding before delivery ● Severe bleeding after delivery ● Increase in maternal deaths.	● Perinatal deaths ● Increased birth defects ● Increased number of orphans
Too many and too close spaced births	● Bleeding before delivery ● Bleeding after delivery ● Ineffective child care ● Increased in maternal deaths ● Ruptured uterus	● Low resistance to infections ● Prone to contagious diseases due to overcrowding ● Children do not get enough love from the parents.

ROLES OF CHW IN FAMILY PLANNING

- Integrate family planning counselling during home visits in pregnancy and after birth.
- Sensitize individuals and couples on schedules for contraceptive uptake.
- Provision of family planning methods by trained providers only.
- Referring clients to a next level if he/she cannot provide the method or if method is not available.
- Conducting awareness campaigns on all SRH services.

KEY POINTS:

Family planning Methods are provided at both facility and community levels

HSAs provide all short term FP methods

CBDAs provide Pills and Condoms only.

SESSION 10

TEENAGE PREGNANCY

Learning Outcome

By the end of this session you should be able to:

- Define teenage pregnancy
- Explain contributing factors to teenage pregnancy
- Explain problems associated with teenage pregnancy
- Discuss preventive measures to reduce teenage pregnancy

Definition of teenage pregnancy

It is pregnancy in girls or women under the age of 20.

Pregnancy can occur with unprotected sexual contact after the start of ovulation, which can be before the first menstrual period (menarche) but usually occurs after the onset of periods.

Contributing factors to teenage pregnancy

There are many factors that contributes to teenage pregnancies, some of which include;

- Peer pressure and the desire to establish individuality.
- Exposure to sexual content in the media encourages experimentation, which can lead to unintended pregnancies.
- Younger age of menarche, combined with cultural practices like initiation ceremonies, may result in early pregnancy as society treats young girls as adults.
- Lack of education on safe sex and limited access to information on contraception.
- Poor socioeconomic status.
- Substance abuse, including alcohol and drugs.

- Low self-esteem.

Problems associated with teenage pregnancy

1. **Medical problems**
    - High blood pressure
    - Anemia
    - Preterm births
    - Low birth weight
    - Fistula
    - Abortions
    - STI/HIV

2. **Socioeconomic Burden**
    - Rejection by family and community
    - Stigmatization by peers.
    - Dropping out of school early.
    - Low socioeconomic status.

3. **Psychological Burden**
    - Guilt
    - Unhappiness
    - Anger towards self, father of child and sometimes towards baby
    - Self-isolation or depression.
    - Suicidal ideation.
    - Puerperal psychosis

Roles of CHW in prevention of teenage pregnancies.

- Teach boys and girls on abstinence from sexual activity.
- Making information on contraception more accessible.
- Making contraception available to the youths.
- Community engagement of gate keepers (influential leaders and parents) to address 'taboos' regarding sex education.

- Encourage open discussion about sexual health and risks.
- Raise awareness on sexual violence and report any incident.
- Advocate against child marriages as it often leads to teen age pregnancies

SESSION 11

CERVICAL CANCER AWARENESS AND PREVENTION

Learning objectives

By the end of this session, you should be able to:

- Define cervical cancer.
- Describe the risk factors to cervical cancer.
- Mention Signs and Symptoms of Cervical Cancer.
- Describe ways of preventing cervical cancer.
- Discuss the common Myths and misconceptions about HPV and cervical cancer.
- Explain the roles of CHW in cervical cancer prevention.

Cervical Cancer

Cervical cancer is the uncontrolled growth of the abnormal cells in the cervix caused by human papilloma virus, which is sexually transmitted.

Cervical cancer is invasive which means it can grow deep into the cervix and uterus. It can spread to other parts of the body.

Risk Factors of cervical cancer

- Infection with the Human Papilloma Virus (90%).
- Family history of cervical cancer.
- Smoking.
- Early age at first sexual intercourse (before 20 years).
- Increased number of sexual partners.
- HIV infection.

Signs and Symptoms of Cervical Cancer

Usually, no symptoms at the onset of the disease. Symptoms often do not begin until the cancer becomes larger and grows into nearby tissue. When this happens, the most common symptoms are:

- Abnormal vaginal bleeding, such as:
    - Bleeding after vaginal sex,
    - Bleeding after menopause,
    - Bleeding and spotting between periods
    - Prolonged or heavy menstrual bleeding.
    - Bleeding after douching may also occur.
- An unusual discharge from the vagina:
    - Contains some blood.
    - Abnormal smell
    - Pus discharge
- Pain during vaginal sex.
- Lower abdominal pain.
- Leg swelling/Oedema.
- Blood in the urine.
- Problems with urination or defecation.

Prevention of cervical cancer.

i. Abstinence is the only 100% effective method of HPV prevention.

ii. Avoid having many sexual partners.
iii. Getting screened early for cervical cancer.
iv. Use condoms to avoid HIV infection which predisposes to HPV infection and progression to cervical cancer.

v. HPV vaccine prior to sexual debut.

- The HPV vaccination protects girls aged between 9-14 from being infected with HPV and thus reduces the risk of developing HPV related cervical cancer later in life.

Myths and facts about HPV and the HPV Vaccine.

- It causes adolescents to be sexually active. – There is no evidence that HPV vaccination increases sexual activity.
- The Vaccine is treatment for HPV. – It is just a preventive measure against the HPV
- HPV is not common and usually affects women. – HPV can affect any woman or girl in the Child bearing age.
- Vaccines causes infertility. – This is not true; studies have shown that there is no connection between the vaccine and infertility.

Myths and misconceptions about cervical cancer

The table below shows some of the common myths and misconceptions about cervical cancer and facts that a community health worker should give to deal with the myths.

No.	Myth about Cervical Cancer	Facts about Cervical cancer
1	Cervical cancer is not preventable	• Not having sex (abstinence) is the only 100% effective way to prevent HPV infection, other options that reduce the risk of infection includ e vaccination and the consistent use of condoms.
2	HPV infection rare	• It is estimated that in the Sub-Saharan Africa, almost 24% of women aged 14-59 are infected with HPV.
3	Only women with multiple sex partne rs or unfaithful part ners can get infecte d by HPV	• HPV may be transmitted in a single sexual experience. Even people who have had only one sexual partner may be infected.

4	Men do not get inf ected with HPV	• Men DO get infected with the virus and, like women, are resp onsible for the transmission of the virus to their sexual partners. Both men a nd women can get genital warts from some types of HPV.
5	HPV is the same as HIV or Herpes	• The viruses that cause HIV and herpes are not related to the human papillomavirus.
6	Young women do not need Pap tests	• Anyone who has been sexually active needs to be examined b y a healthcare professional. It is recommended that women st art getting tested three years after sexual activity begins.

ROLES OF CHW IN CERVICAL CANCER PREVENTION

- Demand creation and community sensitization on cervical cancer screening and vaccination
- Clear myths and misconceptions of people sabout Cervical cancer and HPV Vaccine.

SESSION 12

PROMOTE BIRTH IN A HEALTH FACILITY

Learning Outcomes

By the end of this session, you should be able to:

- Help the family have a birth preparedness plan.
- Explain the importance of giving birth in a health facility.
- Identify problems that families may have in preparing for birth and help them find potential solutions.

Birth preparedness plan and complication readiness.

During the first visit to a pregnant woman, besides talking about antenatal care, the CHW will also help the family prepare for the birth. Birth preparedness plan include the following; choosing of place of delivery, knowledge of danger signs, mode of transport, birth companion, money saving, somebody to look after home, name of the unborn baby and other materials as advised by the health facility staff.

Having a birth plan can reduce confusion at the time of birth and increase the chance that the woman and her baby will receive appropriate and timely care**.**

Importance of including family members in birth preparedness plan

It is important to include the husband and family members for the following reasons:

- They support in resource mobilization, as facility delivery involves money.
- If everyone agrees beforehand, when labour starts there will be no problem in making the decision to go to the health facility.
- Leaving home means that there is need for someone to look after the house and other children; this may involve other family members**.**

Importance of giving birth in a health facility

It is safe for all women to deliver with a skilled birth attendant at a health facility for the following reasons;

- Prevention, early detection and timely management of complications.
  Problems may arise during labour and delivery, like bleeding or fits, which require skilled health workers, medications and equipment to treat. Without that treatment, the mother

and baby could die.

- Elimination of Mother to Child Transmission of HIV; If a woman has HIV, the skilled birth attendant at the health facility will have the necessary supplies and will follow infection control procedures to prevent transmission of HIV to the newborn. In addition, the baby will be given ARV prophylaxis immediately after birth to protect the baby from HIV.

Reasons for not delivering in a health facility

a) Cost of delivery items and the health facility fee
b) Perception that home birth is safe
c) Feeling more comfortable delivering with TBA at home
d) Lack of knowledge on importance of health facility delivery
e) Lack of transport
f) Fear of the procedures at a health facility or fear of health facility staff
g) Birth occurs suddenly at home or on the way to the facility

Potential advice for Reasons for not delivering in a health facility

Problem	**POTENTIAL ADVICE**
Cost of delivery	• Let families know how much a health facility delivery costs; include 'hidden costs' even if the delivery itself is free. • Help them see how saving a very small amount of money each week adds up to a significant amount over the pregnancy, especially if the entire family is involved. • Emphasize that delivering in a health facility helps ensure a safer delivery and a healthy baby. If complications occur during home birth, it will cost much more to get emergency treatment than the cost of a health facility birth.
Perception that home birth is Safe	• Explain to the family that the health facility is the best place to prevent and treat delivery complications. • Explain that complications such as prolonged labour, delayed placenta delivery and bleeding after delivery can happen to any woman, even those who usually have safe deliveries.
Feeling comfortable delivering with TBA	• Acknowledge the existence of TBAs, but they should not conduct deliveries. Their role is to refer pregnant women to health facilities.

Lack of transport	● Help families identify a means of getting to the health facility anytime. ● Encourage families to make transport arrangements in advance. ● Community planning to provide transport for birth and emergencies ● Encourage the pregnant woman to await labour and delivery at the health facility towards the end of pregnancy.
Lack of transport	● Help families identify a means of getting to the health facility anytime. ● Encourage families to make transport arrangements in advance. ● Community planning to provide transport for birth and emergencies. ● Encourage the pregnant woman to await labour and delivery at the health facility towards the end of pregnancy.
Fear of health facility procedures and health facility staff	● Explain to the family that the health facility procedures are always done to save lives. If these procedures are not conducted when they are required, it is likely that the woman or her baby will die. ● Explain to the family that it is their right to demand the services and the health workers are there to serve them ● Explain that a mature person could accompany the pregnant woman to the health facility to support her and help to communicate with health facility staff
Birth sometimes occurs very quickly	● Explain that it is important to go to health facility for delivery as soon as labour starts. That is why it is important to plan for the delivery during pregnancy. ● Towards the end of pregnancy, encourage the woman to await labour at the health facility.

Helping Families Prepare for Health Facility Birth

When conducting the **First home visit during pregnancy, Card 2:** ***(Prepare for Birth in a Health Facility)*** will guide you to assist a family to prepare for birth in a health facility.

Then let the family members think it over. Talk to them again about health facility birth at the next visit.

First home visit during pregnancy Card 2: Prepare for Birth at a Health Facility

1. **Prepare for birth at a health facility**
   It is safe to deliver at a health facility. Many problems for the mother and the newborn can be prevented and any complication that may arise can be managed promptly with the required skill and medications.
2. **Identify transport to get to the health facility**
   It is important to identify how the pregnant woman will get to the health facility for delivery because labour can start at any time, and it may be difficult to find transport at the last moment.
3. **Save money for transport and other expenses at the health facility**
   It is important to save small amounts of money throughout pregnancy in order to have enough money to cover the costs of transport and other expenses for birth at the health facility.
4. **Gather the supplies needed for health facility delivery**
   To give birth in most health facilities women need to bring soap, sanitary napkins and clean clothes for the mother and the baby. If the mother has HIV, she should bring her ARVs including NVP syrup for the baby. As these supplies can be expensive, families may need to buy them bit by bit. It is important that the family keep the items clean and together so that they are ready and can be easily found when needed.
5. **Decide who will accompany the pregnant woman to the health facility;** This person should be identified early in pregnancy and should know the transportation plan and the importance of going to the facility early in labour. Try to include the person in your discussions during the home visits. It is important to go to the facility at 8 months to await labour. **Plan who will care for the household while the pregnant woman and other family members are at the health facility. It is** important that arrangements are made beforehand for someone to take care of the household.

PRACTICE ROLE PLAYS -- Talking with families about their problems with delivering in a health facility, and proposing possible solutions:

1. **Case 1:** Neena and her husband want to have the birth in the health facility but they are afraid they do not have enough money.
2. **Case 2:** Mary has HIV. She says she wants to deliver at home because it is easier; she does not have to leave her other children and she will be more comfortable.
3. **Case 3:** Nancy lives in a remote area; the health facility is two hours away by car and transport is not available at all times.

SESSION 13

HOME CARE FOR THE PREGNANT WOMAN

Learning Outcomes

By the end of this session, you should be able to:

- Counsel women on how to care for themselves during pregnancy
- Describe the Scaling Up Nutrition (SUN) initiative
- Make proper food choices and combinations for maternal nutrition
- Explain additional care for the pregnant woman who has HIV
- Explain danger signs during pregnancy

HOME CARE FOR THE PREGNANT WOMAN

Nutrition in Pregnancy

A pregnant woman needs extra food for the provision of additional energy and nutrients for herself and the growing unborn baby. Adequate nutrition during pregnancy improves pregnancy outcomes such as normal birth weight, child survival and mental development.

It is also recommended that a pregnant woman should eat a variety of foods every day from the six food groups; staples, legumes, vegetables, animal products, fruits and oils. She should also eat more by having an extra or additional meal to meet the high-energy need. The CHW should emphasize on use of locally available food sources.

CHW should encourage a pregnant woman to have snacks/fruits in addition to the normal meals and to drink many fluids. Poor nutrition status especially during the **first 1,000 Days** of child life (which covers **270 Days of pregnancy and first 730 Days from birth**) pause a serious challenge to physical, mental growth and development of a child

SUN Initiative

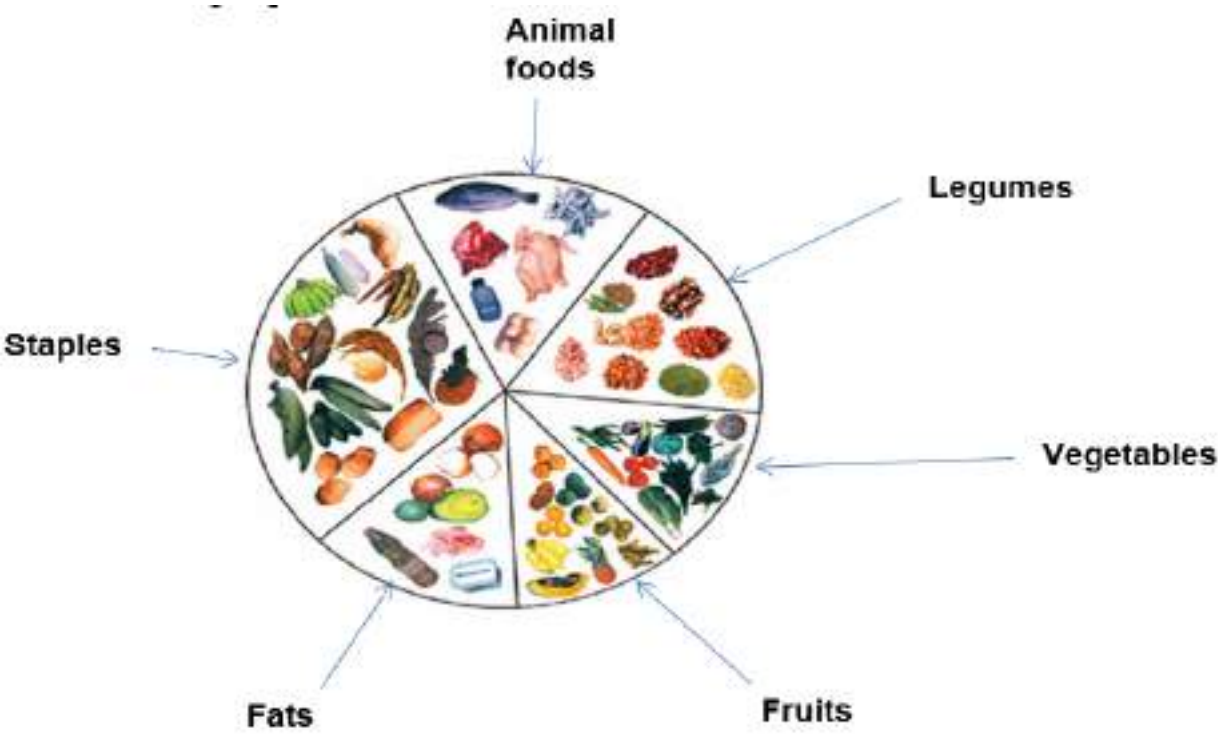
Previously, SUN 1000 special days initiative was aimed at ending stunting in children under the age of two years. The current SUN 3.0 campaign which Malawi adopted expands the scope from ending stunting to eliminating all forms of malnutrition with emphasis on stunting and overweight through intensive social behaviour change and communication, strengthening food and health systems, promotion of nutrient dense diversified diets and healthy lifestyles.

Overweight and obesity have shown to be associated with nutritional related non-communicable diseases (NCDs) such as diabetes, stroke, hypertension, heart diseases and other types of cancer (Eat Well To Live Well Guide, DNHA, MoH) hence their inclusion as one of the key focus areas in the SUN movement. Nutritional related NCDs are contributing

to morbidity and mortality in the human life cycle. While over nutrition is responsible for NCDs particularly in adults and adolescents, under nutrition is the main underlying cause of under-five mortality. Key Contributing factors include little attention to nutrition (e.g. knowledge deficit in food preparation and feeding practices) and limited resources allocated to nutrition at different levels

Proper Food Choices and combinations for maternal nutrition

Different foods contain a mixture of nutrients. Proper and correct food selection and combinations helps to ensure adequate supply of nutrients in the diet. These should be made from 6 food groups.



Examples of recipes that have proper food combinations:

1. **Phala(staple) lotenderakapena la soya (legume and fat).**

The meal contains 3 food groups. If eaten with a fruit in season it will have four food groups.

2. **Nsima ya mgaiwa (staple) ndi nkhwani (vegetable) otendera (legume and fat)**

The meal contains 4 food groups. If eaten with a fruit, then this meal alone contains five food groups.

3. **Cassava (staple) boiled with usipa (animal food) and beans (legume) and carrot (vegetable) or eaten with some vegetables**

This meal contains four food groups and if eaten with a fruit, it will contain five food groups.

4. **Green banana (plantain) (staple) stewed with meat or fish (animal food) and nandolo**

(legumes), tomatoes, onions (vegetables) and some cooking oil (oil/fat).

This meal contains five food groups and if eaten with fruit, the meal will contain six food groups

5. **Futali (from yellow sweet potato) (staple, fats and legumes) eaten as a snack or a meal eaten with some vegetables.**

If eaten as snack, it will contain 3 food groups: staple (yellow sweet potato), Legume and fat (nsinjiro) but if eaten as meal with some relish such as vegetables, it will contain 4 food groups. If eaten with a fruit in season, it will have five food groups.

Importance of avoiding heavy work and getting more rest during pregnancy

If a pregnant woman works hard, there is less energy available for the baby to grow. If a woman rests and eats well, the baby will grow healthier and it reduces risks of miscarriage and preterm delivery.

Importance of sleeping under a long-lasting insecticide-treated bed net during pregnancy

Malaria is a serious disease, especially during pregnancy, and can be very dangerous to both the mother and the baby. To prevent getting sick, everyone especially pregnant women, mothers and babies should sleep under a Long-Lasting Insecticide-Treated bed net.

Importance of taking iron and folic acid tablets during pregnancy

During pregnancy, delivery and after delivery a woman needs enough blood to carry oxygen and nutrients to avoid health related problems to the mother and baby such as anaemia.

Importance of Physical Exercises and Healthy Diets During Pregnancy

Pregnant women are encouraged to do physical exercises to keep fit. Physical exercises help to improve blood and oxygen circulation in the body. It also helps to break down fats and maintain normal body weight which can help to prevent nutritional related NCDs. It is also recommended to eat diversified diets with more fruits and vegetables for improved digestion, vitamin and mineral intake as well as fibre. Fatty foods should be taken in moderation. *The Eat Well To Live Well Guide* provides more information on the healthy life style behaviours and food choices for optimal nutrition and health status of an individual.

Home care for a pregnant woman who is HIV negative.

A pregnant HIV negative woman must be encouraged to tell her partner her HIV status and encourage him to test for HIV. She must protect herself from HIV and other infections by practicing safe sex using condoms. She should be tested for HIV again in third trimester and be re-tested in maternity. If a woman becomes infected with HIV during pregnancy, there is a high risk of passing HIV to the baby.

Additional home care is important for a pregnant woman who has HIV.

A pregnant woman who has HIV should take ARVs at the same time every day, without missing a dose, throughout pregnancy, labour, breastfeeding and for the rest of her life. The

ARVs will keep the woman healthy, as well as protect her baby and her partner from HIV. Babies are much more likely to get HIV if their mothers are not taking ARVs.

The pregnant woman should attend the HIV care clinic according to schedule. At the health facility, a blood sample will be collected to check her viral load.

The pregnant woman is encouraged to disclose her HIV status to her partner and encourage him to go for a test. She must also be encouraged to practice safe sex by using condoms to prevent infection with any STI and re-infection.

During the first home visit to a pregnant woman, you will also use **card 3: Home Care for the Pregnant Woman**

Danger signs during pregnancy

Danger signs during pregnancy must be discussed during home visits to alert the woman and seek proper medical care. These may include:

Danger signs during pregnancy
● Any vaginal bleeding. ● Fits/ convulsions. ● Severe abdominal pain. ● Severe headache. ● Blurred vision. ● Dizziness. ● Difficult breathing. ● Fever. ● Draining liquor before labour. ● Oedema of feet and face.

If any of these danger signs appear, the family should seek care at the health facility as soon as possible.

During the first home visit to a pregnant woman, you will also use **card 5: Danger signs** to review them with the woman.

SESSION 14

CLASSROOM PRACTICE: FIRST HOME VISIT DURING PREGNANCY

Learning Outcomes

By the end of this session, you should be able to:

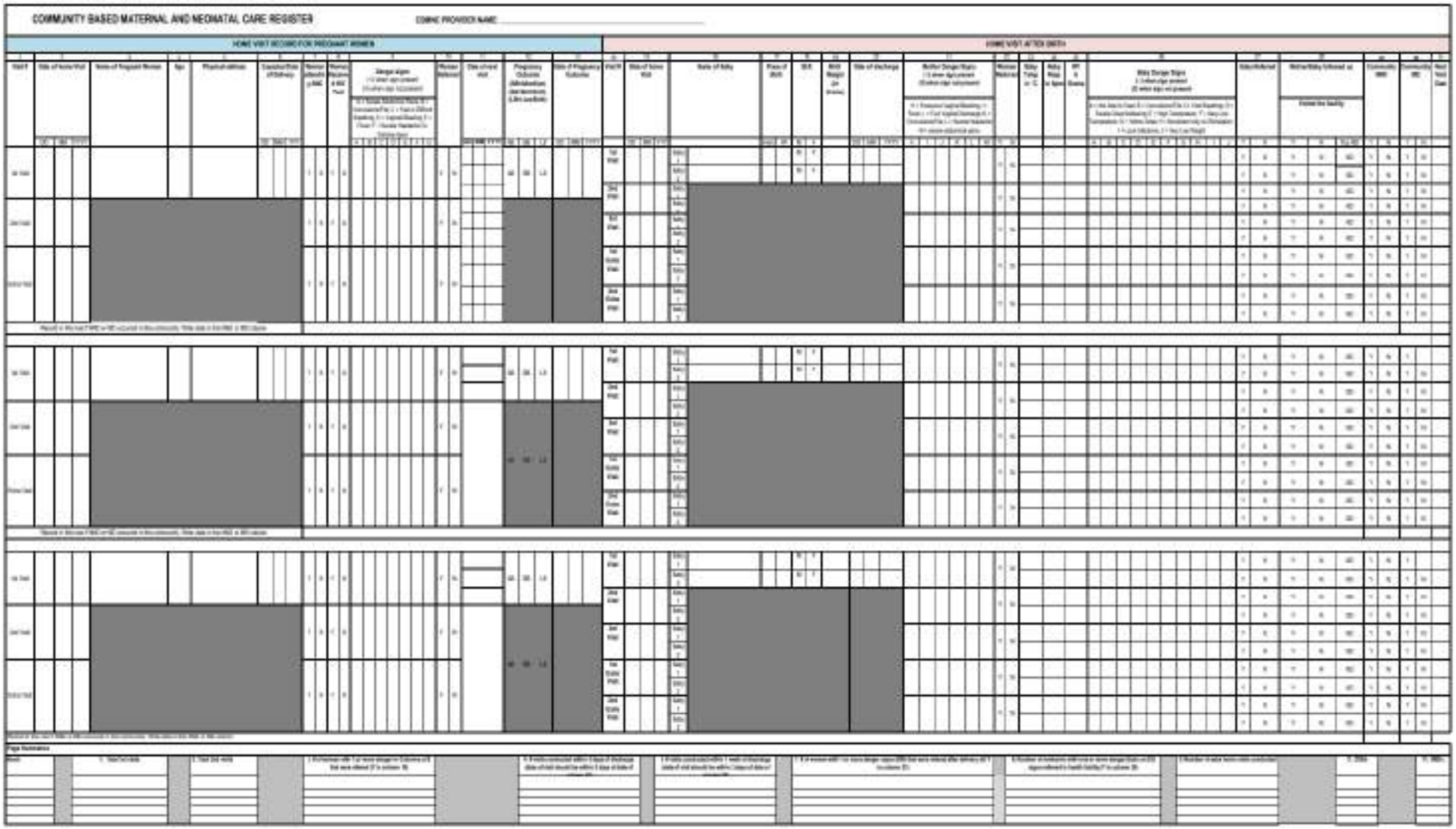
- Explain the sequence of the first home visit during pregnancy.
- Demonstrate how to fill in the CBMNC register.
- Demonstrate how to schedule the second home visit during pregnancy.
- Demonstrate how to use the counselling cards for the first home visit during pregnancy appropriately.

Sequence for First Home Visit during Pregnancy

1. Greet the family and develop good relations.
2. Use First home visit during Pregnancy Card 1: Promote Early Antenatal Care.
3. Use First home visit during Pregnancy Card 2: Birth preparedness.
4. Use First home visit during Pregnancy Card 3: Home care for a pregnant woman
5. Use First home visit during Pregnancy Card 4: *Home care of the Pregnant Woman in an HIV and TB Setting.*
6. Use first home visit during pregnancy card 5: Danger signs during pregnancy
7. Ask the pregnant woman and family to tell you what they have understood about the care needed by women during pregnancy and about danger signs in pregnancy.
8. Decide with the family on the second pregnancy home visit date.
9. Enter information about the visit and the next appointment date in the CBMNC Register
10. Thank the family.

DEMONSTRATION AND PRACTICE: Completing the CBMNC Register at the first pregnancy visit.

See the recorded information in the CBMNC Register on list of pregnant women from the exercise you completed in Session 5.


COMMUNITY BASED MATERNAL AND NEONATAL CARE REGISTER

CBMNC PROVIDER NAME: _____

HOME VISIT RECORD FOR PREGNANT WOMEN

HOME VISIT AFTER BIRTH

Pregnant woman 1: *Maria Phiri, age-22, she lives at Katsengaminga village near catholic church, was visited by CHW on 10 Oct, 2022; EDD 20 Jan,2023 and HIV test was done at antenatal, no danger signs identified.*

Pregnant woman 2: *Mary Luo; Age – 21*; She lives at Madeya village, near Kapalamula primary school, EDD 24 Feb,2023, was visited by CHW on 12 Oct, 2022 and was tested for HIV. During the visit. She complained of experiencing vaginal bleeding

Pregnant woman 3: *Grace Matumba; Age – 24; Physical address:* Katsekaminga Village near mosque; EDD 4 March 2023; was visited by CHW on 19 October 2022. *No danger signs identified and HIV test was done.*

Scheduling second home visit during pregnancy.

The second visit should be conducted about 2 months before delivery (or if the estimated date of delivery is not known, when the woman has completed 7 months of pregnancy). If the first home visit during pregnancy is conducted after 7 months, the CHW should still schedule the second home visit depending on gestational age.

For example, Maria Phiri's expected date of delivery is 20 January 2023. Two months before that will be around 20 November 2022.

The CHW asked the family if it would be convenient to visit again on 20 November. They agreed that it would be fine. The CHW documented the next appointment date in the CBMNC Register

EXERCISE;

Schedule second pregnancy visit for:

1. Mary Luo with EDD of 24 FEB, 2023.
2. Grace Matumba with EDD of 04 March, 2023.

DEMONSTRATION ROLE PLAY: First home visit during pregnancy.

Monica, the CHW, found out that Taziona was pregnant a few days earlier. Monica is visiting Taziona today to carry out the first home visit during pregnancy.

This role-play demonstrates how first home visit during pregnancy must be done. Watch the interaction and observe the following:

- The counselling cards that are used. How they are used.
- How the CHW greets, asks, listens, and understands the situation, gives advice, checks understanding, praises and solves any problems.
- The sequence of the visit.
- When and how information is documented in the CBMNC Register

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ROLE PLAY SCRIPT: First home visit during pregnancy.

GREET THE FAMILY

CHW: Hello, Taziona, are you home?

Taziona: Hello Monica. Welcome.

CHW: Thank you. How are you and the family? Feeling okay?

(Smiles and looks at her)

Taziona: Oh, yes. I get tired more easily than before I was pregnant but otherwise I feel fine.

CHW: Yes, getting tired more easily can happen when carrying a baby ***(Reflecting feelings)***, that is normal, and I am glad you feel fine otherwise. ***At the same time the mother-in-law (M-I-L) comes in (greetings are exchanged and she is asked to join them)***

EXPLAIN THE REASON OF THE HOME VISIT

CHW: As I said the other day, part of my responsibility is to visit pregnant women and discuss what you can do to make sure you and the baby are healthy.

Taziona: ***(Nods) I*** was looking forward to your visit

CHW: Remember what I said last time—whatever we discuss is confidential.

Taziona: Yes, I remember that.

CHW: ***(Opens counselling cards to First Pregnancy Visit Card 1 and has the illustrations facing Taziona)***

ASK AND LISTEN TO UNDERSTAND THE SITUATION

CHW: Taziona, do you have other children?

Taziona: Yes, I have two children.

CHW: Did you attend the antenatal clinic during the previous pregnancies?

Taziona: Yes, I attended once during my last pregnancy.

CHW: Have you started antenatal care for this pregnancy?

Taziona: Not with this pregnancy. I plan to go at six month

CHW: I am glad to hear you are planning to go ***(Understands her stage of adopting the behaviour).*** It is important to go there early in pregnancy so you can begin receiving the necessary care right away. I am going to tell you a story about a woman named Abena, who had a very healthy baby. First, what do you see in these pictures?

M-I-L: I see a woman at the clinic and the health worker is examining her.

CHW: Yes, that is correct. What else?

Taziona: Here she is getting an injection, and here she is holding some tablets. Here it looks as if they are taking some blood.

TELL THE STORY OF ABENA AND ADAPT ADVICE ACCORDINGLY

CHW: Yes, that is right. Abena went to the clinic so the Midwife could check her because she knew that check-ups were important to make sure she and the baby were healthy throughout the pregnancy. The first time she went, they gave Abena an injection against tetanus, screened her for TB and syphilis, and they checked her for any problems. They gave her iron and folic acid tablets to prevent anaemia.

Taziona: hmmm

CHW: Abena also received a long lasting insecticide-treated bed net to ***prevent malaria.*** Abena also was given Fansidar, which she took to prevent her from getting malaria. Lastly, Abena agreed to get a test for HIV. It is important to test for HIV because if a woman has it, she can receive ARVs to keep her healthy, to prevent HIV from passing to the baby, and to protect her partner.

Taziona: I didn't know that. How many times did you say she went to the clinic?

CHW: Abena went 8 times for antenatal care. It is important to go back because in the subsequent visits they check for any problems that may have come up, and help you prepare a birth plan. The 8th visit is usually a few weeks before delivery and includes checking to make sure the baby is in a good position for delivery. You will be tested again for HIV if you did not have HIV on the first visit.

Taziona: I have learned a lot.

CHECK UNDERSTANDING AND SOLVE ANY PROBLEMS

CHW: Good. Can you tell me what you understood from our discussion? ***(Checking question).***

Taziona: Yes, I should go early for antenatal care because I will be examined and receive medicines and information. I will be tested for HIV, and I should go at least 8 times like Abena.

CHW: That is excellent. Now that you know these things, what are your plans about antenatal care? ***(Asking what family will do)***

M-I-L: I think it is good for Taziona to go. We will talk to my son when he gets back from the fields.

Taziona: If possible, I will go to the clinic in the next day or so, because now I know how important it is.

CHW: Very good. Now let us talk about the baby's birth.

(Turns over counselling card so that First Pregnancy Visit Card 2 is open with the illustrations facing Taziona)

ASK AND LISTEN TO UNDERSTAND THE SITUATION

CHW: Taziona, where did you have your previous babies?

Taziona: Both of them were born at home. My aunt who lives nearby delivered them but she is now too old. My sister-in-law recently had her baby in the health facility.

CHW: I see. What do you think of giving birth in the facility?

M-I-L: It costs some money.

Taziona: Yes, it may be okay, but I am afraid it may cost a lot of money. It is also far from the house. ***(CHW now knows her stage of adopting behaviour = thinking about it)***

CHW: Yes, it is in some ways and there may be extra costs, but we can discuss how you can plan for these ahead of time.

TELL THE STORY OF ABENA AND ADAPT ADVICE ACCORDINGLY

Let me tell you what Abena did. What do you see in these pictures?

Taziona: This is a picture of the health facility.

CHW: Good, that is exactly right. Abena chose to deliver in the health facility because she knew that problems during birth like heavy bleeding can happen to any woman, and it is safer to deliver where these problems can be taken care of.

Taziona: Can this happen even if I have had no problems the previous two deliveries?

CHW: Yes, unfortunately problems can happen any time, so it is safer to deliver in the health facility where they can perform a clean and safe delivery and manage any problems that may come up.

What do you see here?

Taziona: I see a bicycle.

CHW: Yes, very good. And here?

Taziona: I see a bunch of money

CHW: Yes, that is correct. Abena and her husband saved a small amount of money every week. (Points to the illustration of saving money) to cover any costs and to pay for transportation to the facility. What do you see here?

Taziona: I see a bicycle taking Abena somewhere….

CHW: Yes, Abena's husband arranged transport to take them to the health facility as soon as labour started. (Pointing at the illustration). And here, Abena prepared clothes for the baby and things for herself that she would need in the health facility (pointing at the illustration). If Abena had HIV, she would also pack her ARVs.

CHECK UNDERSTANDING AND SOLVE ANY PROBLEMS

Do you think you can prepare in the same way? ***(Checking question)***

Taziona: Thank you for letting me know all this.

M-I-L: It seems possible.

Taziona: I will discuss delivering in the health facility with my husband when he comes from work this evening. We should be able to save a little money each week, and I can definitely prepare clothes for the baby and gather supplies that I will need like cloths.

CHW: Good. We will discuss it further during my next visit. I would now like to talk about how to care for yourself during pregnancy. ***(Opens counselling cards to First Pregnancy Visit Card 3 and has the illustrations facing Taziona)***

ASK AND LISTEN TO UNDERSTAND THE SITUATION

CHW: What kind of care do you think pregnant women need at home?

Taziona: I do not really know for sure, but I remember that when I went for antenatal care with my last pregnancy, I was told to eat more food and I took iron and folic acid tablets to prevent anaemia. The Midwife also advised me to avoid heavy work and get more rest.

CHW: That is right Taziona. Very good**.** What do you see in these pictures?

Taziona: Oh, I am right, here a woman is eating…it looks like good food. And here she is taking tablets, and sleeping under a bed net.

M-I-L: Yes, she is eating a lot of good food.

CHW: ***(Nodding)*** Uh huh. ***(Shows she is listening)*** Excellent. What do you think about doing these things? **(checking question)**

Taziona: Since I feel tired with this pregnancy, I think maybe I need more rest, so I think that is a good advice. But do I really have to eat more? I really don't feel like eating these days?

TELL THE STORY OF ABENA AND ADAPT ADVICE ACCORDINGLY

CHW: It is good that you will avoid heavy work and try to rest more. ***(Praise)*** About eating more, let me tell you the story of Abena. ***(Points to the picture of a woman eating more nutritious food)*.** Abena eats more than usual during pregnancy to help the baby grow. This is important because if you do not eat well, the baby will not grow healthy. You should try to eat (*facilitator to pick local and acceptable foods*) an extra portion of rice, bread, or beans each day, and if possible add an egg, fish or meat, fruit and vegetables. Do you think that is possible?

Taziona: I don't know. I really don't feel like eating these days.

CHW: I understand what you are saying; you don't have a good appetite ***(Reflecting feelings).*** Do you think you could try eating a little more at each meal, like an extra bowl of beans and an orange or vegetable? You could also try eating a snack between meals. ***(Making suggestions)***

Taziona: Yes. I will try. I want the baby to be strong.

CHW: Good. Now as you said, here Abena is sleeping under the long-lasting insecticide

treated bed net so she will not get malaria. Do you think this will be possible for you to do?

Taziona: Well, I don't have a bed net…..Where can I get one?

CHW: You can get one when you go to the antenatal clinic, so please remember to ask for one when you go.

Taziona: Yes, I will.

CHW: Earlier we spoke about Abena testing for HIV. **(Opens counselling cards to First Pregnancy Visit Card 4 and has the illustrations facing Taziona.)**

Taziona: Yes, you said she had the test on her first antenatal visit.

CHW: What can you see in these pictures about Abena? **(CHW points to pictures on left side of card.)** This is what would happen since Abena did not have HIV.

Taziona: Here she is talking with her partner, here I see some condoms, and there she is having a blood test.

CHW: Correct, it is important to tell your partner your HIV status even if you do not have HIV and encourage him to also test for HIV. The nurse encourages Abena to have safe sex by using condoms, even while she is pregnant. Since Abena did not have HIV on her first visit, she will test for HIV again before delivery and breastfeeding.

What do you see in these other pictures? **(CHW points to pictures on right side of card)** These pictures tell the story of Maria. This is Maria and she has HIV.

Taziona: She is also talking to her partner, she is taking some tablets, and I see condoms.

CHW: Well done. It was difficult for Maria to tell her partner that she has HIV, but it is important to tell him. It is also important to encourage him to be tested for HIV and to practice safe sex using condoms.

HIV can be passed from the mother to the baby during pregnancy and while breastfeeding, so it is important the mother takes ARVs to protect her baby from HIV. The ARVs should be taken at the same time every day while she is pregnant, during labour, while breastfeeding and for the rest of her life. The ARVs will keep Maria healthy, and protect the baby and her partner from HIV.

Often when a person has HIV, they may also have TB, so the nurse checked Maria to see if she may have TB.

Taziona: Now I understand why it is important to test for HIV when a woman is pregnant—she can get medications to keep her healthy and protect the baby.

CHW: Excellent. Now let us look at the danger signs Card.

CHECK UNDERSTANDING AND SOLVE ANY PROBLEMS

CHW: Can you tell me what you remember about the care you need during pregnancy, and what you will try to do? ***(Checking question)***

Taziona: Yes, I need to eat more, avoid heavy work and get more rest, take iron tablets and sleep under a net.

As I said, I will go to the clinic for antenatal care, test for HIV, and I will ask for a bed net. With my mother-in-law's help, I will try to rest and eat more because I know it is good for the baby and my own health.

CHW: I am happy to hear that. Before I go, I want to ask you both to look at this. ***(Points on the danger signs during pregnancy)*** What do you see here?

M-I-L: These are pictures of sick women.

CHW: Yes, that is correct. These pictures show the problems or danger signs that can happen in pregnant women: vaginal bleeding, fits, severe headache, severe abdominal pain, fever and difficulty breathing. If any of these happen to you Taziona, you must go to the health facility immediately. We need to think how you would get there, and it is best for you to save some extra money.

Taziona: There is a taxi in the next village and one of the men in this village has a mobile phone. We can call for a taxi.

CHW: Very good. Do you have any questions about these danger signs and what they mean, or anything else we discussed today?

Taziona: No.

CHW: Very good. ***(Looks at the calendar)*** I will come back in 4 weeks, the third week of next month just after the harvest holiday. Is that alright?

Taziona: That is good; I look forward to seeing you.

CHW: (. *Opens the CBMNC Register and writes the proposed date of the next visit).* When I come back, we can talk about how you are and if you are able to do these things for yourself. Please call me if you need my help.

Taziona: Thank you, I will.

CHW: Bye, remember to go to the clinic and congratulations for doing the best for yourself and the baby.

END OF ROLE PLAY

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PRACTICE ROLE PLAY in pairs: First home visit during pregnancy.

Take turns playing the role of CHW and the mother and remember to fill in the CBMNC Register.

Remember:

The counselling steps for the first home visit during pregnancy include:

- Greet and build good relations
- Ask questions and listen (reflect, empathize, etc.); understand the situation
- Give relevant information based on what the family knows
- Check understanding (open-ended questions)
- Discuss what the woman and family will do
- Together, try to solve any problems
- Thank the family
- Use the First home visit during Pregnancy Cards 1, 2, 3, 4 and 5) which provide the relevant information. You will encourage a woman to get antenatal care including HIV testing, prepare in advance for birth, take care of herself at home during pregnancy, and get care at a health facility if she has any danger signs.
- Fill in your Register.
- Remember that how you interact with a pregnant woman and her family will affect how relaxed and confident she feels and whether she decides to follow your advice.

SESSION 15

REVIEW ACTIONS

SINCE FIRST PREGNANCY VISIT

Learning Outcome

By the end of this session, you should be able to:

- Demonstrate how to use Card 1 during second home visit in pregnancy.

This session demonstrates how to use card 1 during second home visit in pregnancy, to review the family's progress in caring for the pregnant woman and preparing for birth.

QUICK QUIZ: Selecting Card

a. **Lily** and her family have decided to deliver in the health facility and have already saved enough money. Lily's husband will accompany her and Lily's mother-in-law will stay with the children. They have identified transport.

   Which card would you use?

b. **Esther** and her family have decided to give birth in a health facility. Because they live a long distance from the facility and Esther has had fast births in the past, they have arranged to move to their relative's house in town some days before the birth is due. They have saved some money for birth in a health facility.

   Which card would you use?

SESSION 16

CARE OF THE NEWBORN IMMEDIATELY AFTER BIRTH

Learning Outcomes

By the end of this session, you should be able to:

- Explain to families, ways of keeping the baby warm immediately after birth
- Explain why keeping the baby warm is important
- Explain to families why early initiation of breastfeeding is important
- State the main messages on second home visit during pregnancy -Card 2.

KEEPING THE BABY WARM IMMEDIATELY AFTER BIRTH

Ways of Keeping the Baby Warm

Babies get cold easily immediately after birth when they are exposed to colder temperature than inside the womb because they cannot adjust their temperature like adults. The following ways can help keep the baby warm after birth:

- Dry the baby immediately after birth, remove the wet cloth or towel and replace with a dry cloth
- Keep the baby on skin-to-skin contact immediately after birth and cover them with a dry sheet or blanket.
- Put the baby to the breast within 60 minutes of birth.
- Put a hat/cap and socks on the baby
- Avoid bathing the baby for the first 24 hours of birth. If delaying bathing is unavoidable, wipe with warm water, dry and wrap the baby immediately.

Why is keeping the baby warm immediately after birth important?

Newborn babies need to be kept warm especially in the first weeks of life. If the baby gets cold it cannot suckle the breast well, it gets sick easily and is more likely to die.

DISCUSSION IN SMALL GROUPS: Identify practices that help to keep the baby warm

Read the case study below and list:

- 2 good practices: Give reasons why each is good.
- 2 bad practices: Give reasons why each may be harmful.

Case study

Maria gave birth at night. The baby was dried immediately after birth, was given to Maria to keep her warm through skin-to-skin contact, and to breastfeed. After 20 minutes, the grandmother took the baby from Maria to bathe her. As the birth was at night, there was no fire to heat the water, so the grandmother bathed the baby with cold water, dried the baby and gave the baby back to Maria to feed.

PROMOTE EARLY INITIATION OF BREASTFEEDING

Why is early initiation of breastfeeding important?

Breastfeeding should be started as soon as the baby is ready usually within the first 60 minutes after birth when the baby is alert. The family can see that the baby is ready for breastfeeding when she/he opens his/her mouth, turns the head as if searching for the nipple or sucks on his/her fingers or hand. Starting to breastfeed early is one of the best actions a mother can do to help her baby be healthy, and has many advantages for both the newborn and the mother. Some of these advantages are:

- The baby gets all the benefits of the first milk (colostrum or yellow milk), which is like the baby's first vaccination.
- It protects the baby from illness and contains all necessary food nutrients.
- Early suckling helps make more milk.
- Breastfeeding helps keep the baby warm.
- Promotes bonding between mother and baby.
- Helps contraction of the uterus there by reducing vaginal bleeding of the mother and can prevent breast engorgement.

Should initiation of breastfeeding be delayed for some reasons?

The only reason feeding should be delayed is; if the mother requires medical assistance (such as she has excessive bleeding or the mother is convulsing) or if the baby is unwell (for example, has difficulty breathing). You can counsel families about other perceived reasons such as:

Problem	Potential Advice
Family feels that the first milk is dirty	• Some families think that the first milk is dirty or bad for the baby, so they wait or squeeze this milk out before they start feeding. • The first milk is very beneficial for the baby as it acts like the first vaccine and helps the first black stool come out. All babies should be fed the first milk.
Mother feels that the milk has not "come-in" yet	• Some mothers do not start breastfeeding until they feel the breasts are full, which can occur as late as three days after birth. • Breastfeeding as soon as the baby is ready after birth actually helps to increase the milk supply and should be done by all women. Babies do not need a lot of milk in the first 1-2 days

	of life to be satisfied. ● Usually, even when a mother thinks that she does not have enough breast milk, she does have enough to give her baby all it needs. ● Explain that this small amount of milk is all that most babies need before the mature milk comes in.
Baby doesn't cry for milk	● Not all babies show they are hungry by crying. The baby should be put to the breast even if it does not cry for milk. ● The signs that a baby is ready to breastfeed are that she/he opens his/her mouth, turns the head as if searching for the nipple or sucks on his/her fingers or hand – usually within 1 hour of birth. Breastfeeding as soon as the baby is ready is beneficial for mother and baby.
Performing other activities after birth	● Sometimes families think that the mother or the baby needs to be bathed before they start breastfeeding. ● Other families do not know the importance of starting to breastfeed as soon as the baby is ready and therefore spend time resting or eating before they start breastfeeding. ● It is important that the baby be put to the breast as soon as he/she is ready to feed. Other activities should be delayed until after the baby has been fed.
Afraid HIV will be transmitted to the baby in the breast milk	● If the mother has HIV, she or other family members may be reluctant for her to breastfeed ● They may not know that ARV treatment can reduce the risk of HIV transmission from mother to the baby during breastfeeding. It is important for the mother who has HIV to continue taking ARVs during breastfeeding and to give ARV prophylaxis to the baby every day for 6 weeks. These ARVs will reduce the risk of HIV from being passed to the baby. It is also protective to breastfeed the baby exclusively for the first 6 months.

SESSION 17

CLASSROOM PRACTICE:

THE SECOND HOME VISIT

DURING PREGNANCY

Learning Outcomes

By the end of this session, you should be able to:

- Demonstrate how to conduct a second home visit to a pregnant woman
- Demonstrate how to use the counselling cards for this visit appropriately (Second home visit during Pregnancy Card 1, card 2 and card 3).
- Demonstrate how to fill in the CBMNC Register.
- Demonstrate how to assess danger signs during pregnancy.

Cards to use during the second home visit in pregnancy.

The CHW will use three counselling cards in the second visit during pregnancy:

- Review Actions since the First home visit during Pregnancy (second home visit during pregnancy card 1).
- Advise on Immediate Newborn Care (second home visit during pregnancy card 2)
- Review with the family on danger signs during pregnancy (second home visit during pregnancy card 3).

The CHW will also fill in the CBMNC Register

Sequence of tasks for second home visit during pregnancy.

1. Greet the family.
2. Use card 1: Review Actions Since First home visit during Pregnancy:
   a. Is she attending ANC?
   b. Was she tested for HIV?
   c. Was she screened for TB?
   d. How is she caring for herself?
   e. How is the family preparing for a facility birth?
   f. Which family planning method will she use after delivery?
3. Praise if doing well; solve any problems by using the second home visit during pregnancy card 1.
4. Use card 2: Advise on Immediate New born Care.
5. Use card 3: danger signs during pregnancy.

6. Update the CBMNC Register.
7. Remind the family to contact you (CHW) as soon as birth takes place.
8. Thank the family.

DEMONSTRATION ROLE PLAY: Second home visit during pregnancy

Monica, the community health worker (CHW), is visiting Taziona to conduct second home visit during pregnancy.

Watch the demonstration and be prepared to discuss the following:

1. How did the CHW start the second home visit?
2. Explain how the CHW built on what she discussed with Taziona during the first visit.
3. How did the CHW use the counselling cards?
4. How did the CHW use her knowledge of how behaviour changes?

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ROLE PLAY SCRIPT: Second home visit during pregnancy.

CHW: Hello Taziona. Is this a good time to visit?

Taziona: Oh Monica, hello. Yes, last time you were here we agreed you would come this morning. Let me call my mother-in-law, she enjoyed your last visit and has helped me a lot since then.

Taziona calls her mother-in-law who joins the discussion. There are greetings and then CHW continues with visit.

CHW: (***opens Second home visit during Pregnancy Card 1)*** How are you feeling Taziona?

Taziona: I am feeling well.

CHW: That is very good. I am here today to see how you are and how preparations for the birth are coming along. I also want to talk about what care the baby needs immediately after birth. Have you been to the antenatal clinic?

Taziona: Yes, I went twice since your last visit. My husband accompanied me there and my mother-in-law stayed with the kids. They said the baby will arrive at the end of February, around the 21st.

CHW: Were you tested for HIV?

Taziona: Yes, I was tested and my husband was also tested for HIV.

CHW: Very good, Taziona. It is good that you both know your HIV status now. Now tell me, how have you been taking care of yourself?

Taziona: Well, I am taking the iron and folic acid tablets every day and trying to eat more, and my mother-in-law is helping with my chores so I am resting more.

CHW: That is very good. Are you sleeping under an insecticide- treated bed net?

Taziona: Yes I am.

CHW: That is fine. Last visit we talked about planning for the birth. Have you thought more about it?

M-I-L: Yes. We discussed it with my son and we agreed that Taziona should go to the health facility for the delivery. I am putting aside a little money each week.

Taziona: And I am preparing some towels and baby clothes. We have talked to our neighbour who drives a taxi and he says he can take me to the health facility when labour starts

CHW: I am very pleased with all you have done! ***(Takes out Second home visit during Pregnancy Card 2: Advise on Immediate Newborn Care)*** *Now* we are going to talk about the care a baby needs immediately after birth. What kind of care do you think a newborn baby needs?

Taziona: The baby comes out wet and needs to be dried.

CHW: Very good. What else?

M-I-L: The baby needs to be fed.

CHW: That is right. How did you feed your other children?

Taziona: I breastfed my other children and I will breastfeed this one too.

CHW: Excellent. Breast milk is the best food a baby can have. Let me tell you about the care Abena's baby received. What do you see in the pictures?

Taziona: In this picture, a baby is being put in the cloth. And here the baby is lying on the mother's chest. Here the baby is lying on the mother's chest with a hat on, and here the baby is breastfeeding.

CHW: Good. The birth attendant dried Abena's baby immediately after birth. She then placed the baby directly on Abena's chest – the baby's skin touching Abena's skin – and covered them with a blanket. After cutting the cord, the birth attendant placed the baby skin-to-skin between Abena's breasts. Abena's mother-in-law put a hat on the baby's head and socks on his feet and covered Abena and the baby with the blanket. This helps keep the baby warm. After a few minutes, the baby was alert and moving his mouth and Abena's mother-in-law helped her to put the baby to the breast. Early breastfeeding helped the milk to come in and reduced Abena's bleeding. The mother-in-law knew that breast milk is like the baby's first vaccination as it protects the baby from disease and provides the best possible food. To make sure the baby stayed warm, the family decided to wait until the next day to bathe the baby. What do you think about the care given to Abena's baby immediately after birth?

Taziona: I like it. It is very loving.

CHW: This last picture is of Mary. You remember Mary has HIV. When her baby was born, she did all the same things as Abena. In addition, the baby was started on ARV prophylaxis to be protected from HIV.

M-I-L: We are planning to deliver in the health facility. Will they allow her to breastfeed immediately?

CHW: Yes. They are doing all that I described in the clinic because they know it is best for the baby.

Taziona: I never knew it was so important to keep the baby warm.

CHW: Yes, it is. If a baby gets cold, he or she can get sick.

M-I-L: Well we will certainly do this for the baby. But what if people want to see the baby right after birth?

CHW: Well, since it is so important to keep the baby warm, to keep the mother and baby skin-to-skin and to start breastfeeding soon after delivery, I am sure the family will understand if they have to wait to see the baby for an hour or so until the baby is fed and warm.

Taziona: Yes, I think we can explain it to the family beforehand.

CHW: That is fine**. (CHW opens card with danger signs)**.

Before I go, I want to review the danger signs that could occur during pregnancy. Do you remember them?

Taziona: Yes, they are bleeding, severe abdominal pain mmmh what else?

CHW: Look at the card….

Taziona: oh, fits, severe headache, difficult breathing and fever.

CHW: Very good. Remember that if you have any one of these you must go to the health facility immediately. Well I must be going now. You are doing the best for yourself and the baby. Keep it up. And don't forget to let me know as soon as the birth takes place so I can visit you as soon as possible and meet the new family member!

(Then Monica writes in the CBMNC register)

Good-bye.

END OF ROLE PLAY

PRACTICE ROLE PLAY in small groups: Second Home Visit during

Pregnancy (2 months before the expected date of birth)

In groups of four, take turns playing the CHW role to practice conducting the second home visit during pregnancy.

SESSION 18

FIELD PRACTICE:

FIRST HOME VISIT DURING PREGNANCY

Learning Outcomes

By the end of this session, you should be able to:

- Explain the purpose of conducting the first home visit during pregnancy
- List materials to be used during the home visit
- Follow the proper sequence for conducting the first home visit during pregnancy

Purpose for conducting the first home visit during pregnancy

- To encourage the pregnant woman to go for early antenatal care
- To encourage her to learn her HIV status so that she can take action to best protect her health and protect her baby from HIV
- To promote birth in a health facility
- To help prepare for birth
- To teach home care for the pregnant woman

Materials to be used during the home visit

- Counselling cards
- CBMNC register
- Referral form
- Pen

Sequence for First Pregnancy Visit

1. Greet the family, develop good relations and explain the purpose of the visit.
2. Use First home visit during Pregnancy Card 1: Promote Early Antenatal Care, HIV Testing and TB Screening.
3. Use First home visit during Pregnancy Card 2: Prepare for birth in a health facility.
4. Use First home visit during Pregnancy Card 3: home care for pregnant woman
5. Use First home visit during Pregnancy Card 4: Care of the pregnant woman in an HIV setting.
6. Use First home visit during pregnancy card 5: danger signs during pregnancy.
7. Ask the pregnant woman and family to tell you what they have understood about the care needed by women during pregnancy, and about danger signs in pregnancy.
8. Decide with the family when you will visit again
9. Enter information about the woman in the CBMNC Register

10. Write the appointment for the second pregnancy visit in the CBMNC Register
11. Thanking the family

UNIT II: HOME VISITS AFTER BIRTH

Sessions 19 through 33

SESSION 19

INFECTION PREVENTION

Learning Outcomes

By the end of this session, you should be able to:

- Define infection prevention
- Explain measures of preventing infection
- Explain the Covid - 19 considerations during CBMNC service delivery
- Explain the importance of washing hands before touching a new born
- Demonstrate the hand washing technique (using WHO protocol)

DEFINITION

Infection prevention and control is a practical evidence-based approach, which prevents patients / clients and health workers from being harmed by avoidable infection because of antimicrobial resistance.

Measures of preventing infection

As part of reinforcing infection prevention measures and COVID response, adhere to the following measures:

- Hand washing with soap
- Use of hand sanitizer
- Maintaining social distance from others (of least 1metre)
- Wearing face mask
- Conducting meetings in open and ventilated spaces
- Getting fully vaccinated

NOTE: CBMNC remains an essential reproductive health service during the COVID-19 pandemic and any other pandemic. CHW should therefore continue doing home visits

COVID - 19 (and other pandemics) considerations during CBMNC service delivery

CBMNC providers should observe IPC measures including observing physical distancing, of between 1 to 1.5 meters during home visit

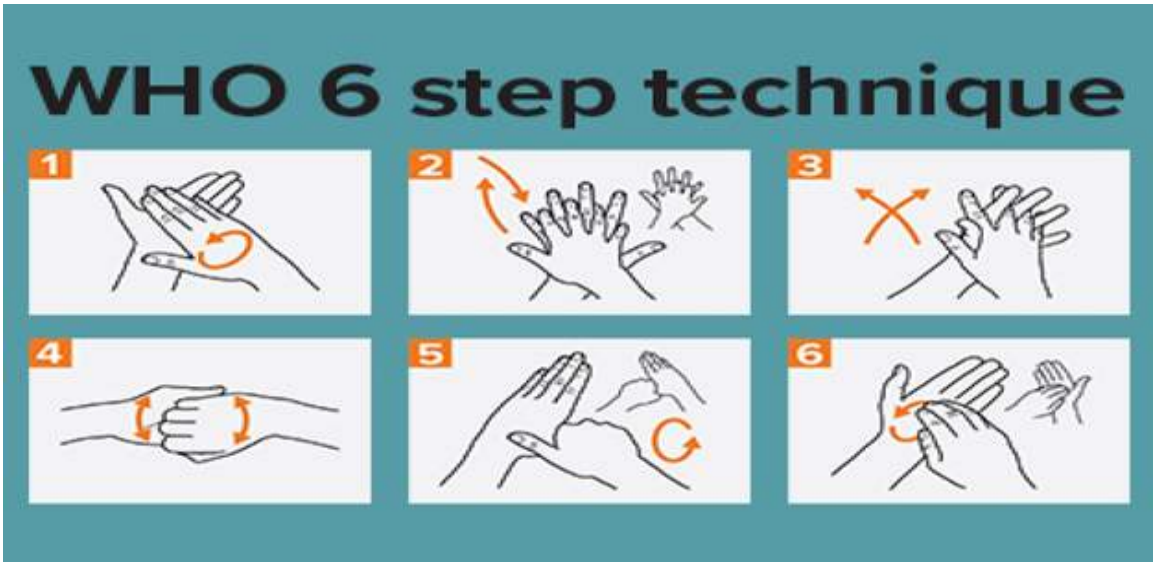
- Providers should wear appropriate PPE as stipulated in the Malawi Personal Protective Equipment Guidelines for COVID-19. i.e. face mask
- Suspected or probable COVID-19 clients should be referred to health facility.
- Observe hand hygiene before and after home visit especially before touching a neonate.
- Avoid hand shake during home visit

Why is it important for CHWs to wash hands before and after touching a neonate?

Neonates can get infections more easily than adults or older children. This can be dangerous. Frequent and correct hand washing is one of the most effective ways to prevent infections. As a CHW, it is very important to always wash hands with soap before and after touching the baby to prevent infections.

WHO Steps for hand washing to be followed

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



SESSION 20

SUPPORTING INITIATION OF BREASTFEEDING

Learning Outcomes

By the end of this session, you should be able to:

- Explain how breastfeeding works
- Check whether the mother has initiated breastfeeding
- Support a mother to initiate breastfeeding
- Observe a breastfeed to assess positioning and attachment.
- Demonstrate ways to strengthen a mother's confidence when supporting breastfeeding
- Explain the importance of exclusive breastfeeding
- Explain the common breastfeeding conditions and management

HOW DOES BREASTFEEDING WORK?

There are three important things to understand on how breastfeeding works:

1. **Mother's brain controls production of breast milk**: When the baby suckles at the breast, it makes the mother's brain send a signal to the breast to let the milk out and make more breast milk. This is why the more the baby suckles at the breast, the more breast milk is produced and released. In addition, this process is easily affected by a mother's thoughts, feelings and sensations. The following stimulate the mother's brain to produce more breast milk for the baby:

- Thinking lovingly of the baby
- Hearing sounds of the baby
- Looking at the baby
- Touching the baby
- Confidence that she can breastfeed the baby

On the other hand, the following factors may make the mother to produce less or no breast milk.

- Worry
- Pain
- Lack of confidence to breastfeed the baby. Fortunately, this effect may be temporary.

2. **A breast stops producing milk if it remains full:** This means that if the baby does not suckle frequently to empty the breast, milk production will decrease

3. **The baby should suckle on the areola, not on the nipple:** During a feed, milk flows and is collected in spaces under the areola (the dark area of the breast around the nipple). The baby has to suckle on this area to get the milk from the breast. If the baby only suckles on the nipple, his/her mouth and tongue will rub the skin of the nipple making the nipple painful and sore.

WAYS OF BUILDING MOTHERS' CONFIDENCE WHILE SUPPORTING HER TO BREASTFEED

The following communication skills can be applied to build the mothers confidence during breastfeeding:

Acknowledge what the mother thinks and feels. Do not disagree with her even if she has an incorrect perception because this may demoralise her and result in her not talking to you further about her concerns. However, it is also important not to agree with her if you think she has incorrect perception. First, respond to her in a way that tells her that you acknowledge her concern.

EXAMPLES

Which of the following three responses of the CHW is appropriate and is likely to build the mother's confidence?

First interaction:

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

CHW: Oh no! Milk is never thin and weak.

Second interaction:

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

CHW: Yes, thin milk can be a problem

Third interaction:

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

CHW: I see, you are worried about your milk

Praise the mother for what she does well. For example, the CHW could continue like this:

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

CHW: I see, you are worried about your milk

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

CHW: It is good that you asked before deciding.

Then give relevant information in a positive way to correct a mistaken idea or to reinforce a good idea. For example, the CHW could continue like this:

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

CHW: I see, you are worried about your milk

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

CHW: It is good that you asked before deciding. Mother's milk is the best food for the baby because it has all the necessary nutrients, even if it looks thin. In addition, it protects the baby against diseases.

Avoid giving information in a negative way because this can make the mother feel that she is doing something wrong, and will reduce her confidence. For example, the following is negative and less appropriate:

CHW: Mother's milk is essential for the baby. The baby can get sick and can die if you give him bottle feeds.

ROLE PLAY: Building Mothers' Confidence

This mother gave birth 7 days ago and is breastfeeding, but seems worried.

Mother: I am afraid of transmitting HIV to my baby when I breastfeed.

CHW: I see, you are worried that you will transmit HIV to your baby

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

CHW: It is good that you asked before deciding. Mother's milk is the best food for the baby because it has all the necessary nutrients. In addition, it protects the baby against diseases.

Mother: But I have HIV.

CHW: I see**,** you are worried about that.

Mother: Yes, I take my ARVs every day, but I do worry.

CHW: It is very good that you know your HIV status and that you take ARVs. The ARVs that you are taking will prevent you from passing HIV to your baby even through breastfeeding. Do you give your baby his/her ARVs at the same time every day?

Mother: Yes. I make sure that I do.

CHW: Very good. How are you feeding the baby now?

Mother: Only breast milk so far, but I have been thinking about changing to formula.

CHW: I know you would want to do the best for your baby, but you are already doing the best by only breastfeeding your baby. The ARVs are protecting your baby from HIV. In addition, exclusive breastfeeding protects the baby from serious illnesses like pneumonia and diarrhoea. You should continue exclusive breastfeeding, just as you are doing now, until the baby is 6 months old.

Mother: Oh thank you. That makes me feel much better.

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PRACTICE ROLE PLAY: Building confidence

Practice how to build a mother's confidence while giving correct information.

Remember to:

- **Acknowledge** what the mother thinks and feels
- **Praise** the mother for what she does well
- **Then** give relevant information in a positive way to correct a wrong idea or reinforce a good idea.

Practice in the following situations:

Case 1: Mother has not put the baby to the breast because she thinks her breasts are empty and baby will not get any milk.

Case 2: Mother has not put the baby to the breast because she thinks the first milk is dirty and could harm the baby.

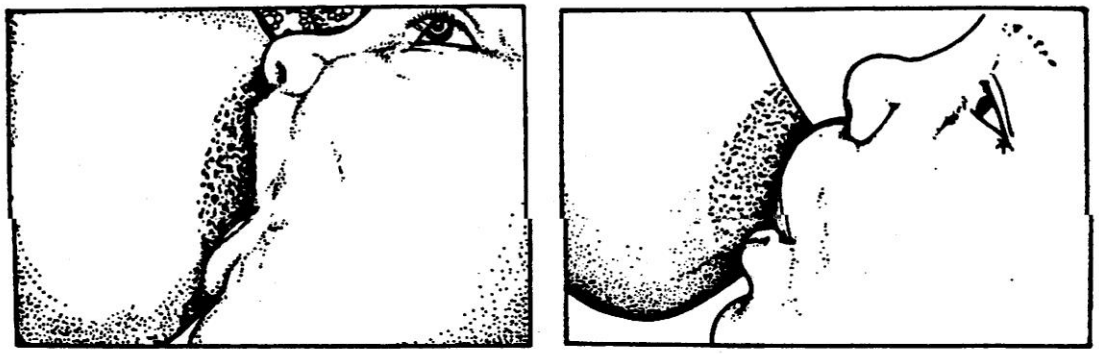
Case 3: Mother has not put the baby to the breast because she thinks the baby is not hungry, as he is not crying for milk.

OBSERVING A BREASTFEED

Signs of good attachment

The baby is well attached to the breast if

- More areola is seen above than below the baby's mouth
- Baby's mouth is open wide
- Lower lip is turned outwards; and
- Chin is touching breast



Good attachment **Poor attachment**

Effective suckling

The baby is suckling effectively if:

- Takes slow, deep sucks sometimes pausing in between
- You can hear the baby swallow

HELPING THE MOTHER TO IMPROVE ATTACHMENT

If the attachment is not good or the suckling is not effective, the CHW should try to help the mother to improve attachment. It is important to first observe the breastfeed carefully before starting to help the mother. A common cause of poor attachment is poor positioning of the baby while feeding.

Explain to the mother that improving baby's attachment would make it better for her to feed the baby. Ask if she would like you to show her. If she agrees:

1. **Make sure the mother is relaxed and comfortable:**
   The mother can breastfeed in sitting, reclining or lying down position. It is very important that she is relaxed and comfortable. As you have learnt earlier, if the mother is worried or has pain, her milk may not come out easily.
2. **Ensure that the baby's position is good**
   The baby is in a good position for breastfeeding if:
   - Baby's head and body are in line (which means neck is not twisted)
   - Baby is held close to mother's body, facing the breast; and
   - Baby's whole body is supported

Good position

Baby's head and body are in line (which means neck is not twisted)

Baby is held close to mother's body, facing the breast; and

Baby's whole body is supported

Poor position

Neck twisted, head and body not in line

Baby's body is away from the mother,

Only upper body supported

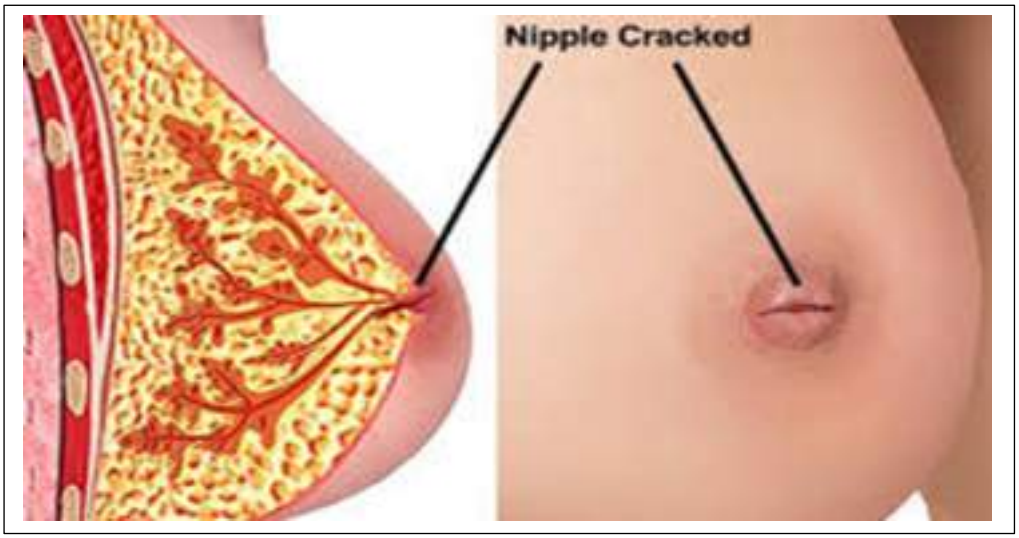
If the baby is not in a good position, explain to the mother how to position her baby and show her if necessary.

1. **Help the mother to improve attachment**
   Ask her to touch the baby's lips with her nipple, wait until the baby's mouth is wide open, and move the baby quickly onto her breast, aiming his lower lip below the nipple. Chin and lower lip touching the breast.
2. **Notice how the mother responds and ask her how the baby's suckling feels.**

Look for signs of good attachment. If attachment is not good, try again.

COMMON BREASTFEEDING CONDITIONS AND THEIR MANAGEMENT

a. Cracked / Sore Nipple

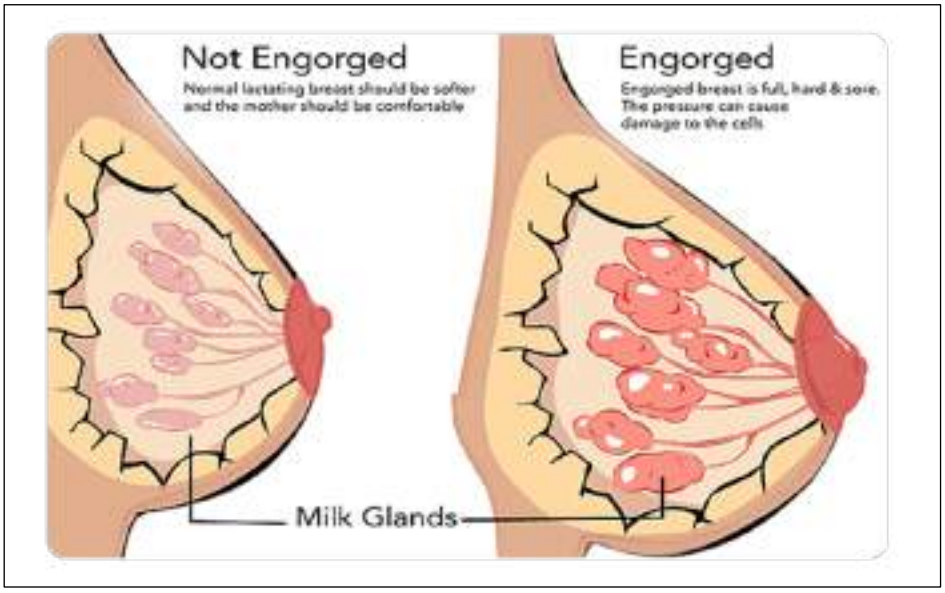


Management of Cracked/Sore Nipple

Encourage the woman to:

- Continue breastfeeding with good attachment
- Begin to breastfeed on the side that hurts less
- Change breastfeeding positions
- Let the baby come off breast by itself
- Apply drops of breast milk on the nipples
- Avoid use of soap or cream on the nipples
- Breast feed frequently to avoid breast becoming full

b. Breast Engorgement



Management of Breast Engorgement

Encourage the woman to:

•Wear a well--fitting bra

•Feed frequently, including prolonged feeds from the affected breast

•Proper positioning and positioning and attachment

•Apply cold compress to reduce swelling

•Massage breasts and if necessary, hand express milk to relieve pressure

SESSION 21

DANGER SIGNS IN A NEWBORN:

Learning Outcomes

By the end of this session, you should be able to:

- Explain why it is important to assess a baby for danger signs soon after birth.
- Assess danger signs in a newborn.

Why is it important to assess a new born for danger signs?

A newborn can fall sick easily in the first days after birth and the sickness can get serious quickly. A delay in receiving treatment can be life threatening for the baby.

Signs of illness in newborn babies can be difficult for families to identify, but a trained CHW can assess and identify babies who need urgent treatment. The CHW should therefore assess all babies for signs of illness ("danger" signs) during each home visit.

Danger signs in a new born
• Not able to feed since birth, or stopped feeding well. • Convulsed or fitted since birth. • Fast breathing: Two counts of 60 breaths or more per minute. • Severe chest in drawing. • High temperature: 37.5°C or more. • Very low temperature: 35.4°C or less. • Yellow soles. • Movement only when stimulated or no movement even on stimulation. • Signs of local infection: umbilicus red or draining pus, skin boils, or eyes draining pus.

21. 1 NOT ABLE TO FEED SINCE BIRTH, OR STOPPED FEEDING WELL AND CONVULSIONS

Learning Outcomes

By the end of this session, you should be able to:

- Assess for the danger sign "Not able to feed or stopped feeding well"

- Assess for the danger sign "Convulsions or fits"

A. NOT ABLE TO FEED SINCE BIRTH, OR STOPPED FEEDING WELL

If the baby is not able to suckle at the breast even when the mother has tried to put the baby to the breast several times over a few hours, this indicates the baby may have a severe illness, and is therefore a danger sign. But, if you have already observed the baby at the breast while trying to help the mother initiate and sustain breastfeeding, it means there's no danger sign. A baby with a danger sign should be referred to a health facility immediately. If the CHW finds a danger sign, there is no need to spend time to complete the rest of the assessment; instead, the CHW should make urgent arrangements for referral.

B. CONVULSIONS OR FITS

A convulsion or fit indicates severe illness in the baby and is therefore a danger sign. During a fit, the baby's arms and legs may become stiff. The baby may stop breathing and become blue. Many times, there may only be a recurring movement of a part of the body, such as twitching of the mouth or blinking of eyes.

When you ask the mother "Has the baby convulsed or fitted since birth?" and she says yes, this is a danger sign. If she does not understand what a fit is, explain. If she says the baby did not have a fit, do not ask any further questions.

DISCUSSION: Decide if this baby has a danger sign:

1. Mother is not sure she has enough breast milk.
2. Baby brings out curdled milk after breastfeeding.
3. 6-hours-old baby does not suck at the breast; mother has tried to put the baby to the breast 4 times since birth.
4. Baby makes a jerky movement when there is a sudden noise.
5. Baby had rhythmic twitching of the face lasting for a few minutes this morning.

DEMONSTRATION ROLE PLAY: Assessing for danger signs – not able to feed since birth or stopped feeding well and convulsed or fitted

Mrs. Haji gave birth to a baby girl at the health facility; and have been discharged early this morning. The CHW came to her house to make the first home visit as soon as Mrs. Haji's husband informed her about her discharge from the health facility. Observe the interview and discuss what you have seen.

- How did the CHW greet Mrs. Haji?
- How did the CHW explain the purpose of her visit?
- Did the CHW check about initiation of breastfeeding?
- How did the CHW observe breastfeeding?
- Do you think the baby had the danger sign "not able to feed since birth, or stopped feeding well"?

- Do you think the baby had the danger sign "convulsed or fitted since birth"?

***

ROLE PLAY SCRIPT: Assessing for the danger signs – not able to feed since birth or stopped feeding well, or convulsed or fitted

CHW: Hello. Congratulations on the new baby! She is so beautiful. How are you and the baby doing?

Mrs. Haji: I am fine but quite tired. The baby looks fine.

CHW: Yes, one can be quite tired after labour and birth. Do you have any other problems?

Mrs. Haji: I am having some bleeding but it is not heavy.

CHW: That is good. As I had explained earlier, the purpose of my visit today is to check if you and the baby are doing well. Is this a convenient time?

Mrs. Haji: Yes, please sit. I am happy that you could come so soon after my husband informed you about my discharge from the health facility.

CHW: Thank you. I would like to wash my hands before I touch the baby. Could someone pour water?

Mrs. Haji: Yes, my sister will help you. She is in the kitchen preparing tea (CHW leaves and comes back after washing hands)

CHW: Have you fed the baby?

Mrs. Haji: Yes, I had put the baby to the breast just a few minutes after birth, as you had advised me.

CHW: Excellent. I would like to see how the baby is breastfeeding. Is it possible for you to feed the baby now?

Mrs. Haji: Yes, but I have one concern. I think I don't have any milk in my breasts.

CHW: I can see that you are concerned about the amount of milk. It is normal to have a small amount of milk during the first days, but giving it to the baby is very important. You are doing the best thing for the baby. If you continue to put the baby to the breast frequently, the milk supply will increase in a day or two.

Mrs. Haji: Thank you. I think the baby wants to feed ***(Mrs. Haji Puts the baby to her breast)***

CHW: I can see that the baby's mouth is wide open so she has more than just the nipple in her mouth. She is well attached to your breast and is suckling well. You and the baby are doing very well!

Let me ask you another question. Has the baby convulsed or fitted since birth?

Mrs. Haji: No, I don't think so but she sometimes moves her hands and legs when there is a

sudden noise.

CHW: If she only moves once when there is a sudden noise that is normal. A fit means the baby repeats the movement many times over a few minutes.

Mrs. Haji: In that case, no, she has not had a fit.

END OF ROLE PLAY

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21. 2 FAST BREATHING AND SEVERE CHEST IN DRAWING.

Learning Outcomes

By the end of this session, you should be able to:

- Count the breaths that a newborn takes in one minute.
- Decide if the newborn has fast breathing or not.
- Assess a new born for severe chest in drawing.

A. FAST BREATHING

Counting Breaths that the Newborn Takes in One Minute

What is a full breath?

Breathing is taking air in and out of the body through the mouth or nose. Breaths can be counted by looking at the breathing movements. The chest and abdomen move out when we breathe in, and move in when we breathe out. One outward and inward movement of the chest and abdomen together makes one breath.

What is fast breathing in a newborn?

If the breathing rate of a new born is 60 per minute or more the first time, the

CHW should repeat the count. This is important because the breathing rate of a newborn is often irregular. The newborn will occasionally stop breathing for a few seconds, followed by a period of faster breathing.

If the second count is still 60 breaths per minute or more, the newborn has "fast breathing", which is a danger sign. A baby with fast breathing should be **REFERRED urgently** to a health facility.

Why should the baby be calm and not breastfeeding when you count the breaths?

The baby must be quiet and calm when you look at the breathing. If the baby is crying or uncomfortable, you will not be able to obtain an accurate count.

Why count for a full minute?

Babies often have irregular breathing: a few fast breaths and a slower period. Therefore, it is important to count breaths for a full minute (60 seconds).

How to count breaths in a newborn.

Counting breaths in one minute
• *Wait for the new born to be calm (or sleeping). Do not count when the baby is breastfeeding.* • *Make sure that there is enough light to see the breathing movements.* • *Gently lift the baby's shirt so you can see breathing movements. The chest and abdomen rising and falling once makes one breath.* • *Watch a few breaths until you are sure when the baby is breathing in and out.* • *Start the timer and count the breaths for one full minute (until the final beep, which is at the end of one minute).* • *Record the number of breaths.* • *If there are 60 breaths per minute or more, repeat the count and record the number of breaths counted the second time.*

Common errors in counting breaths.

Some common mistakes that can happen while counting breaths in one minute are listed in the box below.

Common errors in counting breaths

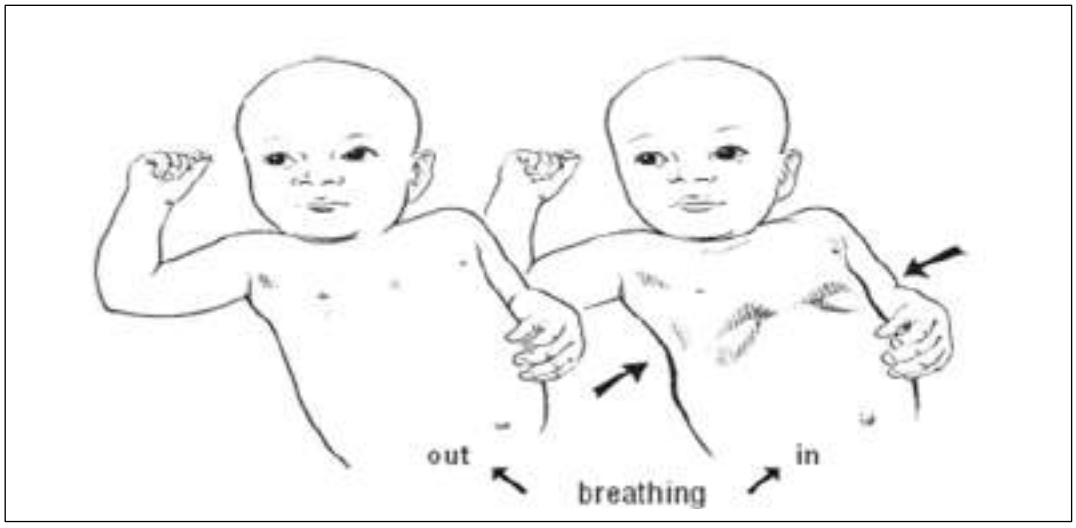
- *Counting when the baby is not calm or is breastfeeding*
- *Generating your own rhythm of respiratory movements and not actually observing the abdomen of the baby*
- *Counting for less than a minute and multiplying the result. This does not take account of irregular breathing, which is normal in newborn babies.*
- *Counting breaths loudly and slower than the actual movement of the abdomen*
- *Counting up and down movements of chest and abdomen as 2 breaths instead of one.*
- *Not repeating the count when the first count is 60 or more.*
- *Counting the beep of the timer instead of the movement of the chest / abdomen*

A. SEVERE CHEST IN-DRAWING.

What is chest indrawing?

Normally the abdomen and chest move out when the baby breathes in. Both the upper and lower part of the chest move out when the baby breathes in.

When the baby has lung problems, the LOWER chest wall goes IN when the child breathes IN. At the same time, the upper chest and abdomen move out. You can therefore see a groove forming between the chest and abdomen this is called severe chest in drawing. A newborn with severe chest in drawing should be referred urgently to a health facility.



Chest in drawing: Lower chest wall going in while breathing in

In the picture above, the baby on the left is breathing out. On the right, the same baby is breathing in. See the groove between the chest and abdomen as the baby on the right breathes

in. The lower part of the chest moves in while the abdomen and upper chest move out normally.

Why should the baby be calm and not breastfeeding when you look for chest indrawing?

Even normal babies can seem to have chest indrawing when they are breastfeeding or are crying. The baby should therefore be calm and not breastfeeding when you look for severe chest in drawing

How to look for chest in drawing

- To look for severe chest indrawing, the child must be calm and should not be breastfeeding.
- Ask the caregiver to raise the child's clothing above the chest just like while counting breaths.
- Look at the lower chest wall when the child breathes IN.
- For chest indrawing to be present, it must be clearly visible and present at every breath.
- If you see chest in drawing only when the baby is crying or feeding, the baby does not have chest indrawing. If you are unsure, decide that the baby does not have chest in drawing.

Look for severe chest in drawing

Look for severe chest in drawing as you would look for chest in drawing in an older infant or young child. However, mild chest in drawing is normal in a new-born because the chest wall is soft. Severe chest in drawing is very deep and easy to see. Severe chest in drawing is a sign of pneumonia and is serious in a new-born.

REFER the sick new-born with severe chest in drawing to a health facility.

21. 3 HIGH OR VERY LOW TEMPERATURE

Learning Outcomes

By the end of this session, you should be able to:

- Use the digital thermometer to measure temperature of a new born
- Read the thermometer and decide if temperature is high or low

Why should the CHW measure the temperature of a newborn?

In a previous unit, you learnt about the importance of keeping babies warm. If a baby gets cold, he/she has problems in suckling at the breast, can get sick easily and is more likely to die.

A well-baby is neither hot nor too cold. When a newborn has a serious infection, his body can become very hot or cold. Thus, both very high and low temperature are danger signs indicating severe illness in a baby.

It can be difficult to tell whether the baby is too hot or too cold just by touching them. The best way to know is to use a thermometer.

TEMPERATURE SCALE

34……35….…..36……37…..**…..38……39**

VERY LOW TEMPERATURE

(Danger sign)

HIGH TEMPERATURE

(Danger sign)

STEPS IN MEASURING BODY TEMPERATURE

Measuring temperature

- *Take thermometer out of the box, hold at broad end*
- *Clean the area from the tip of the thermometer extending 4 cm (the length of half a finger), with warm (not hot) soapy water. Air-dry thoroughly before using.*
- *Press the "on" button once to turn the thermometer on.*
- *Hold the thermometer upward and place the shining tip in the centre of the armpit. Press the arm against the side of the baby. Do not change the position.*
- *When you hear 3 short beeps, and the numbers stop changing, remove the thermometer (this will take a few minutes).*
- *Remove the thermometer and read the number in the display window. Record the temperature reading.*
- *Turn the thermometer off; clean the shining tip with warm soapy water, air dry, and place it in the storage case.*

Common errors that can happen during measurement of temperature are listed in the box below.

COMMON ERRORS

- *Thermometer not properly placed in the armpit so that the tip juts out at the other end of the armpit of the baby.*
- *Thermometer not held firmly in the armpit of the baby.*
- *Thermometer inserted before 00 digits does not record.*
- *Removing the thermometer from the armpit without hearing the three beeps, because you think it has been there for a long time.*
- *Not recording the temperature immediately after measuring it.*

How to interpret temperature?

If a baby's temperature is:

- **37.5°C or more:** the baby has high temperature (fever) -- this is a danger sign and the baby should be URGENTLY referred to a health facility for treatment and care.

- **35.4°C or less:** the baby has very low temperature and this is a danger sign and the baby should immediately be put on skin-to-skin and URGENTLY referred to a health facility for treatment and care.

A baby with temperature between 35.5°C and 37.4°C does NOT have a danger sign. However, the family of a baby with temperature between 35.5°C and 36.4°C should be counselled on keeping the baby warm.

21. 4 YELLOW SOLES, MOVEMENT ONLY ON STIMULATION AND NO MOVEMENT EVEN ON STIMULATION AND LOCAL INFECTION

Learning Outcomes

By the end of this session, you should be able to:

- Demonstrate how to look for yellow soles
- Demonstrate how to assess the baby's movement
- Demonstrate how to look for signs of local infection

A. YELLOW SOLES

How to look for yellow soles

Many babies have some jaundice (yellow eyes or skin) in the first week of life. This is normal and disappears in a few days. However, some babies can develop severe jaundice, which can be dangerous. If the baby has yellow soles, it means that the jaundice is severe.

Assess every baby for yellow soles:

- Always look for this sign in natural light because it is difficult to accurately decide if the skin colour is yellow in artificial light.
- Press the infant’s soles with your thumbs to blanch, remove your thumbs and look for yellow colour.

A baby with yellow soles should be URGENTLY taken to a health facility for treatment of severe jaundice.

B. MOVEMENT ONLY ON STIMULATION OR NO MOVEMENT EVEN ON STIMULATION

Assessing movement

Babies often sleep most of the time, and this is not a sign of illness. Observe the baby's movement while you do the assessment. If a baby does not wake up during the assessment, ask the mother to wake up the baby.

- A baby who is awake will normally move his arms or legs or turn his head several times

in a minute if you watch him closely. If CHW see the baby moving on his or her own, then the baby does not have the danger sign

- If the baby is awake but does not move on his/her own, gently stimulate the baby by tapping or flicking the sole. If the baby moves only on stimulation and then stops moving, the baby has a danger sign.

- If the baby does not move at all even after stimulation, this is also a danger sign. A baby who cannot be woken up even after several efforts to wake him or her up also has danger sign.

A baby who moves only on stimulation or does not move even on stimulation should be URGENTLY taken to a health facility for care.

C. SIGNS OF LOCAL INFECTION

Assessing for signs of local infection

Most common local infections occur on skin, umbilicus and eyes. Pus and redness are signs of local infection. CHW should therefore look at the:

1. **Umbilicus:** Is there pus coming out of umbilical stump? Is the skin around the umbilical stump red?

2. **Skin:** Are there skin pustules (pustules are red spots or blisters that contain pus)? Look at the whole body including the back, armpits and groin area.

3. **Eyes**: Is pus coming out from the eyes? Look at both eyes.

A baby with any local infection needs treatment because local infection may progress to a severe infection if it is not treated. **Refer** a baby with a local infection to a health facility.

NEONATE WITH POSSIBLE SERIOUS INFECTION (0 up to 28 days)

This assessment step is done for every young infant. In this step, you are looking for signs of infections. A neonate can become sick and die very quickly from serious infections. The common problems are convulsions, fast breathing, severe chest in drawing, jaundice, eye discharge, redness or pus discharge around the umbilicus, low or high temperature, many or severe skin pustules, irritability, very sleepy or unconscious and less movements.

PROBLEMS	IDENTIFY AS:	WHAT TO DO
• Unable to feed,	**POSSIBLE SERIOUS**	• Advise the mother on the need for referral

• Convulsions or • Fast breathing (60 breaths per minute or more after a repeat count) or • Shallow breaths (less than 30 breaths per minute) • Severe chest in drawing or • Umbilicus redness or pus draining from the umbilicus • Fever (37.5°C or above or feels hot) or low body temperature (less than 35.5°C or feels cold) or • Skin pustules or a boil or • Movements less than normal or • Irritable, very sleepy or unconscious • Jaundice	**INFECTION**	• Advise mother how to keep the infant warm on the way to hospital • Breastfeed more frequently (or expressed breast milk if unable to breastfeed but conscious) • Advise mother on the need for referral • Refer URGENTLY to hospital
PROBLEMS	**IDENTIFY AS:**	**WHAT TO DO**
• No problem	**NO INFECTION**	• Reassure the mother • Advise the mother to return immediately if any of the problems listed above appear • Advise mother how to keep the infant warm. • Breastfeed more frequently.

SESSION 22

MEASURING BABIES WEIGHT AND IDENTIFYING SMALL BABIES

Learning Outcomes

By the end of this session, you should be able to:

- Explain the importance of weighing the new born
- Demonstrate how to use a hand-held scale correctly and safely
- Read and interpret the colour coding on the scale
- Record the weight correctly in the CBMNC Register.
- Identify if the baby needs special care because of low weight.

Why should a newborn's weight be measured?

It is difficult to tell if a baby has low or normal weight just by looking at him or her; the best way is to weigh the baby. If a baby is born in a health facility, weight is taken soon after birth. It is usually recorded in the health passport.

The baby should be weighed on the day of delivery. Small babies are most vulnerable during the first days and their special care needs to start as soon as possible. If you find a danger sign during your assessment on the day of the visit, the CHW should not waste time to measure weight but rather arrange for referral urgently, in Kangaroo Mother Care (KMC) position.

Babies who are small may have been born early or may not have grown well enough in the womb. This means that small babies may not be fully ready to live outside the womb and can have many problems. Small babies are more likely to become seriously ill or die than normal babies. Small babies need special care to prevent them from becoming ill and dying.

The box below describes common problems faced by small babies:

Problems faced by small babies

- ***Low temperature****:* Small babies have little fat on their bodies and are often not able to maintain their temperature. This means that they can easily get cold and sick, and need to be kept extra warm.
- ***Feeding problems****:* Small babies need breast milk to survive and grow, but they have small stomachs, tire easily as they do not have enough energy to suckle, and may not attach well to the breast. This means small babies are at risk of not getting enough

breast milk and need to be fed very often to ensure they are adequately fed. Small babies need to be fed on schedule, as they may not demand feeding and supplement with expressed breast milk

- ***Infection****:* Small babies may not have strong immunity to fight disease and so can get infections and illnesses easily. This means that it is even more important to do things that help prevent infection, such as hand washing.
- ***Breathing****:* Very small babies may have difficulty in breathing because their lungs have not yet matured

Steps in weighing the baby

- Explain to the family why you are weighing the baby. Be sure to explain what you are doing throughout the weighing process.
- Place the weighing scale and the wrapper on a clean surface.
- Hang the wrapper (*chitenje*) on the hook of the scale and adjust the knob to make sure that the scale reads ZERO.
- Ask the mother to undress the baby so he or she is wearing only a hat, shirt and nappy and place the baby on the wrapper (*chitenje*).
- Draw the sides of the wrapper (*chitenje*) up and attach the wrapper to the hook on the scale.
- Holding the top bar carefully, lift the scale and wrapper (*chitenje*) with baby off the ground until the scale is at eye level. Do not hold or touch the baby from below, as the weight will be incorrect.
- When the scale is fully extended and has stopped bouncing, read the scale at eye level. Look where the coloured inner part of the scale meets the top of the outer case of the scale.
- Read the weight. Look at the colour zone. Then read the weight in grams to the completed 100 grams, i.e. if the weight is between 1900grams and 2000grams, it should be read as 1900grams.
- Gently put the wrapper (*chitenje*) and the baby back down and unhook the wrapper (*chitenje*).
- Ask the mother to take the baby out of the wrapper (*chitenje*) and encourage her to calm the baby.
- Record the weight in the register: encircle the zone on scale (red, yellow or green). Then write the weight in grams in the space provided.
- Explain the findings to the family

It is very important to make sure that the baby does not fall. You should hold the top bar carefully, and can support your hand holding the top bar with the other hand if needed. For additional safety, it is better to weigh the baby over a soft bed or close to the ground. You should not worry if the baby cries, this is normal. You or the caregiver should not hold or touch the baby from below, as the weight will be incorrect.

NB: The CHW should use a light personal wrapper for easy adjustment of the knob.

How do you interpret the weight?

If the weight is in the:

Red zone (less than 2000 grams): The baby is very small and can have severe problems with keeping warm, feeding and breathing. This baby should be REFERRED to a health facility urgently.

Yellow zone (2000 to 2400grams): The baby is small and needs special care because they can get sick easily. You will learn about care for the small baby at home in later sessions.

Green zone (2500grams or more): This is a normal baby and needs normal care. You will learn about care for the normal baby in later sessions

However, remember that if a baby has any danger sign, even if the weight is in the yellow or green zone, you should refer the baby to the health facility.

PRACTICE: How to interpret the weight

Weight in grams	**Colour zone on weighing scale**	**Refer the baby**	**Counsel on care for the small baby**	**Counsel on normal care**
1,400	Red	√		
2,900				
2,000				
2,100				
1,300				

CLASSIFICATION OF PROBLEMS RELATED TO WEIGHT (0 up to 2 months)

A low birth weight baby is one who is less than 2500 grams at birth. A very low birth weight baby is one who weighs less than 1500 grams at birth.

A baby born with weight less than 2500grams would either be a preterm or low birth weight (small for gestation age). The difference between these two babies will be that a preterm will be less active compared to the low birth weight baby. A preterm baby may have problems with breathing, feeding, fighting infection and keeping warm. A small for gestational age baby is usually full term but underweight. He/she is often able to breathe and feed well.

If the baby is born with low birth weight or preterm, CHW should advise the mother to continue breastfeeding with expressed breast milk, initiate KMC and refer the baby to the health facility

If the baby is under KMC, the role of the CHWs is to provide frequent follow up twice weekly until the baby is 2000 grams then once a week until the baby is 2500 grams. If the baby is not gaining weight, refer to the health facility

SIGNS	IDENTIFY AS	WHAT TO DO
Weight < 1500grams	**VERY LOW BIRTH WEIGHT**	• Advise mother to initiate feeding with expressed breast milk regardless of HIV status of mother • Advise mother to initiate skin to skin contact (KMC) • **Refer URGENTLY**
Weight 1500 to <2500grams	**LOW BIRTH WEIGHT**	• If already counselled by a health worker, check mothers understanding and advise caregiver to follow the advice given • If not counselled by a health worker, continue feeding with expressed breast milk regardless of HIV status of mother • Advise mother to continue skin to skin contact (KMC) • Refer URGENTLY to the nearest Health facility
Weight ≥2500grams	**NORMAL WEIGHT**	• If home delivery, counsel on exclusive breastfeeding regardless of HIV status of mother • Refer URGENTLY to health facility • If already counselled by health worker, check mothers understanding and counsel on exclusive breast feeding regardless of HIV status of mother • Keep baby warm • Counsel mother/caregiver on prevention of infection

		• Provide follow up visits at day 1, day 3 and day 8.

SESSION 23

CLINICAL PRACTICE: ASSESSING A POSTNATAL MOTHER AND A NEW BORN IN A HEALTH FACILITY

Learning Outcomes

By the end of this session, you should be able to:

- List the materials to be used during assessment
- Assess a mother and her new born for danger signs
- Observe a mother breastfeeding

Materials to be used during assessment

- A set of counselling cards
- Thermometer
- Timer
- Note pad
- Pen
- CBMNC Register

PRACTICE: ASSESSING MOTHER AND NEW BORN FOR BREASTFEEDING AND DANGER SIGNS

- Greet the mother (and other caregivers if present)
- Ask how the mother and baby are doing
- Has the mother initiated breastfeeding? Praise her if she has; encourage her to do it now if she has not.
- Assess positioning and attachment during breastfeeding
- If the baby is not well attached or positioned, ask the mother if you could help her to improve the baby's position for breastfeeding and improve attachment. If she agrees, help her to improve position and attachment. Assess the baby for all other danger signs.

- Thank the mother.

SESSION 24

DECIDING HOW TO PROCEED AFTER ASSESSMENT

Learning Outcome

By the end of this session, you should be able to:

- Decide what to do after assessing danger signs and measuring weight.

How to proceed after assessment.

In the previous sessions, you have learnt how to use the First Home Visit after birth Card 1: "Assess Feeding, Danger Signs and Weight". The next two cards for this visit are:

- First home visit after birth Card 2: Care of the Normal Baby.
- First home visit after birth Card 3: Care of the Small Baby.

You will use one of these cards or the referral note depending on what you found during assessment.

Most babies will not have any danger sign and their weight will be in the green zone (2500 grams and above). These babies are normal. For all these babies, proceed to use Card 2: Care of the Normal Baby. There is no need to use Card 3 for these babies.

Some babies will not have any danger sign but a weight in yellow zone (2000grams to 2499 grams). These small babies need additional care at home. For these small babies, instead of Card 2, use Card 3: Care of the Small Baby.

A baby who has one or more of the danger signs or has weight in the red zone (less than 2000 grams) needs urgent care and treatment in a health facility. Refer this baby urgently to the health facility using a Referral Note.

SESSION 25

CARE OF THE NORMAL BABY

Learning Outcomes

By the end of this session, you should be able to:

- Promote and support exclusive breastfeeding.
- Explain how to prevent passing HIV from mother to baby during breastfeeding.
- Teach how to keep the baby warm.
- Promote infection prevention.
- Promote baby's development.
- Counsel families on newborn care in relation to TB.
- Help families in identification of signs of illness and prompt care seeking

PROMOTE AND SUPPORT EXCLUSIVE BREASTFEEDING

A baby should be given only breast milk.

An infant should be given only breast milk for the first 6 months of life. Breast milk is the best food for the baby and provides all the food and fluid that the baby needs. It protects the infant against infections. Giving other food or fluids, even water, can be harmful for the baby.

Reasons for a baby not to get enough breast milk

Below are some of the reasons babies may not get enough milk;

- **Family giving other feeds:** A baby who is being given other food or fluids (artificial milks, solids, or drinks including plain water) before 6 months suckles less at the breast. This reduces the amount of milk the mother makes.
- **Infrequent feeds:** A baby should be breastfed at least 8 times or more a day in the first 6 months – even if they do not cry that often. Mothers also need to feed the baby at night. If the mother does not breastfeed the baby often, during the day and night, her milk supply will decrease.
- **Feeds not long enough:** Breastfeeds may be too short or hurried, so that the baby does not get enough milk. This may be because the baby pauses, and his/her mother decides that she/he has finished or the mother may be in a hurry. The mother should allow the baby to feed until the baby lets go of the breast him or herself.
- **Mother lacks confidence, is worried or tired:** Many mothers worry about their breast-milk supply and want to wait to start breastfeeding until they have enough milk. These mothers lack confidence and may wait to start breastfeeding or decide to start

artificial feeds, which may decrease breast-milk supply.

- **Baby not positioned or attached well:** If a baby is in the wrong position or is not attached to the breast well they cannot suck well and may not get enough milk.

Relevant advice for a mother reluctant to exclusively breastfeed

After you have identified the reason why the family is reluctant to exclusively breastfeed, you should try to address this concern by giving relevant advice and encouragement.

Relevant advice for a mother reluctant to exclusively breastfeed	
Problem	**Advice**
Family thinks water should be given in hot weather.	Explain that breast milk contains water that the baby needs. In hot weather, the baby can suckle more often. Giving water or other fluids can make the baby sick.
Mother does not think that she has enough breast milk.	Help the mother relax and be comfortable. Advise her to put the baby to suckle more often. The more the baby suckles, the more milk will come. Check breastfeeding attachment and positioning. If there is a problem, help the mother correct the position and improve attachment.
Family wants to give at least one formula or animal milk feed so that the baby gets used to it, because the mother has to return to work in a few days.	Explain the advantages of exclusive breastfeeding and risks of giving other fluids or foods. Advise that the mother can learn to express breast milk, which can be kept at room temperature for 8 hours, and be fed to the baby by the caregiver in the mother's absence.
Mother is reluctant to breastfeed because she has HIV	Explain that mother's milk is still the best food for the baby. When a woman takes ARVs every day, and when she gives the baby ARV prophylaxis every day for the first 6 weeks of life, the ARVs reduce the risk of HIV transmission to the baby. Explain the advantages of exclusive breastfeeding and risks of giving other fluids or foods. Advise the mother who has HIV that it is important to breastfeed exclusively for 6 months.

How do you prevent HIV transmission during breastfeeding?

A breastfeeding mother needs to know her HIV status and encourage her partner to also test for HIV. While a mother is breastfeeding, she must practice safe sex by using a condom to avoid becoming infected. A mother who did not have HIV during pregnancy should test for

HIV again during breastfeeding.

If a mother has HIV, she is given ARVs to take every day during pregnancy, in labour, delivery, while breastfeeding and for life. The baby will be given ARVs by the health facility immediately after birth, and the mother should give the baby ARVs at the same time every day for 6 weeks. The ARVs taken by the mother and the baby prevent HIV from being passed from the smother to the baby.

The family can support the mother to take her ARVs and give the baby ARV prophylaxis at the same time every day.

A mother who has HIV should exclusively breastfeed her baby for 6 months and continue breastfeeding up to 1 year and 10 months. Stopping breastfeeding should be gradual within 2 months duration.

Keeping the baby warm.

It is very important to keep the baby warm at all times because:

- If the newborn babies get cold, they use up a lot of energy and can become sick.
- Low birth weight and premature babies are at greater risk of getting cold.
- Newborn babies lose heat in the first few minutes after delivery if left wet and naked

Several practices can help keep the newborn warm. Some of them are listed below:

- Delay bathing the newborn for 24 hours after birth even if the baby has whitish stuff on the body because it is harmless and it keeps the baby warm.
- Keep the room where the mother and newborn stay warm and free from draughts.
- Dress the newborn in several layers of clothes, and keep the baby in the same bed as the mother.
- Keep the newborn's head covered with a hat.
- When necessary to bathe the baby, use warm water and bathe quickly. Dry and dress the baby immediately after the bath.
- Breast feed the baby frequently (every 3 hours and on demand)

How can infection be prevented?

Newborn babies can get an infection if caregivers are not careful about hygiene. A family can help their baby stay healthy by following these simple points:

- Wash hands with soap after visiting the toilet or after changing soiled nappies.
- Keep the cord clean and dry,
- Do not apply anything to the cord.
- Clean the baby every time he or she passes stools or urine.
- Baby should put on clean clothes.

How can the baby's development be promoted?

It is important for the family to know that the baby learns from birth through the following ways;

- **Play**: If the baby is provided ways to see, hear, move arms and legs freely and the baby is touched, gently stroked and held. It helps in baby's development.

- **Communicate**: If the mother and other family members look into the baby's eyes and talk to the baby, it also helps in the baby's development**.** They should try to do this as often as possible. The mother can also talk to the baby while breastfeeding as the newborn can see the mother's face and can hear her voice.

Care of a normal baby in relation to TB.

Anyone who lives in a household with a person who has TB is at risk of becoming infected and sick with TB. Infants are at even higher risk than older children and adults.

If a mother has TB, the newborn will be at risk of getting TB. These risks increase if the newborn is exposed to HIV.

It is important that the newborn receive BCG vaccine at birth to prevent TB. If the newborn has not received BCG vaccine, ask why, and refer the newborn to the health facility.

It is important to check whether the newborn may be exposed to TB. To do this, ask whether the mother had TB while she was pregnant, or if she lives in a household with anyone who is on treatment for TB. If there is concern that the newborn may be exposed to TB, refer the baby to the health facility for TB screening. If the newborn was exposed but does not have TB, the health facility will start the baby on isoniazid preventive therapy (IPT).

When should a family seek care from a health facility?

You have learnt that a baby with a danger sign needs to be taken for URGENT treatment in a health facility. However, you will only see the baby two times during the first week of life. A baby may become sick in between your visits or after the first week of life. It is therefore important to teach the family about the conditions that require immediate treatment and how they should look for them.

The family should take their baby to a health facility urgently if the baby has any of the following:

- Stops breastfeeding well
- Convulsions or Fits
- Difficulty or fast breathing
- Fever or unusually cold
- Becomes less active
- Whole body becomes yellow
- Pus discharge from eyes or the umbilicus.

Relevant advice for a family reluctant to take their sick baby to a health facility

Some families may be reluctant to take their sick baby to a health facility. As a CHW, you should try to help them overcome their problems. Below are some examples of problems and their probable relevant advice:

Problem	Advice
● Family thinks they should take a sick baby to the faith healer first	● A baby with danger signs needs urgent treatment in a health facility, and could die quickly if he/she does not get this treatment.
● Family has fear of the health facility	● Explain that treatment using injections is necessary for a baby who has a severe illness. This can be done only in a health facility.
● Family thinks it would cost them too much to get treatment	● Explain what it usually costs to get treatment at the health facility, and ask if it would be covered by their savings for an emergency.
● Family does not have any transport to take the baby to the health facility	● Help the family explore options for arranging transport

SESSION 26

CARE OF THE SMALL BABY AND FOLLOW-UP VISITS

Learning Outcomes

By the end of this session, you should be able to:

- Explain why small babies need extra care
- Support the mother to exclusively breastfeed a small baby
- Support the family to keep the small baby warm
- Advise the family on infection prevention
- Advise the family on promoting the baby's development
- Support the family on care of an exposed baby.
- Support the family on care of a small baby in relation to TB.
- Understand recommended schedule of home visits to a small baby and cards to be used.

Reasons for giving extra care to small babies.

Small babies need to be given extra care because**:**

- They get cold easily
- They can have difficulty in breastfeeding
- They are more likely to get an infection than normal weight babies
- Very small babies can have difficulties breathing.

Extra care that small babies need

a) Referring very small babies (weight in red zone) to a health facility as these babies may have breathing problems and may not be able to feed.
b) Extra support for breastfeeding
c) Extra care for keeping warm
d) Extra attention to hygiene.

Support breastfeeding of a small baby

Breast milk is the best food for a small baby. The mother's body produces milk that is suited to the needs of the small baby, particularly if birth has occurred early. It protects the baby

against infections, which are more likely in the small baby than in a normal baby.

A small baby needs to be fed more often because they can take very small amounts of breast milk at a time. The baby can get cold if not fed frequently. Advise the mother to try to feed a small baby at least every 2 hours, day and night. If a baby is sleeping for longer than 2 hours, the mother should wake the baby up to breastfeed. This should continue until the baby is six months old.

A small baby may also have difficulties in attaching to the breast. CHW should help the mother to improve positioning and attachment. The picture below shows breastfeeding position which may be easier for small babies.

If a baby is unable to attach even after trying, refer to the health facility for additional support (such as learning how to express breast milk and feed by a cup).

How to keep a baby warm immediately after birth?

- Keep the room warm and free from draughts of air.
- Dry the baby as soon as the baby is born.
- Keep the baby in skin-to-skin contact with the mother and cover the baby with warm clothes.
- Put a hat on the baby's head and a pair of socks on his/her feet.
- Put the baby to the breast as soon as the mother and baby are ready (within 1 hour of delivery).
- Delay bathing until the baby weighs 2500 grams

Skin-to-skin care (Kangaroo Mother Care)

Small babies need extra attention for keeping them warm in the first days of life. The best way to keep them warm at all times is to keep them in skin-to-skin contact with the mother and

breastfeed at least every 2 hours, for them to grow and develop well.

Explain to the mother and the family the benefits of skin-to-skin care. If they agree, explain how this can be done and help the mother place the baby in skin-to-skin contact.

Steps in placing the baby on skin-to-skin position (use first home visit after birth: card 3b)

i. Undress the baby except for a nappy, hat and socks.
ii. Place the baby on mother's chest and turn the baby's head sideways.
iii. The legs should be in a frog like position
iv. Secure the baby with a cloth *(Chitenje*) tied around the mother and the baby.
v. The mother can then wear a blouse, sweater or shawl if she wants.
vi. Ask the mother to breastfeed the baby as often as the baby wants, but at least every 2 hours.

CARING FOR SMALL BABIES AT THE COMMUNITY LEVEL

Low birth weight (LBW) babies should be initiated on kangaroo mother care (KMC) at health facility and continue follow up at home after discharge.

CHW should follow up babies with birth weight of 1800 grams up to 2000 grams twice weekly. When the baby weighs 2000 grams, follow up should be done once a week until the baby weighs 2500 grams. If the baby weighs 2500grams or more, discontinue KMC. CHW refers to the health facility any LBW baby with danger signs for proper management.

For babies born before arrival at the health facility should be initiated on KMC in the community and refer the mother and baby to health facility immediately.

What to do if family does not agree to skin-to-skin care?

If a family is unwilling to try skin-to-skin care, counsel them to:

- Keep the baby's room warm and free from draughts of air
- Wrap the baby in multiple layers of clothes and keep close to the mother.
- Put a hat and socks on the baby.

For all small babies

Advise all families to delay bathing the baby until the baby weighs 2500grams. Instead, ask them to clean the baby by wiping quickly with a cloth soaked in warm water, then drying and wrapping immediately after that.

Advise all families on maintaining hygiene since preventing infections is even more important for the small baby than the normal baby.

Advise all families on identification of signs of illness in the newborn and prompt care

seeking.

How can the baby's development be promoted?

Same as care of a normal baby covered in session 23

Care for the small baby if the mother has HIV

The baby will be given ARV prophylaxis to protect him or her from HIV. The amount of syrup may be less than what a normal baby receives. It is important that the mother gives the baby the ARV prophylaxis at the same time every day for 6 weeks since birth. She should return to the health facility at 6 weeks of life so that the baby can be tested for HIV and started on cotrimoxazole to prevent pneumonia.

Care of a small baby in relation to TB.

Same as care of a normal baby covered in session 23

When should the CHW make visits to a small baby?

A CHW should make home visits to a small baby on day 1, day 2, day 3, day 8, and day 14 after discharge. The extra follow-up visits to a small baby are those on day 2 and14 after discharge. On these visits, refer to the counselling card titled Extra Visits for a Small Baby. The table below shows cards to be used during home visits after birth:

VISIT NUMBER	DAY	VISIT CARDS
Visit 1	1	First home visit after birth card 1, 3, 4 and 5.
First extra Visit	2	Second home visit after birth card 1, 3, 4, 5 and 6.
Visit 2	3	Second home visit after birth card 1, 3, 4, 5 and 6.
Visit 3	8	Third home visit after birth card 1, 3, 4, 5 and 6.
Second extra visit	14	Third home visit after birth card 1, 3, 4, 5 and 6.

Key Messages in care of small babies

Small babies may have difficulties in breastfeeding, so it is important to give the mother extra support for breastfeeding during the early days to ensure the baby is feeding well.

Small babies need more attention to keep them warm. Therefore, the CHW should check how the mother is keeping the baby warm and give guidance.

The CHW can also encourage the family to delay bathing (so the baby does not become chilled) and instead just quickly wipe and dry the baby.

SESSION 27

CARE OF THE MOTHER

Learning Outcomes

By the end of this session, you should be able to:

- Identify mothers with danger signs after birth.
- Counsel mothers on how to care for themselves after birth.

DANGER SIGNS OF THE MOTHER AFTER BIRTH

If the mother experiences any of the below danger signs, she should be referred immediately to the health facility

- **Heavy vaginal bleeding:** Minimal vaginal bleeding after birth is normal. It decreases as days pass and the colour of discharge becomes less red. However, if the mother reports that the bleeding is heavy and she has to change pads several times a day, that is a danger sign
- **Fever** is a sign of infection.
- **Severe headache, blurred vision and/or dizziness** are signs that the mother's blood pressure may be too high or anaemia.
- **Difficult breathing** may indicate that the mother has anaemia or other illnesses.
- **Severe abdominal pains** may indicate problems after delivery.
- **Offensive vaginal discharge.** This is a sign of infection.
- **Convulsions or fits** is a sign of severe illness.
- **Oedema** can be a sign of anaemia, high blood pressure.

CARE OF THE MOTHER AFTER BIRTH

Why should the mother attend a postnatal care clinic after birth?

If the birth occurs in a health facility, the mother is told when to return for a postnatal care visit. If the birth occurs at home, the mother should go for a postnatal care visit within 24 hours of the birth.

At the clinic, a health professional examines the mother and baby to rule out any problems. The mother is screened for TB and other infections. The mother would also get vitamin A, iron and folic acid tablets, Advice on family planning, and the baby would receive necessary vaccinations. If the mother did not have HIV during pregnancy, she is retested for HIV.

If the mother has HIV, she is encouraged to continue taking her ARVs.

Why should the mother go for family planning counselling?

Having another birth soon increases risk of death and illness in the mother and her children. Spacing births by at least 2 years can help the woman and her baby to be healthier. It is important that the family continues to use condoms and a family planning method while breastfeeding to protect herself from HIV and to prevent an unwanted pregnancy.

Why should the mother drink more fluids and eat food that is more nutritious?

After delivery, the mother needs to drink more fluids and eat more to ensure she has enough energy to produce breast milk. She needs to take nutritious food and continue with iron tablets to prevent anaemia and stay healthy.

Why should the mother and baby sleep under long lasting insecticide-treated net?

Malaria is a serious disease, and sleeping under an insecticide-treated net can prevent it. This is particularly important for pregnant women, mothers and young children.

What special attention should be given to adolescent first time mothers?

Adolescents and first-time mothers may need extra support from the CHW and the family. The CHW can show the adolescent and first-time mother how to care for the baby. She/he may also enquire about where the adolescent mother will stay with the baby after delivery and whether she has support from her family.

The CHW should ask the family to give the adolescent and first-time mother extra support, especially for breastfeeding. The adolescent mother may need to go back to school. The CHW can show the adolescent mother and family how she can continue to breastfeed exclusively by expressing breast milk, which the family members can give to the baby when the adolescent mother is at school.

The CHW should ask if the adolescent mother has thought about taking a family planning method after her baby is born. The CHW can help her decide on the most appropriate method and advise on where she can access these contraceptives and receive support from the health facility.

An adolescent mother who has HIV will need special support. The CHW should ask the family to give her extra support to go to the clinic for postnatal care, take her ARVs at the same time every day, and give the baby ARV prophylaxis at the same time every day for 6 weeks. The CHW should further explain that if the baby tests HIV positive at 6 weeks, the baby will be initiated on ARVs for life. If negative further tests will be done at 12 and 24 months.

SESSION 28

CLASSROOM PRACTICE:

FIRST HOME VISIT AFTER BIRTH

Learning Outcome

By the end of this session, you should be able to:

- Demonstrate how to conduct first home visit after birth

Sequence of tasks in the First Home Visit after Birth

a. Greet the family and ask how the mother and baby are doing. If the mother has one or more danger signs, REFER her urgently to the health facility (use Referral Note and fill in CBMNC Register

b. Wash your hands before proceeding with assessment.

c. Ask if the mother has put the baby to the breast since birth. Praise the family if she has. If not, ask why and encourage the mother to put the baby to the breast now. (Use **First Home Visit After Birth Card 1**, Assess Feeding, Danger Signs and Weight)

d. Observe the mother breastfeeding the newborn. If necessary, explain to her the correct positioning and attachment.

e. Assess for danger signs
   i. Based on the above, decide if the baby is not able to feed, or has stopped feeding well.
   ii. Ask if the baby has had fits or convulsions since birth.
   iii. Look at the baby's breathing. Count the breaths that the baby takes in one minute. Count again if you counted 60 breaths or more the first time. Decide if baby has fast breathing. Then look for severe chest in drawing.
   iv. Measure the baby's temperature. Decide if the temperature is high or very low.
   v. Look at the baby's soles to check if they are yellow.
   vi. Look at the baby's movement. If the baby has been asleep and has not moved during the assessment, ask the mother to wake up the baby and gently stimulate the baby. Decide if the baby moves only on stimulation or does not move even on stimulation.
   vii. Assess for signs of local infection-
      - Look at the umbilicus – if it is red or draining pus.
      - Look at the skin – if there are blisters filled with pus
      - Look at the eyes if they are draining pus

If the baby has any danger sign, skip the next step of weighing.

f. Weigh the baby and decide if the weight is in red, yellow or green zone. Record the date of birth, birth weight, and current weight in the CBMNC Register
g. Based on your assessment decide how to proceed further and take appropriate action:
    - counsel on care for a normal baby (Use Card 2).
    - counsel on care for a small baby (Use Card 3A and 3B), or
    - Refer to health facility if any danger signs present, or weight in red zone (use Referral Note).
h. Use First Home Visit after Birth Card 4: Care of the Mother.
i. Use First Home Visit after Birth Card 5: Danger signs of the Mother and baby.
j. Discuss and agree with the family on the date of the next appointment date.
k. Fill in CBMNC register.
l. Thank the family.

NOTE: The order of the tasks can vary according to the situation of the mother and baby. If the mother had recently breastfed and the baby is sleeping peacefully, assess for danger signs first and then observe a breastfeeding

In situation where a mother or a baby died within the scheduled visits, the CHW should still conduct the visits and do the following:

- If the mother died, the CHW should use card 1 but skip questions about the mother, then use card 2 or 3 depending on baby's weight, skip card 4 and finally use card 5 focusing only on danger signs of the baby.
- If the baby died, the CHW should use card 1 but skip assessment of danger signs for the baby, skip card 2 and 3 then use card 4 and 5 focusing only on danger signs of the mother.

EXERCISE: Completing the CBMNC Register during the First Home Visit after Birth

When you visit a woman after the birth, obtain all the information needed to complete CBMNC register.

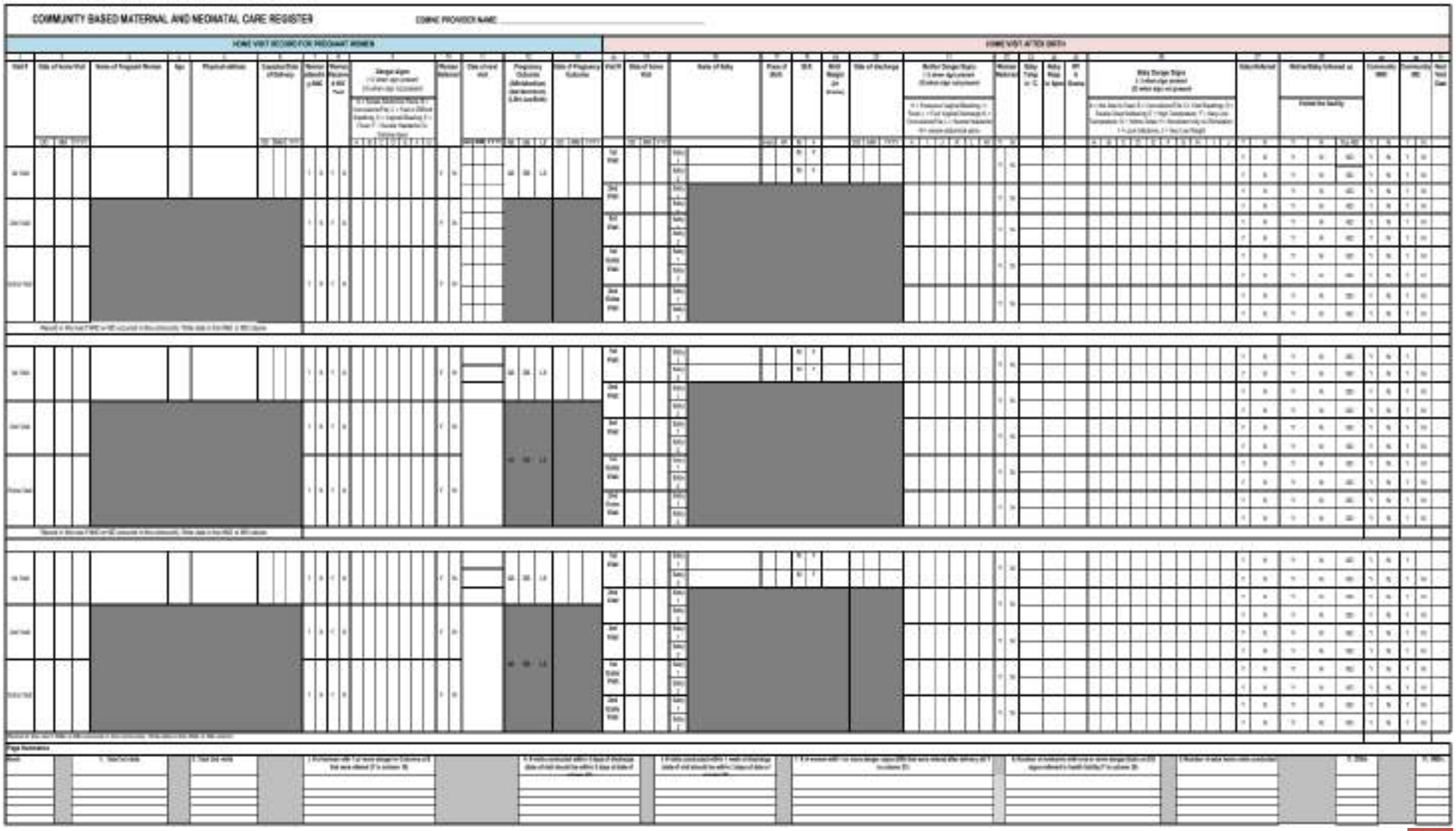
Case 1

Maria Phiri gave birth to a girl at the health facility on 9 January 2023. The CHW visited her on 11 January 2023 (the first day after discharge) as soon as Maria's husband informed the CHW about the birth. During the visit, the CHW found that the mother and baby had no danger signs, and the baby had a temperature of 36.8 ^{O}C, respiratory rate of 48breths/ minute, no severe chest indrawing, was able to breastfeed, had no convulsions, no yellow soles, movements were normal weighed 2200grams. The parents named the baby Lilly.

Case 2

The CHW visited Mary Luo on 22nd February 2023 who delivered a baby boy on 20th February 2023 at the health facility. The parents named him Joe. The baby's birth weight was 2600grams and was able to breastfeed; had no convulsion, had a Respiration rate of 52 bpm, no yellow soles, temperature of 34.4^{O}C and movements were normal.

Enter this information in your Register.


COMMUNITY BASED MATERNAL AND NEONATAL CARE REGISTER
CBMNC PROVIDER NAME:
HOME VISIT RECORD FOR PREGNANT WOMEN
HOME VISIT AFTER BIRTH

DEMONSTRATION ROLE PLAY: First Home Visit after Birth

Monica, CHW, found out that Taziona gave birth at a health facility and has been discharged. Monica is visiting her today to carry out the first home visit after birth.

***

ROLE PLAY SCRIPT: First Home Visit after Birth

CHW: Hello, Taziona, congratulations. The baby is so beautiful.

Taziona: Thank you Monica.

CHW: How are you and the baby doing? ***(Smiles and looks at her)***

Taziona: Yes, I am fine. I have some bleeding but it is just a little.

CHW: I am glad you and the baby are fine. As I said when I visited you last time, part of my responsibility is to assess the baby after birth and discuss care for you and the baby.

Taziona: ***(Nods)*** Yes, I remember. That is why I told my husband to inform you about the birth this morning

CHW: Thank you, you did the right thing. I would like to wash my hands before I touch the baby -- washing hands before touching the baby can prevent infections.

Taziona: Of course. The washbasin is just outside the room.

MIL: Please come with me.

(CHW goes out and washes the tip of the thermometer and air dries it then washes her hands with soap with the help of mother- in-law and air-dries them)

CHW: Have you put the baby to the breast?

Taziona: Yes, I did that a few minutes after birth, just as you had advised.

CHW: That was very good -- you are a wonderful mother. Is it okay for me to watch while you breastfeed the baby now?

Taziona: Yes, that is fine. ***(Puts the baby to the breast)***

CHW: The baby really wants to breastfeed, doesn't she? ***(Looks at the attachment and positioning)***

Taziona: Yes, but I feel that my breasts are empty. I don't think the baby is getting anything**.**

CHW: When the baby suckles, your breasts will start producing more milk. Even the small amount that she is getting now is sufficient for her today.

Taziona: Thank you, I was a little worried.

CHW: I see that the baby is sucking at the nipple. To get milk from the breast, she needs to press on the dark area around the nipple. You can improve the way she is attached to your breast by changing her position a little. Please turn her towards you so that her belly touches

yours and hold her very close to you. Would you like me to show you?

Taziona: Yes.

CHW: Could you please take the baby off the breast. Yes, now keep the baby like this **(*the CHW corrects the position and asks the mother to attach the baby to the breast again*).**

Taziona: hmmm. This feels much better. My nipples were hurting earlier.

CHW: The nipples can get sore if the baby is not attaching well to the breast. I am glad you feel better, and the baby will be able to get more milk from the breast now.

Taziona: Thank you for your help.

CHW: You should let the baby feed as long as she wants and until she leaves the breast herself. After she has finished feeding, I would like to assess her

Taziona: OK.

CHW: While you are feeding, I will ask a couple of questions. Did the baby have any fits or convulsions since birth?

Taziona: No, she has not. Oh, the baby has finished feeding for now.

CHW: Very good. Can I check the baby now?

Taziona: Yes.

(*CHW opens to First Home Visit after Birth Card 1: Assess Feeding, Danger Signs and Weight; prepares her timer, thermometer and weighing scale)*

CHW: Now let me look at the baby's breathing. ***(Opens blanket and lifts baby's shirt to expose the chest)*** I will first count the breaths she takes in one minute. ***(Counts)*** I counted 46 breaths per minute, this is normal. In addition, I see she has no difficulty in breathing. I am now going to measure her temperature.

Taziona: OK.

CHW: ***(, Took the thermometer and switches it on, places it in the axilla until she hears 3 short beeps)*** the temperature is 37oC, which is normal. I am now looking at the soles of the baby's feet -- they, are not yellow. I also do not see any pus or redness from the cord stump, and the skin and eyes are also normal. Your baby does not have any danger sign of illness.

Taziona: That is very good to know.

CHW: Yes, I will now weigh the baby ***(Weighs the baby and records in the register).*** The weight is in the green zone, this is also normal.

Taziona: Could you tell me the baby's weight?

CHW: Yes, she weighs 2.9 kg. Your baby has a normal weight. Now, let us talk about how to care for your baby. **(*Opens to Card***

2: Care of the Normal Baby) what do you see in these pictures?

Taziona: I see a woman breastfeeding her baby. Here she is sitting up and here she is lying down…perhaps it is night time. That boy is washing his hands. The woman is smiling at her baby, and that baby is getting some medicine.

CHW: How are you caring for yourself and the baby?

Taziona: Well, I eat and drink more, and we have a bed net that I have been using during pregnancy, so we can sleep with the baby under the net.

When should I go to the clinic?

CHW: You should go in a couple of days—that would be on day seven after birth.

Taziona: OK, I will ask my husband to arrange for transport to take us there

MIL: Yes, I can stay to look after the household.

CHW: Excellent. Lastly, these pictures ***(Holds up danger signs Card)*** show danger signs that can occur to you or the baby. Can you tell me what you see?

Taziona: I can see that this mother is not well. In addition, this baby looks so tired.

CHW: ***(Points to pictures of danger signs)*** if you have heavy bleeding, fever, severe headache, fits, difficulty breathing or severe abdominal pain, you should go to the health facility immediately. If the baby stops feeding well, has fits, fast or difficult breathing, has fever or feels unusually cold, becomes less active or the whole body turns yellow, you should take her immediately to the health facility.

Taziona: I am glad that you have reminded me on the danger signs

CHW: Good. I will come to see you and check on the baby again the day after tomorrow. **(*Completes the CBMNC Register, and marks the date of the next visit in the register*).** Goodbye, congratulations for doing the best for yourself and the baby.

END OF ROLE PLAY

*** * ***

PRACTICE ROLE PLAY: First Home Visit after Birth.

SESSION 29

FIELD PRACTICE:

FIRST HOME VISIT AFTER BIRTH

Learning Outcomes

By the end of this session, you should be able to:

- List items to be used during field practice
- Conduct a First Home Visit After Birth
- Follow the proper sequence for conducting the first home visit during pregnancy

Materials to be used during the home visit

- Set of counselling cards
- CBMNC register
- Referral form
- Pen
- Handheld weighing scale
- Thermometer
- Count down timer

Sequence for First Home Visit after Birth

a. Greet the family and ask how the mother and baby are doing. If the mother has one or more danger signs, REFER her urgently to the health facility (use Referral Note and fill in CBMNC Register

b. Wash your hands before proceeding with assessment.

c. Ask if the mother has put the baby to the breast since birth. Praise the family if she has. If not, ask why and encourage the mother to put the baby to the breast now. (Use **First Home Visit After Birth Card 1,** Assess Feeding, Danger Signs and Weight)

d. Observe the mother breastfeeding the newborn. If necessary, explain to her the correct positioning and attachment.

e. Assess for danger signs
   i. Based on the above, decide if the baby is not able to feed, or has stopped feeding well.
   ii. Ask if the baby has had fits or convulsions since birth.
   iii. Look at the baby's breathing. Count the breaths that the baby takes in one minute. Count again if you counted 60 breaths or more the first time. Decide if

baby has fast breathing. Then look for severe chest in drawing.

iv. Measure the baby's temperature. Decide if the temperature is high or very low.

v. Look at the baby's soles to check if they are yellow.

vi. Look at the baby's movement. If the baby has been asleep and has not moved during the assessment, ask the mother to wake up the baby and gently stimulate the baby. Decide if the baby moves only on stimulation or does not move even on stimulation.

vii. Assess for signs of local infection-

- Look at the umbilicus – if it is red or draining pus.
- Look at the skin – if there are blisters filled with pus
- Look at the eyes if they are draining pus

If the baby has any danger sign, skip the next step of weighing.

f. Weigh the baby and decide if the weight is in red, yellow or green zone. Record the date of birth, birth weight, and current weight in the CBMNC Register

g. Based on your assessment decide how to proceed further and take appropriate action:
   a. counsel on care for a normal baby (Use Card 2).
   b. counsel on care for a small baby (Use Card 3A and 3B), or
   c. Refer to health facility if any danger signs present, or weight in red zone (use Referral Note).

h. Use First Home Visit after Birth Card 4: Care of the Mother.

i. Use First Home Visit after Birth Card 5: Danger signs of the Mother and baby.

j. Discuss and agree with the family on the date of the next appointment date.

k. Fill in CBMNC register.

l. Thank the family.

NOTE: The order of the tasks can vary according to the situation of the mother and baby. If the mother had recently breastfed and the baby is sleeping peacefully, assess for danger signs first and then observe a breastfeeding.

Learning Outcomes

By the end of this session, you should be able to:

- Explain the importance of referring a mother and baby with danger signs.
- Discuss with the family the barriers to health seeking behavior and counsel them on how to overcome these barriers.
- Counsel the family on care that a sick baby needs on the way to the health facility.
- Demonstrate how to fill a referral note
- Conduct a follow-up home visit following referral.

ACTIVITY

Story of a sick new born

The CHW visited Chrissie when her baby was 3 days old. On assessment, she found that the newborn had a temperature of 35°C. There were no other danger signs and weight was in yellow zone. The CHW decided to refer the new born to the health facility because of the danger sign - very low temperature.

She explained to the family that the newborn might be very sick and urgently needed to be checked by a doctor, in the health facility where medicines and other necessary treatment are available.

She asked Chrissie if she would manage to go to the facility. Chrissie was worried about who would care for the other children but she knew she had enough money for a transport to get to the facility. The CHW suggested that Chrissie should ask her neighbour to care for the children and the neighbour agreed.

The CHW advised and showed Chrissie how to keep the new born on skin-to-skin contact. She advised Chrissie to breastfeed him frequently on the way to the facility. She gave Chrissie a Referral Note to take to the health facility.

Upon reaching the facility, the newborn was admitted and given injections, 2 days later the newborn got better. The doctor congratulated Chrissie and told her that the newborn got well quickly because they came to the health facility in time.

Try to answer these questions about the story:

1. How did the CHW convince Chrissie to take the newborn to the health facility?
2. What did the CHW do to help Chrissie get to the health facility?

3. What did the CHW advise Chrissie to do on the way to the health facility?

Sometimes even if the family knows the baby should go to the health facility, they do not go. It is therefore important for the CHW to understand their reasons so she can help families overcome these obstacles.

Overcoming Barriers in taking the baby to a health facility	
Problem	**Advice**
Fear that the health facility is a place where babies often die	Explain that the health facility has skilled health care workers, supplies, and equipment that can help sick babies get better. Sick babies with danger signs can get worse without treatment.
No one to care for the other children or to do the daily tasks	Ask who could help with the children/tasks, for example, a relative or neighbour. Help the mother contact these people.
Lack of transport	Assist the family in finding means of transport.
Lack of money	Ask if the family had saved money for an emergency during pregnancy. If not available, suggest that they approach other family members or a Village Health Committee for help.
Family wants to take the mother and /or baby to a faith healer first	Explain that a mother or a baby with danger signs needs urgent treatment in a health facility. Delaying treatment may make their conditions worse.
Mother is alone and needs permission of a family elder or her husband	Help the mother to contact a person who can give her permission to go to the health facility.

DEMONSTRATION: Using the Referral Note

Read the example below:

Takondwa Phiri (72 hours old) from Chepuka village visited on 1 February 2021. On assessment, the CHW found the following:

- Able to feed
- No convulsions

- 64 breaths/minute; repeat count 66 breaths/minute
- Severe chest in drawing
- temperature 36.6 **c**
- Soles not yellow
- Moving on his own
- No pus from umbilicus, skin or eyes
- Weight: green zone

Exercise: filling referral note:

CBMNC REFERRAL NOTE

Name of woman/baby : ______________________________________

Age of baby when referred : ______________________________________

Address : ______________________________________

Date referred : ______________________________________

Urgent reasons for referral (tick):

MOTHER HAS:

Heavy vaginal bleeding
Fever
Foul smelling vaginal discharge
Severe abdominal pains
Convulsions
Other problems

BABY HAS/IS:

Not able to breastfeed or stopped breastfeeding
Convulsions
Fast breathing
Severe chest in drawing
Temperature 35.4oC or less
Temperature 37.5oC or more
Yellow soles
Movement only on stimulation or no movement even on stimulation
Signs of local infection
Weight in red zone

Non-urgent reason referred (tick):

MOTHER / BABY referred for:

TB screening
HIV testing
HIV care and treatment
Vaccines
Family planning

Name of CHW: ____

- -

To be filled by the health facility worker on discharge.

Name of woman/baby: ____

Comments: ....

....

....

Name ____________________________ Cadre____________ Phone#________________

Advise about care on the way to the health facility

The backside of the Referral Note summarizes the care the baby needs on the way to the health facility:

- **Frequent feeding**: A sick baby can become sicker if he or she does not get any milk. It is important that the CHW counsel the mother to breastfeed frequently and encourage the mother to express breast milk if the baby is unable to suckle.

- **Keep the baby warm**: As you have learnt earlier, babies can become cold quickly, especially when they are sick or small. Sick babies need to be kept warm by keeping on skin-to-skin contact, as you have learnt in the session on care for the small baby. There are instructions on how to keep the baby on skin-to-skin contact on the Referral Note. If it is not possible to keep the baby on skin-to-skin contact, wrap the baby in multiple layers of clothing and put on a hat and socks. However, if the baby has high temperature, he or she should be covered with a light blanket or lightly wrapped.

Page 2 of referral note

On the way to the hospital

- ☐ Breastfeed the baby at least every two hours.
- ☐ Give only breast milk.

- ☐ Keep the baby warm. Keeping the baby skin-to- skin is best. The baby is:
- ☐ Naked except for a nappy, hat and socks
- ☐ Placed between the mother's breasts with the baby's legs along her ribs and the head turned to the side
- ☐ Secured with a cloth

- □ If skin-to-skin care is not possible, wrap the baby well and keep him or her close to the mother

PRACTICE ROLE PLAY: Assisting referral

One trainee in your small group will assist the mother to take the baby to a health facility. Observe the role play and be prepared to answer some questions.

The situation: A CHW is making a home visit to Mebo Banda who was discharged from a health facility yesterday. Mebo is resting and the baby is sleeping in another room with her mother-in-law. Mebo says that she has only breastfed the baby once so far. The CHW asked the mother-in-law to bring the baby to Mebo. Then she encourages and helps Mebo to wake the baby and put him to the breast. When she assesses the newborn, she finds one danger sign -- Very Low Temperature (35ºC). The CHW decides that the baby needs immediate referral to the health facility for further management. She stops the assessment and does not weigh the baby.

Follow-up visit to a referred mother and/or baby

You should make a follow-up home visit to a referred mother and/or baby the next day to check on them. This is very important because they have a high risk of death, particularly if they are not taken to a health facility for care.

Sequence of tasks in a follow-up visit for a referred mother and/or baby

a. Greet the family and ask how the mother and baby are doing. Ask if the mother or baby was taken to the health facility. If yes, ask what happened there. Look at the Referral Note.
b. Wash your hands with soap and then assess the baby – feeding and danger signs. If the baby still has a danger sign, refer again.
c. Asses the mother for danger signs. If **any danger sign, refer** again to a health facility. Assist referral.

   If the mother and/or baby was not taken to health facility, find out why and solve any problem.

d. If the baby does **not** have any danger sign, **counsel** on care for the normal baby or for the small baby, as appropriate.
e. Update the CBMNC Register.
f. Make appointment for the next visit.
g. Thanking the family.

SESSION 31

SEQUENCE OF SECOND AND THIRD HOME VISITS AFTER BIRTH

By the end of this session, you should be able to:

- Demonstrate how to conduct the second and third home visits after birth.
- Recall the Community health worker tasks in CBMNC.

Sequence of tasks in the second home visit after birth

a. Greet the family and ask how the mother and baby are doing.

b. Explain the purpose of the visit.

c. Check whether the mother has any danger signs and if present, refer urgently to hospital.

d. Wash your hands with soap before proceeding with assessment.

e. Assess the baby for danger signs (Second home visit after birth Visit Card 1: Assess the Mother and Baby for Danger Signs)

   i. Ask if the baby is able to breastfeed, or has stopped breastfeeding well.

   ii. Ask if the baby has had fits or convulsions since birth.

   iii. Look at the baby's breathing. Count the breaths that the baby takes in one minute. Count again if you counted 60 breaths or more the first time. Decide if baby has fast breathing. Then look for severe chest in-drawing.

   iv. Measure the baby's temperature. Decide if the temperature is high or very low.

   v. Look at the baby's soles to check if they are yellow.

   vi. Look at the baby's movement. If the baby has been asleep and has not moved during the assessment, ask the mother to wake up the baby and gently stimulate the baby. Decide if the baby moves only on stimulation or does not move even on stimulation.

   vii. Look at the umbilicus -- is it red or draining pus? Look at the skin -- are there pustules? Look at the eyes. Are they draining pus?

e. Take action based on the assessment findings.
   - If baby has any danger sign, refer to health facility urgently (Write a referral note).
   - If baby has no danger sign, and the weight on first home visit was in the green zone, counsel on care for a normal baby (Second home visit after birth Card 2) including observation of breastfeeding.
   - If baby has no danger sign, and the weight on first home visit was in the yellow or red zone, counsel on care for a small baby (Second home visit after birth Card 3), including observation of feeding.
   - Use second home visit after birth card 4: Care of the Mother in an HIV setting to tell the stories of 2 women and their care.

f. Use second home visit after birth card 5: Care of the Mother to check on the care the mother is receiving and counsel as needed.
g. Use second home visit after birth card 5: danger signs of the Mother and baby
h. Make an appointment for next visit
i. Fill in the CBMNC register.
j. Thank the family.

Sequence of tasks in the third home visit after birth

The third home visit after birth is very similar to the second. The main difference is the addition of counselling on continued care of the baby beyond the first week of life. This is your last home visit for a normal baby.

a. Greet the family and ask how the mother and baby are doing.
b. Check whether the mother has any danger signs and if present, refer urgently to hospital.
c. Wash your hands with soap before proceeding with assessment.
d. Assess the baby for danger signs (Third home visit after birth Card 1: Assess the Baby for Danger Signs)
   i. Ask if the baby is able to breastfeed, or has stopped breast-feeding well.
   ii. Ask if the baby has had fits or convulsions since birth.
   iii. Look at the baby's breathing. Count the breaths that the baby takes in one minute. Count again if you counted 60 breaths or more the first time. Decide if baby has fast breathing. Then look for severe chest in drawing.
   iv. Measure the baby's temperature. Decide if the temperature is high or very low.
   v. Look at the baby's soles to check if they are yellow.
   vi. Look at the baby's movement. If the baby has been asleep and has not moved during the assessment, ask the mother to wake up the baby and gently stimulate the baby. Decide if the baby moves only on stimulation or does not move even when stimulated.
   vii. Look at the umbilicus – is it red or draining pus? Look at the skin -- are there pustules? Look at the eyes – are they draining pus?

e. Take action based on the assessment findings.

- If a baby has any danger sign, refer to health facility urgently (Write a referral note).
- If baby has no danger sign, and the weight on first home visit was in the green zone, counsel on care for a normal baby (Third home visit after birth Card 2) including observation of breastfeeding.
- If baby has no danger sign, and the weight on first home visit was in the yellow or red zone, counsel on care for a small baby (Third home visit after birth Card 3), including observation of breastfeeding.

f. Use third home visit after birth card 4: On-going Care of the Mother in an HIV setting to tell the stories of two women and their care.
g. Use third home visit after birth card 5: On-going Care of the Mother and Baby to check on the care that the mother is receiving and counsel as needed. Then counsel on continued care of the baby beyond the first week of life.
h. Use third home visit after birth card 6: danger signs of mother and baby.
i. If the baby is not small, explain to the family that this is your last home visit, but they can contact you in case they have any concerns. For a small baby, tell the family that you will return in one week.
j. Fill in the CBMNC register.
k. Thank the family for their cooperation.

CLASS ACTIVITY: Ball game

REVIEW OF CHW TASKS

1. **Identify pregnant women in the community** so that CHW can make home visits during pregnancy and in the first days after birth for the greatest impact.
2. **Make two home visits to all pregnant women in the community:**

   First home visit during pregnancy — as early in pregnancy as possible/during the first trimester:

   Second home visit during pregnancy — about 2 months before delivery

3. **Make 3 home visits after birth for all mothers and babies.**

   First home visit after birth — on Day 1 after discharge from the health facility:

   Second home visit after birth — on Day 3 after discharge from the health facility:

   Third home visit after birth — on Day 8 after discharge from the health facility:

4. **Make two extra home visits after birth for small babies (birth weight less than 2500 grams)** — on day 2 and day 14 after discharge from the health facility — so that the CHW can provide the extra care that small babies need
5. **Make a follow-up visit on the following day** for a baby or a mother who is referred to a health facility for illness and after discharge from the facility.

SESSION 32

COMMUNITY MOBILISATION IN CBMNC

Learning Outcomes

By the end of this session, you should be able to:

- Define community
- Define community mobilization
- Explain the purpose of community mobilization in CBMNC
- Describe the process of community mobilization
- Describe the common obstacles to maternal and neonatal care
- Describe the implementation of community mobilization in CBMNC
- Describe methods used in CBMNC community mobilization

DEFINITION OF A COMMUNITY

A community is a group of people, based on common values and norms, who live within a geographically defined area and who share a common language, culture or values.

DIFINITION OF COMMUNITY MOBILISATION

Community mobilization is a capacity-building process through which community individuals, groups or organizations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health and other needs, either on their own initiative or stimulated by others.

THE PURPOSE OF COMMUNITY MOBILISATION IN CBMNC

- To create awareness about the availability of the program in the community.
- To create community will by assisting people to identify and share MNH problems
- To assist people to understand their environment such as MNH services offered both at community and facility levels.
- To make full use of local community resources such as CHW providers to improve people's quality of life.
- To demonstrate, guide and assist people to do things for themselves such as early health seeking if having any danger sign at little or no cost using locally available resources
- Strengthen community-level ownership and engagement in community programmes and interventions. This includes CHVs to manage some of the responsibilities of the

CHW such as identification of pregnant women, home visiting, and raise community awareness in MNH etc.

- To persuade and encourage people towards social awareness and behaviour change such as early ANC and health facility delivery.
- To encourage community efforts and activities based on voluntary participation and action.
- To identify the problems and seek means of solving the problems together
- To establish a relationship with the community throughout the process of mobilisation which promotes program sustainability

THE PROCESS OF COMMUNITY MOBILISATION

CBMNC providers should champion promotion of health, alleviation of myths and misconceptions related to pregnancy, child birth and neonatal period in their catchment areas.

The providers should facilitate promotion of best health practices and lead or participate in community mobilisation in MNH such as MNH awareness campaigns, MNH open days, interface meetings and others.

The process of community mobilisation includes; assessing the needs, Developing plans, Mobilising resources, implementing actions, Monitoring and evaluation together.

Assessing the needs

Ensure that the program is relevant to that particular community by establishing the presence of the problem in the area such as delay in starting ANC, community deliveries, community maternal deaths etc.

Developing plans

Ensure that community members take ownership. This is the starting point for communities in taking responsibility. Community members are able to plan and manage MNH activities in their area. Implementation of CBMNC requires availability of resources such as equipment, supplies, infrastructure for healthcare delivery, therefore involvement of both community and private sectors in planning facilitates resource mobilisation and sustainability of the program.

Mobilising resources

Identify internal community resources and acknowledge individual skills and talents. Recognize the fact that community member's area already dealing with the issue of MNH and that they can be more effective if they work together.

Implementing actions.

Ensure active participation by involving as broad and representative group of community members as possible. The CHW also need to work together with different types of community health structures; VHCs, ADCs, CHAGs, Care groups, secret women groups, committee on

maternal care for sustainability of the program. Provide for equal partnership and mutual respect between the community and CHW. Uphold the rights and dignity of people in the community to promote trust relationship**.**

Monitoring and evaluation.

Monitor the progress of your program and evaluate whether you have been successful or not through SCORE CARD

Involve technical and community structures at every stage using various mechanisms and tools.

Ensure that the community and CHW t ake ownership for the success or failure of the program such as CBMNC.

COMMON OBSTACLES TO MATERNAL AND NEONATAL HEALTH CARE

The obstacles to receiving care are often presented in a form known as Three Delays which are **delay in deciding to seek care**, **delays in reaching care** and **delays in receiving care** and they can occur during the antennal period, at the time of labor and delivery and during the postnatal period. Therefore, mobilizing the community to improve maternal and neonatal health will always involve eliminating one or more of these obstacles to receiving care.

COMMUNITY MOBILISATION IMPLEMENTATION IN CBMNC

The community health workers need to build a good relationship with the community for mobilization to be effective and successful. CHW need to live with the community, learn from them, and start with what the community has. The implementation of community mobilization in CBMNC can be done through the following:

- Home visits of pregnant women, postnatal mothers and new-born babies by CHW and volunteers.
- Mobile and outreach services, MNH providers give health education on MNH.
- Community gatherings such as during Community Score Card.

METHODS USED IN IMPLEMENTING COMMUNITY MOBILIZATION

There are many methods on how to mobilize the community for action. The aim is to empower communities to define their problems / needs and identify strategies, actions and resources in order to realize sustainable health interventions. Some of the methods are as follows:

1. Participatory Rural Appraisal (PRA).

PRA is a broad empowerment approach that seeks to build community knowledge and encourages grassroots action. It uses a lot of visual methods, making it especially useful for

participants who find other methods of participation intimidating or complicated. Some of the methods used include:

• Problem tree analysis

• Fish borne

• interviewing

• Community mapping

• Ranking

2. Community Score Card (CSC)

It is a two-way and ongoing participatory tool for assessment, planning, monitoring and evaluation of services such as CBMNC. Easy to use and can be adapted into any sector where there is a service delivery scenario. Brings together the demand side ("service user") and the supply side ("service provider") of a particular service or program to jointly analyze issues underlying service delivery problems and find a common and shared way of addressing those issues.

The main purpose of the Community Score Card is to positively influence the quality, efficiency and accountability with which services such as CBMNC are provided at different levels. It is not about finger-pointing or blaming. It is not designed to settle personal scores and not supposed to create conflict. Generates information through focus group interactions and enables maximum participation of the local community. Provides immediate feedback to service providers and emphasizes immediate response and joint decision making.

SESSION 33

MONITORING AND EVALUATION IN CBMNC PROGRAM

Learning Outcomes

By the end of this session, you should be able to:

- Fill and complete the CBMNC Register
- Fill and complete the CHW monthly reporting form
- Demonstrate how to complete health facility monthly reporting form

Monitoring and evaluation in CBMNC is required to provide necessary data to guide strategic direction and planning in the program. CBMNC providers should ensure that the following tools and processes are functional and utilized:
Required to provide necessary data to guide strategic direction and planning in the program. CBMNC providers should ensure that the following tools and processes are functional and utilized:

a. **Register:** Must be used when clients fitting criteria are visited at home
b. **CHW reporting form**: CBMNC providers must fill in the report every month by 2nd day of the following month. This form should be filled in duplicate.
c. **Health facility reporting form**: This is used by the CBMNC facility focal person to verify and consolidate all the CBMNC providers' reports by fifth of the following month. The facility reporting form should be filled in duplicate.
d. The facility CBMNC focal person must send one copy of the verified and consolidated report to facility data clerk for entry into DHIS2 by 14th of the following month. The second copy must be sent to the CBMNC district coordinator who will send it to the HIMS office for filling.
e. The district CBMNC program coordinator and HMIS officer must verify the hard copy of the consolidated facility report and verify report entered into DHIS2 by facility data clerks.
f. The coordinator must generate a consolidated district CBMNC report from DHIS2 and file it for back up.
g. **A supportive supervision checklist:** must be used when supervising CBMNC providers at all levels.
h. CBMNC providers at all levels must ensure that they analyse and use the data.
i. CHWs are expected to track their performance and keep reporting documents in good order at all times.

ID	Indicator Name
1a	Percentage of pregnant women visited at least once by a CHW
1b	Percentage of pregnant women visited twice by a CHW
2	Percentage of pregnant women with one or more danger signs referred to health facility by a CHW
3a	Percentage of postnatal mothers visited by CHW at least once within 3 days after discharge
3b	Percentage of postnatal mother visited by CHW twice or more within 8 days after discharge
4	Postnatal Mothers danger signs referral rate
5a	Percentage of neonates visited by CHW at least once within 3 days after discharge
5b	Percentage of neonates visited by CHW 3 times or more within 14 days after discharge
6	Neonatal danger signs referral rate
7	Home deliveries rate
8	Community neonatal death rate
9	Community maternal deaths

Unique Identifier	RHD01a CBMNC
Indicator Name	Percentage of pregnant women visited at least once by a CHW
Indicator Definition	Pregnant women visited at least once by a CHW. The indicator measures **Coverage** of services offered.
Alignment HSSP III/SDGs/Agenda 2063	Yes/yes/yes
Numerator	Number of pregnant women visited at least once by CHW
Numerator Source:	CBMNC Register/ CBMNC Report
Denominator	Expected pregnancies
Denominator Source:	CBMNC Register / Community health register/CBMNC Report
Calculation Method	Numerator/ Denominator * 100
Lowest administrative level	Community
Disaggregation	Number of pregnant women visited at least once
Reporting Frequency	Monthly
Rationale	To monitor the ANC services coverage in the community
Notes for interpretation	This indicator measures the proportion of pregnant women that have been visited at least once by the CHW.
Custodian of indicator	RHD
M&E framework level	Outcome
Baseline / recent estimates	30.5%, DHIS2 2023
Targets (2025; 2027; 2030)	35%, 45%, 65%
Unique Identifier	RHD01b CBMNC
Indicator Name	Percentage of pregnant women visited twice by a CHW
Indicator Definition	Pregnant women visited twice by a CHW. The indicator measures Coverage of services offered.
Alignment HSSP III/SDGs/Agenda 2063	Yes/yes/yes
Numerator	Number of pregnant women visited twice by CHW
Numerator Source:	CBMNC Register / CBMNC Report
Denominator	Expected pregnancies in the catchment area
Denominator Source:	Community health register/CBMNC Report
Calculation Method	Numerator / Denominator * 100
Lowest administrative level	Community
Disaggregation	Number of pregnant women visited twice
Reporting Frequency	Monthly
Rationale	To monitor the ANC services coverage in the community

Notes for interpretation	This indicator measures the proportion of pregnant women that have been visited twice by the CHW.
Custodian of indicator	RHD
M&E framework level	Outcome
Baseline / recent estimates	4.4% DHIS2 2024
Targets (2025; 2027; 2030)	5%, 10%, 15%

Unique Identifier	RHD02 CBMNC
Indicator Name	Percentage of pregnant women with one or more danger signs identified by a CHW
Indicator Definition	Pregnant women with one or more danger signs referred to health facility by a CHW
Alignment HSSP III/SDGs/Agenda 2063	Yes/yes/yes
Numerator	Number of pregnant women with one or more danger signs identified by a CHW
Numerator Source:	CBMNC Register/ CBMNC Report
Denominator	Number of pregnant women visited by CHW
Denominator Source:	CBMNC Register / CBMNC Report
Calculation Method	Numerator / Denominator * 100
Lowest administrative level	Community
Disaggregation	None
Reporting Frequency	Monthly
Rationale	To know if pregnant women are being referred to health facility for further management if having danger signs.
Notes for interpretation	This indicator measures the proportion of pregnant women that have been referred to health facility with danger signs for treatment
Custodian of indicator	RHD
M&E framework level	Outcome
Baseline / recent estimates	
Targets (2025; 2027; 2030)	

Unique Identifier	RHD03a CBMNC
Indicator Name	Percentage of postnatal mothers visited by CHW at least once within 3 days after discharge
Indicator Definition	Postnatal mother visited at least once within three days by CHW after discharge. The indicator measures **Quality** of services provided
Alignment HSSP III/SDGs/Agenda 2063	Yes/yes/yes

Numerator	Number of postnatal mothers visited by CHW at least once within 3 days after discharge
Numerator Source:	CBMNC register/CBMNC Report
Denominator	Expected deliveries
Denominator Source:	Community health register / CBMNC register/CBMNC Report
Calculation Method	Numerator /Denominator * 100
Lowest administrative level	Community
Disaggregation	By number of days: Number of postnatal mothers visited within 3 days
Reporting Frequency	Monthly
Rationale	To know number of postnatal mothers visited by CHW within 3 days after discharge for early detection of complications and early referral to health facility
Notes for interpretation	This indicator measures the proportion of postnatal mothers that were visited within 3 days after discharge.
Custodian of indicator	RHD
M&E framework level	Outcome
Baseline / recent estimates	4.7%
Targets (2025; 2027; 2030)	6%, 10%, 15%

Unique Identifier	RHD03b CBMNC
Indicator Name	Percentage of postnatal mother visited by CHW on day 8 after discharge
Indicator Definition	Postnatal mother visited by CHW on day 8 after discharge. The indicator measures **Quality** of services provided
Alignment HSSP III/SDGs/Agenda 2063	Yes/yes/yes
Numerator	Number of postnatal mothers visited by CHW on day 8 after discharge
Numerator Source:	CBMNC Register /CBMNC Report
Denominator	Expected pregnancies/deliveries
Denominator Source:	Community health register / CBMNC register/CBMNC Report
Calculation Method	Numerator / Denominator * 100
Lowest administrative level	Community
Disaggregation	Number of postnatal mothers visited on day 8
Reporting Frequency	Monthly
Rationale	To know number of postnatal mothers visited by CHW on day 8 after discharge for early detection of complications and early referral to health facility
Notes for interpretation	This indicator measures the proportion of postnatal mothers that were visited on day 8 after discharge.
Custodian of indicator	RHD

M&E framework level	Outcome
Baseline / recent estimates	
Targets (2025; 2027; 2030)	10%, 15%, 20%

Unique Identifier	RHD05a CBMNC
Indicator Name	Percentage of newborns visited by CHW at least once within 3 days after discharge
Indicator Definition	Newborns visited by a CHW at least once within 3 days after discharge
Alignment HSSP III /SDGs	Yes / yes
Numerator	Number of newborns visited by CHW at least once within 3 days after discharge
Numerator Source:	CBMNC register/CBMNC Report
Denominator	Number of Live births
Denominator Source: Current / Proposed	Facility estimates
Calculation Method	Numerator / Denominator * 100
Lowest administrative level	Health Centre
Disaggregation	By number of visits after discharge: within 1, 2 and 3 days
Reporting Frequency	Monthly
Rationale	To know percentage of newborns visited by CHW within 1, 2 and 3 days after discharge for early detection of complications and early referral to health facility
Notes for interpretation	This indicator measures the proportion of newborns that were visited within 1, 2, and 3 days after discharge.
Custodian of indicator	RHD
M&E framework level	Outcome
Baseline / recent estimates	N/A
Targets (2025; 2027; 2030)	40%, 60%, 85%

Unique Identifier	RHD05b CBMNC
Indicator Name	Percentage of low birthweight newborns visited by CHW 3 times or more within 14 days after discharge
Indicator Definition	Low birthweight newborns visited by a CHW 3 times or more within 14 days after discharge
Alignment HSSP III /SDGs	Yes / yes

Numerator	Number of low birthweight newborns visited by CHW 3 times or more within 14 days after discharge
Numerator Source:	CBMNC Register/CBMNC Report
Denominator	Number of low birthweight babies
Denominator Source: Current / Proposed	Community health register/CBMNC Report
Calculation Method	Numerator /Denominator * 100
Lowest administrative level	Community
Disaggregation	None
Reporting Frequency	Monthly
Rationale	To know percentage of newborns visited by CHW 3 times or more within 14 days after discharge for early detection of complications and early referral to health facility
Notes for interpretation	This indicator measures the proportion of newborns that were visited 3 times or more within 14 days after discharge.
Custodian of indicator	RHD
M&E framework level	Outcome
Baseline / recent estimates	N/A
Targets (2025; 2027; 2030)	40%, 50%, 65%

Unique Identifier	RHD07 CBMNC
Indicator Name	Home deliveries rate
Indicator Definition	Percentage of home deliveries
Alignment HSSP III	Yes
Numerator	Number of home deliveries registered by the CHW
Numerator Source:	CBMNC Register/ Community health register/CBMNC Report
Denominator	Expected number of deliveries
Denominator Source:	Community based maternal and neonatal care register/ Community health register
Calculation Method	Numerator / Denominator * 100
Lowest administrative level	Health Centre
Disaggregation	None
Reporting Frequency	Monthly
Rationale	To find out how many pregnant women delivered in the home.
Notes for interpretation	This indicator finds out if women are seeking skilled birth assistance.
Custodian of indicator	RHD
M&E framework level	Outcome
Baseline / recent estimates	2.2%

Targets (2025; 2027; 2030)	2%, 1.5%, 1%

Unique Identifier	RHD08 CBMNC
Indicator Name	Community neonatal death rate
Indicator Definition	Proportion of neonatal deaths that occurred in the community per 1,000 live births
Alignment HSSP III	Yes
Numerator	Number of community neonatal deaths
Numerator Source:	CBMNC Register/ Community health register/CBMNC Report
Denominator	Total number of live births registered (facility and community).
Denominator Source: Current / Proposed	CBMNC Register/ Community health register
Calculation Method	Numerator / Denominator * 1000
Lowest administrative level	Facility
Disaggregation	None
Reporting Frequency	Monthly
Rationale	To find out the prevalence of neonatal deaths.
Notes for interpretation	This indicator measures the proportion of neonates that have died in the community.
Custodian of indicator	RHD
M&E framework level	Outcome
Baseline / recent estimates	24/1,000, MDHS 2024
Targets (2025; 2027; 2030) Reduce existing by:	19/1000, 18/1000, 17/1000

Unique Identifier	RHD09 CBMNC
Indicator Name	Community maternal death
Indicator Definition	Number of maternal deaths in the community out of total deliveries.
Alignment HSSP III	Yes
Numerator	Number of maternal deaths in the community
Numerator Source:	CBMNC Register/ Community health register/CBMNC Report
Denominator	N/A
Denominator Source: Current / Proposed	CBMNC Register/ Community health register/
Calculation Method	N/A
Lowest administrative level	Facility
Disaggregation	None
Reporting Frequency	Monthly

Rationale	For assurance of quality care
Notes for interpretation	N/A
Custodian of indicator	RHD
M&E framework level	Outcome
Baseline / recent estimates	91, DHIS2, 2024
Targets (2025; 2027; 2030) Reduce existing data by:	80, 50, 20