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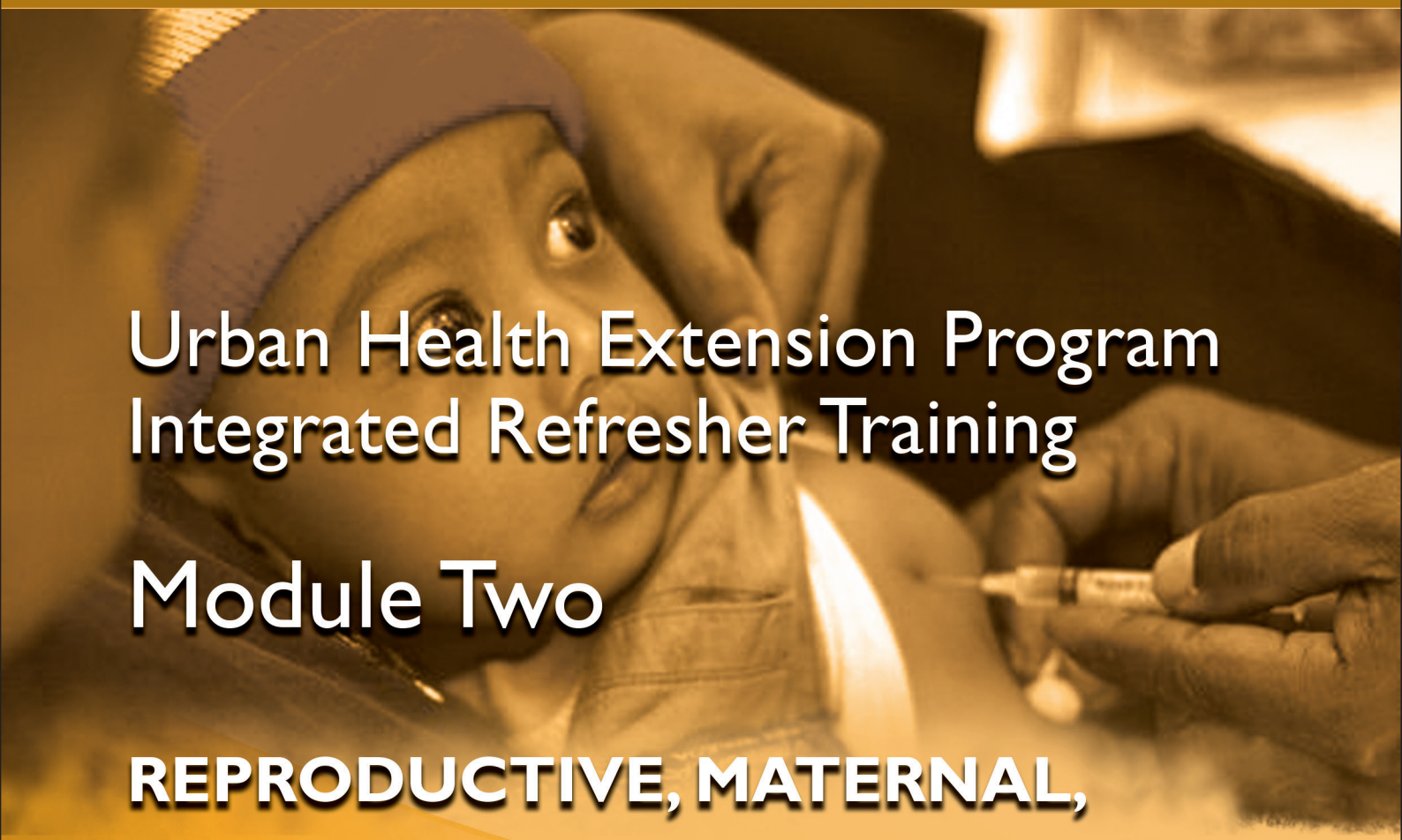

Urban Health Extension Program Integrated Refresher Training

Module Two

REPRODUCTIVE, MATERNAL, NEW BORN AND CHILD HEALTH

Facilitator's Guide

February, 2017

Federal Ministry of Health

Urban Health Extension Program

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Acknowledgement

The preparation and finalization of the integrated refresher training modules for Urban Health Extension Professionals (UHE-ps) has been made possible through a series of consultative meetings and workshops. During this process, the valuable contributions of our partners and program stakeholders have been crucial. This module is meant for UHE-ps in order to improve their attitude, skill and knowledge, which in turn help them provide quality health services to their clients. Therefore, the Federal Ministry of Health (FMOH) acknowledges all organizations for their contributions in the preparation, fine-tuning and finalization of this document.

FMOH is grateful to all partners involved and in particular USAIDJSI/SEUHP, JHU CCP, World Vision, Challenge TB, UNICEF, for the technical support provided to develop this Integrated Refresher Training(IRT) module in a harmonized approach.

Special acknowledgement is made by the FMOH to team of experts from the government and nongovernmental organizations who tirelessly involved in the entire processes of producing the module.

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Federal Ministry of Health

Acronyms

ANC	Antenatal care
ASK	Attitude, skill and knowledge
ART	Antiretroviral therapy
AYRH	Adolescent Youth Reproductive Health
BCC	Behavior change communication
BP	Blood pressure
CAR	Contraceptive acceptance rate
CBO	Community based organization
COC	Contraceptive prevalence rate
CPR	Contraceptive prevalence rate
DMPA	Depot medroxy progesterone acetate
FANC	Focused ante-natal Care
FP	Family planning
GUT	Genito- urinary tract
HAD	Health development army
HIV	Human immunodeficiency virus
HC	Health center
Hx	History
IDA	Iron deficiency anemia
IEC	Information, education and communication
IUCD	Intra-uterine device
LAM	Lactational amenorrhea method
MAM	Moderate acute malnutrition
MMR	Maternal Mortality Ratio
MUAC	Mid-Upper Arm Circumference
NGO	Non-governmental organization
OC	Oral contraceptive
OI	Opportunistic Infections
OTP	Out-patient Therapeutic program
PID	Pelvic inflammatory disease
PMTCT	Prevention of Mother to Child Transmission
PNC	Postnatal care
PoP	Progestin only pill
RDT	Rapid diagnostic test
RH	Reproductive Health
RMNCH	Reproductive, Maternal, Neonatal and Child Health
SAM	Severe acute malnutrition
SE	Side effect
SOP	Standard operative procedure
STI	Sexually transmitted disease
TL	Tubal ligation
TFR	Total Fertility Rate

TT	Tetanus Toxoid
UHE-P	Urban health extension professional
VPD	Vaccine Preventable Diseases
VSC	Voluntary surgical contraception
Wt	weight

Introduction

Urban Health Extension Program was introduced in Ethiopia in 2009, based on lessons learnt from successful implementation of the health extension program in rural areas. The program is designed with the aim of ensuring health equity by creating demand for essential health services through the provision of health information and basic health services at household level, school and youth centers and improving access to health services through referral to health facilities. Subsequent evaluations conducted on the program implementation have shown that, Urban HEP has contributed for increased health service awareness and utilization among urban dwellers. However, there was a wide disparity in implementation of the program and its achievements among cities. Low competency of Urban Health Extension Professionals (UHE-ps) and lack of integrated and continuous training has contributed for the discrepancy in implementation of the program.

Hence, a training need assessment was conducted to identify the competency gaps of UHE-ps when providing basic services. Therefore, considering the type of competencies that the UHE-ps need to have and identified competency gaps, six modules have been identified and developed based on Competency Based Training approach to provide in-service integrated refresher trainings. In addition, the modules were pre-tested and further refined. These modules are: -

Module 1: Social and Behavioral Change and Communication

It encompasses the health communication component to improve the knowledge and skill of UHE-ps to conduct effective health communication and improve UHE-ps attitudes affecting their performance in provision of health communication activities.

Module 2: Reproductive, Maternal, Neonatal, Child Health and Nutrition

The overall purpose of this module is to improve the attitude, knowledge and skills of UHE-ps to carry out quality family planning, maternal, neonatal, child health and nutrition services as well as enhance the UHE-ps understanding of attitudes affecting their performance in provision of family planning, maternal, neonatal, child health and nutrition services.

Module 3: Water, Hygiene and Sanitation

The overall purpose of this module is to improve the knowledge and skills of UHE-ps to carry out quality Water, Sanitation and Hygiene services as well as enhances the UHE-ps understanding of attitudes affecting their performance in provision of Water, Sanitation and Hygiene services.

Module 4: Major Communicable Diseases Prevention and Control

This module prepares Urban Health Extension professionals (UHE-ps) to provide TB/HIV and malaria-related services including reaching vulnerable populations with key TB/HIV prevention messages, HIV/STI counseling and testing (HCT), TB case detection, TB and HIV/AIDS care and support, referrals to services and malaria prevention and control in malarias areas.

Module 5: Non Communicable Diseases Prevention and Control and Mental Health

The Purpose of the module is to enable the participant s (UHEPs) explore and use their Attitude, Skill and knowledge to improve their performances in terms of providing quality health services related to major NCDs and mental health

Module 6: Basic First Aid

The purpose of this module is to improve the knowledge, attitude and skill of UHE-ps to provide quality first aid service and injury management. The module will also consist of transferring information regarding first aid and injury management to household and communities. This module also includes pre hospital cares.

Module Syllabus

Module description: This module contains theoretical and practical lessons which are intended for improving competencies of the trainees to help them provide quality RMNCH services.

Module goal: Enhance the capacity of the trainees (UHE-Ps) by equipping them with enabling [attitude, skill and knowledge (ASK)] on the basics and practical application of AYRH, FP, MNCH services to their communities

Learning objectives: By the end of this training module, the participants will be able to:

- Explain the AYRH needs, show enabling attitude toward provision of AYRH service and effectively provide AYRH service
- Describe methods of FP and their common features, counsel client on all family planning(FP) methods and provide short term FP methods
- Explain the priority health needs of the mothers, new born infants and children in the communities and demonstrate their ability how to provide effective MNCH services..
- Elucidate the basics of common childhood illness,VPDs and child immunization and show their improved skills on how to provide home- based immediate care for a sick child.

Training methods

- Brain storming,
- Group discussion/ Group work
- Plenary discussion
- Question and Answer
- Agree/ Disagree exercises
- Presentation
- Role play
- Case study
- Demonstration

Training materials and equipment required

- LCD
- Video CD/DVD
- PC
- Flipchart
- Markers
- Index cards
- Case studies
- Images
- Social- ecology map
- SOPs, flowcharts, algorithms
- Note book
- Figures and template

- Penile model
- FP drugs/equipment
- Facilitator/participant handouts
- Adult height and weight scale Mid-Upper Arm Circumference (MUAC) tape
- Blood pressure apparatus and stethoscope
- Pregnancy test kit
- Toys/models
- Body mass index chart
- Fetoscope
- Vaccines
- Food items
- Cooking wares (for nutritional demo)
- Referral slip
- UHEP Integrated Refresher Training (IRT) facilitator guide.
- UHEPIRT participant guide.
- UHEP implementation manual(revised)

Participant selection criteria: Those who work on the UHEP with position of UHE-Ps and UHEP supervisors/ coordinator

Module assessment: Assessment of the module (pre-test, post-test, and continuous practical assessments) should be based on attainment of the learning outcomes with reference to the performance criteria indicated in the course objectives.

Time allocated: 4days

Optimum class size

- Participants: 25–30 trainees per class
- Trainer: two trainers per class and with environmental health background and who have taken TOT

Module outline

Units and sessions	Time in minutes	Training methods
Unit one: Adolescent and Youth Reproductive Health	**155**	
Session 1: Introduction and Basics of AYRH	90	Group discussion, Brainstorming, group exercise
Session 2: Provision of AYRH	65	Role-play, Brainstorming and Demonstration
Unit two: Family Planning	**355**	
Session 1: Overview of population and FP	90	Brain storming and group discussion, Group exercise, buzz group discussion
Session 2: Family planning service provision	265	Q&A, Brainstorming , Group activities, "Agree/ Disagree exercise, role-play,
Unit three: Maternal and Newborn Health Care	**745**	
Session 1: Introduction to maternal and new born health	80	Card exercise, Buzz group discussion, Group Activity
Session 2: Focused Antenatal Care Service(FANC)	180	Class activity, buzz group discussion, role play, demonstration, experience sharing, case study
Session 3: Maternal Nutrition	135	Class activity, brain storming, role play, Demonstration, Gallery walk
Session 4: Prevention of Mother to Child Transmission	120	Group activity, role play, group discussion, group play
Session 5: Delivery and post-partum care	110	Brain storming, group discussion and experience sharing, role- play, group exercise
Session 6: Care for neonates	120	Brainstorming and experience sharing, demonstration and group discussion, case study, group exercise, group activity with case study

Unit four: Child Health	**385**	
Session 1: Immunization	85	Group exercises, demonstration
Session 2: Identification and care of sick child	90	Case study
Session 3: Child nutrition	210	Demonstration, case study, brainstorming, class exercise, group discussion

Module Schedule

Day and Time			Activity
Day 1	Morning	08.30 am – 10.00 am	Registration, opening introduction to the course and pre-test
		10.00 am – 10.30 am	Tea break
		10.30 am – 12.00 pm	Unit 1: AYRH session 1: Introduction to AYRH
		12.00 pm – 01.00 pm	Lunch
	Afternoon	01.00 pm – 02.00 pm	Session 2: Provision of AYRH services
		02.00 pm – 03.30 pm	Unit 2: Family planning Session 1: Overview of FP
		03.30 pm – 03.45 pm	Tea break
		03.45 pm – 05.15 pm	Session 2: FP services
		05.15 pm – 05.30 pm	Daily evaluation
Day 2	Morning	08.00 am – 08. 30 am	Day 1 Recap
		08.30 am - 10.00 am	Session 2: FP services continues
		10.00 am – 10.15 am	Tea break
		10.15 am – 11.40 am	Session 2: FP services continues
		11.40 am- 12. 40 pm	Unit 3: Maternal and newborn health care Session 1: Introduction to maternal and newborn health
		12.40 pm- 01.40 pm	Lunch
	Afternoon	01.40 pm – 02.00 pm	Session 1: Introduction to maternal and newborn health cont.
		02.00 pm- 04. 00 pm	Session 2: FANC
		04.00 pm – 04.15 pm	Tea break
		04.15 pm – 05.15 pm	Session 2: FANC continues
		05.15 pm – 05.30 pm	Daily evaluation
Day 3	Morning	08.00 am – 08.30 am	Day 2 Recap
		08.30 am – 10.45 am	Session 3: Maternal nutrition
		10.45 am – 11.00 am	Tea break
		11. 00 am- 01. 00 pm	Session 4: PMTCT
	Afternoon	01.00 pm – 02.00 pm	Lunch
		02.00 pm- 03.45 pm	Session 5: Delivery and post-partum care continues
		03.45 pm – 04. 00 pm	Tea Break
		04. 00 pm – 05. 20 pm	Session 6: Care for newborn
		05.20 pm – 05. 30 pm	Daily evaluation

Day 4	Morning	08.00 am – 08.30 am	Day 3 Recap
		08.30 am – 09: 10 am	Session 6: care for newborn continues
		09.10 am- 10. 35 am	Unit 4: child health Session 1: Immunization
		10.35am – 10. 50 am	Tea break
		10. 50 am- 12. 30 pm	Session 2: Identification and care of sick child
		12. 30 pm- 01:30 pm	lunch
	Afternoon	01. 30 pm –04.00 pm	Session 3: child nutrition
		04. 00 pm- 04.15 pm	Tea break
		04. 15 pm – 05. 00 pm	Session 3: child nutrition continues
		05. 00 pm – 05. 45 pm	Post test, module evaluation and conclusions

Module units

UNIT ONE: ADOLESCENT AND YOUTH REPRODUCTIVE HEALTH (AYRH)

Session 1: Introduction and Basics of AYRH

Session 2: Provision of AY RH services

UNIT TWO: FAMILY PLANNING

Session 1: Overview of FP

Session 2: Family planning services

UNIT THREE: MATERNAL AND NEWBORN HEALTH CARE

Session 1: Introduction to maternal and new born health

Session 2: Focused Antenatal Care Service(FANC)

Session 3: Maternal nutrition

Session 4: Prevention of Mother to Child Transmission

Session 5: Delivery and post-partum care

Session 6: Care for neonates

UNIT FOUR: CHILD HEALTH

Session 1: Immunization

Session 2: Identification and care of sick child

Session 3: Child nutrition

Pre-test, (40 min)

Before starting the module, the facilitator has to administer the pre-test. Therefore, he/she needs to have the print-out of pre-test questions and make sure that all participants have taken the test.

At the end of the day, the facilitator needs to provide the participants with "take-home -assignments as required

Unit one: Adolescent & Youth Reproductive Health

Unit description: This unit is developed to enhance the trainees' competencies to understand adolescent and youth reproductive health needs, to promote enabling attitude toward provision of AYRH service and equip them to effectively provide AYRH service.

Unit Objective: To enhance the trainees' knowledge, skills, and attitude for identifying AYRH needs, and enhance their competencies to provide AYRH services.

Specific objectives : By the end of this training unit the participant will be able to:

- Define who adolescent, youth and young people are, and describe the major reproductive health problems of young people.
- Demonstrate accepting attitude and improved skills to provide adolescent and youth reproductive health services.

Time: 155 minutes

Session 1: Introduction and basics of AYRH

Session Objective: By the end of this session the participant will be able to describe adolescent, youth and young people and identify the major reproductive health problem of young people.

Time: 90 minutes

Enabling Objectives: By the end of this session, the participant will able to:

- Understand the difference between adolescent, youth and young people
- Outline the major reproductive health problems of young people
- Explain the importance of addressing sexual and reproductive health problems of young people

Enabling objective 1: Understand the difference between adolescent, youth and young people

Training Methods: Group discussion (15 min) and brainstorming (10 min)

Group work

- Write the following questions on the flipchart **OR** ask participants to read the questions from the participant manual)

Questions :

- Define adolescents, youth or young people?
- What are the features or characteristics of adolescents or young people?
- Ask participants to be in a group of 2-3 and discuss the questions for 5 minutes.
- Ask volunteers to share their responses (one person should answer only one question to give chance to others)

- Summarize the discussion by telling participants the following points

Facilitator's note

Adolescents are those individuals between the ages of 10 and 19 years. Youth are individuals between the ages of 15 to 24 years. Young people refers to individuals from age 10 to 24 years.
Adolescence is the period of transition between childhood and adulthood. During this time, several key developmental experiences occur. These experiences include physical and sexual maturation, movement toward social and economic independence, and development of identity.
Adolescents and youth are characterized by • Body changes – development of secondary sexual characteristics like development of breast among girls, growth of body hair, change in voice etc • Adolescents will become independent- make decisions by themselves • Experimentation and curiosity increases- with sex, alcohol and drug use etc. • Concern about their body image

Brain storming

- Ask participants to estimate the proportion of young people in their communities?
- Tell them that Ethiopia has a very young population, with 1 out of 3 individuals being in the age range 10 to 24 years.

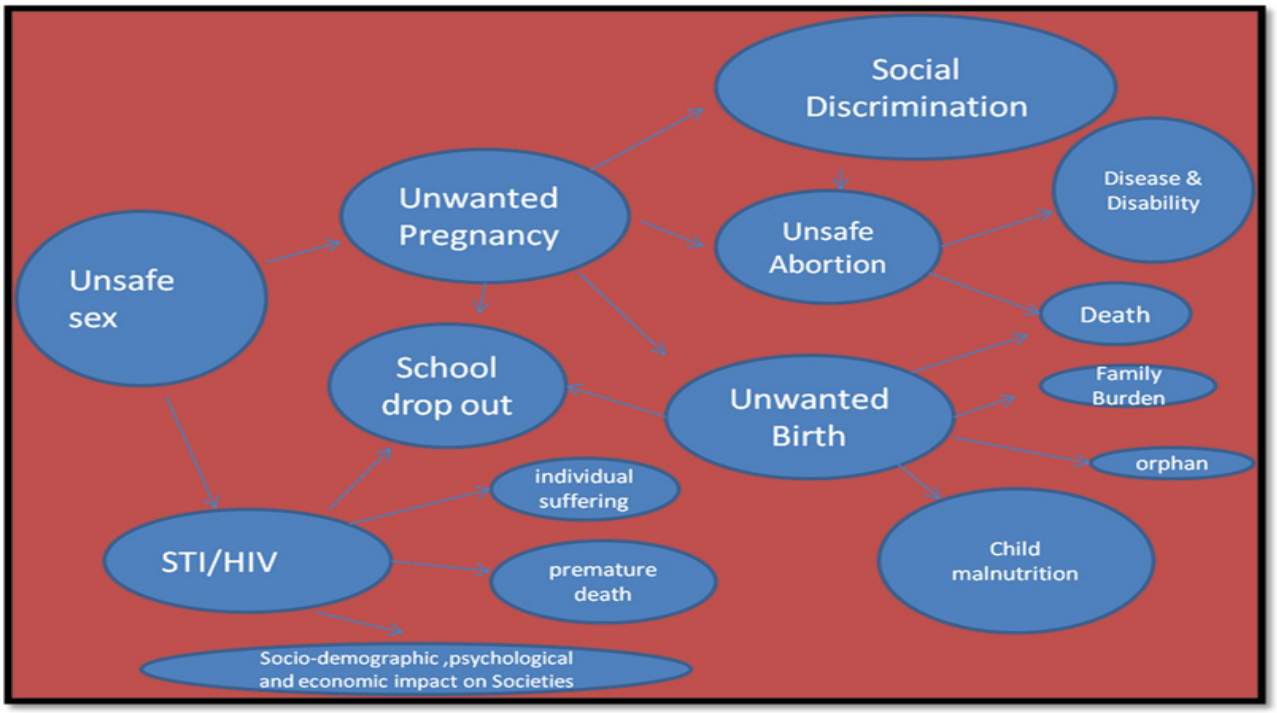
Enabling objective 2: Outline the major reproductive health problems of young people

Time: 35 minutes

Training Methods: Group discussions (35 minutes)

- Divide the participants into groups of four
- Ask them to discuss and identify major health problems of young people in their communities and, give them flipchart to write their answers. Ask one of the groups to present for the large group.
- Invite the remaining groups to complement on the presentation.
- Using the following points summarize the session.

Facilitator's note



Major reproductive Health Problems of Young People

- Unwanted pregnancy
- Early marriage
- Underage pregnancy and delivery
- Fistula
- Unsafe abortion
- HIV/AIDS and Sexually Transmitted Infections (STIs)
- Harassment
- Sexual abuse
- Rape

Next, divide the participants into 3 groups and ask them to discuss on the following questions

***Group 1**: What is unprotected sex and its consequences*

***Group 2:** What are STIs including HIV/AIDS and their consequences*

***Group 3:** What is smoking, alcohol and substance abuse and its consequence*

- Give each group a flipchart and a marker
- Ask each team to present the summary of their discussion and invite the rest of participants to supplement on the presentations.
- Summarize the session using the following facilitator's note.

Facilitator's note:

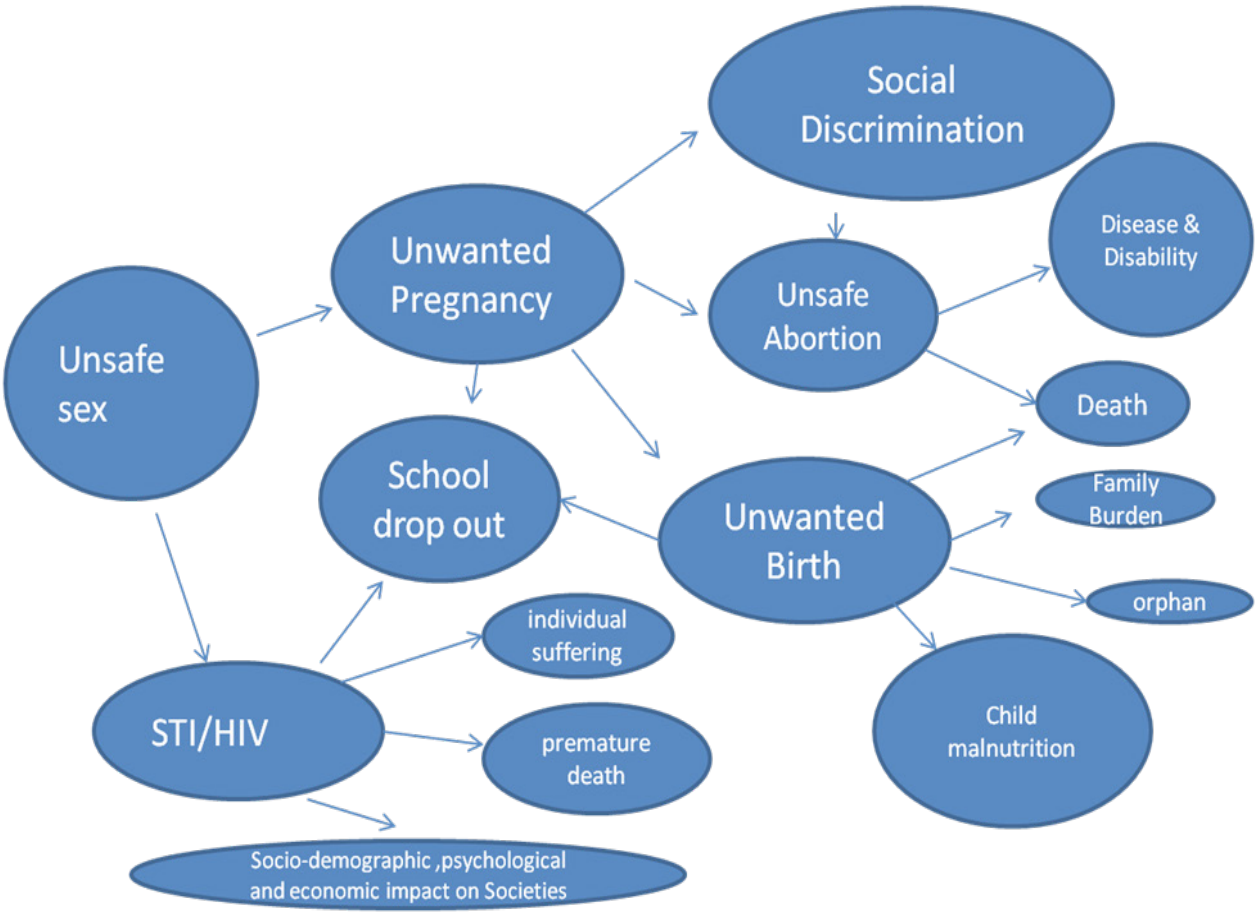


Fig : The consequences of unprotected sex.

- Ask if there are questions. Summarize the session by describing the major reproductive health problems of young problems and their consequences as follow;
  - Sexually Transmitted Infections (STI) including HIV/AIDS and their consequences
  - Higher chance of acquiring HIV when infected with other STIs
  - Lost school days or work days due to illness
  - Treatment cost
  - Miscarriage during pregnancy
  - Ectopic pregnancy
  - Fetal deformity and negative health effects for children born from mothers with STIs
  - Premature death
  - Long term effects on fertility and urinary system
  - Substance use and its consequences
  - Rejection by families and friends
  - Conflict with other people
  - Neglecting duties and responsibilities

- Poor school performance and dropout
- Financial constraints leading to economic deprivation
- Involvement in criminal acts and conflict with the law leading to conviction and imprisonment

Enabling objective 3: Explain the importance of addressing sexual and reproductive health problems of young people

Time: 30min

Training Methods: Brainstorming (10 min) and experience sharing (15 min)

Brainstorming

- Now participants have discussed the major health problems, ask the participants why it is important to provide sexual and reproductive health services for young people.
- Encourage participants to actively participate.
- Write the responses on flipchart for everyone to see.
- Ask for more answers until all answers are exhausted.
- Summarize the following to the participants at the end of the discussion

Facilitator's note

Importance of Addressing Sexual & Reproductive Health Problems of Young People:

Young people account for a third of the Ethiopian population. Sexual and reproductive health problems (such as HIV/AIDS/STIs, unwanted pregnancy and unsafe abortion) are more common and have serious consequences among young people. Risky behaviors which start during adolescence (like smoking, alcohol and substance abuse) frequently leads to severe health problems. Future socioeconomic development of our country depends on having healthy and educated young people, therefore early intervention is important to prevent common reproductive health problems and produce productive young citizens.

Experience sharing

- Ask two to three participants to share their experience on working with adolescents. Ask them the following questions to facilitate the exercise:
  - How often do you encounter adolescents seeking services during your home visit?
  - What are the common issues raised by the adolescents? How do you address their questions?
  - What are the key challenges you face during counseling adolescents? How do you handle such challenges?
  - What are the areas UHEPs need to improve to properly address adolescents' problems?
- Encourage the rest of the participants ask questions and facilitate the response from within the group.
- Summarize the activity by addressing issues that have not been addressed during the discussion.

SESSION SUMMARY:

Ask if there are questions. Summarize the session by asking the group to:

1. Explain the difference between adolescents, youth and young people.
2. List the major health problems of young people.
3. Describe the importance of addressing the sexual and reproductive health problems in young people.

Answers

1. According to the United Nations (UN) classification, adolescents are people between 10 and 19 years, youth are those between 15 and 24, and young people are between 10 and 24 years old.
2. The major reproductive health problems of young people include unsafe sex, STIs and HIV, unwanted pregnancy and unsafe abortion, substance use, and violence.
3. Young people account for the majority of the population, so their problems are of utmost concern. In addition to that they are windows of hope for majority of the reproductive health issues. We can prevent most of their health problems and avoid complication if we address them early.

Session 2: Provision of AYRH services

Session Objective: By end of this training session, the participant will be equipped with the required knowledge, attitude and skill to provide counseling and group education to young people on sexual and reproductive health matters as well as demonstrate proper condom use.

Enabling Objectives: By the end of this sub session, the participant will able to:

- Demonstrate the proper counseling and group education skills on reproductive health for adolescent and youth
- Exhibit enhanced skills on demonstration of proper use of condom

Time:65 minutes

Enabling objective 1: Demonstrate proper counseling and group education skills on reproductive health for adolescent and youth

Training Methods: Role-play (40 min)

- Divide participants into three groups. Distribute scenarios for participants.
- Participants review the respective scenarios and relevant sections in the training manual. Give samples of family planning method for group 2 along with the scenario.
- Each group should select two volunteers for a role-play. One will act as a client and the other will act as a counsellor based on the topic given to the group. For group 3 the volunteers will act as group educators.
- Each group will write their counseling /group education plan on flipcharts. Each group will present the counseling / group education plan followed by the role-play for the big group.
- Ask the class to discuss how the session went, specifically focusing on the counsellor after each role-play. Write the points raised on flipchart. The following can be used as discussion points.
  - What were the strengths of the counsellor?
  - Do you think the counsellor was helpful in addressing the concerns of the client? How?
  - What went wrong during the counseling?
  - What did the provider do to establish trust with the young client?
  - How does this role-play help you in improving your skills in counseling young people?
  - What could the counsellor have done to improve the session?

Group 1will counsel a sexually active unmarried adolescent on safer sexual behavior (focusing on unwanted pregnancy, unsafe abortion, HIV and STIs).

Group 2 will counsel a married adolescent on early childbearing and family planning.

Group 3 will provide sex education to young adolescents (focusing on menarche and its psychological implication) in second-cycle primary school.

Scenarios for role-play

Group 1-scenario one

A UHE-p has a meeting to counsel Bekele on safer sexual behavior. Bekele is a 19-year-old boy who is sexually active but does not have a regular partner or a girlfriend. Demonstrate how you will counsel him using the family plaining flipchart. The person who acts as Bekele will listen, ask, and answer questions in a realistic manner.

Group 2-scenario two

Ayantu is 16-year-old girl who has been married for three months to a merchant who is nine years older than her. When you visit her at home, you suspect that she might not be using family planning. Demonstrate how you will counsel her using the family planning flipchart. The person who acts as Ayantu will listen, ask, and answer questions in a realistic manner.

Group3-scenariothree

A UHE-p has to give sex education to grade six students. You estimated their average age to be 12 years. Demonstrate how you will facilitate the group discussion. Those playing students will listen, ask, and answer questions in a realistic manner.

Observer checklist

SN	Activities to be observed	Response			Comment
		Fully	**Partially**	**No**	
1	Did the UHE-p greet the adolescent warmly?				
2	Did the UHE-p use probing types of open ended question to identify the adolescent's problem and its root causes?				
3	Did the UHE-p ensure the comfort of the adolescent (seating arrangements, greeting, and facial expressions)?				
4	Did the UHE-p avoid judgmental body languages and words?				
5	Did the UHE-p congratulate the adolescent for seeking help?				
6	Was the UHE-p respectful?				
7	Did the UHE-p provide enough information?				
8	Did the UHE-p answer the adolescent's questions?				
9	Did the UHE-give information about where to get further help or services?				
10	Did the UHE-p make a follow up appointment?				
11	Did the UHE-p document what s/he accomplished on the service data recording tool?				

Facilitator's note

Establishing trust with young people is very important to deliver sexual and reproductive health services to them. There are things that UHEPs can do to encourage a young person to trust them. Facilitators can use the following note while facilitating feedback on role-play.

To promote trust with young people you have to:

- Be genuinely open to their questions and need for information
- Avoid judgmental words or body languages

- Understand that the young person may have feelings of discomfort and uncertainty.
- Demonstrate sincerity and willingness to help
- Reinforce their decision to seek counseling and/or healthcare
- Exhibit honesty, including an ability to admit when you do not know the answer
- Demonstrate responsibility in fulfilling your professional role
- Exhibit confidence and professional competence

Behavior likely to promote trust: Non-verbal communication

ROLES (using this abbreviation one can memorize the following non-verbal communication)

R = Relax the client by using facial expressions that show interest

O = Open up to the client by using a warm and caring tone of voice, i.e. help them to talk

L = Lean towards the client, not away from them

E = Establish and maintain eye contact with the client

S = Smile.

Behavior likely to promote trust: practical arrangements

Here are some practical tips to create a good and friendly first impression.

- Start on time.
- Smile and warmly greet the client.
- Introduce yourself and explain what you do.
- It will help to establish rapport during the first session if you:
    - Face the young person, sitting in similar chairs
    - Use the young person's name during the session
    - Begin the session by allowing the young person to talk freely before you ask questions
    - Congratulate the young person for seeking help.

Enabling objective 2: Demonstrate proper use of condom

Training Methods: Brainstorming (10 min) & demonstration (15 min)

Brainstorming

- Write the following question on the flip chart

Question: What strategies can prevent HIV and other STI transmission from one person to another?

- Ask the participants to respond to the question and write each response on the flip chart.
- Encourage more responses.
- Invite participants to compare their answers to the following points:

Facilitator`s note

The most widely known strategies for prevention of sexual HIV transmission are often known as the 'ABC rules:'

'A' stands for 'abstinence,' which means refraining from premarital sexual intercourse.

'B' stands for 'be faithful,' which means maintaining faithful relationships with a long-term partner.

'C' stands for 'proper use of condoms,' which means correct and consistent use of condoms in sexual relations.

Condom demonstration

- Ask two volunteers to demonstrate proper use of condom for the participants.
- Ask the rest of the participants to provide feedback on the condom demonstration.
- Display or distribute printed copy of checklist for proper condom use.
- Facilitate discussion by asking:
    - Why are condoms important for adolescents?
    - How do you demonstrate proper use to adolescents?
    - Did the volunteers demonstrate condom use correctly? If not, what did they miss?
    - What would be the effect of such incorrect demonstration of condom use for adolescents?

Checklist for proper condom use

Buying and storing condoms:

Check expiry date on the package. Do not use an 'out of date' condom.

Make sure that the package doesn't have any tears (opening) or signs of damage.

Do not store condom in very hot places. Extreme heat may damage the protective effect.

Using condoms:

Open the package carefully. Take care not to tear the condom, or damage it with your fingernails.

Pinch the end of the condom and place it on the erect penis.

Still pinching the end, unroll the condom down the shaft of the penis.

If you want to use a lubricant, choose one that is water-based. Oil-based lubricants can cause condoms to disintegrate.

After ejaculation, hold the condom and withdraw the penis before it becomes soft. Never re-use a condom.

Wrap and dispose the condom in the trash bin where it cannot be accessed by people or animals. Do not throw condom into a flush toilet.

SESSION ASSESSMENT

Ask the participants:

1. What are key ways to build trust during adolescent counseling?
2. What does 'ABC' stand for in HIV and STI prevention?

Answers

1. Attitudes such as sincerity, warmth, and non-judgment. non-verbal communications (ROLES).
2. A= abstinence, B=be faithful C= proper condom use.

SESSION SUMMARY

Ask if there are any outstanding questions. Summarize the session by asking:

- What knowledge, attitudes, and skills have you learned from unit one?
- How will you implement what you have learned?
- Why is it important to address the sexual and reproductive health problems of young people?

UNIT 2: FAMILY PLANNING

Unit description: This unit is developed to improve trainees' competency to help them understand the basics of FP and provide quality FP services to their communities

Unit objective: To equip the participants with required knowledge, attitude and skills which enable them to distinguish benefits of FP and administer some of the FP methods or refer clients for advanced choices.

Unit specific objectives: By the end of the training unit the participant will be able to:

- Define common terms of FP, identify all benefits of FP and describe the common social- ecology factors that affect the utilization of FP services.
- Demonstrate the enhanced skills how to provide basic and effective FP services to their clients (counseling on and administering FP methods including referral linkages).

Time:355 min

Session 1: Overview of Family Planning

Session Objective: By end of this training session, the participants will be able to define common terms of FP, identify all benefits of FP and describe the common social ecology factors that affect the utilization of FP services

Enabling Objectives: By end of the training session, the participant will be able to;

- Express their understanding about the definition and benefits of FP
- Demonstrate expanded knowledge of scanning social- ecology factors that affect the utilization of FP services

Time: 90 min

Enabling Objectives1: Understand definition and benefits of Family Planning

Training Method; Brainstorming(10 min) and group discussion (40 min)

Brainstorming

- Write the following questions on the flipchart

  Q1. What is FP?

  Q2. What is Contraception?

- Give the participants to take few minutes to memorize
- Ask the audience to reflect on the questions
- Write their responses on the flipchart
- Encourage the participants to actively take part in the discussion
- Based on their own reflection, probe more by asking the following questions:
  - Why are we very concerned about FP?

Facilitator`s note

Definition of key terms

Family Planning (FP). Family planning is the decision-making process by couples, together or individually, on the number of children that they would like to have in their lifetime, and the age interval between children. This means that both halves of a couple have equal rights to decide on their future fertility.

Contraception: The deliberate use of artificial methods or other techniques to prevent pregnancy as a consequence of sexual intercourse. The major forms of artificial contraception are barrier methods, of which the most common is the condom; the contraceptive pill, which contains synthetic sex hormones that prevent ovulation in the female; intrauterine devices, such as the coil, which prevent the fertilized ovum from implanting in the uterus; and male or female sterilization.

As a health professional, from your experience, who decides on the size of the family? Why?

group discussion

Divide the participants into smaller groups; different group will be working on different tasks with regard to "the benefits of FP" using the following cards

Benefits of FP to Child Health	Benefits of FP to maternal Health	Social and economic benefits of FP

- Post the cards at different corner of the room
- Divide the participants in to 3 groups
- Assign each group to the corresponding card randomly and encourage them to discuss it.
- Ask them to write down their responses on the flipchart and stick it under their respective card on the wall
- Invite all participants to gather at one corner at a time and ask all to reflect on what has been presented on the wall so as to discuss the matter in more depth.
- Ask them to move around all corners turn by turn and do the same.
- Then instruct them to return to their seats. Finally ask the groups the following questions:
  - ☛ Why do you need to know these benefits? and how they interlinked?
  - ☛ What is the overall benefit of all these benefits?
  - ☛ What new things have you learnt from this exercise if any? and how, as an UHE-P, do you apply your new knowledge to your daily activities?
  - ☛ How do you prioritize the problems and what can you do about them?

Facilitator`s note

Benefits of FP

Health benefits to the mother

Contraceptive use reduces maternal mortality and improves women's health by preventing unwanted and high-risk pregnancies and reducing the need for unsafe abortions. Some contraceptives also improve women's health by reducing the likelihood of disease transmission and protecting against certain

cancers and health problems.

Avoiding too early and too late pregnancies: Family planning helps mothers avoid pregnancy when they are vulnerable because of their youth or old age. The risk of having pregnancy-induced hypertension (high blood pressure) is much higher in younger mothers. On the other hand, older mothers, who have

given birth to S or more children, have a tendency to uterine rupture during labour, which can cause severe vaginal bleeding and shock. In places where emergency obstetric care facilities are lacking, these two consequences of age have been leading causes of maternal deaths.

Limiting the number of pregnancies: Once the desired number of children has been achieved, a woman can avoid further pregnancy by using family planning methods. Any pregnancy and birth equal to, or higher than, five can have greater risks for the mother. The risk of dying from multiparity (giving birth more than once) increase for a woman who has given birth to five or more children; her risk is 1.5 to 3 times higher than those who have given birth to two to three children.

Preventing abortion: Most abortions result from unwanted pregnancy, and significant numbers of maternal deaths can be attributed to unsafe abortion induced by untrained practitioners. In Addis Ababa, abortion is one of the leading causes of maternal death. Family planning helps mothers prevent such

unwanted pregnancies.

Benefits to the children

Together with other health services, such as diarrhoea and pneumonia management, the nutrition programme and the expanded programme on immunization, family planning directly contributes to the improvement of children's health and growth. It also indirectly contributes to children's wellbeing and development by improving maternal health. Adequately spaced children can be well-fed and healthier than closely spaced children. Mothers can have ample time and good health to care for their children. Parents should be able to seek healthcare for them without being constrained.

Social and economic benefits

Family planning reduces health risks to women and gives them more control over their reproductive lives. With better health and greater control over their lives, women can take advantage of education, employment and civic opportunities. Families with fewer children are often able to send those children to school so girls get a chance to attain higher education, and as an outcome, the age of their first marriage is often later and their years of fertility reduced. They also benefit from being an employee.

In addition, it is not difficult for parents to clothe and feed their children if they can limit their family size. The expenses that they need to care for a small-sized family will be less, so they can save more and be self-sufficient. With regard to social services, both the government and the family invest less if the family and population size is small. This can help save essential resources and thereby contribute to the economic growth of the nation as a whole.

In general, having a larger proportion of well-educated, healthy, productive and self-sufficient families can contribute a great deal to the sustainable development of a country. In this regard, the social and economic benefits of the family are essential.

> **Enabling Objective 2 :** Demonstrate expanded knowledge of scanning social- ecology factors that affect the utilization of FP services

Training Methods: Group exercise and buzz group discussion (40 min)

Step 1:

- Give a task to the group to map the social -ecology factor related to FP services based on their own experiences.
- Divide the participants into 4 groups
- Give each group social ecology map (Fig 2).
- Explain to the groups that they need to work on different social ecology stratum (individual, community, institution and policy). They will discuss in groups about FP services and identify the common factors that affect the provision of FP services at individual, community, institution and policy level (both provider and demand side).
- Ask **Group 1** to work on an individual level, **Group 2** on community level, **Group 3** on an institution level and **Group 4** on a policy level
- After completing the exercise, ask them to resume their seats and present their works to the larger group (all should present but one at a time)
- Encourage the participants to reflect in the plenary on what has been presented.

***Hint*:** as a facilitator, you need to make sure those social norms, values and gender issues are included in all FP topics in general and social- ecology mapping and analysis in particular.

- Finally, ask the groups the following more questions:
  - Why do you need to identify these factors? And how they are interlinked?
  - What are the factors affecting the implementation of FP services?
  - How do you prioritize the problems and what can you do about it?
- To conclude, invite one or two of the participants to summarize Step 1. Add your views if there is a need. Give all a printout of Social Ecology map (Fig 2) and move to Step 2

Step 2:

provide the participant with the following case scenario. Based on the scenario, they need to identify and solve W/ro Kumele`s FP problems.

- Divide the participants in to buzz groups
- Give each pair a case scenario and social- ecology map (Fig 2). Explain to the groups that they need to read and understand the scenario and then identify and solve Wro Kumele's FP problems.
- Encourage them to summarize their work using the following matrix (Table 1). Provide each group with a pre- prepared blank matrix (Table 1)
- Invite volunteer groups (not more than 4) to present their work to the plenary while the rest of the groups reflects on what have been presented.
- Finally ask the groups the following questions to provoke more reflections:
  - From your past experience as a health professional, how did you confront with such problems while giving FP services what new thing did you learn from this exercise?
  - How this learning will impact your real day to day activities?
  - If you were given another chance, how would you do it differently?

Case scenario

During her household visit, Sr. Chaltu met Wro Kumele, 38, who looks desperate. Wro Kumele told Sr. Chaltu that she had given birth to 5 children (all alive and all girls) before she moved to Adama last year. She did not attend school, but is married to a carpenter. Currently, she is not feeling well and she has no money to care for herself. On the other hand, she is under pressure as her husband has decided to have more babies (boys). She lives in a community where the misconception 'modern contraceptive damages maternal health' is widespread. She is aware of the availability of free of charge long acting FP methods at the nearby HC. Hence, she always dreamed to stop child bearing nonetheless she does not know how to negotiate this with her husband.

Table 1: Social Ecology factors by stratum

Stratum	Identified problems	Possible solutions
Individual/ family	1.	1.
	2.	2.
	3.	3.
Community	1.	1.
	2.	2.
	3.	3.
Institution	1.	1.
	2.	2.
	3.	3.
Policy	1.	1.
	2.	2.
	3.	3.
	4,	4.

Fig 2: Social Ecology map

Facilitator`s hint:

Based on the scenario; Poverty, illiteracy, lack of power, feeling of being out-sider for Adama can be mentioned as an individual factors. Similarly, male dominance, demand for more babies, (particularly males), low income cold also be additional problems for the family. The community factors are limited to misconception about modern FP and possible stigma and discrimination against use of such FP methods. At the institution, there might be lack of out-reach FP services and limited BCC activities for the community. On the other hand, there could be no clear guideline for the 1st level health care providers on how to address gender issues and improve the livelihood of such family

Please note, this is just assumption. As a facilitator you are not supposed to provide the concrete answers to such questions. Instead, you have to encourage the participants to find answers based on their local context and past experiences

SESSION SUMMARY:

Ask if there are any outstanding questions. Invite some of the participants to summarize the whole session by asking:

- What is the definition of FP and contraception? Why we need to know these concepts?
- What are the benefits of FP for maternal and child health?
- What are the social and ecological factors that deter clients from using FP services?

ASSIGNMENT SHEET: Reading assignment

Directions: Instruct the participants to refer to the ***note*** on " benefits of FP" and read the topic individually.

Session 2: Family planning services

Session Objective: By end of this training session, the participant will be able to provide basic information about FP methods, clarify his/ her personal inhibiting attitudes and exhibit enhanced skills to effectively counsel and administer contraceptives to the clients

Time: 265 min

Enabling Objectives: By end of the session, the participant will be able to;

- Provide basic information on all FP methods
- Clarify self inhibiting attitude against FP services and how such attitude impacts their day- to-day activities
- Demonstrate the advanced skills how to provide effective FP counselling to the clients
- Demonstrate enhanced skill how to administer contraceptives to the client

Enabling objective 1: Provide basic information on all FP methods

Training methods: (Q&A) (10 min) Brain Storming (30 minutes) and Group exercise (45)

Step 1:Questions and answers

Question: What type of FP methods do you know?

Ask all participants in the room to respond to the following question

- Write the question on the flipchart boldly
- Ask each of the participants to answer;A respondent should only give only one answer at a time.
- Write all answers on the flipchart
- Thank the participants and proceed to the following step

Step 2: Brainstorming

Assume that in step 1, the participants were able to identify all or some of FP methods. Now, they need to group those methods under the following classifications.

- Prepare the cards labeled with the classification of the FP methods
- Stick the card on the top left corner of the blank flipchart and put the flipchart on the wall at different corners.
- Display the types of the FP methods listed by the participants (Step 1)
- Ask some of the participants to choose at least one method from the list first and to mention where that specific method belongs and why? Write their responses on the corresponding flipchart.
- Ask others whether the categorization is correct or not. Ask again and again until correct grouping is made.
- Once the categorization is over, read the name of the methods under each categorization
- In the end, ask the following practical question:
  - Why we need to know types and classifications of FP methods? How does this knowledge help you improve your performance?
  - Appreciate their participation and remind them that they will be learning more about the features of some common contraceptives in "Step 3".

Step 3: group exercise

- Ask the participants to work on some common features of selected contraceptives.
- Form some small groups (at least 5).
- Provide the group with the classification of the FP methods (one each); (step 2)
- Ask them to select some common contraceptives from the list under each category.
- Encourage them to discuss the feature of their favorite contraceptive (indication, advantages, disadvantages, side effect, contraindication, etc.)
- Ask the groups to summarize their discussion using "participants` template (table 2).
- When the time is over, invite all 5 groups to present turn by turn. After each presentation, try to have more reflections.
- To conclude, ask the following practical question:
    - ✓ How do the contraceptives work in general?
    - ✓ Why we need to know the features of a contraceptive? How best we apply this knowledge to our routine activities of FP services?
    - ✓ What will happen if we provide incorrect information to our clients about the FP methods?
    - ✓ What are the differences between regular and emergency contraception?
    - ✓ Invite a person from the audience to summarize step 3. Enrich the summary if needed.

Table 2: Participant Template: summary of contraceptive features by types and categories

Contraceptive methods	How it works	Advantages	Disadvantages	Side effects	Contra-indications
Natural methods					
LAM					
Short-acting methods					
COC					
PoP					
DMPA (injectables)					
Long acting methods					
Copper T- *380A*					
Norplant (6 rods) Jadelle (2 rods) Implanon (1 rod)					
Barriers and IUCD					
Male and female condoms					
Diaphragm					
Permanent methods					
VSC- male sterilization					
Tubal ligation- female sterilization					

Facilitator's note: refer to the following table for the summary of contraceptive features by types and categories (Table 3).

Table 3: summary of contraceptive features by types and categories

Methods	How it works	Advantage	Disadvantage	Side effect	Contraindication
1. Natural Methods					
LAM	• Prevents the release of eggs from the ovaries (ovulation)	• Effectively prevents pregnancy for 6 months • Encourages the best breast feeding patterns • can be used immediately after birth • No hormonal side Effects (SE)	• Not a suitable method if the mother is working outside the home • Not effective if the mother doesn't feed her baby continuously (day and night)	• No side effect	• No contraindication
2. Short acting methods					
COC	• Prevents the release of eggs from ovaries (ovulation)	• Very effective when taken consistently and correctly • safely taken throughout the reproductive life • Fertility returns soon after stopping it • helps prevent IDA • helps prevent endometrial tumors, ovarian cancer/ cyst and PID	• Not recommended for breast feeding woman and in woman with increased BP • It causes stroke or heart attack • Not protect against STI	• In small number of women, it causes nausea, headache, sore breast, mood change and spotting	• Severe headache, severe chest pain, leg swelling, breathing difficulty, collapse and coughing up blood
PoP	• Thickens cervical mucus to block sperm and egg from meeting and prevents ovulation	• Can be used by nursing mother • Free of Estrogen related SE such as stroke or heart attack • helps prevent endometrial tumors, ovarian cancer/ cyst	• For women who are not breast feeding, irregular periods, spotting and amenorrhea for several months • Not protect against STI		
DMPA	• Thickens cervical mucus to block sperm and egg from meeting and prevents ovulation	• Very effective and long acting • Can be used by nursing mother • Free of Estrogen related SE (stroke or heart attack) • helps prevent uterine tumors	• Causes disturbance of menstrual cycle • Delays return of fertility • Doesn't protect against STI		• In small number of women, it causes nausea, headache, dizziness, breast tenderness, hair loss and acne

Methods	How it works	Advantage	Disadvantage	Side effect	Contraindication
3. Long acting methods (IUCDand Implants)					
Copper T-*380A*	• Copper component damages sperm and prevents it from meeting the egg	• Very effective and long acting cost- effective method • No hormonal SE and suitable for lactating mother • Fertility returns sooner. it can be removed any time • helps prevent ectopic pregnancy	• Requires skilled provider • PID and increased risk of HIV • Expulsion: causes an expected pregnancy	• Uterine perforation may occur if the provider is a less- skilled • Pelvic pain and dysmenorrhea	• Current PID • Known or suspected pregnancy • Undiagnosed irregular GUT bleeding • Known allergy to IUCD
Norplant (6 rod), Jadelle (2 rods), Implanon (1rod)	• Thickens cervical mucus to block sperm and egg from meeting and prevents ovulation	• The most effective and long acting (3-7 Yrs) • Can be used by women who can't use those contraceptives having estrogen and who have difficulty to take pills on daily basis • can be removed at any time if needed	• requires highly skilled professionals to insert and remove it • causes irregular periods • Not protect against STI • delays return of fertility	• Wt gain, nervousness, anxiety, dizziness, nausea, depression and infection at incision site in few women	
4. Barriers					
Male and female Condoms ***Diaphragm***	• Forms a barrier to prevent sperm and egg from meeting	• Very effective if taken consistently and correctly • No hormonal SE • Fertility returns shortly • helps prevent STI/ HIV	• Women have to rely on the man`s corporation to protect her selves • May break if not kept well or possibility of slippage: causes an expected pregnancy	• May causes allergy in few men or women	
5. Permanent methods (Male and Female Sterilizations)					
VSC- **Tubal ligation-**	• Keeps sperm out of ejaculated semen in male sterilization (VSC) and blocks eggs from meeting sperm in female sterilization (tubal ligation (TL))	• Very effective and permanent • No hormonal SE • Doesn't affect sexual pleasure	• VSC is not immediately effective and needs to stay away from having sex for 2-3 months • Requires highly skilled personnel to do VSC and tubal ligation • Once done, both methods are not reversible. Critical decision and consultation needed • There might be regrets for what have been done • Doesn't protect against STI		

Enabling objective 2 : Clarify self inhibiting attitude against FP services and how such attitude impacts their day- to-day activities

Training Method: Brainstorming (30 min)

- Invite the participants to do the 'Agree-Disagree' exercise so as to identifytheir own individual inhibiting attitudes against the use of any contraceptive
- Write the following statements (Box 1) on the card
- Put the cards in a small box
- Invite the participants to get around the corner, make a circle and draw a card from each box.
- Encourage the individual to read the statement on the card loudly and ask those individuals who agree with the statement to stay in the circle and those who disagree to move apart then ask both the "Agree" **or** "Disagree" group "why?" If one gets convinced by others explanation of the others group, he/ she can re-join the opposite group. if not convinced at all, however, he/s she can stay where he/she is.

Box1: Agree or Disagree Statements

- COCs cause cancer.
- The pill can cause deformity to the baby if a woman takes it for a long time.
- A woman can take any contraceptive method safely throughout her reproductive life
- You often need to encourage a woman to take injectable contraception or hide implants from her husband, so that she will not be forced by her husband to become pregnant
- Taking in to consideration Ethiopian culture, a woman should not use any contraceptive before marriage.
- Wide use of emergency contraception (EC) may encourage couples to have extra-marital sex and young girls to experience pre-marital sex, which are not supported by the community.

Repeat the same until the cards are finish. You need to be neutral; don't comment on what has been said but you need to know the correct answer (see your "Facilitators'` resources, on the agree/ disagree statements box 2 and "myths/rumors and facts" Box 3)

- At the end, ask the following questions:
    - Why do we need to do such exercises?
    - How may this affect our communication while serving an individual or the community? Why?

Facilitator`s note

Box 2: Hints for "agree/disagree" statements

COCs cause cancer- **Disagree**

The pill can cause deformity to the baby if a woman takes it for a long time-**Disagree**

A woman can take the oral contraceptive method safely throughout her reproductive life -**Agree**

You often need to encourage a woman to take injectable contraception or hide implants from her husband so that she will not be forced by her husband to become pregnant-**Disagree**

Taking in to consideration Ethiopian culture, a woman should not take any contraceptive before marriage-**Disagree**

A wide use of emergency contraception (EC) may encourage couples to have extra-marital sex and young girls to experience pre- marital sex, which is not supported by the community-**Disagree**

Box 3: Myths/rumors and facts about contraceptive pills

Myth: Women who stop taking the pill may not be able to get pregnant. They become infertile.

Fact: Most women who use a method of contraception, including the pill, can later get pregnant if they wish. The pill will not cause women to be infertile.

Myth: The pill causes cancer.

Fact: The pill does not cause cancer. In fact, the pill actually reduces the risk of getting certain cancers, such as endometrial and ovarian cancers.

Rumor: Oral pills build up in a woman's body. Oral pills do not build up in a woman's body.

Women need to rest from taking oral contraceptives on sex-free days.

Fact: Women do not need a rest from oral contraceptives. They have to take them every day,

Whether or not they are having sex that day.

Rumor: Oral contraceptives cause birth defects or multiple births.

Fact: Oral contraceptives do not cause birth defects or multiple births

Rumor: Oral contraceptives change women's sexual behavior.

Fact: Oral contraceptives do not change women's sexual behavior.

Rumor: Oral contraceptives accumulate in a woman's stomach.

Fact: Oral contraceptives do not collect in the stomach. Instead, the pill dissolves each day.

Enabling objective 3: Demonstrate the advanced skills how to provide effective FP counselling to the clients

Training methods: Brainstorming, role-play (60 min)

Fig. 2: Counseling for FP

Step 1: Brainstorming

Encourage the participants to discuss their own experiences in terms of doing effective counseling

Write the following questions on the flipchart

Q 1: From your experience how do you organize FP counseling? Who are your common targets for FP?

Q2: What are the common myths and rumors about FP methods in your community? How do you overcome this?

- Seek for responses; encourage the participants to reflect on these questions
- Write down on the flipchart their responses

Step 2: Role-play

Case Scenario

WroTuna, 38, comes to you to have FP method. This is her first time visit for FP services. After having more discussion with her, you realized that Wro Tuna was diagnosed for having malignant hypertension 5 years ago. Now, she wants to take oral pills for the rest of her reproductive life. Besides, she needs your help to convince her husband about her choice and about FP in general

- Divide class into two groups. The first group nominates 2 actors; one to play the 'client' and the other to act as an 'UHE-p' to perform initial individual counseling.
- The 3 performers in the second group will play the role of a 'client', her 'husband' and the 'UHE-p' to accomplish couples- counseling. The rest of the participants would be observers.
- Both groups will play the same role based on the above case scenario and their exiting experiences. Both groups need to do initial and follow up counseling for their clients.

Fig 3: Couples counseling

- Explain the task to the groups

- Ask the groups to divide roles among them selves
- Encourage both groups to practice the play within given period of time (20 minutes for practicing and 25 minutes for performing and feedback)
- When the time is up, call up on both groups and ask them to present their plays to the audience (start with the volunteer group). *please note; while presenting, the performers need to apply the principles, approaches and steps of FP counseling (see your facilitators` note)*
- Provide check-list (checklist 1) to the observers; ask observers to attend the play and take notes carefully
- Follow the performance being played using your checklist (Table 4).
- Note that whether they effectively demonstrate their ASK in the role-play.
- After the role play, have a debriefing with those who played the role of the 'client' in the individual counseling and the 'client and the husband' in couple counseling one after the other. Encourage them to provide their feedback by asking the following questions:
    - How helpful was the interaction that you have had with the health professional (UHE-p) and why?
    - As a client, how effective was the health professional in helping you to understand what was being discussed?
    - As a client, what did the health professional do well to make you feel comfortable to openly discuss about sensitive RH issues?
    - What did the health professional do well to help you overcome negative feelings or fears about the myths and rumors of FP methods?
    - If you met this heath professional again, what would you like her to do differently to better help you? Why?
    - Next, debrief the presenters: Ask them to reflect on how they managed their knowledge, attitudes and skills to help their clients decide on their choices of FP methods to plan their family.
    - Ask those actors who played UHE-p the following questions:
    - What did you do well to communicate with you audiences and what were your limitations (if any)?
    - What did you do well to address the client/s concerns about FP?
    - What did you do well to address the family's misconceptions about FP?
    - In your presentation how did you manage to demonstrate your enabling attitude? How best exhibited your understanding about FP methods?
    - If you were given a chance to repeat this any other time, what would you change and how? Why? Why would the changes be useful to improve your job performance?
    - Ask the observers to give the performers a feedback. Remind them to use their learning on how to give constructive feedback.
    - Return to UHE-p and ask which feedback is useful for you and why? Appreciate all and let them return to their seats.
    - Ask someone to summarize the step by asking the participants the following questions:
    - ☛ What is the importance of doing such role-play? How this related to your day-to-day activities?
    - ☛ Which gender- based factors or other social factors you think would be potential for compromising the use of FP services? How? As a professional how do you overcome such problems?

Hint: Use the information below (box 5) as a checklist for counselling for FP

Facilitator's note: There are a number of tools readily available to help counselling for FP. For this training purpose, however, please refer to the Standard counseling guide which is found in the "National Guideline for Family Planning Services in Ethiopia"; FMOH, October 2011. The following box provides insights to the approach of counselling

Box 5: Overview of the stages of counselling for family planning

General counselling

The first contact usually involves counselling on general issues to address the client's needs and concerns. You will also give general information about methods, and clear up any mistaken beliefs or myths about specific family planning methods. All this will help the client in your village arrive at an informed decision on the best contraceptive method to use. During this session you would also give information on other sexual and reproductive health issues, like sexually transmitted infections (STIs), human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS) and infertility.

Method-specific counselling

In method-specific counselling, you give more information about the chosen method. In this case, you can explain the examination for fitness (screening), and instruct on how and when to use the given method. You will also tell the client when to return for follow-up, and ask them to repeat what you have said on key information.

Return follow-up counselling

Follow-up counselling should always be arranged. The main aim of follow-up counselling is to discuss and manage any problems and side effects related to the given contraceptive method. This also gives you the opportunity to encourage the continued use of the chosen method, unless problems exist. Also use this opportunity to find out whether the client has other concerns and questions.

Steps in family planning counselling: See "National Guideline for Family Planning Services in Ethiopia"; FMOH, October 2011

Enabling objective 4: Demonstrate enhanced skill how to administer contraceptives to the client

Training method: role-play (90 min)

Step 2: Role-play

Participants are required to demonstrate how to administer different methods of contraceptives to their clients. Four groups of 6 members will be formed to play the role of an UHE-P who provides (a) oral contraceptives (b) injectable contraceptives and (c) male condoms (d) referral service for long acting and permanent FP methods. Group a, b and c need to have all these products and perform their respective play based on their existing experiences while group (d) will based on the following "case scenario 3" to perform its role-play.

Fig 4. A health professional providing a contraceptive

Case Scenario 3

During your visit to a household, suppose you find a 37-year-old married woman who has 5 children. She is sexually active but wants to stop bearing children and has decided to use a permanent FP method.

- Instruct the participants to break into four groups
- Explain the task to the groups. Remind them that they have learnt about the type and features of FP methods in sessions 1 and 2 above.
- Ask the groups to divide roles among themselves (one as a provider [UHE-p] and the other as a client from each group and the rest of the group members as observers).
- Encourage all groups to practice and present the role-play within given period of time for practicing and for performing and feedback)
- When the time is over, call upon all groups and ask them to present their plays to the audience one by one (start with the volunteer group). *Note; they need to assume that they have done a counseling before.*
- Provide a checklist to the observers and ask them to follow the play and take notes carefully.
- Follow the performance being played using a checklist. Note that whether they effectively demonstrate their ASK in the role play

After each role play, have a debriefing with those who played "the client" first and then the provider by asking the following questions:

- How helpful was the interaction that you have had with the (UHE-p) and why?
- As a client, how effective was the health professional in helping you understand what was being discussed?
- As a client, what did the health professional do well to make you feel comfortable to talk openly about sensitive RH issues?
- What did the health professional do well to help you overcome negative feelings or fears about the myths and rumors of FP methods?
- If you met this heath professional again, what would you like her to do differently to better help you? Why?

Next, debrief the presenters: Ask them to reflect on how they managed their attitudes, skills and knowledge to make their clients satisfy with the service that they provided

Ask those actors who played the providers the following questions

- What did you do well to communicate with you audiences and what was your limitation (if any)?
- What did you do well to address the client/s concerns about FP method (dose, effectiveness, advantage, disadvantage and/ or side effects)?
- What did you do well to address the rational use of FP drugs?
- For group (a) how would you play if you meet a client who missed taking COC between 8th and 14th day counting from her LMP
- In your presentation how did you manage to demonstrate your enabling attitude?
- How best were you exhibiting your skills in administering FP methods?
- If you were given a chance to repeat, what would you change? And why?
- Why would the changes be useful to improve your job performance?

Ask the observers to give the performers a feedback. Remind them to apply their learning on how to give constructive feedback.

Return to those who played UHE-p and ask them which feedback was useful for them and why? Appreciate all and let them resume their seats.

Ask someone from the participants to summarize the step by asking the participants the following questions:

- ☛ What is the importance of doing such role-play? and how this relate to your day to day activities?
- ☛ Which gender- based or other social factors you think would be potential barriers to the intended use of the chosen methods by the client at your level or at the referral points?
- ☛ As a professional, how do you overcome such problems?

Finally: Remind the participants to refer to their handout on the classification and features of FP methods, table 3 .

Facilitator's note: see the following box and table (box 6 and Table 4) for the information on missed pill/s

Box 6: Rules for missed pills

ALWAYS:

1. Take a pill as soon as you remember

2. Take the next pill at the usual time. This may mean taking two pills on the same day or even at the same time

3. Continue taking active pill as usual, on each day

Table 5 Information kit for the providers for the missed pills		
When pills are missed	**How pills are missed**	**Follow the three rules in box 8 and instructions below**
In the first 7 days	Start the pack two or more days late, or missed any two to four pills	Avoid sex or use additional contraception for next seven days
Days8–14	Missed any 2 to 4 pills	Follow the three 'Always' rules in box 8
Days15–21	Missed any 2 to 4 pills	Go straight to the next pack. Throw away inactive pills from 28-day pack (day 22- 28); don't wait seven days before starting a 21- pill pack.
In the first 3 weeks (day 1-21)	Missed five or more in a raw	Avoid sex or use additional contraception for next seven days. Go straight to the next pack. Throw away inactive pills from 28-day pack (day 22- 28); don't wait seven days before starting a 21- pill pack.

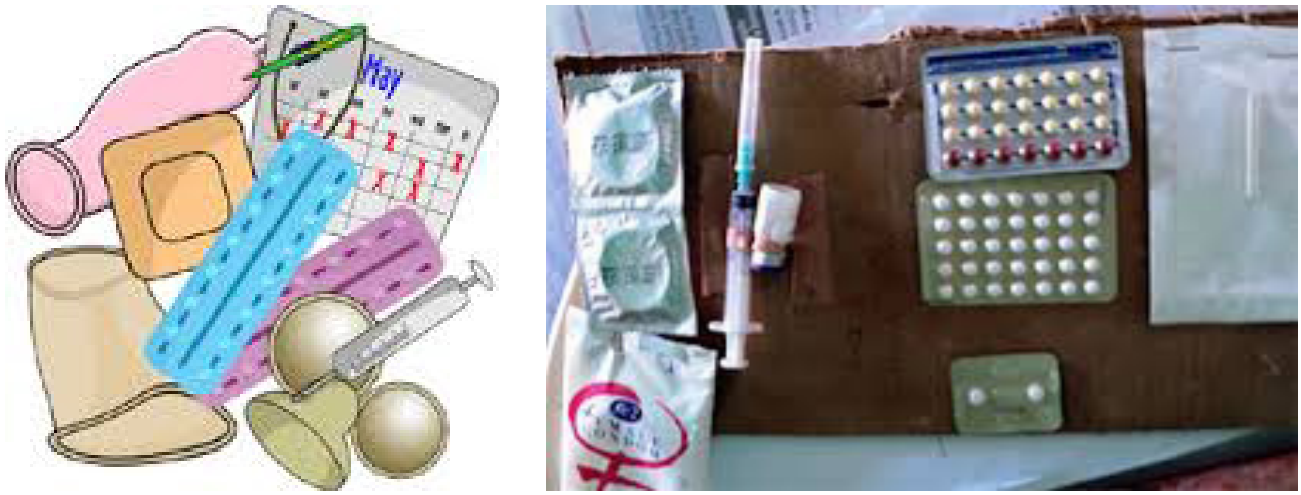


Figure 5: Different types of Contraceptive methods

Administering contraceptive methods: Role Play Checklist 1

Structure	Examples of what she might say	Performance	
		Yes	No
Rapport Building	Use of simple and understandable language; explaining the purpose advantage of this conversation; avoiding discriminatory words, showing kindness and support, share their feelings, and statements on the issues of maintaining confidentiality.		
Exploring risks	***COC*** Take history of Hypertension, thrombosis, heart disease, smoking, liver disease, etc. Give the right instruction on the property and rational useof the drug Gives right drugs Records the service being given		
	Injectables Give right information about the property of the drug Gives injection according to standard procedure Records the service being given		
	Male Condoms Gives right information about the proper, consistent and correct use of male condoms Demonstrates how to wear a condom according to standard procedure and provide condoms to the client. Records the service being given		
Provision of referral service	Identify the client as referral case Explain objectives and use of referral linkage Identify and locating appropriate referral points including the explanation of its profile (the services beingprovided) Record information on referral registration book and issue the referral slip Schedule and agree the follow-up visits		
Cross-cutting issues	Showing positive attitude Demonstrating use of effective communication skills and enabling attitudes. Exhibit use of problem solving skills.		

SESSION SUMMARY

Invite some of the participant to summarize the whole session based on the following questions:

- What are the advantages of oral contraceptives, injectables, implants and condoms?
- Describe the FP method-specific counseling?
- How do you administer the FP methods (condoms and oral pills)?

ASSIGNMENT SHEET

- Directions: instruct the participants to refer to "table 3" and ask them to read and understand the concepts individually. Tell them that they would be discussing all information in table 3 during the next recap session.

UNIT THREE: MATERNAL AND NEWBORN HEALTH CARE

Unit description: This unit is developed using competence based training approach to help the trainees improve their knowledge, attitude and skills on how to describe major cause of and recommend interventions to reduce maternal morbidity and mortality. It also enhances the skills of the trainees to how to diagnose pregnancy and danger signs. In addition, basics of PMTCT, Nutritional screening and services, components of post-natal and newborn care are included in this unit.

Unit Objective: At the end of this unit participant will be able to identify, discuss and demonstrate skills on major causes of maternal and neonatal morbidity and mortality, pregnancy and danger signs of pregnancy, postnatal Care (PNC), nutritional screening, counseling and supplementation, adherence to PMTCT counseling, and essential new born care.

Unit specific objectives: By the end of this unit participants will demonstrate the required knowledge, attitude and skill to:

- Discuss the major cause of and recommend intervention to reduce maternal morbidity and mortality, and demonstrate skill to identify danger sign during pregnancy
- Detect pregnancy and danger sign.
- perform nutritional screening, counseling and supplementation for pregnant women
- Discuss basics of PMTCT service and provide adherence counseling service for HIV positive mother
- Discuss post-natal care components and provide home based PNC service
- Explain essential Newborn Care components and demonstrate related skills

Time:745 minutes

Session 1: Introduction to maternal and new born health

Session objective: By the end of this session the participant will demonstrate required knowledge attitude and skills to discuss the major causes of maternal and neonatal morbidity and mortality, recommend interventions to reduce morbidity and mortality, explain roles and responsibility to improve maternal and neonatal health services.

Enabling objectives: By the end of this session participants will be able to:

- Identify and discuss major causes of maternal morbidity and mortality
- Identify and discuss cause of neonatal morbidity and mortality.
- Explain the important interventions targeted to reduce maternal morbidity and mortality and demonstrate roles and responsibilities to improve maternal health services.

Time: 80 min

Enabling objective 1: Identify and discuss major causes of maternal morbidity and mortality

Training Method: Card exercise (30 min)

- Write the following phrases "**Major cause of maternal morbidity and mortality**" and "**not major**

cause of maternal mortality and morbidity" on a separate piece of color paper and post it on the wall. Make sure that there is enough space in between the two posted papers.

- Using different colored card write the major causes of maternal morbidity and mortality and other related issue.

Unsafe abortion	Eclampsia (Caused by dangerously high blood pressure)	Anemia during pregnancy
Malaria during pregnancy	Puerperal sepsis (Infection)	Postpartum hemorrhage (Bleeding after childbirth)
Obstructed labor	HIV/AIDS	Cardiovascular disease
Malnutrition	Tuberculosis	Diarrheal disease
Tetanus	Excessive vomiting during pregnancy	Sepsis

- Randomly distribute at least one card to all participants until all of the cards are taken off. You can write single phrase/word on more than one card.
- Ask participants to come to the wall on which the phrase "**Major cause of maternal morbidity and mortality**" and "**not cause of maternal mortality and morbidity**" are posted. Tell them to post the card under one of the two categories where they feel appropriate.
- Once all participants post the card, facilitate the discussion by asking the following questions.
    - Which card/s is/are misplaced and why?
    - What do feel you can do about the issues discussed in the exercise?
    - What are the different factors affecting maternal morbidity and mortality?
    - What are the gender inequities issues that most affect maternal mortality and morbidity in your communities? What measures can you take to solve these problems?
    - How do current strategies address gender issues in maternal morbidity and mortality?

Facilitator's tip- The major causes of maternal mortality are described in enabling objective 2

Enabling objective 2: Explain the important maternal health interventions and demonstrate roles and responsibilities to improve maternal health services.

Training method: Buzz group discussion (20 min)

- Ask the participants to brainstorm in pair on the following two questions:
    - What are the high impact interventions (interventions that bring the most change) to reduce maternal mortality?

- How do UHE-ps contribute in improving maternal health condition?
- Ask volunteer pairs to share their brainstorming to the larger group and let others to supplement on the list.

Facilitator's notes

Note 1

The five **major direct causes** of maternal mortality are:

- Unsafe abortion
- Eclampsia (caused by high blood pressure during the pregnancy)
- Prolonged Obstructed labor
- Ante partum (bleeding before birth) and Postpartum hemorrhage (bleeding after child-birth)
- Puerperal sepsis (bloodstream infection after childbirth)

Note 2

High impact interventions to reduce maternal mortality are those that are given around the time of birth including:

- Delivery service provided by a skilled health professional (Basic and comprehensive emergency obstetric care)
- Comprehensive abortion care
- Early PNC (within 24-48 hrs)

Other supportive interventions to reduce maternal mortality include:

- Family planning
- Focused antenatal care (FANC) – mention about quality of care and content (early initiation / < 16weeks/, frequency, focuses on: BP, Weight, urinalysis, blood group, Hgb, VDRL and RDT for malaria prone areas)
- Maternal Nutrition
- Appropriate exercise and rest
- Creation of women friendly environment attached to delivery room.

Note 3

Role of UHE-Ps to improve maternal and newborn health service

- Identification and proper documentation of pregnant mothers, infants, under five children;
- Prioritizing of households with pregnant mothers, infants, under five children and during house visit and provision supports as needed;
- Counselling of women on importance of FANC, PMTCT, institutional delivery, early PNC, nutrition, FP and essential newborn care, etc;
- Health education and pregnant women conference on the importance of MNH services;
- Preventive services – immunization and bed nets;
- Refer pregnant women for ANC, PMTCT and delivery service; and follow up after referral;
- Vitamin A supplementation for children aged 6 – 59 months semi-annually;
- Nutritional screening;
- Work with women developmental army for promotion of MNCH services at large in the community; and
- Organizing women's group to support each other.

Enabling objective 3: Identify and discuss cause of newborn morbidity and mortality.

Training methods: Group activity (10 min), case study (20 min)

Group Activity

- Divide the class into three groups.
- Write the following question on flipchart and ask the group to discuss the questions:
    - What are the major causes of neonatal morbidity mortality?
    - What interventions are there to address the common causes of neonatal morbidity and mortality?
- Give the groups flipchart to write their answers.
- Ask a group to present. Ask the second group to supplement additional ideas on the presentation.
- Ask the whole class if they agree on the lists provided.
- Encourage participants to ask questions and make additional comments.
- At the end, summarize what was presented and give additional information.

Case study

Lelise a 25 years old first time mother, has given birth at the nearby health center two days before. She was told that her baby weighted 2.7kg at the time of birth. When the UHEP goes to her house, her child was crying and Lelise was stressed because she couldn't breastfeed the child as she doesn't have enough milk. During assessment UHEP have found out that the child has a temperature of 39 degrees centigrade. Lelise told UHEP that the child was given some sugar water and her mother-in-law has put butter on the umbilical cord saying it would speed up the healing.

- Distribute this case scenario and ask participants to work in pair on the following questions
  1. What is the major health problem of the child?
  2. What immediate action you would take?
  3. What do you think are the underlying causes of the problem?
  4. What advice would you give Lelise later on?
- Give time for the participants to discuss and answer the questions.
- Ask a volunteer group to present their answers. After the presentation invite all the participants to give additional answers if any and discuss on the list.
- Summarize the session using the note below.

Facilitator's note

The most common cause of neonatal morbidity and mortality are

- Prematurity- born before 37 week of pregnancy
- Low birth weight- born with weight less than 2.5kg
- Hypothermia
- Infection, and
- Birth asphyxia

Please note that common causes of morbidity and mortality among neonates are interrelated most of the time. Premature babies are most likely to have low birth weight and easily tend to loss body heat leading to hypothermia. If you suspect one of the above causes of neonatal morbidity, check to ensure the baby doesn't have the others. Manage all the causes immediately without delay and advice parents/caregivers on how to give proper care at home. Refer the neonate immediately if you cannot manage any of the above symptoms.

Proven interventions to reduce newborn morbidity and mortality include:

- Proper assessment and early resuscitation.
- Preventing infections – proper cord care is essential.
- Warming – kangaroo mother care is a cheap and effective way of providing warmth especially for premature and low birth weight neonates.
- Early breastfeeding in the first hour of birth.

SESSION ASSIGNMENT

Ask for and answer any outstanding questions. Summarize this session by asking the following key questions:

1. What are the major causes of maternal mortality?
2. What are the high impact interventions (interventions that bring the most change) to reduce maternal mortality?
3. What are the major causes of neonatal mortality?
4. What are some on the proven intervention to reduce neonatal mortality?

Answers

1. Unsafe abortion, eclampsia, prolonged obstructed labor, antepartum and postpartum hemorrhage and puerperal sepsis are the major causes of maternal mortality.
2. High impact interventions to reduce maternal mortality are those that are given around the time of birth.
3. Prematurity, low birth weight, hypothermia, infection and birth asphyxia.
4. Proper assessment and early resuscitation, prevention and early treatment of infection, providing heat especially for premature and low birth weight neonates and initiation of early breast feeding.

Session 2: Focused Antenatal Care Service (FANC)

Session objective: by the end of this session the participant will able to identify, define, explain and demonstrate knowledge, attitude and skills on FANC and its schedule, birth preparedness, complication readiness, danger signs and STI screening.

Enabling objectives: By the end of this session participants will be able to:

- Discuss FANC service and explain how it is scheduled.
- Explain birth preparedness and complication readiness.
- Detect pregnancy and identify danger signs and symptoms during pregnancy.
- Provide Screening for STIs.

Time: 180 minutes

Enabling objective 1: Discuss FANC and explain how it is scheduled**.**

Training methods: Class activity (10 min)and case study (20 min)

Class Activity

- Write the following questions on flip chart and post on the wall where everyone can see it.

  Questions:

  - What is the best time to start ANC follow up for a pregnant woman?
  - How many ANC visits are essential throughout a pregnancy period?
  - At what stage of the pregnancy must a woman see health professional regardless of her health status?

- Let a participant give only one answer at a time.Allow participants to discuss, argue and come to consensus on each question.

- Summarize the responses and add essential points from the facilitator's note if needed.

Facilitator's note

Definition of FANC

- FANC is goal oriented ANC approaches that aims to promote the health of mothers and their babies through targeted assessments of pregnant women. FANC facilitates
- Identification and treatment of already existing disease and conditions.
- Early detection of complications and other potential problems that can affect the outcome of pregnancy.
- Prophylaxis and treatment for anemia, malaria, STIs including HIV and urinary tract infection. Provision of tetanus toxoid vaccination as well as addressing other common diseases that may affect the outcomes of pregnancy.

Recommended Schedule for FANC	
Visit	timing of visit
First visit	before 16 weeks of pregnancy
Second visit	24-28 weeks of pregnancy
Third visit	30-32 weeks of pregnancy
Fourth visit	36-40 weeks of gestation

Case study

Write the following case scenario on flipchart

Aynalem is a 30 years old mother. She has one living child . She has missed her period for the last two months and suspects that she is pregnant but hasn't visited health facility yet to confirm. If you meet Aynalem at her home, what advice would you give her about ANC follow up?

- Ask participants to discuss in pair for 10 minutes.
- Ask 2-4 volunteer pairs to present the summary of their discussions.
- Let all the participants discuss on the presentation using the following questions
    - Did the presenters give all essential information for Aynalem?
    - Was there anything that was not included during the presentation but would be essential to tell for clients like Aynalem?
    - Was there any misleading information given for Aynalem?
- Summarize the presentations and add essential points if needed based on the facilitator's note.

Enabling Objective 2: Discuss birth preparedness and explain complication readiness

Training methods: Role-play (40 min)

Definition of birth preparedness and complication readiness

Birth preparedness and complication readiness (BP/CR) is comprehensive packages aimed at promoting timely access to skilled maternal and new born services. It promotes active preparation and decision making for delivery by pregnant women and their families.

Role-play

Divide participants in to four groups. Distribute the following case scenario to participants and facilitate discussion by asking questions that follow. Group 1 & 2- work on case scenario 1 while the remaining groups work on scenario 2. The group can enrich the case scenario based on local context. In each group, ask the group members to select three volunteers. One volunteer will act as UHE-p, the second volunteer as pregnant woman and the third volunteer as a husband of the

Case scenario # 1

Terhas is a 20-years old woman living in slum corner of Adigrat. She is a primi-gravida pregnant woman who had never attended antenatal care. Her pregnancy is progressing and her abdomen is getting bigger and bigger but she did not remember the exact date of last normal menstrual period. So far she did not decide the place of delivery and do not know about birth preparedness. Terhas is living in the catchment area of Sr. Shawit (UHEp). Sr. Shawit has planned to visit Terhas and discuss with her about birth preparedness and complication readiness.

Case scenario # 2

W/ro Lemlem is 35 years old pregnant women, who live with her husband and 3 children. She has seen her period for the last 8 months. She remembers her last date of menstruation. Sr Kolone (UHE-p) visited her frequently. W/ro Lemlem delivered her third child at home before three years. Sr Kolone has planned to discuss with W/ro Lemem on her birth preparedness plan and complication readiness.

pregnant woman. In each group the other participants will observe and take note.

- Participant should do the role-play within their own group. After the role-play, guide the groups to undertake discussion on the session and write the outcomes on flipchart. Session within their groups.
- Remind participants to record the service they provided using the observation checklist provided below.

Observation checklist

SN	Activities to be observed	Response			Comment
		Fully	Partially	No	
1	Did she greet the woman warmly?				
2	Did she use a probing type of open ended questions to identify woman's problem and its root cause?				
3	Has she discussed on birth preparedness plan?				
4	Has she discussed on complication that might happen during pregnancy it their management?				
5	Did she support the client to make informed decisions on the place of delivery?				
6	Was she judgmental?				
7	Was she respecting the woman?				
8	Was she prescribing key health messages to the client?				
9	Did she make consensus with the clients on follow up actions?				
10	Did she make appointment for follow up?				
11	Did she document what she accomplished with the service data recording tool?				

- Facilitate group discussion by asking the following questions. Allow participants to provide reflections based on the observer checklist.

Discussion Questions

- What did the UHE-p do well to help the client prepare for the upcoming birth? How?
- What useful attitudes were demonstrated by the UHE-p? How?
- What was done to help the client make informed decisions? How?
- What was done to help improve communication and negotiation between the client and her husband?
- Can the interaction between the UHE-p and the couple be improved? How?

Facilitator's note

Birth preparedness, complication readiness and emergency planning:

Birth preparedness: is the process of planning for a normal birth.

Complication readiness is anticipating the actions needed in case of an emergency.

Emergency planning is the process of identify and agreeing all the actions that need to take place quickly in the event of an emergency, and that the details are understood by everyone involved, and the necessary arrangements are made.

Birth preparedness:

Educate the mother and her family to recognize the normal signs of labor. Delivery may occur days or even weeks before or after the expected due date based on the date of the last normal menstrual period. Knowing what labor means will help the mother know what will happen, and this in turn helps her feel comfortable and

assured during the last days or weeks of her pregnancy. Provide clear instructions on what to do when labor starts (e.g. in the event of cramping abdominal pain or leaking of amniotic fluid). Make sure that someone will call you or another skilled attendant for the birth as soon as possible. Support your verbal advice with written instructions in the local language.

Birth preparedness should cover:

- **Honoring her choices** - You should give all the necessary information about safe and clean delivery, but ultimately you should respect a woman's choice of where she wants to give birth and who she wants to be with during delivery.
- **Helping her to identify sources of support** for her and her family during the birth and the immediate postnatal period.
- **Planning for any additional costs associated with the birth**, preparing supplies for her care and the care of her newborn baby.

Birthing supplies the mother should prepare:

The birthing supplies that a pregnant woman and her family should be advised to prepare before the delivery are listed below:

- Very clean clothes to put under the mother and for drying and covering the newborn.
- New razor blade to cut the cord.
- Very clean and new string to tie the cord.
- Soap, a scrubbing brush and (if possible) medical alcohol for disinfection.
- Clean water for drinking and for washing the mother and your hands.
- Three large buckets or bowls.
- Supplies for making rehydration drinks, 'atmit' or tea.
- Flashlight if in case of power out or is no electricity in the area.

Complication readiness and emergency planning:

As noted earlier, complication readiness is the process of anticipating the actions needed in case of an emergency and making an emergency plan. Pregnancy-related disorders such as high blood pressure and bleeding can begin any time between visits for antenatal check-ups, and any other illness may occur during the pregnancy. If such conditions are suspected at any stage, you should refer the woman immediately, and repeatedly counsel her to report to you or seek medical care quickly if danger symptoms are seen.

Enabling objective 3: Detect pregnancy and identify danger signs and symptoms during pregnancy

Training method: Buzz group discussion (15 min), demonstration (30 min) and class exercise (15 min)

Buzz Group Activity

- Print and distribute the following table to the participants and let them work in a group of three. Invite randomly selected 2-3 group to present their work and let other supplement on the presentation.

Table: sign and symptoms of pregnancy		
Possible sign and symptoms of pregnancy	Probable sign and symptoms	The positive sign

- Distribute printed copy of below table to all participants and tell them to compare their work with the printed one. Ask if they have any question and address accordingly.

Table: sign and symptoms of pregnancy		
Possible sign and symptoms of pregnancy	Probable sign and symptoms	The positive sign
Missing menstrual period	Abdominal enlargement	Fetal heart bit
Breast tenderness, fullness, enlargement and darkening of areola	Pregnancy test for human chorionic gonadotropine hormone (HCG)	Palpation of the fetus part
Nausea & vomiting	Painless uterine contraction	Diagnosis by ultra sound
Tiredness		
Frequent urination		
Darkening of the skin over the forehead, bridge of the nose, or cheekbones,		

Facilitator's note

A. Signs and symptoms of pregnancy

- The indications of pregnancy are generally classified into three groups:
- **The possible symptoms**: changes in her body that a woman can identify for herself and tell you about, which may mean she is pregnant. But they could also be caused by something else. You only have the woman's subjective report on which to base your diagnosis. However, at community level, the possible symptoms are often all the evidence that is available to you in the first three to six months.
- **The probable /presumptive signs and symptoms**: some of these indicators are reported by the woman, but you can also see them for yourself. There is also a pregnancy test that you may be able to conduct, or that could be done at the next level health facility.
- **The positive signs:** these are absolute proof of pregnancy, based on objective findings.

***Demonstration*: How to detect pregnancy using HCG test**

- Distribute the procedure to be followed while conducting urine pregnancy test:
- To begin testing, open the sealed pouch by tearing along the notch after checking for expiry date. Remove the test from the pouch. **Note:** First morning urine usually contains the highest concentration of HCG and is therefore the best sample when performing the urine test. However, randomly collected urine specimens may be used.
- Holding the strip vertically, carefully dip it into the specimen (you may collect urine in a clean, dry container). Immerse the strip into the urine sample with the arrow end pointing towards the urine. Do not immerse past the MAX Line (Marker Line). Take the strip out after 10 seconds and lay the strip flat on a clean, dry, non-absorbent surface. (Note: In rare instances when dye does not enter the result area, dip the tip of the test strip in the urine as instructed above until the dye begins traveling across the white result area).

- Wait for colored bands to appear. Depending on the concentration of HCG in the test specimen, positive results may be observed in as little as 40 seconds. However, to confirm negative results, the complete reaction time of 5 minutes is required. It is important that the background is clear before the result is read. Do not read results after the specified reaction time.

INTERPRETATION OF RESULTS

Negative: Only one color band appears on the control region. No apparent band on the test region. This indicates that no pregnancy has been detected.

Positive: Distinct color bands appear on the control and test regions. Presence of both test line and control line indicate presence of pregnancy. The color intensity of the test bands may vary since different stages of pregnancy have different concentrations of HCG hormone.

NOTE: A positive test line will appear directly below the control line on the same test surface (or 'result window' area). Any line or accumulation of color/dye that appears at the juncture between test components should not be mistaken for "test line" (this is only the source of the test reagent & dye).

Invalid: No visible band at all. The control band will not appear if an insufficient volume of specimen is added into the test kit. Proper procedures may not have been followed in performing the test. Repeat with a new test kit. Please consult above instructions and follow precisely.

Note: the above is a general instruction. Always read the instruction on the test strip package carefully before use. There could be some variation on how to apply the urine sample. However, the interpretation of the results is the same. The picture below shows the different types of test strips as an example and how the readings are interpreted.

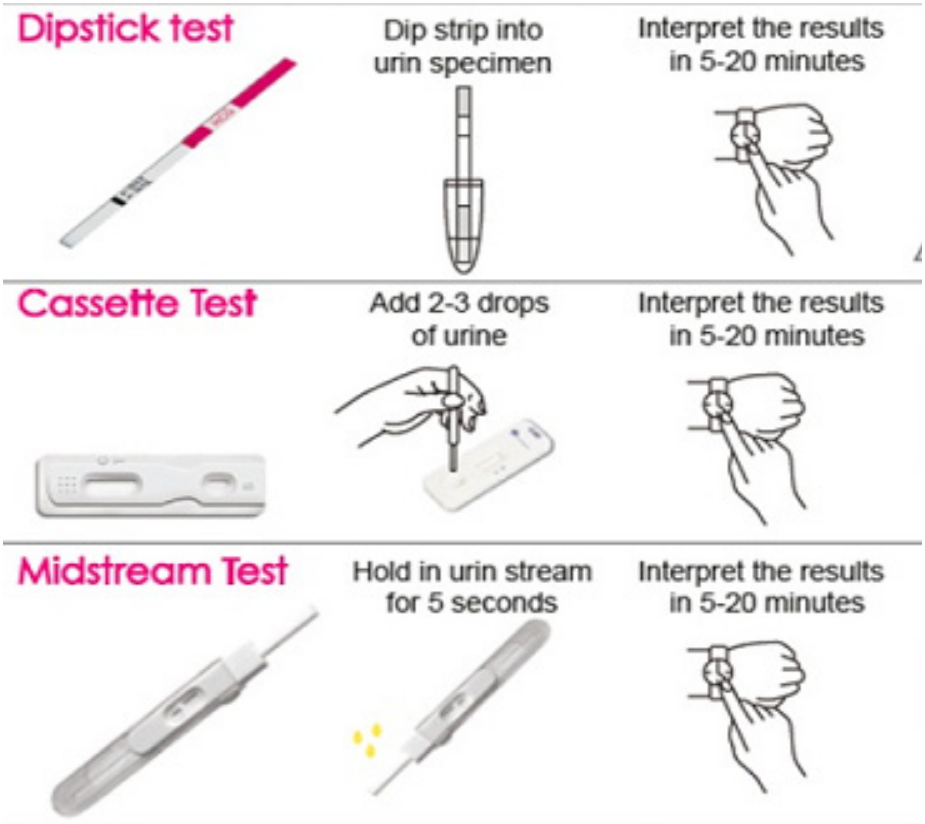


Figure 6: different ways of applying urine sample for HCG test

Positive test Negative test

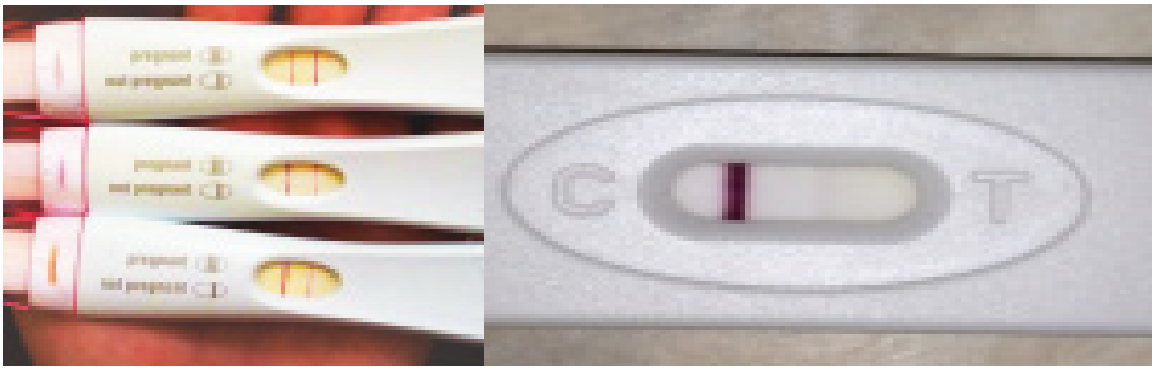


Figure7: Examples of HCG test results

- Make sure that the participants have understood the written procedure for pregnancy test using HCG.
- Ask two participants to re- demonstrate on how to use the test strip using a sample in front of the class. You can use water or other liquid for demonstration.
- Ask participants to follow the demonstration carefully and note.
- At the end ask participants to comment on the demonstration.
    - Did they demonstrate correctly?
    - Was there anything that was done wrongly? How could that be improved?

***Class exercise: Identifying* Danger signs and symptoms during pregnancy**

- In a plenary, distribute two blank cards and marker to all participants.
- Ask them to write general danger signs during pregnancy in the first blank card and the role of UHE-ps in dealing with the situation in the second blank card.
- Once they did this, ask all participants to come together to one side of the training hall which has enough space to post the cards. On one side of training wall, let them post danger signs during pregnancy and role of UHE-ps on the other side in dealing with these problems.
- Let participants review the postings for and ask if there is any additional point anyone would like to make. Encourage participants to ask question and discuss the points posted.
- Then provide the handout on the general danger sign during pregnancy and role of UHE-p, which is presented in the facilitators' note attached below. Then, ask participants to compare the postings on the wall and the handout and respond to the following questions. (15 minutes)
    1. What difference is there between the list in the wall and the handout?
    2. In your experience, what is the most important role that UHE-p can play in addressing danger signs? Why?
    3. If the UHE-ps did not exist, who would play this role?
- Summarize the main learning points of the activity.

Facilitators' Note

Danger signs during pregnancy

Danger sign is a serious condition that threatens the life of the mother or her unborn child or both. During every antenatal care visit, the UHE-p should ask if the pregnant woman has danger sign. If she has danger sign, the UHE-p should refer her immediately to the health center. If she does not have any danger signs, UHE-ps should counsel on the need to recognize danger signs and seek care immediately.

The following are the most important danger signs during pregnancy:

1. Vaginal bleeding
2. Severe abdominal pain
3. Fever
4. Headache, dizziness, or blurred vision
5. Convulsion or unconsciousness
6. Swollen hands and face

Role of UHE-ps in addressing danger signs during pregnancy:

- Create awareness to pregnant mother on what are danger sings observed during pregnancy and their possible implications.
- Advice mothers to early seek medical care whenever she observes these signs.
- As appropriate, accompany the mother to the health facility for intervention.
- Follow-up visits to maintain adherence to treatment and/or services.

Enabling objective 4: Provide counseling and screening for Sexually Transmitted Infection during pregnancy

Training methods: Class activity (20 min) and experience sharing (30 min)

- Write the following question on flipchart and ask the participants to give answers

Questions:

- What are the common sign and symptoms of STIs?
- Who should be considered most likely to acquire STI? Why?
- Why is it important to address the issue of STI during pregnancy?
- What information should be given to a pregnant woman about STI?

- Ask each question at a time and write the response on flipchart.
- Encourage participants to add more ideas.
- Summarize the discussion using the points in facilitator's note.

Experience sharing

Invite 3-4 volunteer participants to share their experience in relation to STI counseling during their work. Ask the following questions to start discussion in the class room.

1. Have you ever encountered a pregnant mother with signs and symptoms of STI during your home visit?

2. How did you identify her? (Did you ask for signs and symptoms of STIs or did the mother started the discussion?)
3. What advice and services have you given her?
4. Did you have a chance to discuss with her husband/ partner about treatment options?
5. What was the most difficult part of discussing STI with your client? How did you manage it?

Facilitator's note

Sign and symptoms of STIs:

- Pain or burning sensation during urination
- Heavy menstrual bleeding or bleeding between periods
- Itching (Anal or vaginal)
- Lower abdominal pain
- Vaginal discharge (Clear, white, greenish or yellow with strong odor)
- Pain during sexual intercourse
- Swollen lymph glands
- Rash following nerve ending lines
- Vaginal ulceration

With a consideration of the above sign and symptoms ask the following social and medical history

- Previous diagnosis of STI
- Sexual history
- Past general medical history
- Current medications
- Risk factors for the acquisition of HIV and STIs

see also Major Communicable Disease Module- AIDS/STI session

SESSION ASSIGNMENT

Ask for and answer any outstanding questions. Summarize this session by asking the following key questions:

1. What is FANC?
2. What are the timings of the recommended visit for FANC?
3. What is birth preparedness and complication readiness?
4. What are the possible danger signs of pregnancy?

Answers

1. Goal oriented ANC approaches that aims to promote the health of mothers and their babies through targeted assessments of pregnant women.
2. At least one visit in the first trimester, one visit in the second trimester and two visits at the beginning and end of the third trimester.

3. Birth preparedness and complication readiness (BP/CR) is comprehensive packages aimed at promoting timely access to skilled maternal and new born services. It promotes active preparation and decision making for delivery by pregnant women and their families.
4. Vaginal bleeding, severe abdominal pain, fever, headache, dizziness and blurred vision, convulsion, unconsciousness, swollen hands and face.

Session 3: Maternal Nutrition

Session objective: By the end of this training session, the participant will demonstrate required knowledge, attitude and skill on nutritional counseling and life cycle approach of nutritional interventions, explain special nutritional requirement for pregnant and lactating mother, conduct pregnant women nutritional screening using Mid Upper Arm Circumference (MUAC) measurement and supplement micro nutrients.

Enabling Objectives: By the end of this session, the participant will able to:

- Demonstrate nutritional counseling and life cycle approach of nutritional interventions and explain special nutritional requirement for pregnant and lactating mother.
- Conduct pregnant women nutritional screening using MUAC.
- Supplement micro nutrient and deliver appropriate message on nutritional supplementation.

Time: 135 minutes

Enabling Objective 1: Demonstrate nutritional counseling and explain life cycle approach of nutritional interventions and special nutritional requirement for pregnant and lactating mother.

Training Method: Class activity(15 min), Brain Storming (10 min) and role play (40 min)

Class activity

- Ask participants the following questions
    - What is the importance of discussing about nutrition?
    - What is nutrition in the lifecycle?
    - What is intergenerational malnutrition cycle?
    - What is the significance of maternal nutrition during pregnancy?

- Write the responses on flipchart and supplement the responses using the points given in the facilitator's note
- Show participants the picture on nutrition at the lifecycle

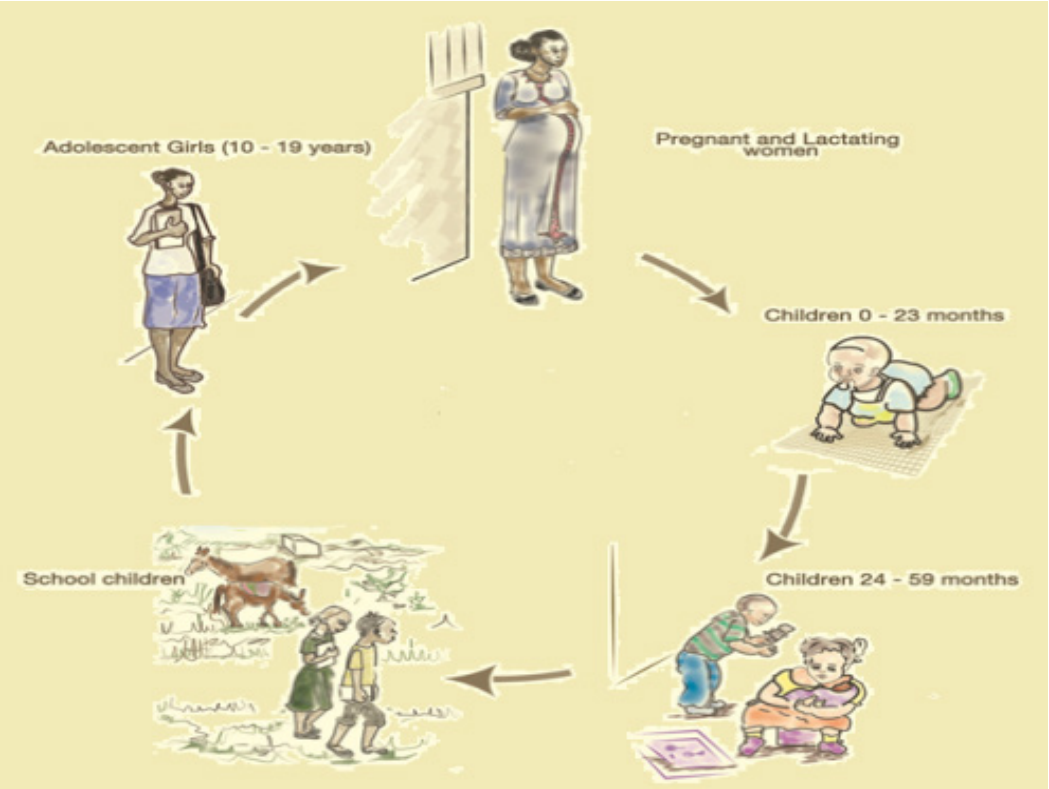


Figure 8: Nutrition in a lifecycle

Facilitator`s note

Explain Nutrition in the lifecycle and the intergenerational malnutrition cycle as follow

- Nutrition in the lifecycle is addressing the nutritional need of individual throughout the life cycle including pregnancy, childhood, adolescences, adulthood and old age.
- A stunted adult has some functional limitations compared to a taller one (referring to direct effects of small size)

- Stunted women result in intra-uterine growth retardation (inter-generational cycle of stunting).
- Stunted adults have a reduced working capacity (perpetration of poverty in labor-intensive societies).
- Growth catch-up is possible in later childhood with sustained improvement in living conditions.
- Children, who remain in poor living condition, in which they became stunted, experience little or no catch-up in growth later in life.
- Mental and cognitive impairment are often permanent and irreversible after the age of 24 months.
- Stunting commonly occurs during fetal life, and soon after birth up to until the second year of life (the first 1000 days of life).
- This critical period is equivalent to first 1000 days of life = *270 days (9 months of pregnancy) + 365 days (1st year of life) + 365 days (2nd year of life).*

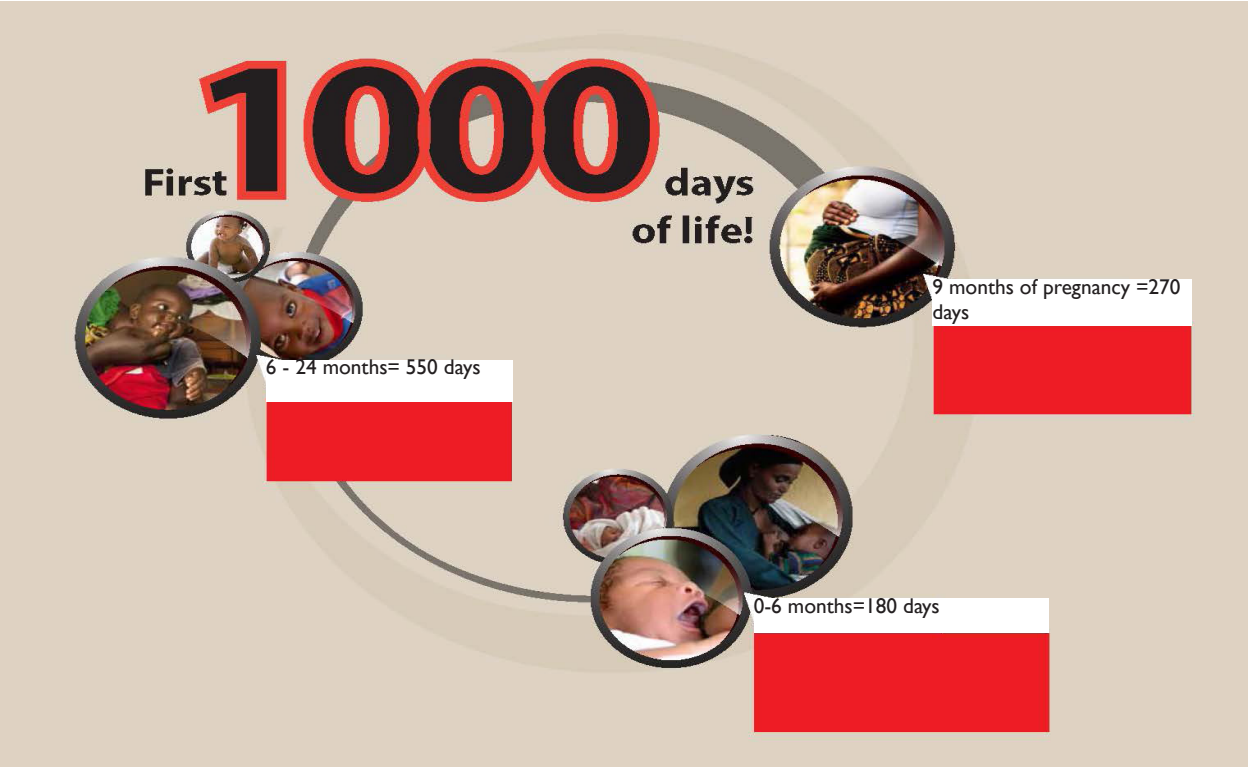


Fig. 9: description of the first 1000 days of life

Adolescent Girls (10-19)

- The second window of opportunity, to break the intergenerational malnutrition cycle of Pregnancy
- Most of the stunting/under nutrition status started during intrauterine period
- Eating diversified foods and one extra meal during pregnancy period.
  - Helps a woman resist illness during her pregnancy and after the birth
  - Keeps a woman's teeth and bones strong
  - Gives a woman strength to work
  - Helps the baby grow well in the mother's uterus
  - Helps a mother recover her strength quickly after the birth
  - Supports the production of plenty of good quality breast milk to nourish the baby.

Brainstorming

- Facilitate brainstorming using the following questions
  - Some pregnant women feel nauseated and do not want to eat food. How can we ensure their required food intake?
  - Many families cannot afford to buy enough food or wide variety of food? What do you advice in that circumstance?

Role -Play

- Divide participants into four groups and provide them with below case scenarios. One scenario is given to

two groups and the other case scenario to the remaining 2 groups. The groups should select two people each to play a role of a client and an UHEP.

- The other participants will observe and take note

Scenario 1:

W/ro Azeb is 3-months pregnant women. It is her first pregnancy and because of nausea her appetite has decreased significantly. Since she is government employee and her husband is merchant, relatively they are financially better-off. As a result of low intake of food she is excessively tired and could not accomplish here routine office work.

Scenario 2:

W/ro Genet, who is 32 years, is living in peri- urban kebele of Hawasa town. They have small farmland and four children. Currently W/ro Genet is 28 weeks pregnant and did not make any change on her dietary intake. Besides, working on the small farm land her husband sometime goes to the town and work as daily laborer and earn additional money

- In the role play the UHE-p will give nutritional advice for the clients.
- In the breakaway groups ask all the participants to discuss and list the most important issues that should be discussed with the client. They should write their answer on flipchart, post it on the wall and resume their seat.
- Ask volunteers to do the role play in front of all participants (one role play per case scenario)
- Other participants should take note using the observation checklist below
- Facilitate a discussion after each role play by raising the following questions.

Facilitation questions:

- What did the UHE-p do well to help the client? How?
- What useful attitudes were reflected during the counseling session? How?
- (for UHE-p) What was/were the most challenging issue during interaction the client, and why? How did you manage it?
- Was there anything that the UHEP failed to raise and discuss during the counseling session? How could that be addressed?

Summarize the session by providing additional points if needed.

Observation checklist

S.N	Activities to be observed	Response			Comment
		Fully	Partially	No	
1	Did the UHE-p greet the woman warmly?				
2	Did the UHE-p use a probing type of open ended questions to identify the nutritional issues and root causes?				
3	Has the UHE-p explore the client's circumstances?				
4	Has the UHE-p enough information about nutrition during pregnancy and beyond and the benefit of it?				
5	Did the UHE-p explain further on how to use available food items in the household to prepare balanced diet?				
6	Was the UHE-p respectful?				
7	Did the UHE-p ensure the client has understood and encouraged to ask further question?				
8	Did the UHE-p gave information about where to get further help?				
9	Did the UHE-p make appointment for follow up?				
10	Did the UHE-p document what the UHEP accomplished with the service data recording tool?				

Enabling Objective 2: Conduct pregnant women nutritional screening using MUAC

Training Method: Brainstorming (10 min) and demonstration (20 min)

Brainstorming

- Ask participants the following question and write the answers on flip chart. One participant should give only one answer at a time. Encourage all participants to contribute

> **Question:** What methods of nutritional screening do you know for pregnant and lactating mothers?

- When the discussion is over distribute the chart below and ask participants to compare their responses with that of the chart

Table 6: Nutritional assessment

Assessment	What to Ask or Measure
Nutrition history	• Dietary intake (frequency, quantity and diversity) • Eating habits (dieting, craving, food myths & taboos) • Food intolerance and dislikes • Fatigue and physical activity • Nausea, vomiting • Availability of clean and safe water • Sanitation and hygiene practices in food preparation and handling (personal hygiene, food preparation and handling) • Daily intake of iron and folic acid supplements • Use of iodized salt
Physical Assessment	**Anthropometric measurements:** • Height • Pre-pregnancy weight • Weight gain during pregnancy • MUAC **Other physical features** • Edema • Pallor (palm, tongue, conjunctiva) • Goiter
Medical history	As per the national ANC guideline
Lab investigation	As per the national ANC guideline
Micronutrient control	Provide iron folic acid to prevent anemia on confirmation of pregnancy Treat anemia in confirmed cases Provide albendazole during 2nd or 3rd trimester

Facilitator's note

A woman at pre-conception is considered underweight when the MUAC reading is < 21cm. A pregnant or lactating woman whose MUAC is less than 23.5cm are considered to be underweight.

Demonstration: Using MUAC to determine the nutritional status of pregnant and lactating women

- Ask a volunteer participant to come to the front of the class for demonstration of MUAC mea-

surement.

- Ask them to stand in a place where every participant can clearly see what theyare doing
- As they demonstrate other participants should observe and take note
    - Do they demonstrate correctly?
    - Was there anything that was done wrongly? How should that be corrected?
- Ask them to use the MUAC tape to measure the circumference of the mid arm. Writ the result on flipchart and ask participants to interpret.
- Ask participants if the demonstration is clear. If you see confusion repeat the procedure
- Distribute MUAC tape to participants.
- Ask participants to be in pair and practice how to measure MUAC and interpret the findings.
- Walk around in the class room and help pairs who have difficulty or questions.

Enabling objective 3: counsel and Supplement micro nutrient to pregnant mothers

Training Methods: Brainstorming (10 min), gallery walk (10 min), and case study and discussion (20 min)

Brainstorming

Ask the following question and write the responses on flipchart

- What are the most important vitamins and minerals during pregnancy?
- Why are these vitamins and minerals important?

Write the responses on a flip chart.

Facilitator's tip

Make sure that the participants have mentioned iron, folic acid, Vitamin A, and iodine.

Gallery walk

- Group the participants into four and provide them the following table (table 7). provide the groups with a table having a list of Vitamin & minerals and header but empty field. Allow them to fill the importance and source column for each of the micronutrients listed. Provide them with flip chart and marker to write their response.

Table 7: Micronutrients by source and benefits

List of Vitamin & minerals	Why important	Source
Iron	Production of red blood cells by the fetus, the mother needs more iron as blood volume increases during pregnancy.	Organ meat, red meat, grains and legumes.
Iodine	For the fetal brain development, proper metabolism.	Iodide salt and dark green vegetables.
Folic acid	Proper fetal formation especially at earlier period of pregnancy.	Organ meat, milk and dairy products and citrus fruits such as orange

- Ask the groups to post their flip chart on different sides of the room.
- Invite all participants to go around and see other groups work and note any difference from their own group work.
- Provide/display correctly filled table.
- Facilitate questions and discussion.

Case study and discussion

Kedija is 29-year-old pregnant women who care for her unborn baby. Her husband is giving her all round support she needs. She is attending routine antenatal care visit at one of the health center and received two tetanus toxoid vaccine. At the health center she was provided with iron folate tablet free of charge and was advised her to take one tablet on daily bases. Recently she is experiencing nausea, epigastric pain, and difficulty of passing stool and change in her stool color. While she shares her problem one of her friends told her that iron tablet is the cause of the problem. Finally, kedija decided to quit taking the iron tablet.

- Ask the following questions based on the above- mentioned case
  - What would you advise kedija in this context?
  - What will happen if no one addresses kedija's concerns appropriately?

Facilitator's note

The iron pills may cause nausea, make it hard for the woman to pass stool (constipation), and her stool may turn black, but it is important for the woman to keep taking the iron pills because anemia can cause complications during pregnancy, during delivery, and after the baby is born. It is helpful for the woman to take the iron pill with a meal, drink plenty of fluids, and eat plenty of fruits and vegetables to *avoid* nausea and constipation. The black color of the stool is side-effect from the iron but is not harmful.

- Ask for volunteers to summarize the major learning points and how it help them improve maternal nutrition.

SESSION ASSIGNMENT

1. What is nutrition in a life cycle?
2. What is the benefit of using MUAC to assess the nutritional status of women?

3. What are the four most important micronutrients for pregnant mothers?

Answers

1. It is about the impact of nutritional status of a child starting from preconception to elderly. A girl child with poor nutritional status will give to small babies in the future and will face more pregnancy and birth complications as compared to women who have had good nutritional status during their childhood period.
2. It is cheap, simple and can be done at any time and place. In addition, MUAC measurement is acceptable standard way of assessing malnutrition among pregnant and lactating mothers.
3. Iron, folic acid, vitamin A and iodine

Session 4: Prevention of Mother to Child Transmission (PMTCT)

Session objective: By the end of this session participant will be able to discuss components of PMTCT, provide adherence counseling and counseling on breast feeding and FP for HIV positive mother.

Enabling objectives: By the end of this unit participants will demonstrate the required knowledge, attitude and skill to:

- Explain methods of PMTCT
- Provide adherence counseling
- Counsel about breast feeding
- Counsel about FP for HIV positive mothers

Time: 120 minutes

Enabling objective 1: Discuss methods of PMTCT

Training Method: Group activity (20 min)

- Divide the participants into four groups.
- Provide each group a copy of Tables 8 and 9 (shown below) and let them completes the information missing in the tables.
- Once the groups completed filling Tables 8 and 9, give them Tables 10 and 11 which are completed with full information and ask them to compare what they wrote on Tables 8 and 9 with what is written on Tables 10 and 11.
- Ask the groups to discuss and comment on the differences.
    - Once the groups compared, ask the groups to continue discussing and filling the roles of UHE-ps at each level of the National PMTCT strategy using the 3rd column of table 11 and write their response on flipchart
    - Post the flipcharts on the wall. Gather the participants around the flipcharts and discuss responses one group at a time.
    - Ask participants how important their role is in the national PMTCT strategy? What can you contribute even if when you don't have direct activity related to PMTCT?
    - Provide additions and address misconceptions, if any, and ask them what they have learned from the session and how it will help them do a better job with PMTCT.

Table 8: Estimated risk of MTCT

Timing	Transmission rate without intervention
During pregnancy	
During labor and delivery	
During breastfeeding	

Table 9: National strategies for PMTCT

Activity	National strategy
Primary prevention of HIV infection	
Prevention of unintended pregnancies among HIV- positive women	
Prevention of HIV transmission from infected women to their infants	
Treatment, care, and support of HIV-positive women and their infants and families	

Table 10: Estimated risk of MTCT

Timing	Transmission rate without intervention
During pregnancy	5-10%
During labour and delivery	10-15%
During breastfeeding	5-20%

Table 11: National Strategies for PMTCT

Activities	National strategy	UHE-P`s role
Primary prevention of HIV infection.	- Explain the Abstain, Befaithful, or Condom approach to protect reproductive-age people from becoming infected with HIV and other STIs. - Provide voluntary counselingand testing services following the National HIV Counselingand Testing Guidelines. - Promote correct and consistent use of condoms. - Early diagnosis and treatment of STIs.	- Provide counseling for all pregnant women - Refer to appropriate health facility when need arises
Prevention of unintended pregnancies among HIV-positive women.	- Integrate family planning counselingat potential PMTCT and VCT service sites.	- Provide appropriate FP planning for all HIV positive women and refer to services
Prevention of HIV transmission from infected women to their infants.	- Ensure availability of antiretroviral drugs and other appropriate supplies for PMTCT. - Provide counseling services integrated with ANC, labor, and delivery and postnatal care. - Safer obstetrical practices. - Provide appropriate counseling on infant feeding and support. - Promote exclusive breastfeeding.	
Treatment, care, and support of HIV-positive women, and their infants and families	- Provide pregnant women ART. - Ensure appropriate follow-up of infants born to HIV-positive women including: OI prophylaxis and early infant diagnosis. - Provide HIV testing for family. - Link PMTCT with care and support initiatives organized for infants and HIV- positive women	

Facilitator`s Note

Prevention of Mother-To-Child Transmission of HIV:

Mother-to-child transmission (MTCT) is the transmission of HIV from an infected pregnant woman to her infant. The more technical term for MTCT is *vertical transmission* or *perinatal transmission.* The

majority of children infected with HIV acquire the virus through MTCT.

MTCT of HIV occurs during pregnancy (ante partum transmission), during labor and delivery (intra partum transmission), and through breastfeeding (postnatal transmission). Children also can become infected with HIV through the same modes as those by which adults are infected (exposure to contaminated blood or other body fluids, e.g., through transfusions of infected blood products, through contact with needles or other instruments contaminated with infected blood or other body fluids, and through sexual abuse).

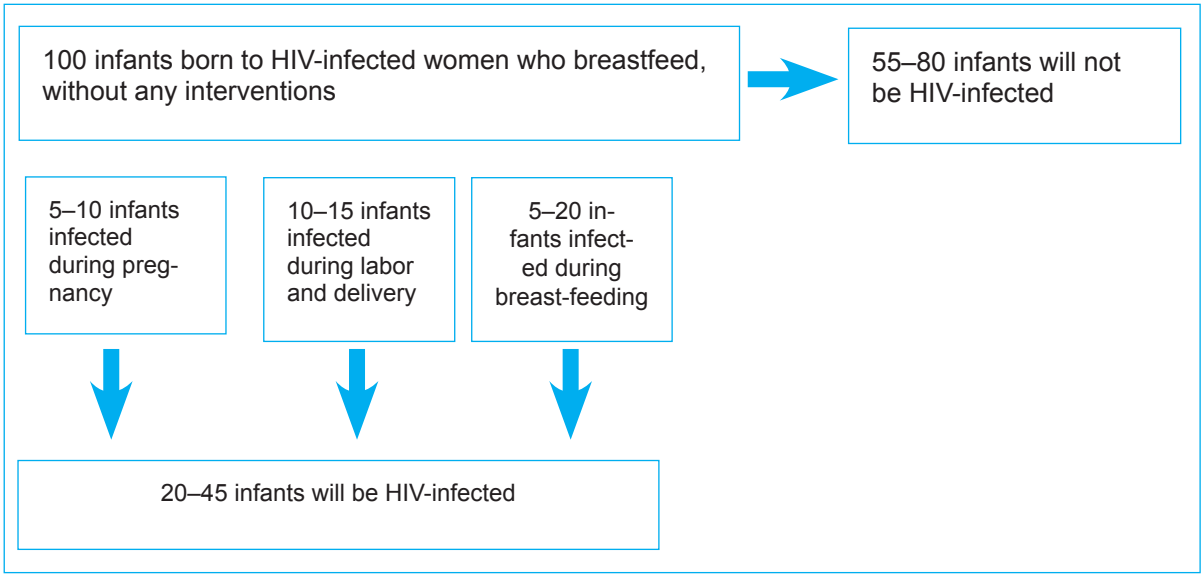


Fig. 10: Outcomes of Infants Born to HIV-Infected Women without Preventive Measures

Reducing HIV infection in infants and young children requires a comprehensive approach that comprises the four prongs listed below:

Activity 1: Primary prevention of HIV infection

Activity 2: Prevention of unintended pregnancies among HIV-infected women

Activity 3: Prevention of HIV transmission from HIV-infected women to their offspring

Activity 4: Provision of care and support to women infected with HIV, their infants, and their families.

Activity 1: Prevention of Primary HIV Infection

The ideal way of preventing children from HIV infection is prevention of the parents-to-be from HIV infection. Decreasing the number of mothers who are becoming HIV-infected is the most effective way of reducing MTCT. All efforts should be made to involve men in primary prevention intervention.

Primary prevention strategies include the following components:

This approach has come to be known as the “ABC” approach:

A = **A**bstinence

B = **B**e faithful—Be faithful to one HIV-uninfected sexual partner (known serostatus)

C = **C**ondom use—Use condoms correctly and consistently

- Promote safer and responsible sexual behavior and practices

- Provide access to condoms
- Provide early diagnosis and treatment of sexually transmitted infections
- Make HIV testing widely available
- Provide suitable counseling for HIV-negative women

Activity 2: Prevention of Unintended Pregnancies among HIV-Infected Women

Unintended pregnancy is largely preventable and effective family planning counseling and service is important to help HIV-infected women prevent unintended pregnancies and space births. It can also help women who are HIV-infected protect their own health while taking care of their families. The cost of infection and child deaths averted through family planning is substantially less than the cost of child death averted through the third and fourth activities of PMTCT. (WHO/CDC, January 2008)

Activity 3: Preventing HIV Transmission from HIV-Infected Women to their Infants

Specific interventions to reduce HIV transmission from an infected woman to her child include initiation and maintenance of ART (specific combination to be taken once daily), safer childbirth practices, Provision of ARV prophylaxis for the newborn/ baby and safer infant feeding practices. When an ART is given to the mother and ARV prophylaxis is given to the infant to prevent MTCT, it is referred as Option B+ PMTCT intervention. Here the mother who started ART at pregnancy will continue for life, which benefits the baby and her own health also.

Activity 4: Provision of Care and Support to Women Infected with HIV, their Infants, and their Families

The comprehensive care of all people living with HIV/AIDS, including HIV-positive women and their exposed or HIV-positive infants and children with her spouse is the fourth prong of PMTCT. The provision of care and support to HIV-infected and affected families paves the way for decreasing the stigma and discrimination associated with the HIV/AIDS.

Enabling objective 2: Provide counseling for HIV positive mothers to enroll and adhere to PMTCT services

Training Method: Role play (40 min)

- Divide participants in to four groups. Assign individuals within the group to assume the role of UHE-p, HIV positive pregnant mother and observer.
- Provide case scenarios for each group. Let the groups prepare for some minutes to do the role play based on the case scenario they are provided with.

Scenario 1: HIV positive pregnant sex worker who started PMTCT but defaulted.

Scenario 2: HIV positive pregnant unmarried adolescent girl who doesn't start PMTCT services.

Scenario 3:HIV positive pregnant married woman who knows that she got HIV from her husband. She is very upset and has no interest to seek medical help.

Scenario 4:HIV positive pregnant married woman who starts PMTCT services without the knowledge of her husband.

- Groups should discuss and list essential points that should be used for counseling session on flip chart and post in on the wall.
- Let the group present their role play for the class. During the role play, help them to demonstrate proper counseling of HIV positive pregnant woman to seek and adhere to PMTCT service.
- Decide the number of role play to be presented based on the available time.
- Facilitate discussion after each group play using the following questions.

Discussion Questions

- What did the counsellor do well to help the client?
- What did the counsellor do to make the client feel at ease and willing to discuss her situation?
- What was done to find out and address the specific concerns of the client?
- What did the counsellor do well to help the client make informed decisions and check that she would be able to carry them out?
- Is there anything that the counsellor has missed during the counseling session? How could that be improved?
- Summarize the activity by reminding the purpose of the activity and asking participants what they have gained from the session. Let two or three participants reflect on the main learning points they have gained from the activity.

Observation checklist

S.No	Activities to be observed	Response			Comment
		Fully	**Partially**	**No**	
1	Did the UHE-p greet the client warmly?				
2	Did the UHE-p make the client at ease and willing to discuss?				
3	Has the UHE-p explore the client's circum-stances?				
4	Has the UHE-p enough information about PMTCT that enables her to make informed decision?				
5	Did the UHE-p missed anything?				
6	Was the UHE-p respectful?				
7	Did the UHE-p ensure the client has under-stood and encouraged to ask further ques-tion?				
8	Did the UHE-p gave information about where to get further help?				
9	Did the UHE-p make appointment for follow up?				
10	Did the UHE-p document what the UHEP accomplished with the service data recording tool?				

Facilitator's Note:

Adherence:

Adherence is defined as a patient's ability to follow a treatment plan, take medications at prescribed times and frequencies, and follow restrictions regarding food, behavior, and other medications.

How much adherence is required for successful therapy?

- Goal of Highly Active Anti-Retroviral Treatment(HAART) = maximal and durable viral suppression (undetectable levels)
- Successful HIV therapy requires adherence > 95%
- Failure rates increase sharply as adherence decreases

Forms of non-adherence:

- Missing one dose of a given drug
- Not observing the intervals between doses
- Not observing the dietary instructions

Consequences of poor adherence:

- Incomplete viral suppression
- Continued destruction of the immune system-CD4 cell counts
- Disease progression
- Emergence of resistant viral strains
- Limited future treatment options
- Higher costs to the individual and ARV program

Factors affecting adherence:

- Patient/provider relationship
- Disease characteristics
- Clinical settings
- Treatment regimen
- Patient variable

1. Patient factors:

- **Socio-demographic factors**:
  - ✓ Gender
  - ✓ Ethnicity
  - ✓ Age
  - ✓ Employment

- ✓ Income
- ✓ Education and literacy

➢ **Psychosocial factors**:

- ✓ Active drug or alcohol use
- ✓ Degree of social support
- ✓ Social stability
- ✓ Depression and other psychiatric illnesses

2. Patient/provider relationship:

The patient/provider relationship has an important role in improving adherence to prescribed medications in chronic disease and is believed to be a motivating factor for adherence to HAART. Trust and confidence in providers has been found to influence adherence positively.

3. Disease characteristics:

Prior opportunistic infections (OI) contribute to increased adherence. Patients who have had serious opportunistic infections may perceive their illness to be severe and adhere better to their treatment.

4. Treatment regimen:

➢ The higher the pill burden, the lower the adherence.

➢ When patients experience treatment side effects, they tend to stop treatment or take it irregularly. Common side effects include:

- Diarrhea, fatigue, nausea, and vomiting; peripheral neuropathy, physical changes in body appearance, metabolic changes.

5. Clinical settings:

A friendly, supportive, and non-judgmental attitude of health care providers, including UHE-ps, convenient appointment scheduling, and confidentiality contribute to better adherence.

Adherence counseling needs:

➢ Knowledge

- o Infections, CD4 counts
- o Medications and side effects

➢ Attitudes

- o Positive belief and perceptions
- o Self-efficacy and commitment

➢ Practices and support systems

- o Disclosure to buddies, family

➢ Identifying and addressing barriers

- Integrating treatment regimen into patient daily routine
- Providing reminder cues

Enabling objective 3: Counsel breast feeding

Training Methods: Group discussion (40 min)

The activity involves a debate between the infant feeding options of breast feeding or formula feeding. The participants will be divided into two, one group will debate supporting breast feeding and the other formula feeding for HIV positive mothers. There will be a team of three who serve as a judge. The facilitator's role here is to clearly tell the instructions the intent of the activity.

- Tell each group to select secretary to capture the group discussion and chairperson to present the group's points of argument in the debate session.
- Tell the group to spend some minutes discussing the advantages of respective feeding options before the debate starts.
- In the plenary, each group will present their argument why they select either of the options turn-by-turn. After each presentation, there will be a time for the other group to present counter argument points and questions.
- The assigned judges will capture the arguments and give points as per the decision they made among themselves.
- Continue the debate based on the time available. Even if there is sufficient time, stop the debate if you feel that information is saturated.
- Let the judges reflect on the level of arguments from each side. But don't label one as a winner and the other a loser.
- Once the debate is completed, thank the participants for their participation. Distribute the print out of AFASS criteria and let them see the infant feeding options as a reference.
- Remark that there is no hard-and-fast rule with regard to infant feeding options. It all depends on the condition of the mother and the infant under discussion.

Facilitators' Note:

***Counseling the HIV-positive mother about feeding her baby*:**

Mothers who are HIV-positive and their babies need special care before, during and after labor and delivery. Therefore, if the mother is counselled and HIV-tested before or during pregnancy, and she knows that she is HIV positive, you should try to convince her to deliver her baby in a health facility. That way she and her baby will get special care from health professionals with special training in delivering babies from HIV-positive mothers, and preventing maternal to child transmission (PMTCT of HIV).

In the postnatal period, she may need to take antiretroviral (ARV) drugs prescribed for her by the HIV clinic, and your support is vital in helping her to keep to her drug regimen. Maintain confidentiality about her status and conduct frequent visits to this woman as she may require a lot of psychosocial support immediately after the delivery. If it is available link her with the community social support group. Always make sure her partner is counselled and HIV-tested and also involved in the whole care process.

Breast milk or formula?

In this study session our focus is on the risk of HIV being transmitted from the mother to her newborn baby in her breast milk, and how you can support and counsel her about feeding options. If 20 HIV-positive mothers breastfeed their HIV-negative babies exclusively for the first six months, on average one to three of the babies will become infected with HIV through its mother's breast milk. So the mother has a difficult choice to make. She has to balance the risk to her baby from HIV transmission during breastfeeding, against the risk of not breastfeeding and losing all the benefits described above. Formula feeding also exposes the baby to increased risk of infection from unsterilized bottles and malnutrition from incorrectly made feeds.

Replacement feeding and the AFASS criteria

Exclusive breastfeeding is NOT recommended for the babies of HIV-positive women, since the only way to protect the baby completely from HIV transmission from its mother is to feed it on formula milk. This is known as replacement feeding. However, many families cannot afford to buy milk formula to feed the baby, and bottle feeding may be socially unacceptable in some communities. With all these issues in mind the World Health Organization (WHO) has set the following criteria (known as the AFASS criteria), which need to be met before counseling an HIV-positive mother to use formula milk:

- ***A**cceptable:* Replacement feeding for breast milk is acceptable by the mother, the family and others who are close to the family.
- ***F**easible:* The mother has access to clean and safe water for cleaning the feeding bottles, teats, measuring cup and spoon, and diluting the formula milk if it comes as a powder.
- ***A**ffordable:* The family can afford to buy enough formula milk or animal milk to feed the baby adequately.
- ***S**ustainable:* The mother is able to prepare feeds for the child as frequently as recommended and as the baby demands.
- ***S**afe:* The formula milk should be safe and nutritious for the health of the baby.

The AFASS criteria are illustrated in the figure below. When replacement feeding fulfils the AFASS criteria, avoidance of all breastfeeding by HIV-positive mothers is recommended.

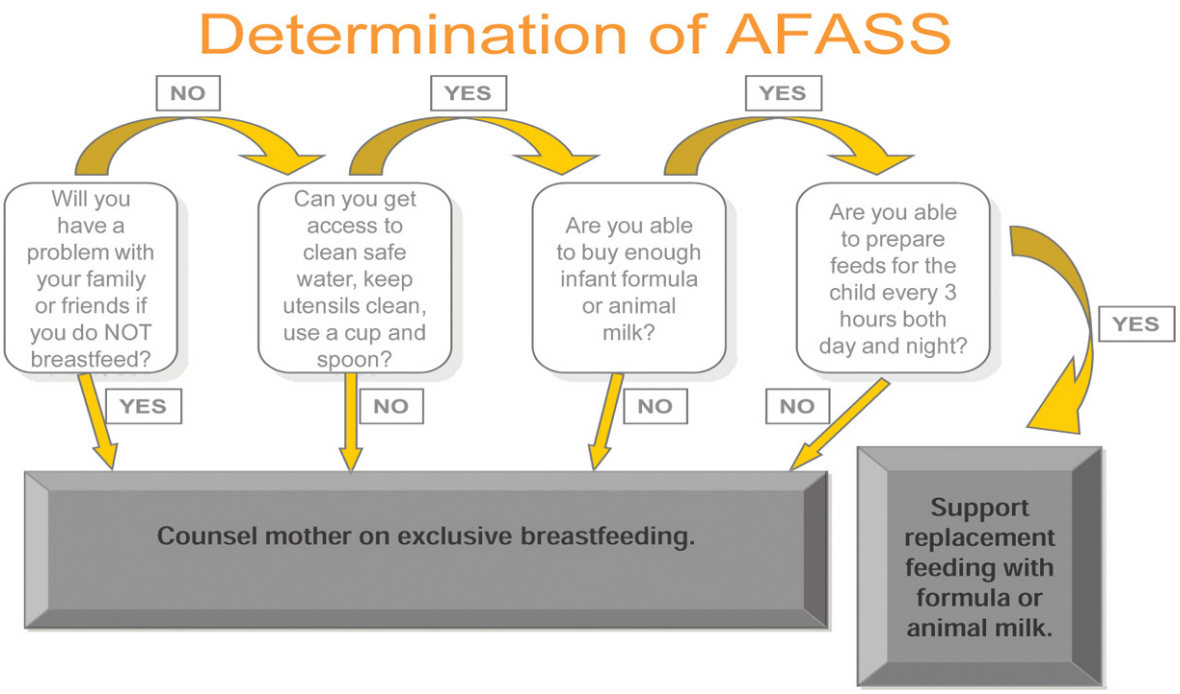


Fig.10: The AFASS criteria help you to counsel HIV-positive mothers about feeding options for their newborns. (Source: Ethiopian Federal Ministry of Health, based on WHO, 2010, Guidelines on HIV and Infant Feeding)

Reducing the HIV risk from breastfeeding

If replacement feeding is rejected by the HIV-positive mother, for whatever reasons, there are some things that she can do to reduce the risk of HIV transmission during breastfeeding. Counsel her to:

- Keep the intervals between breast feeds as short as possible (no longer than three hours) to avoid accumulation of the virus in her breast milk.
- If she develops a bacterial infection (mastitis) of the breast, or she has a cracked nipple, stop feeding from the infected breast and seek urgent treatment.
- Check the infant's mouth for sores and seek treatment if necessary.
- Make a transition to replacement feeding if her circumstances change and she can meet the AFASS criteria.

At six months, if replacement feeding is still not acceptable, feasible, affordable, sustainable and safe, counsel her to continue breastfeeding, but with additional complementary foods. All breastfeeding should stop once a nutritionally adequate and safe diet without breast milk can be provided

Enabling objective 4: Counsel Family Planning for HIV positive mothers

Training Methods: Group play (20 min)

The purpose of this activity is to enable participants reflect on the issues of providing family planning options for women infected with HIV. Like that of any other women, women living with HIV have their own reproductive health needs. Thus, this activity will provide an opportunity for participants to explore their knowledge and attitude with regard to the family planning options for HIV positive women

- Posts cards written with words of '**AGREE'** and '**DISAGREE'** on opposite side of the room.
- Let the participants stand in the center.

- Read one statement at a time and ask participants to move to either side of the posted cards according to their agreement or disagreement.
- Participants can change their mind in the middle of the discussion, thus let them do that at any point.
- Take one participants from the 'disagreed group' and ask why he /she disagreed? Repeat for two or more participants with the same question. Do the same for the agree group.
- If there is/are participants who shift from one category to another because they are convinced by the other person's explanation, ask why they changed their idea?
- At the end summarize the activity by asking the following questions

Discussion question

- What new information did you gain from this activity?
- Did the exercise help you clarify misconceptions in the community newborn care?

Statements for agree –disagree exercise:

1. Like any other women in the reproductive age, women living with HIV have the right to decide on her fertility related issues. **Agree**

2. There are family planning options that are specifically forbidden for women living with HIV. **Disagree**

3. All HIV positive women should be avoiding sexual intercourse if they want to avoid unwanted pregnancy. **Disagree**

4. Barrier methods of family planning are recommended for HIV positive women with discordant result with her husband. **Agree**

5. HIV positive women should be blamed if they become pregnant knowing the risks of transmission**. Disagree**

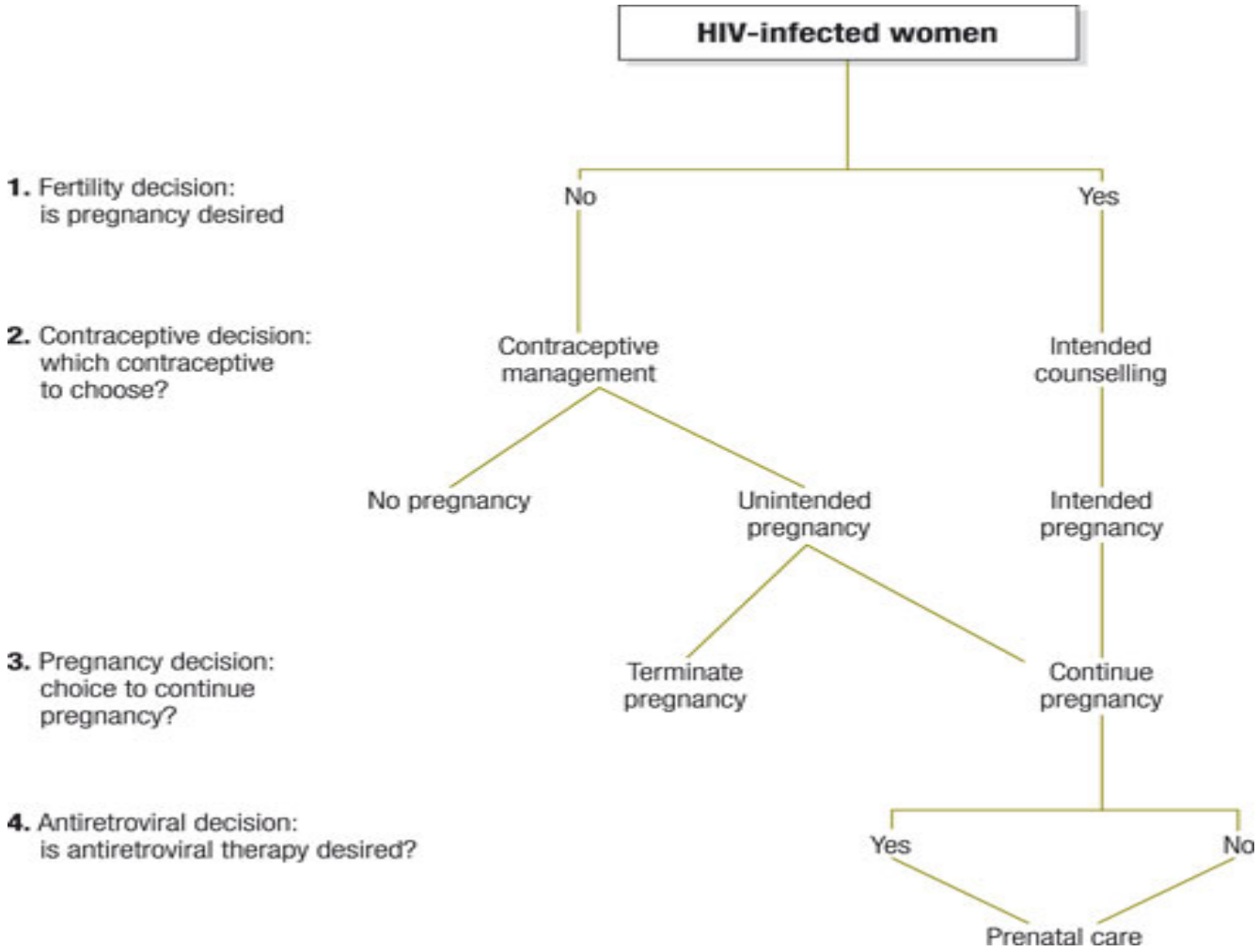
6. It is the irresponsibility of HIV positive woman wanting to have more children**. Disagree**

Facilitators' Note:

Effective linkages between the sexual and reproductive health and the HIV fields are essential to ensuring the reproductive rights of people living with HIV. All women, including those with HIV, have the right "to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights".

The sexual and reproductive decisions faced by women with HIV involve their desire for pregnancy, their contraceptive practices, their choices about an unintended pregnancy, and their prenatal and postnatal options to reduce prenatal transmission of HIV.

Reproductive choices for women with HIV



For women with HIV, linkages between the sexual and reproductive health and HIV fields can maximize the opportunities to address four distinct reproductive possibilities:

- if a woman does not wish to become pregnant, she should be referred to or offered family planning services;
- if she wishes to become pregnant, she should be educated about the local fertility and prenatal services, the types of treatment available to reduce the risks of transmission to her child and, if in a sero-discordant relationship, HIV prevention approaches to minimize the risk of infection transmission to a partner when trying to conceive;
- if she is currently pregnant and wishes to continue her pregnancy, she should be offered the opportunity to obtain antiretroviral therapy to reduce HIV transmission risks; and
- if she is currently pregnant but does not wish to continue her pregnancy, she should be referred to safe abortion services. Postpartum contraception could be offered as an option for those who do not wish to become pregnant again.

Regardless of HIV status, increasing access to sexual and reproductive health services will not only offer women more control over their reproductive lives and help them safely achieve their desired fertility, but also will produce major public health benefits on maternal and infant morbidity and

mortality. Voluntary contraceptive services, in particular, will benefit the health of women and infants in a variety of ways by delaying first births, lengthening birth intervals, reducing the total number of children born to one woman, preventing high-risk and unintended pregnancies, and reducing the need for unsafe abortion.

For those who are living with HIV, linking the sexual and reproductive health and HIV fields further enhances the public health impact by preventing pregnancies in women with HIV who do not wish to become pregnant. This in turn can reduce the number of infants born with HIV and the number of children orphaned due to AIDS. Indeed, prevention of unintended pregnancies in HIV-positive women is one of the four strategic elements recommended by WHO and its United Nations partners for PMTCT.

SESSION ASSIGNMENT

1. What are the critical times HIV is transmitted from mother to child?
2. What are the key factors that affect adherence o PMTCT services?
3. What is the basis to advise mothers on infant feeding?

Answers

1. During pregnancy, labor and delivery and breast feeding
2. Patient/provider relationship, disease characteristics, clinical settings, treatment regimen and factors from the patient side.
3. Follow AFASS criteria (refer to your notes)

Session 5: Delivery and post-partum care

Session objective: by the end of this session participant will be able to identify, discuss and demonstrate skills on danger signs during labor, delivery and postpartum period.

Enabling objectives: by the end of this session participants will demonstrate the required knowledge, attitude and skill to

- Identify danger signs during labor, delivery and postpartum periods
- Discuss components of essential postpartum care
- Provide postpartum care during home visit

Time: 110 minutes

Enabling objective 1: Identify danger signs during labor, delivery and postpartum periods

Training Methods: Brainstorming (10 min), Group discussion and experience sharing (30 min)

Brainstorming

- Ask participants to list the key characteristics of normal and complicated labor.
- Capture the answers on the flipchart.
- Encourage participants for more answers
- Provide the print out of the key characteristics of normal and complicated labor. Allow par-

ticipants to compare their response with the video they watched and the print out of the key characteristics of normal and complicated labor

- Address any questions raised in the process of discussion.

Group discussion and experience sharing

- Ask participants the following questions:
    - Have you ever come across a mother in labor in the community?
    - If yes, what was the situation? What measure have you take? What support have you provided to the mother? What was the outcome of the labor? How was the status of the mother and the fetus after that incident?
    - What were the key challenges you have faced at the time?
    - If no, what would you do if you encounter a woman in labor while you are doing the routine household visits? How confident are you in providing support for a laboring mother?
- Capture all the answers on flipchart.
  Distribute the print out of key steps in the active management of third stage of labor to the participants.
- If there is a model, use the model to demonstrate the key steps in the active management of third stage of labor.
- Summarize the discussion by adding points that hasn't been raised

Facilitators' Note:

Normal labor:

A normal labor has the following characteristics:

- Spontaneous onset (it begins on its own, without medical intervention)
- Rhythmic and regular uterine contractions
- Vertex presentation (the 'crown' of the baby's head is presented to the opening cervix,
- Vaginal delivery occurs without active intervention in less than 12 hours for a multi-gravida mother and less than 18 hours for a primi-gravida (first birth)
- No maternal or fetal complications.

Any type of labor that deviates from these conditions is considered abnormal, and usually requires referral for specialist care.

How do you know that true labor has begun?

True labor is characterized by regular, rhythmic and strong uterine contractions that will increase progressively and cannot be abolished by anti-pain medication. Pain symptoms may be relieved a little if the woman takes painkilling drugs, but true labor will still progress.

What is adequate uterine contraction?

If true labor is progressing, there will be adequate uterine contraction, evaluated on the basis of three

features — the frequency, the duration and the intensity of the contractions:

- The frequency of uterine contractions will be 3-5 times in every 10 minutes period.
- Each contraction lasts 40–60 seconds; this is known as the duration of contractions.

The woman tells you that her contractions feel strong; this is the intensity of contractions.

Show and leakage of amniotic fluid

During most of the pregnancy, the tiny opening in the cervix is plugged with mucus. In the last few days of pregnancy, the cervix may begin to open. Sometimes the mucus and a little bit of blood drip out of the vagina. This is called show. It may come out all at once, like a plug, or it may leak slowly for several days. When you see the show, you know that the cervix is softening, thinning and beginning to efface (open). Be careful not to confuse the show with the normal discharge (wetness from the vagina) that many women have in the two weeks before labor begins. That discharge is mostly clear mucus and is not colored a little bit red with blood.

True labor may be spontaneously established with or without show and with or without leakage of amniotic fluid (the waters in the fetal membranes surrounding the baby). In many parts of Ethiopia, people think that labor is not progressing if they don't see leakage of amniotic fluid either before or after labor begins. This is not true. You should be clear that show and leakage of amniotic fluid are not required for labor to begin or progress.

Helping the mother recognize a true labor:

There is no way to be sure when a woman's labor will begin, but there are some signs that it will start soon. Babies often drop lower in the mother's belly about 2 weeks before birth, which is known as lightening; commonly, mothers feel that the baby is no longer lying 'high' in the abdomen, and not pushing her stomach upwards. If she has had babies before, this baby may not drop until labor begins.

Other signs may happen only a day or two before labor starts. The mother's stool may change, or a little show (bloody mucus) may come out of the vagina. Sometimes, the bag of waters leaks or breaks (premature rupture of fetal membranes — PROM) before labor begins.

Tell her that true labor is:

- Regularly and progressively increasing pushing-down pain, which happens about 3-5 times in every 10 minutes. (Check whether she knows or can estimate how long 10 minutes is).
- Characterized by a pushing down pain, which is usually felt first in her lower back and moving around to the front in the lower abdomen below her belly button.

Demonstrate on her abdomen:

- What will happen due to lightening
- Where she will feel the abdomen is hard during contractions
- Where she will feel the maximum pushing-down pain.

Stages of labor

First stage of labor

The first stage of labor is characterized by progressive opening of the cervix, which dilates enough to let the baby out of the uterus. For most of the pregnancy, nothing can get in or out of the cervix, because the tiny opening in it is plugged with mucus. Each time the uterus contracts, it pulls a little bit of the cervix up and open. Between contractions, the cervix relaxes. The first stage is divided into two phases: the latent

and the active phase, based on how much the cervix has dilated.

Latent phase

The latent phase is the period between the start of regular rhythmic contractions up to cervical dilatation of 4 cm. During this phase, contractions may or may not be very painful, and the cervix dilates very slowly. The latent phase ends when the rate at which the cervix is dilating speeds up (it dilates more quickly). This signals the start of the active phase.

Active phase

The active phase is said to be when the cervix is greater than 4 cm dilated.

Contractions become regular, frequent and usually painful. The rate of cervical dilation becomes faster and it may increase in diameter by as much as 1.2 to 1.5 cm per hour, but the minimum dilation rate should be at least 1 cm per hour.

Cervical dilatation continues until the cervix is completely open: a diameter of 10 cm is called fully dilated. This is wide enough for the baby to pass through. At this diameter, you would not feel the cervix over the fetal head when you make a vaginal examination with your gloved fingers.

Second stage of labor

The second stage begins when the cervix is fully dilated (10 cm) and is completed when the baby is completely born. After the cervix is fully dilated, the mother typically has the urge to push. Her efforts in 'bearing down' with the contractions of the uterus move the baby out through the cervix and down the vagina.

Third stage of labor

The third stage of labor is the delivery of the placenta and membranes after the baby has been born. The duration is usually a maximum of 30 minutes.

Fourth stage of labor

The first four hours immediately following placental delivery are critical, and have been designated by some experts as the fourth stage of labor. This is because after the delivery of the placenta, the woman can have torrential vaginal bleeding due to failure of uterine contractions to close off the torn blood vessels where the placenta detached from the uterine wall..

The placenta, membranes and umbilical cord should be examined for completeness and for abnormalities. Maternal blood pressure and pulse should be recorded immediately after delivery and every 15 minutes for the first four hours. Normally, after the delivery of the placenta, the uterus will become firm due to sustained contraction, so the woman might feel strong contractions after the birth. Reassure her that these contractions are healthy, and help to stop the bleeding.

Enabling objective 2: Discuss components of essential postnatal care

Training Method: Role-play (40 min)

- The objective of this activity is to equip participants with the skill to provide counseling for mothers in their postpartum period.
- Ask participants to be into three group.
- Assign two participants from the group: one act as a mother in the postpartum period and the other as urban health extension professional. The other group members will be an observer. The group should discuss what key issues should be included in the counseling session based on the case scenario they receive.

- Ask each group to perform the role play for the class. Facilitate discussion after each role play

Case scenario 1: Tamirnesh is a primi-gravida mother who delivered three weeks ago in the nearby health facility. She has started breast feeding immediately after birth with the support of her mother-in-law. After breast feeding for a couple of weeks, she started to experience severe pain on both of her breasts. She experienced excruciating pain whenever the baby sucks milk.

Case scenario 2: Almaz delivered a 2.8 kg baby at home a day before with the support of a traditional birth attendant. She had delivered her previous child at home with no complications. Immediately after delivery, she experienced a heavy bleeding with clot. She complained of having tearing kind of pain in her abdomen which was unbearable to cope with. She feels dizziness and palpitation whenever she tries to stand from her bed.

Case scenario 3: Kebebushdelivered her baby two weeks back when she was 38 weeks of gestational age. Two days after delivery, she started experiencing back ache which started from the middle of the abdomen and descends down to the umbilical area and to the pelvis. She had severe headache accompanied with high grade fever. She feels tired whenever she tries to perform minor activities at her home.

- Questions for discussion
    - What did the UHE-p do to identify the problems of the clients and help them?
    - What attitude has been demonstrated by the UHE-p that facilitated positive discussion?
    - What critical decision has been discussed during the counseling? What was missed?
    - What did you do well to help the client understand her situation and make informed decisions?
    - What could be done to improve the counseling session?
- Provide points in the facilitator's resource and let them compare their reflection with the one listed in the handout (attached). Use the following questions to elicit discussions; (10 minutes)
    - Is there a difference with the one discussed so far? If yes, what is the difference?
- Close the session by playing a hot potato" game to summarize key learning points.
- Ask the participants to make a circle. You will be in the center. Give a ball to one of the participants. The ball represents a potato. Close your eyes and start saying "Faster and Faster". The potato is "warmer and warmer" "---"it is hot!"
  As you say this word, the participants have to pass the ball from one person to another around the circle. When you say the word "hot", the person who happens to hold the ball will share something that she has learnt through the role play. Then she goes in the middle and replaces you to continue the game, and so on.

Observation checklist

S.No	Activities to be observed	Response			Comment
		Fully	**Partially**	**No**	
1	Did the UHE-p greet the client warmly?				
2	Did the UHE-p make the client at ease and willing to discuss?				
3	Has the UHE-p explore the client's concerns and its root cause by asking open ended question?				
4	Has the UHE-p enough information related to the concerns of the woman?				
5	Did the UHE-p missed anything?				
6	Was the UHE-p respectful?				
7	Did the UHE-p ensure the client has understood and encouraged to ask further question?				
8	Did the UHE-p gave information about where to get further help?				
9	Did the UHE-p make appointment for follow up?				
10	Did the UHE-p document what the UHE-p accomplished with the service data recording tool?				

Enabling objective 3: Explain post-natal care services with correct timing of home visit.

Training Methods: Group exercise (30 min)

The purpose of this exercise is to help UHE-ps correctly identify the basic postnatal care services along with the timing of home visits. This will help them provide accurate home care for new mothers and their babies.

- Post flip chart labeled '1st visit', '2nd visit' and '3rd visit' on the wall suitable for participants' discussion.
- Divide participants into three groups and provide them colored cards–red, yellow and green.
- Provide them the print out contain the lists of services that are provided during postnatal period.
- Tell participants categorize the services and words from the list and write on the colored papers after discussing among the group members. Once they have done the categorization, ask them to post on the wall corresponding to the level of visits. Participants should write only one word on a single paper
- Ask participants to gather at the corner of the room where cards are posted. Let the participants observe the posted cards for a while.

- Ask participants the following questions:
    - Is there any card that is misplaced? If yes, which one? Why do you say it is misplaced? Ask the group that posted why they have posted the card there.
    - Let the participants discuss and provide their arguments until they come to consensus. Repost the card where most of the participants agree
- Provide the print out copy of post-natal care services with timing and allow participants to compare with the discussion they had in the exercise.
- By discussing with the participants, re-post any card that is misplaced in the correct position. Make sure that all the participants understand the whole activity.
- Summarize the session by asking two or three participants about the main learning points of the activity.

Table 12:List of services given during postnatal period

Postnatal service	Timing
Vaccinate the baby for polio and BCG	1st visit
Check for vaginal bleeding	1st visit
Advise on baby bating	1st visit
Counseling on family planning	1st visit, 2nd and 3rd visit
Counseling on cord care	1st visit
Check for maternal temperature	1st visit, 2nd and 3rd visit
Advising on exclusive breast feeding	1st visit, 2nd and 3rd visit
Advising on nutrition and hygiene	1st visit, 2nd and 3rd visit

Facilitators' Note:

I. Care to be given during immediate postpartum visit:

***For the Mother*:**

- Ask what problems does the mother have
- If there is vaginal bleeding and if there appear danger signs after delivery
- Counseling on post-partum danger signs using family health card and if they are present, referring to a higher health facility
- Taking body temperature. If it is ≥ 380C refer
- Give TT vaccine as relevant
- If she has not completed taking Iron tablet, encourage her to continue (she has to take it for 6 months totally)
- Counsel about nutrition, hygiene, use of bed net, safe sex and family planning using the family health card
- Giving contraceptives of her choice
- Advising on the importance of ITN and encouraging use

***For the newborn*:**

- Checking for the presence of danger signs on the newborn. Refer if there is any
- Measure body temperature and weight
- Encouraging exclusive breast feeding
- Applying TTC eye ointment on both eyes
- If there is itching on the skin and drainage from the umbilicus, refer
- Advise not to bath/wash the newborn immediately. (Bathing should be delayed at least for one day)
- Make sure that the baby is placed in skin to skin contact with his mother and his whole body including the head and legs is covered
- Vaccinate for polio and BCG
- Counsel using the family health card on the following:
    - Breast feeding
    - Vaccination
    - Cord care
    - Prevention of heat loss
    - Newborn danger signs
    - Hygiene

II. Next visits on 3rd, 7th days and on 6th week after delivery/Care to be given during the visits:

For the mother

- Check for any problem
- Check for danger signs. If there is any, refer
- Counsel about family planning, personal hygiene, nutrition, danger signs using family health card
- Asking if there is any problem related with breast feeding and solving the problem
- Refer the mother if she has many sign of infection/sepsis (fever, convulsion, foul smelling vaginal discharge). Ask if the mother is recovering

For the baby

- Encouraging exclusive breast feeding
- Keeping the baby's temperature, cover the head, legs, hands and establish skin to skin contact
- Checking for newborn danger signs, emergency preparedness and refer if there is any
- Advise to hand wash before touching and caring the baby and to keep the baby's hygiene.
- Follow the baby for weight gain (the baby losses weight in the first few days and has to start

gaining weight gradually)

- Advise to keep the cord clean

Session Assignment

1. How many stages does labor have and which takes the longest time?
2. What is the most important thing we should follow in the first four hours after the baby is born?
3. What are the most important things UHE-ps should advise and do during postnatal visit?

Answer

1. Labor have four stages and the first stage takes the longest time
2. We should look for any sign of vaginal bleeding
3. **Advice** on initiation and continuation of exclusive breast feeding, cord care, vaccination of the baby, nutrition and hygiene, family planning. **Checking** for signs of bleeding and infection for the mother, checking sign of infection for the baby

Session 6: Care for newborn

Session Objective: by the end of this session participants will be able to identify, counsel and demonstrate skills on essential new born care, early initiation of breast feeding and newborn danger signs.

Enabling objectives: By the end of this session participants will demonstrate the required knowledge, attitude and skill to:

- Identify Essential Newborn Care
- Demonstrate Common newborn care practice (clear air way, cord care and preventing hypothermia)
- Counsel on early initiation of breast feeding
- Identify newborn danger signs

Time: 120 minutes

Enabling objectives 1: Identify Essential Newborn Care

Training method: Group exercise with card game (30 min)

The purpose of this activity is to enable participants reflect on the common newborn care practices in the community and see their impact on the health and well –being of the neonate. As participants are coming from different cultural backgrounds, this session will allow them see the common misconceptions in the community. It will also help them identify their own attitude on the common beliefs so that they will have the right approach to provide newborn care.

- Post cards with words ‘Agree’ and ‘disagree’ on opposite walls of the training room.
- Invite all participants to come to the center of the room.
- Read one statement at a time and asks participants to move to either side of the posted card according to their agreement or disagreement. Participants can change their mind in the middle

of the discussion, thus let them do that at any point.

- Take one participants from the 'disagreed group' and ask why he /she disagreed? Repeat for two or more participants with the same question. Do the same with the agree group
- If there is/are participants who shift from one category to another because they are convinced by the other person's explanation, ask why they changed their mind?
- Conclude the activity by asking the following questions
    - What new information did you gain from this activity?
    - Is the exercise helpful to understand misconceptions about newborn care in the community?
    - Would you be able to convince community members about some of the most common misconception after this exercise?

"**Agree/ disagree**" Statements for group exercises:

1. It is wise to apply butter and cow dung on the umbilicus since this practice help the healing process to be faster. **Disagree**
2. It is not advisable to give butter for the newborn because it will affect the digestive system and resulted in diarrhea. **Agree**
3. Keeping the baby in the skin-to-skin contact with the mother protect the newborn form hypothermia. **Agree**
4. The newborn should start breastfeeding soon after the delivery as long as mother and baby are ready. **Agree**
5. It is advisable for the mother to wash her baby on the day of birth. This prevents newborn infections. **Disagree**
6. The level of care that should be provided to the newborn should vary based on sex of the newborn. **Disagree**
7. Women with low education can't really understand the importance of good newborn care. **Disagree**
8. Men should not be involved in newborn care. **Disagree**
9. Men can't be expected to share responsibility for newborn care. **Disagree**

Facilitator`s note:

Essential Newborn Care

- Wash hands with soap and water before handling the baby and encourage all others, including family members, to do the same
- Dry and stimulate the baby-if the baby is not breathing stimulate by drying with cloth, clear mucus from mouth with clean cloth
- Assess the baby's breathing and color
- Tie and cut the cord
- Place the baby in skin to skin contact with the mother (or other adult family member) then

wrap with dry cloth

- Have the mother start breast feeding as soon as possible (within 1 hour of birth)
- Give eye care
- Give vitamin K injection (1mg, on the anterior & middle of thigh)
- Weigh the baby

Keeping a newborn warm

- Hypothermia (low body temperature) of the newborn mostly occurs during the first 5 minutes after birth
- The newborn cannot regulate its temperature as well as an adult and therefore needs to be protected from cold.

Steps to keep the newborn warm:

- Warm the room where the birth takes place and the baby will stay warm (but avoid suffocating the room with smoke or over warming).
- Dry the baby as soon as it is born (comes out of the birth canal). Remove the wet cloth or towel and replace with a dry cloth.
- Keep the baby in skin-to-skin contact with the mother and cover them with a dry sheet or blanket.
- Put a hat/cap and socks on the baby.
- Initiate breastfeeding as soon as the mother and baby are ready to breastfeed, usually within 60 minutes of birth.
- Avoid bathing the baby on the day of birth.
- Keep mother and baby together.
- Keep the baby warm in case of referral.

Care of the Umbilical Cord

1. Hand washing before touching the stump of the baby.
2. Keep the umbilical cord always clean and dry. Don't apply anything on the cord.
3. Check regularly that the cord is not bleeding or oozing blood. If stump oozes blood, check the cord tie and tighten if the tie is loose. If oozing/bleeding doesn't stop by tightening the tie, refer the baby to a health facility.

Extra care for small baby

If given the necessary care, small babies can have a very good chance of survival.

The following problems commonly happen in small babies:

- Get cold easily
- Difficulty in breastfeeding
- More likely to get an infection than normal weight babies

- Difficulties in breathing

Extra care that small baby needs:

- For very low birth weight (<1,500 gms)
    - Refer to a health facility as these babies may have breathing problems and may not be able to feed.
- For low birth weight (1,500 - <2,500 gms)
    - Extra support for breastfeeding, at least every two hours during day and night
    - If not able to breastfeed, feed express breast milk using cup and spoon
    - Extra care for keeping warm- the best way to keep them warm at all times is to keep them in skin to skin contact with the mother or other family members.
    - Extra attention to hygiene– e.g. hand washing.
    - Mothers of small babies need extra support from other family members to feel confident about caring of a small baby.
    - Regular and additional postnatal follow up visits. Include checking for danger signs in the newborn.

Enabling objective 2: Counsel on early initiation of breast feeding

Facilitation methods: Brainstorming (10 min), demonstration and group discussion (50 min)

Brainstorming

- Ask participants to brainstorm on the common breast feeding practices in their locality. Capture the answers on the flip chart. Facilitate discussion using the following questions
    - When do mothers start breastfeeding after delivery?
    - Do they give colostrum (the first milk) for the baby? If not, why?
    - How frequently do they breast feeding within 24 hours?
    - What else is commonly given for newborns besides breast milk? Why?
    - For how long do they exclusively breast feed?

Picture demonstration and group discussion

- Provide a print out of the optimal breast feeding criteria which is found in the facilitators' resource. Let participants read out loud on each of the optimal breast feeding and let the participants discuss on each of the points in relation to the practice at the community level.
- If there occur any misconceptions, throw the point back to the participant and receive their feedbacks first. Discuss the misconceptions yourself and correct the misconception if it not addressed by the participants.
- Show participants the pictures of positioning and latching (attachment to the breast). Show picture 'A' first and picture 'B' next.
- Let them reflect back on the things they observe in the picture. Let them focus on the positioning of the child and its latching with the mother. Let them write their observation on a piece of paper.

- Ask participants which picture demonstrate good positioning and latching, and why.
- Tell them to see first figure 11.
    - Is figures 11A or 11B a correct positioning? Why?

- A -

- B –

Fig 11: Positioning a baby for breast feeding

- After discussing the question with participants, read the following answers and ensure that participants grasp the points.

  Tip to the facilitators:

  Figure 11 A shows correct/good positioning, but Fig 11B is incorrect positioning.

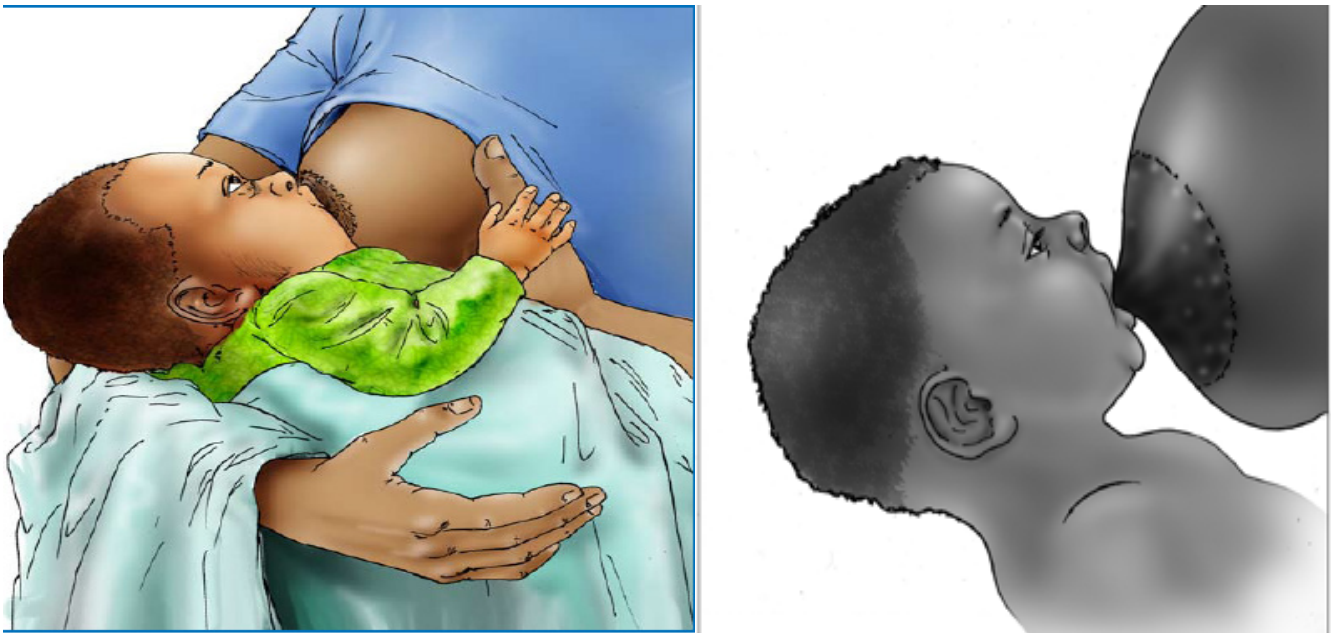
- Provide print out of the components of good positioning and let them compare their observations with the points listed in the print out.

  Good positioning has the following 4 signs:

  1. Body are in straight line (neck not twisted);
  2. Baby is held close to the mother's body,
  3. Baby is held facing the breast; and
  4. Baby's whole body is supported.

- Tell the participants to observe figure 12 and let them reflect their observations on the pictures. Show them picture 12A first and 12B next.
- Ask the participants to focus on the attachment of the child with the mother's breast. Let them write their observations on a piece of paper.

Ask them which one of the figures show correct latching of the baby to the breast, figure 12A or 12B?



- A - **- B –**

Fig 12: Positioning a baby for breast feeding

Tip for the facilitator:

Figure 12B shows correct/good attachment, but Fig 12A is incorrect attachment.

- Once they present their observations in the plenary, provide the print out of the components of proper attachment and let them compare their discussion results with the points listed in the printout.
- Discuss if there was ant misconception raised

Proper latching (attachment) has the following 4 characteristics:

1. More areola is seen above the baby's mouth than below;
2. Baby's mouth opened fully
3. Baby's lower lip opens outwardly
4. Baby's chin touches her breast

Summarize the activity by asking the participants to reflect on the main learning points from the activity.

Case study and group discussion

Tell the participants that next sub activity will be devoted to discuss on the common breast feeding problems using case studies.

Ask the participants to be in four groups.

- Give each group one of the following breastfeeding problem stories. Ask them to deal with the problems by using the following questions.

1. What do you think is the mother's breast problem?
2. What do you think the main cause of her breast problem?

3. What is the key advice you would give to the mother?

- Let each group present for plenary and ask the rest of the participants to reflect on the presentations.
- Summarize the activity with the 'hot potato' game. Procedure for the 'hot potato' game is attached for your references.

Case study

Group I: Abise's story

Abise gave birth to a full-term, healthy baby boy two days ago, and she has been exclusively breastfeeding. The baby started breastfeeding within 20minutes after birth. Abise is complaining of sore nipples. You observe Abise nursing the baby and see that the baby is not opening his mouth wide and is only latching on to the nipple. Counsel Abise. Be sure to include all of the relevant information.

Answers:

1. Sore or cracked nipple
2. Wrong attachment
3. Advice on proper attachment & positioning

Group II: Amarech's story

Amarech gave birth to a healthy, full-term baby girl one week ago. The baby weighed 3.5 kg at birth. Today the baby weighs 3 kg. Amarech complains that her baby sleeps a lot so she is nursing 6 to 7 times in 24 hours. She does not think the baby is getting enough milk. Counsel Amarech. Be sure to include all of the relevant information.

Answers:

1. Thinking of insufficient breast milk.
2. Lack of proper breastfeeding practice (only breastfeeding 6-7 times).
3. Advice on proper breastfeeding practices.

Group III: Tedbabe's story

Tedbabe gave birth to a healthy baby boy three days ago. Tedbabe's mother has been feeding the baby sugar water from a bottle so that Tedbabe can rest. Tedbabe complains that her breasts are very full, hard, and painful. The baby is having trouble latching on. Counsel Tedbabe. Be sure to include all of the relevant information.

Answers:

1. Engorged breast

2. Lack of proper breastfeeding practice

3. Advice on proper breastfeeding practices

Group IV: Letaye's story

Letaye gave birth to a healthy baby girl 7 days ago. She is complaining that her breasts have become hard, tender even to the touch of her cloths, red and hot. Demonstrate how you will counsel Letaye. Be sure to include all of the relevant information.

Answers:

1. Mastitis

2. Incorrect attachment

3. Advice on proper attachment & positioning; Treat the breast with warm and cold water if it doesn't improve refer to health center.

Facilitator`s Note:

Optimal Breastfeeding practices for baby from 0 to 6 months.

1. Give the first yellow milk made especially for the newborn as it will protect your baby from illness.

- This first yellow milk (colostrum) will help to expel your baby's first dark stool.
- Colostrum contain many important antibodies which will protect your new baby from disease. Colostrum is the first vaccination for your child protecting it from common childhood illnesses like tetanus until the baby develops its own resistance.

2. Put your baby on the breast immediately after birth, even before the placenta is expelled, to stimulate your production of milk.

- Immediate breastfeeding within one hour of birth will help to expel the placenta and reduce post-partum bleeding.
- More milk is produced when babies suck on the breast for longer and more frequent time
- Pre-lacteal feeds (such as sugar water, water, butter, other) are not necessary and may interfere with establishing good breastfeeding practices or cause diarrhoea during the first days of the baby's life.

3. Feed your baby only breast milk for the first six months, do not even giving water, to help your baby to grow healthy and strong.

- Feeding the baby only breast milk provides the best nourishment possible for the baby and will protect her/him from diseases such as diarrhoea and respiratory infections.
- Breast milk is a well-balanced and the best food for children under the age of 6 months. Its water and other nutrient contents are sufficient to satisfy the needs of the baby. In addition giving the baby water or other liquids may make your baby sick with diarrhoea. If the baby takes water or other liquids, your baby's appetite for breast milk may decrease meaning s/he sucks less on the

breast leading to poor growth.

- Even during very hot weather, breast milk will satisfy all your baby's thirst for liquids during the first six months.

4. Breastfeed your baby on demand, 10 to 12 times in 24 hours, to produce enough milk and provide your baby with enough food.

- Frequent breastfeeding helps to produce enough milk.
- Increases bonding between mother and child.
- Ensure proper positioning and attachment so baby gets adequate breast milk and to avoid breast problems such as sore and cracked nipples. Advise mothers with nipple and breast problems to seek immediate care from Health Worker.

5. Empty one breast first before switching to the second for your baby to get the most nutritious hind milk to grow strong and healthy.

- Foremilk quenches thirst because it is more watery.
- Hind milk is richer and satisfies the baby's hunger so that s/he will be satisfied.

6. Ensure that woman who is breastfeeding, eats two extra meals a day to maintain her health and the health of the baby.

- To maintain their health, breastfeeding women need to eat a wide variety of foods, particularly, animal products (meat, milk, eggs, etc), fruits, and vegetables.

7. If your baby is ill, increase the frequency of breastfeeding for your baby to recover faster.

- Continue to breastfeed during episodes of diarrhoea. Try to increase the frequency of feeding, to replace the liquid lost.
- Breastfeeding more frequently during illness will help your baby to fight the sickness and not lose weight.
- Breastfeeding also provides comfort to a sick baby.
- Sick mothers can continue to breastfeed their baby unless advised by a medical personal.

8. After each illness increase the frequency of breastfeeding for the baby to regain health and weight.

- Each time a baby is sick, s/he will lose weight so it is important to breastfeed as often as possible.

Enabling objectives 3: Identify newborn danger signs and counsel for further investigation and management

Training method: Group activity with case study (30 min)

- Post three flipcharts labeled as follows on three different corners of the room on the wall. Write the following decision scenario.
    - Flip chart 1: "Care of Normal Baby",
    - Flip chart 2: "Care of a Small Baby", and
    - Flip chart 3: "Refer Urgently to Health Centre or Hospital"
- Divided the participant into small groups. Each group will have three participants. Give each group at least one card from the facilitators' note section.
- Ask participants to assess the case they have been given and post it under one of the decision scenario.
- Once all the participants have finished posting their response to the cases, ask them to present their decision to the group. Let the other groups ask questions and discuss. If the participants misplaced the cards, allow the other group members to provide additional thought on that specific case.
- Display the responses in the facilitators note section and let the participants reflect on the responses.
- Summarize the activity by asking one or two participants to reflect on the new learnings from the activity.

Cards for Newborn Danger Signs Decision-Making Game

Baby A - 6 hours old	Baby B - 8 hours old	Baby C - 20 hours old
• Able to feed • Convulsions • 55 breaths/minute • No chest in-drawing • Temperature 39 ^{0}c • Not moving on his own • Soles not yellow • Pus from umbilicus • Weight 2700 gm	• Able to feed • No convulsions • 55 breaths/minute • No chest in-drawing • Temperature 37.2 ^{0}c • Moving on his own • Soles not yellow • Eyes draining pus • Weight 2900 gm	• Able to feed • No convulsions • 44 breaths/minute • No chest in-drawing • Temperature 36.6 ^{0}c • Moving on his own • Soles not yellow • No pus from eyes, skin or umbilicus • Weight 2500 gm
Answer: Baby A	**Answer: Baby B**	**Answer: Baby C**

• Refer Urgently **Danger signs seen are** 1. Convulsions 2. Temperature >37.5 ^{0}c 3. Not moving 4. Pus from umbilicus	• Refer Urgently **Danger signs seen are** 1. Pus from eyes	• Normal care • No Danger signs are seen
D - 12 hours old baby	**E - 10 hours old baby**	**F - 12 hours old baby**
• Able to feed • No convulsions • 50 breaths/minute • No chest in-drawing • Temperature 35 ^{0}c • Moving on her own • Soles not yellow • No pus from eyes, skin or umbilicus • Weight 2300 gm	• Not able to feed • No convulsions • 58 breaths/minute • No chest in-drawing • Temperature 35.6 ^{0}c • Moving on her own • Soles not yellow • No pus from eyes, skin or umbilicus • Weight 2500 gm	• Able to feed • No convulsions • 52 breaths/minute • No chest in-drawing • Temperature 35.5 ^{0}c • Moving on his own • Soles not yellow • No pus from eyes, skin or umbilicus • Weight 3000 gm
Answer: Baby D	**Answer: Baby E**	**Answer: Baby F**
• Refer Urgently **Danger signs seen are** 1. Temperature <35.5 ^{0}c 2. Low weight	• Refer Urgently **Danger signs seen are** 1. Unable to breastfeed	• Normal care • No Danger signs are seen

G - 8 hours old baby	**H - 14 hours old baby**
• Able to feed • No convulsions • 44 breaths/minute • No chest in-drawing • Temperature 36.6 ^{0}c • Moving on her own • Soles not yellow • No pus from eyes, skin or umbilicus • Weight 2200 gm	• Able to feed • No convulsions • 57 breaths/minute • No chest in-drawing • Temperature 37 0c • Moving on his own • Soles not yellow • No pus from eyes, skin or umbilicus • Weight 3200 gm

Answer: Baby G	Answer: Baby H
• Care of low birth weight baby	• Normal care • No Danger signs are seen

I - 22 hours old baby	J - 16 hours old baby
• Able to feed • No convulsions • 55 breaths/minute • No Chest in-drawing • Temperature 35.8 ^{0}c • Moving on his own • Soles not yellow • No pus from eyes, skin or umbilicus • Weight 2200 gm	• Able to feed • No convulsions • 50 breaths/minute • No chest in-drawing • Temperature 36.9 ^{0}c • Moving on his own • Soles not yellow • No pus from eyes, skin or umbilicus • Weight 2000 gm
Answer: Baby I	**Answer: Baby J**
• Care of low birth weight baby	• Care of low birth weight baby

SESSION ASSIGNMENT

1. Why is it important to provide extra care for small babies?
2. What is the importance of understanding correct positioning and latching of a baby during breast feeding?
3. What is the best time to start breast feeding and how frequently should it be fed?
4. What are some of the danger signs during neonatal period?

Answers

1. They get easily cold, they have difficulty of breast feeding, more likely to get infection as compared to normal weight babies and may have other complications.
2. The baby will be satisfied and less likely to ingest gas which may cause abdominal discomfort, the mother will have less cracking and sour nipples from breast feeding
3. The baby should start on breast feeding immediately after birth, even before the placenta is expelled. A breast feeding baby should be feed on demand and breast feeding should not be discontinued during the mother or the baby illness unless advised by a medical personnel.
4. Very high or low body temperature, sign of cord infection, sign of eye infection, if the baby is unable to breastfeed, any convulsion, if the baby has become 'yellow'

UNIT FOUR: CHILD HEALTH

Unit description: This unit is developed using competence based training approach to improve trainees` knowledge, attitude and skill that they need to better understand vaccine preventable diseases (VPD) and features of vaccines, common childhood illness and home based care for sick child. This unit also enable them to carry out nutritional screening, growth monitoring and supplementations, and follow up visits for healthy children as well as early detection and referral of sick child..

Unit objective: By the end of this unit UHE-Ps will be able to discuss VPDs, explain common features of vaccines, common childhood illness and provide home based immediate care to sick child and demonstrate nutritional screening and supplementation for children.

Training unit specific objectives: By the end of this training unit the participant will be equipped with the required knowledge, attitude and skills to:

- Discuss the types and common side effects of vaccines, immunization schedules, demonstrate administration of each vaccine and trace a child who defaulted from vaccination.
- Explain steps of identifying sick child and Provide immediate care for sick child.
- Effectively demonstrate nutritional screening, explain growth monitoring, explain complementary feeding, and demonstrate vitamin A supplementation and de-worming.

Time: 385 minutes

Session 1: Immunization

Session Objective: By the end of this training session, the participant will have the required knowledge, skill and attitude to discuss the types and common side effects of vaccines, immunization schedules, demonstrate vaccine administration and trace a child who has defaulted from vaccination.

Enabling Objective: By the end of this session, the participant will able to:

- Discuss the types of vaccines, common side effects and immunization schedules
- Demonstrate administration of vaccines
- Trace a child who defaulted from vaccination

Time: 85 min.

Enabling Objective 1: Describe the types of vaccines, common side effects and national immunization schedules

Training Methods: Group exercise (50 min)

Group exercise

- Print out of blank tables with list of questions
- Divide participants in to four groups. Ask participants to name their group using

one of the following fruits; apple, banana, orange and mango.

- Distribute marker and flip chart with at least three different types of vaccine preventable diseases for group one to three and TT and Vitamin A for group four.
- Ask each group to discuss and complete the causative agent (bacteria or viral), vaccine type needed, schedule, rout of administration and dosage for each vaccine preventable diseases
- The group working on TT – Target groups for TT vaccination, disease targeted and causative agent, dose, schedule and site of administration.
- Vitamin A – Dose and schedule

Group 1

VPDs	Causative agent (bacteria or viral)	Vaccine type available	Schedule	Rout of administration	Dosage
Tuberculosis					
Pertussis					
Diphtheria					

Group 2

VPDs	Causative agent (bacteria or viral)	Vaccine type needed	Schedule	Rout of administration	Dosage
Tetanus					
Hepatitis B					
Hemophilus influenza type b					

Group 3

VPDs	Causative agent (bacteria or viral)	Vaccine type needed	Schedule	Rout of administration	Dosage
Measles					
Pneumococcal Diseases					
Poliomyelitis					
Rotavirus disease					

Group 4- TT

Doses	Causative agent (bacteria or viral)	Schedule	Rout of administration	Site of vaccination	Dosage
TT1					
TT2					
TT3					
TT4					
TT5					

- Ask each group to present the table to the large group. After each group presentation encourage participants to ask questions and reflect on the presentation. Ensure that all the points mentioned under facilitator note for activity above are well addressed. If not, please probe with additional questions.

Facilitator's note

Immunization

Immunization is the process of administrating a weakened or killed microorganism or its product to stimulate the host's immunologic response to that antigen.

Types of Vaccines:

Vaccines can be

- Killed microorganisms (pertussis),
- Live but weakened – attenuated – microorganisms (measles, polio TB)
- Toxoids (tetanus and diphtheria).

Target group

- All under one year children and women of childbearing age(15 - 49 years).

Immunization Schedule for children

A. For those who start at birth:

Contact	Age of Child	Vaccines
1st	At birth	BCG and Polio 0
2nd	6 weeks	OPV1 and DPT1
3rd	10 weeks	OPV2 and DPT2
4th	14 weeks	OPV3 and DPT3
5th	9 months	Measles

B. For those who start later

Age of child	Antigens
Less than 6 weeks	BCG and OPV1
Above 6 weeks	BCG if not given previously OPV (3 doses) DPT (3 doses)
Above 9 months	BCG if not given previously OPV DPT Measles

C: PCV 10 vaccinations schedule for children who have received 0 or 1 -3 pentavalent vaccines doses.

(FMOH,June2011,IntroductionofPneumococcalConjugateVaccineinEthiopia:AReferenceHandbookfor-HealthExtension Workers, p.8)

Vaccination status if infant aged less than 1 year at time of PCV1 introduction	At first contact	Subsequent contact after4 weeks	Subsequent contact after 4 more weeks
Never received any Penta	Penta1+PCV1	Penta2+PCV2	Penta3+PCV3
Already received Penta1	Penta2+PCV1	Penta3+PCV2	PCV3
Already received Penta2	Penta3+PCV1	PCV2	PCV3
Already received Penta3	PCV1	PCV2	PCV3

D. Tetanus toxoid vaccine schedule for women (15 - 49 years)

Dose	Minimum interval	Duration of protection
TT1	At any time	0
TT2	4 weeks after TT1	3 years
TT3	6 months after TT2	5 years
TT4	1 year after TT3	10 years
TT5	1 year after TT4	Life long

Note: If a woman was given 3 doses of DPT vaccine when she was a child, provided that a written document of her immunization is available, and the doses are given at the right intervals, the 3 doses of DPT can be counted as two doses of TT.

Rota virus vaccineisgivenintwooraldoses,eachof1.5ml,atthefollowingtime intervals:

- First dose at 6 weeks of age, but not later than 12 weeks
- second dose at least 4 weeks after the first dose
- The two- doses schedule should be completed by 16 weeks, but no later than by 24 weeks of age.

Note that the ideal schedule is to give the first dose of Rota virus vaccine to all infants at 16 weeks of age at the same time with Penta 1 and OPV1, and the second dose at 10 weeks at the same time with Penta 2 and OPV 2.

Enabling Objective 2: Demonstration of vaccine administration

Methods: Demonstration (35 min)

Demonstration

The purpose of this activity is to improve the skills of the participants on vaccine administration.

- Show how the different vaccines are administered at least once for each type of vaccine.
- Divide participants into groups of four members.
- Ask participants to administer the following vaccines.
    - Give time to the group for preparation and demonstrate vaccine administration to the plenary BCG, Penta, OPV, Measles, TT, PCV10, Rota Virus vaccine and vitamin A capsules.
    - Each group has to develop a case scenario for vaccine administration exercise by themselves.
    - Inform participants to follow a complete session of vaccine administration to a child or a mother which includes counseling.

      Group 1: BCG and Penta-valent (DPT-HepB; Hib) vaccine

      Group 2: Measles and PCV10 vaccine

      Group 3: OPV and Rota virus vaccine

      Group 4: TT and vitamin A (for infant 6 to 11 months and 12 to 59 months)
- While one group demonstrates, the other group participants will rate the demonstration based on the checklist described below.

Checklist for rating vaccine administration

Activity	Rate (yes, partly, no)			Remark
	1	0.5	0	
Communicate the client – what the child/client received, side effect, importance of vaccine, etc				
Proper positioning of a child and mother				
VVM stage checked				
Freezing checked				
Dosage checked				
Expiry date checked				
Materials for vaccine administration are ready				
Proper administration of vaccine				
Proper waste disposal				
Proper infection prevention techniques applied				
Recording and documentation of activities				
Total				

- Give all participants turn to demonstrate within their group
- Ask participants the following question.
    1. Which of the activities were done well in general during the demonstration?
    2. What was missed during the vaccination session? (Both counseling and administration). What was the reason behind?
    3. What can UHEP do if they realize that they have made a mistake or missed an important information item?
- Summarize the activity by asking participants what new thing they have learned and how they would apply this demonstration to their daily activities.

Facilitator's note

Common side effects of vaccines

- Low grade fever
- Abscess at injection site
- Swollen lymph glands
- Soreness at the injection site
- Sometimes, several allergic reactions (rash, berating difficulty, rapid pulse, dizziness or fainting)

SESSION ASSIGNMENT

Ask if any there are any outstanding questions. Summarize the session by reviewing the following key points:

1. Which childhood illnesses are currently targeted by the Ethiopia's national immunization sched-

ule?

2. What are the common side effects of vaccines?

Answers

1. Tuberculosis, polio, diphtheria, pertussis, tetanus, Hepatitis B virus, haemophilus influenza type B pneumococcal bacteria, Rota virus and measles.

2. Low grade fever, soreness at injection site, swollen lymph glands, abscess at injection site

Session 2: Identification and care of sick child

Session objective: By the end of this training session, the participant will have the required knowledge, skill and attitude to explain steps of identifying sick child and provide immediate care for sick child.

Enabling objectives: By the end of this session, the participant will able to:

- Explain steps of identifying sick child
- Demonstrate the provision of immediate care for sick child

Time:90 minutes

Enabling Objective 1: Explain steps of identifying sick child

Training Method: Case study (50 min)

- Provide case scenario for each group using a printed case
- Divided the participants into two groups

Case studies

Salem's story

Case study 1: Salem is 15 months old. She weighs 8.5 Kg. Her temperature is 38^0C. She lives in a high malaria risk area. The health worker asked, "'what are the child`s problems?" The mother said ' Selma has been coughing for the last four days, and she is not eating well'. This is Salem`s initial visit for this problem. The health worker checked Salem for general danger signs. She asked, " Is Salem able to drink or breastfeed?" The mother said ' No, Salem doesn't want to breastfeed." The health worker gave Salem some water. She was too weak to lift her head. She was not able to drink from a cup. Next she asked the mother, " is she vomiting?" The mother said, "No". Then she asked, "Has she had convulsion?" The mother said, "No". The health worker looked to see if Salem was convulsing or lethargic or unconscious. She was not convulsing but lethargic.

Case study 2: Fatuma's story

Fatma is 18 months old. she weighs 11.5 KG. Her temperature is 37.5 ^{0}C. The health worker asked, 'what are the child`s problems?'. The mother said ' Fatuma has been coughing for the last six days, and she is having trouble breathing'. This is the initial visit for her illness. The health worker checked Fatuma for general danger signs. The mother said that Fatuma was able to drink. She had not been vomiting. She had not had convulsions during this illness. The health worker asked, ' does Fatuma seem unusually asleep?' The mother said, 'yes'. The health worker clapped her hands. She asked the mother to shake her child. Fatuma opens her eyes, but didn't look around. The health worker talked to Fatuma, but the child didn't watch her face. Fatuma stared blankly and appeared not to notice what was going on around her. The top part of the sick child case recording form for the relevant information from the case study has been recorded

- Ask each group to discuss on the case and list out the general danger signs

Facilitator's note

The general danger signs of serious illness that are seen in children aged 2 months up to 5 years will need immediate action to save the life of the child. There are 5 danger signs and these are set out in the box below (reproduced from IMNCI Assess and Classify Chart Booklet, FMOH, Ethiopia, June 2008). Make sure that any infant or child with any danger sign is referred after receiving urgent pre- referral treatment.

Checking for general danger signs

For **ALL** sick children ask the mother about the child's problem, then
CHECK FOR GENERAL DANGER SIGNS

↓

CHECK FOR GENERAL DANGER SIGNS	
ASK:	***LOOK:***
• Is the child able to drink or breastfeed? • Does the child vomit everything? • Has the child had convulsions?	• See if the child is lethargic or unconscious. • See if the child is convulsing now.
A child with any general danger sign needs *URGENT* attention; complete the assessment and any pre-referral treatment immediately so referral is not delayed	

As you can see there are key questions you need to ask signs you need to look for. A child with a general danger sign has a serious problem. Most children with a general danger sign need urgent referral to hospital. They need live saving treatment with injectable antibiotics, oxygen or other treatments that may not be available at home.

Enabling Objective 2: Demonstrate the provision of immediate care for sick child

Training Method: Case study (40 min)

- Ask participants to go back to the previous group and use the earlier case study
- Ask the participants to discuss in their group what they have to do for the cases they have identified before they refer to health center or hospital.
- Ask each group to summarize and present the management of the cases to the larger group.

SESSION ASSIGNMENT

Ask for and answer any outstanding questions. Summarize this session by reviewing the following key question:

1. What are the important general danger signs among sick children?

Answer

1. The child is unable to drink or breastfeed, the child vomits everything it takes, has convulsion or is lethargic or unconscious.

Session 3: Child nutrition

Primary Objective: By the end of this training session, the participant will have the required knowledge, skills and attitude to effectively demonstrate nutritional screening, explain growth monitoring and complementary feeding, demonstrate administration of vitamin A supplementation and deworming.

Enabling Objective: By the end of this session, the participant will able to**:**

- Effectively demonstrate nutritional screening
- Explain growth monitoring and SAM
- Explain complementary feeding
- Demonstrate vitamin A supplementation and de-worming administration

Time: 210 minutes

Enabling Objective 1: Effectively demonstrate nutritional screening

Training Methods: Demonstration (50 min) and case study (20 min)

Demonstration

The purpose of this activity is to enable participants with the skill of performing nutritional screening using MUAC tape

- Ask two volunteers to demonstrate nutritional screening of children using MUAC tape. During the demonstration the volunteers should explain in detail what they are doing and why it is done. Explain the different colors on the MUAC tape what they indicate and how it is interpreted. At the same time tell the participant the importance of bilateral edema during nutrition screening and how to check the presence.
- Discuss on how the findings of nutritional screening are used for decision making. UHEPs should be able to decide if the family needs simple nutrition counseling or if the child needs referral to health facilities based on the findings.

- Ask participants to be in pair and distribute at least one MUAC tape per pair for practice. Every participant should do a MUAC measurement during this activity.
- Walk around the classroom and support groups who may have questions or who have difficulty of correctly using the MUAC tape.
- Encourage participants to record/document what they have accomplished on the service data recording tool.

Case study

Divide participants into four groups and provide the following four cases for discussion on the classification of acute malnutrition and the role of UHEPs in each specific case. Ask them the following questions.

Case 1: Almaz has a 10-months old son. The measurement of MUAC for the baby is 108 mm and the infant has bilateral pitting edema.

Cases 2: Hirut has an 8-months old son. The measurement of MUAC for the baby is 130 mm and the infant has no any bilateral pitting edema.

Case 3: Tirhas had a 12-months old daughter. The measurement of MUAC for her baby is 118 mm and the infant has no bilateral pitting edema.

Case 4: Mame has a 1 and ½ year old daughter. The measurement of MUAC for her baby is 105 mm and the infant has bilateral pitting edema.

Ask each group to respond to the following questions:

1. Under which classification of malnutrition would the cases fall? (no malnutrition, moderate, acute, serve acute or complicated acute malnutrition)
2. What should be your action if you encounter this case during your house visit?

Conclude the activity using ‘hot potato’ exercise.

Ask the participants to make a circle.

- You will be in the center.
- Give a ball to one of the participants. The ball represents a potato.
- Close your eyes and start saying “Faster and Faster”. The potato is “warmer and warmer” ---“it is hot!”
- As you say these words, the participants have to pass the ball from one person to another around the circle.
- When you say the word “hot”, the person who happens to hold the ball will share something that she has learnt through the role play. Then she goes in the middle and replaces you to continue the game, and so on.

Facilitator’s note:

Mid Upper Arm Circumference:

An accurate way to measure fat-free mass is to measure the Mid Upper Arm Circumference (MUAC). The MUAC is the circumference of the upper arm at the midway between the shoulder tip and the elbow tip on the left arm. The mid-arm point is determined by measuring the distance from the shoulder tip to

the elbow and dividing it by two (Fig. 13). A low reading indicates a loss of muscle mass.

MUAC is a good screening tool in determining the risk of mortality among children, and people living with HIV/AIDS. MUAC is the only anthropometric measure for assessing nutritional status among pregnant women. It is also very simple for use in screening a large number of people, especially during community level screening for community-based nutrition interventions or during emergency situations.

MUAC is therefore used as a screening tool for community based nutrition programs such as an outpatient therapeutic program (OTP), for community-based interventions, supplementary feeding program and enhanced outreach program throughout Ethiopia. MUAC is also used for screening target children and pregnant women for severe acute malnutrition (SAM) and moderate acute malnutrition (MAM).

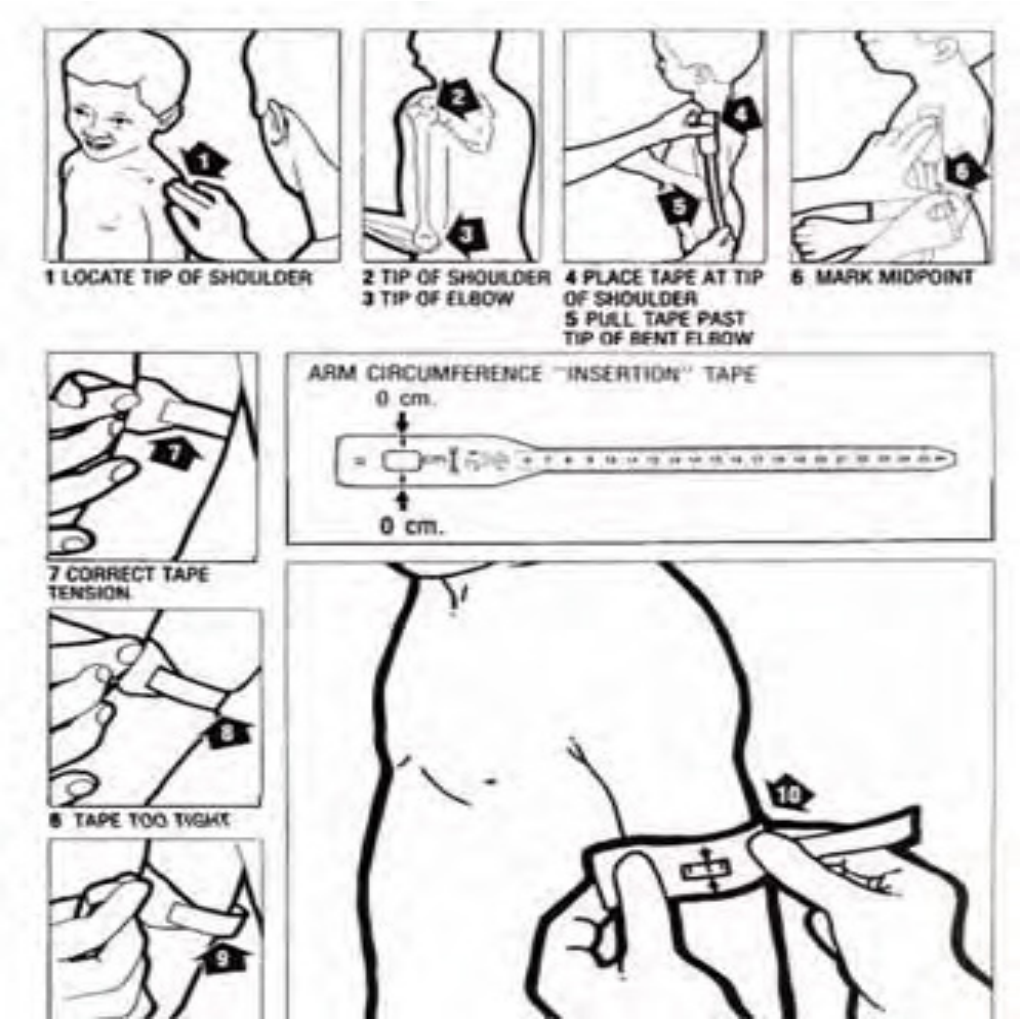


Fig 13: Measuring the MUAC of children:

A special tape is used for measuring the MUAC of a child (see Fig. 14). The tape has three colors, with the red indicating severe acute malnutrition, the yellow indicating moderate acute malnutrition and the green indicating normal nutritional status. Figure shows you how to use the tape to measure a child's MUAC.

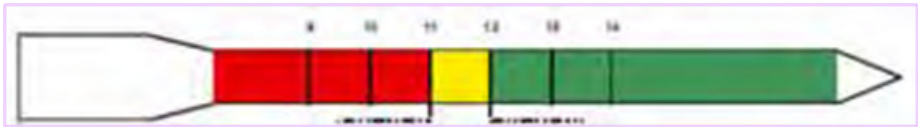


Fig 14: Measuring MUAC. (Source: UNICEF, 1986, How to weigh and measure children: assessing the nutrition status of young children)

Procedures for measuring MUAC (Fig 13)

- Ask the mother to remove any clothing that may cover the child's left arm. If possible, the child should stand erect and sideways to the measurer.
- Estimate the midpoint of the left upper arm (arrow 6).
- Straighten the child's arm and wrap the tape around the arm at the midpoint. Make sure the numbers are right side up. Make sure the tape is flat around the skin (arrow 7).
- Inspect the tension of the tape on the child's arm. Make sure the tape has the proper tension (arrow 7) and is not too tight or too loose (arrows 8 and 9). Repeat any step as necessary.
- When the tape is in the correct position on the arm with correct tension, read the measurement to the nearest 0.1 cm (arrow 10).
- Immediately record the measurement.

Enabling Objective 2: Explain growth monitoring and SAM

Training Method: Demonstration (40 min) and brain storming (20 min)

Ask two volunteers to demonstrate the following measurements for the participants:

- Measuring the length of a child under two years and over two years of age.
- Taking the weight of under two years and over two-year-old children.
- As you demonstrate the measurements let the participants help you. Discuss in detail what you are doing and why you are doing it.
- As the participants to take note of the measurement.
- Ask the participants to interpret the measurements by converting to weight for age index. This index is the one used in growth monitoring chart.
- Make sure that all participants understand the procedures correctly.

Practice

Ask participants to form a group of four and distribute weighting scales, measurement boards and dolls. Let them practice doing the measurements. Ensure that everyone has the opportunity to practice.

Facilitator's note

Measuring length

To measure the length of a child under 2 years you need one assistance and a sliding board. As you can see in Fig 15. you need an assistant to help when you measure a child using this method.

1. Both assistant and measurer are on their knees (arrow 2 and 3).
2. The assistant holds the child`s head with both hands and make sure that the head touches the base of the board (arrow 4).
3. The assistant's arms should be comfortably straight (arrow 5).
4. The child should be looking at an object perpendicular to the best of the board (looking straight forwards) (arrow 6).

5. The child should lie flat on the board (arrow 7).
6. The measurer should place their hands on the child`s knees or shins (arrow 8).
7. The child`s foot should be flat against the foot piece (arrow 9).
8. Read the length from the tape attached to the board.
9. Record the measurement on the questionnaire(arrow1).

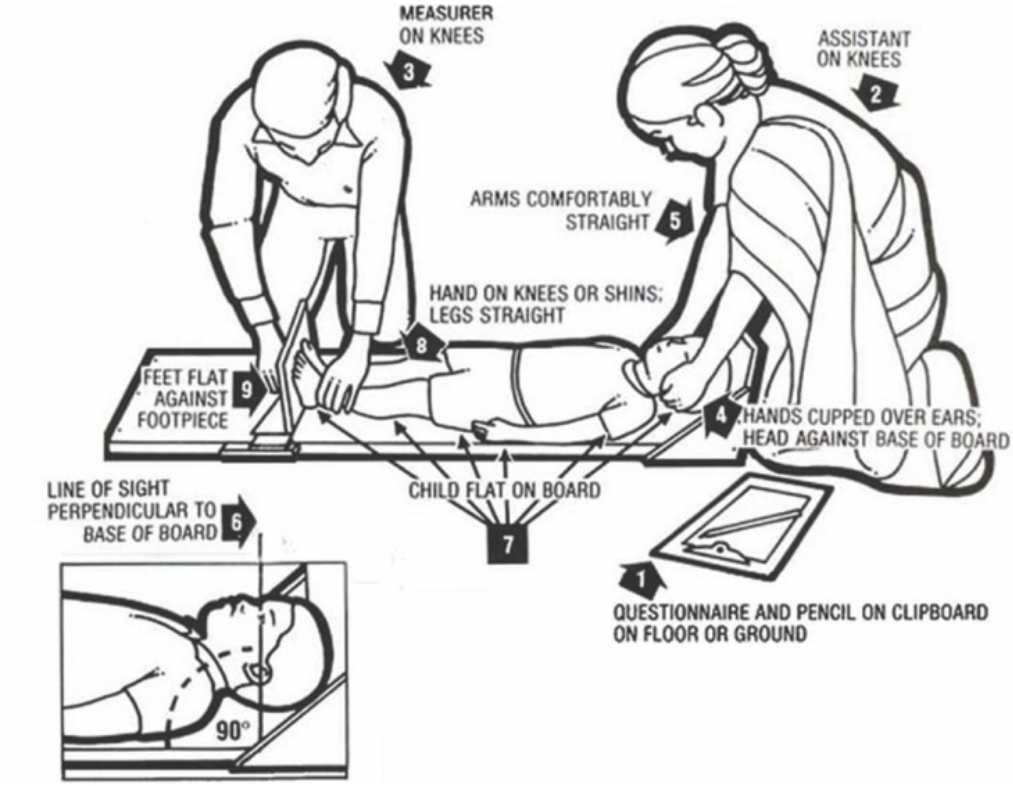


Fig 15 Measuring length. (Source: UNICEF, 1986, How to Weigh and measure children: Assessing the nutrition status of the young children)

Measuring height

This is measured with the child or adult in a standing position (usually children who are two years old or more). The head should be in the Frankfurt position (a position where the line passing from the external ear hole to the lower eye lid is parallel to the floor) during measurement. Shoulder, buttock and the heels should touch the vertical stand. Measurement are recorded to the nearest millimeter.

As with measuring a child's length, to measure a child's height, you need to have another person helping you. Fig 16 illustrates the procedures, and in Figure 17, you can see a young child having his height measured.

1. Both the assistant and measurer should be on their knees (arrows 2 and 3).
2. The right hand of the assistant should be on the shins of the child against the base of the board (arrow 4).
3. The left hand of the assistant should be on the knees of the child to keep them close to the board (arrow 5).
4. The heel, the calf, buttocks, shoulder and occipital prominence (prominent area on the back

of the head) should be flat against the board (arrows 6, 7, 14, 13 and 12).

5. The child should be looking straight ahead (arrow 8).
6. The hands of the child should be by their side (arrow 11).
7. The measurer's left hand should be on child`s chin (arrow9).
8. The child's shoulders should be leveled (arrow 10).
9. The head piece should be placed firmly on the child's head (arrow 15).
10. The measurement should be recorded on the questionnaire (arrow 1).

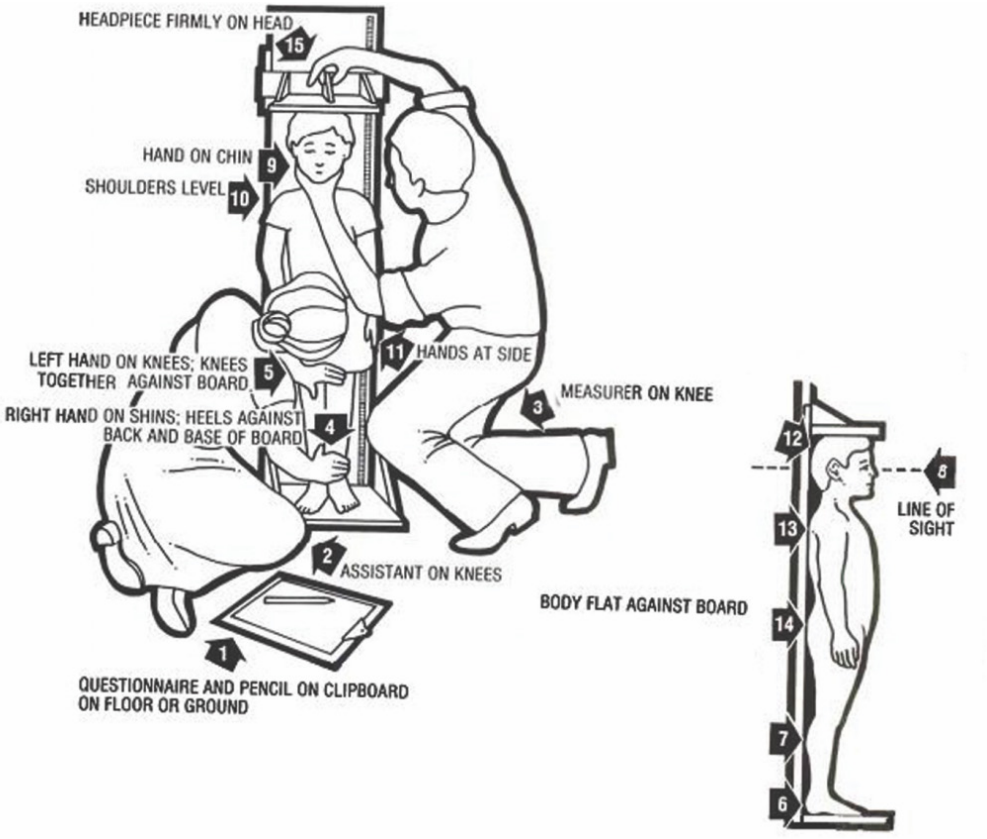


Fig 16: Measuring height. (Source: UNICEF, 1986, How to Weigh and measure children: Assessing the nutrition status of the young children)

Measuring Weight

A weighing sling (spring balance), also called "Salter scale" is used for measuring the weight of children under two years old. A beam balance is used to measuring children over two years and adult persons. In both cases digital electronic scale can be used if available. Don't forget to re-adjust the scale to zero before each weighing. You also need to check whether your scale is measuring correctly by weighing an object of known weight.

Procedures

In Figure 4.3.2.3 you can see the procedures for weighing a children 2 years old using a Salter scale. The photo in Figure 5.4 shows a small boy being weighted using the scale.

1. Adjust the pointer of the scale to zero level

2. Hold the child`s legs through the leg holes (arrow 1)

3. Hold child`s feet (arrow 2)

4. Hang the child on the Salter scale (arrow 3)

5. Read the scale at eye level to the nearest 0.1 Kg (arrow 5)

6. Move the child slowly and safely.

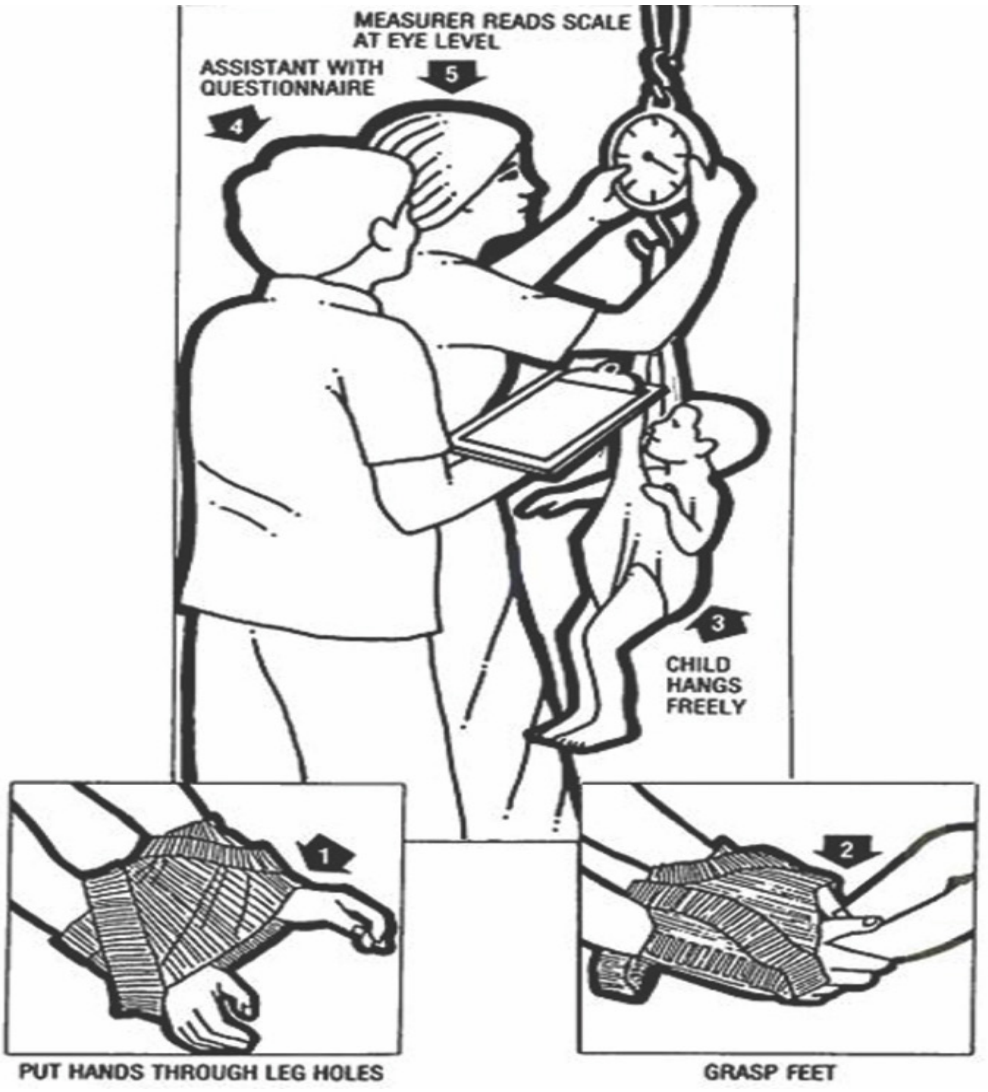


Fig 17: Measuring Child's weight using Salter Scale. (Source: UNICEF, 1986, How to Weigh and measure children: Assessing the nutrition status of the young children)

Calculating index

An index is a combination of two measurements or one measurement plus the person's age. The following are a few indices that you may find useful in your work.

Weight-for-ageis an index used in growth monitoring for assessing the children who may be underweight. you can assess weight-for-age children under two years old when you carry out your community- based nutrition (CBN) activities every month.

Height-for-age is anindex used for assessing stunting (chronic malnutrition children). stunted children have poor physical and intellectual performance and lower work output leading to lower pro-

ductivity at individual level and poor socio-economic development at the community level. stunting of children in a given population indicates the fact that the children have suffered from chronic malnutrition so much so that it has affected their liner growth.

Stunting is defined as a lower weight for age of the child compared to the standard child of the same age. Stunted children have decreased mental and physical productivity capacity

Weight-for-height is an index used for assessing wasting (acute malnutrition). Wasting is defined as a low weight for the height of the child compared to this standard child of the same height. wasted children are vulnerable to infection and stand a greater chance of dying.

Body mass index is the weightof a child or adult in Kg divided by their height in meter squared: Weight (Kg)/ height (meters). Here is how to calculate each index for children in your community.

Weight for Age = Weight of the child

Weight of the reference child of the same age X 100

Weight for Height = Weight of the child

Weight of the reference child of the same Height X 100

Birth Weight

Weight of the child at birth and is classified as follow:

More than 2500 grams	=	Normal birth weight
1500–2499grams	=	Low birth weight
Less than 2500 grams	=	Very low birth weight

***Brainstorming :* Assessment and Classification SAM**

This activity will help the participants assess SAM in children 0-6 months and 6-59months age groups.

- Write down the following questions to the participants
    1. What should we ask mothers/care givers during SAM screening?
    2. What do we look for and measure in SAM screening?
- Invite one of the participants to read the questions loudly.
- Ask the participants to respond to the questions and encourage all to participate.
- Write down the responses on the flip chart.
- Provide them the SAM screening chart and instruct them to compare their answers with the screening chart.
- Ask the following questions
    - Why do we need to know about SAM?
    - How would you do be able to use this in your daily activities?
- Finally invite one or two volunteers to summarize the activity. if necessary add additional information and finalize the activity.

Facilitator's note

SAM screening techniques and classification

Criteria for classification of acute malnutrition among young Infants 0 to 6 months

ASK	LOOK AND FEEL	Signs	Classify	Treat
Ask for signs of medical complications: Is the child: • Too weak to suckle effectively? • Vomiting everything? Does the child have • Recent weight loss or failure to gain weight	**1. Check for presence of edemaof both feet** (orsacrum) • Does the child have edema? **2. Check the weight and Length** •Is the weight-for-length less than-3z-score? **3. Check for signs of medical complications:** • Hypothermia: axillary temp <35 ^{0}C or rectal < 35.5 ^{0}C • Fever ≥ 37.5 ^{0}C • Ineffective feeding (attachment, positioning and suckling) directly observed for 15 to 20 minutes • Any medical or social issue needing detailed assessment or intensive support • severe anemia (sever palmar pallor) • Jaundice • convulsions • Very Weak, Lethargic or unconscious • Pneumonia or fast breathing	• WFL <-3Z score, OR • Visible wasting OR • Edema of both feet And presence of any one of complications	**Complicated Severe Acute Malnutrition**	**Admit for in-patient management** **(CARE PLAN C-Inpatient)**
		• WFL < -3Z scoreAND no complications OR • WFL ≥ -3Z to < -2Z score, AND • No edema of both feet	**Uncomplicated severe acute malnutrition** **or** **Moderate Acute Malnutrition**	Course of broad-spectrum oral antibiotic, such as amoxicillin • Detailed assessment of underlying cause(s) of malnutrition + tailored action to address these • Plot & appraise growth chart for monitoring progress

Criteria for classification of acute malnutrition among children 6 to 59 months of age

ASK	LOOK AND FEEL
Ask for signs of medical complications: Is the child: • Unable to breast feed, drink or feed? • Vomiting everything? Does the child have: • Blood in stool? • Diarrhea≥14d? • Bleeding tendencies? • History of recent sunken eyeball? • Convulsion (more than one or prolonged for >15 min)?	**4. Check for presence of edemaof both feet** (orsacrum) • Does the child have edema? • If yes, is it generalized involving upper arms and face? **5. Check the weight and height** •Is the weight-for-height less than-3z-score? **6. Check MUAC;** is the MUAC <11. 5cm? **7. Check for signs of medical complications:** • Hypothermia: axillary temp <35 ^{0}C or rectal < 35.5 ^{0}C • Fever ≥ 38.5 ^{0}C • Pneumonia/severe pneumonia • Shock • Dehydration (watery diarrhea with recent sunken eye balls.) • Hypoglycemia • Severe anemia (severe palmar pallor) • Jaundice • Dermatosis +++ • Corneal clouding or ulceration • Measles (now or with eye/mouth complications) • convulsions • Very Weak, Lethargic or unconscious

Signs	Classify	Treat
• WFL/H < -3Z scoreOR MUAC <11.5 cm OREdema of both feet (+, ++), **PLUS** ○ Any one ofthe medical complications or ○ Failed Appetite test OR • +++ Edema,OR • Marasmic Kwashiorkor (WFL/H < -3Z with edema, OR MUAC <11.5 cm with edema)	**Complicated Severe Acute Malnutrition**	**Admit for in-patient management** **(CARE PLAN C-Inpatient)**
• WFL/H < -3ZscoreORMUAC <11.5 cm OR • Edema of both feet (+, ++) AND • No medical complication AND pass appetite test	**Uncomplicated Severe Acute Malnutrition**	Manage in OTP using the OTP protocol **(CARE PLAN C-outpatient)**
• WFL/H ≥ -3Z to < -2Z score OR MUAC 11.5 cm to <12.5 cm AND No edema of both feet	**Moderate Acute Malnutrition**	Admit to TSFP if available, Counsel on infant and child feeding/care **(CARE PLAN B)**
• If WFL/H ≥-2Z score ORMUAC ≥ 12.5 cm AND • No edema of both feet	**No Acute Malnutrition**	Congratulate and Counsel the mother on infant and child feeding/care **(CARE PLAN A)**

CRITERIA FOR CLASSIFICATION OF ACUTE MALNUTRITION AMONG CHILDREN 5 TO 18 YEARS OF AGE

ASK

Ask for signs of medical complications:

1. Is the child vomiting everything?
2. Does the child have:

- Blood in stool?
- Diarrhea≥14d?
- Bleeding Tendencies?
- History of recent sunken eyeball?
- Cough more than 21 days
- Active TB on treatment?
- Convulsion (more than one or prolonged for >15 min)?

LOOK AND FEEL

1. **Check for presence of edemaof both feet** (orsacrum)
   - Does the child have edema?
   - If yes, is it generalized involving upper arms and face?
   - Is there no other cause for edema?
2. **Check the weight and height**
   - Is the weight-for-height less than-3z-score?
3. **Check BMI for age**
   - Does he have low BMI for age?
4. **Check MUAC**

Age (years)	MUAC severe (cm)	MUAC moderate (cm)	MUAC normal (cm)
Children 5 to 9	<13	13 - <14	≥14
Children 10 to 14	<16	16 - <18	≥18
Children 15 to 17.9	<17	17 - <19	≥19

5. **Check for signs of medical complications:**

- Hypothermia: axillary temp <35 ^{0}C or rectal < 35.5 ^{0}C
- Fever ≥ 38.5 ^{0}C
- Pneumonia/severe pneumonia
- Shock
- Dehydration (watery diarrhea with recent sunken eye balls.)
- Hypoglycemia
- Severe anemia (severe palmar pallor)
- Jaundice
- Dermatosis +++
- Corneal clouding or ulceration
- Measles (now or with eye/mouth complications)
- Very Weak, Lethargic or unconscious

SIGNS	CLASSIFY	TREAT
• WFL/H < -3Z score OR MUAC in severe category OR BMI for age<-3SD OR • Edema of both feet (+, ++), **PLUS** ○ Any one of the medical complications, or ○ Failed Appetite test OR+++ edema, OR • Marasmic Kwashiorkor (WFL/H < -3Z score with edema, OR MUAC in severe category with edema)	**Complicated Severe Acute Malnutrition**	**Admit for in-patient management** **(CARE PLAN C-Inpatient)**
• < -3Z score OR MUAC in severe category OR • BMI for age <-3SD OR • Edema of both feet (+, ++) AND • No medical complication AND pass appetite test	**Uncomplicated Severe Acute Malnutrition**	Manage in OTP using the OTP protocol **(CARE PLAN C-outpatient)**
• WFL/H ≥ -3Z to < -2Z score OR • MUAC in moderate category OR • BMI for age -3 to <-2SD AND No edema of both feet	**Moderate Acute Malnutrition**	Admit to TSFP if available Counsel on feeding and care **(CARE PLAN B)**
• If WFL/H ≥ -2Z score OR MUAC in normal category OR • BMI for age ≥ - 2SD AND • No edema of both feet	**No Acute Malnutrition**	Congratulate and counsel the mother on feeding and care **(CARE PLAN A)**

CRITERIA FOR CLASSIFICATION OF ACUTE MALNUTRITION AMONG ADULTS 18 YEARS OR OLDER

ASK	LOOK AND FEEL
1. Has the client lost weight unintentionally in the past month? 2. Has the client had • Active TB or on treatment for it? • Diarrhea≥14d? • Other chronic OIs or malignancies? (e.g. esophageal infection, mouth soar or oral thrush) 3. Has the client had noticeable changes in his/her body composition, specifically his/her fat distribution? • Thinning of limbs and face • Change in fat distribution on the limbs, breast, stomach region, back or shoulders? 4. Has the client experienced the following? • Nausea and/ or vomiting • Persistent fatigue • Poor appetite	1. **Check for presence of edemaof both feet** (orsacrum) • Does the client have edema? • If yes, is it generalized involving upper arms and face? • Is there no clear cut other cause? 2. **Measure weight and height** •is the BMI <16? 3. **Check MUAC** • is MUAC <18 cm? • is MUAC <19cm for PLW? 4. **Examine for conditions that cause secondary malnutrition (see above and in "ASK" part)** 5. **Check for signs of medical complications:** •Severe anemia •Severe dehydration •Active TB •Pneumonia •Shock •Jaundice •Dermatosis +++ •Very weak, lethargic or unconscious

Signs	Classify	Treat
• BMI <16 OR MUAC <18cm • for Pregnant and Lactating Women <19 cm • **OR** Edema of both feet without clear cut other cause, **OR** • **FOR HIV Positive client:** BMI >=16 and <17.5 OR MUAC >=18 and <21 cm **PLUS** • Any one of the medical complications,	**Complicated Severe Acute Malnutrition**	**Admit for in-patient management** **(CARE PLAN C-Inpatient)**
• BMI <16 OR MUAC <18cm • for pregnant and lactating women <19 cm OR • Edema of both feet without clear cut other cause, AND • No medical complication	**Uncomplicated Severe Acute Malnutrition**	Manage in OTP using the OTP protocol **(CARE PLAN C-outpatient)**
• BMI >=16 and <17.5 OR MUAC >=18 and <21 cm • **For pregnant women and lactating mothers:** MUAC>=19t and <23 cm OR • **For HIV positive client:** ○ Confirmed (>5% weight loss since last visit) or reported weight loss (e.g. loose clothing) ○ Regardless of BMI or MUAC: Any of the following: ▪ Chronic lung disease, TB, persistent diarrhea, other chronic Opportunistic Infection (OI) or malignancy **AND** • No edema of both feet	**Moderate Acute Malnutrition**	Admit to TSFP if available, Counsel on Critical Nutrition Practice (CNP) **(CARE PLAN B)**
BMI ≥17.5 OR MUAC ≥21 cm (for pregnant and lactating mothers ≥23 cm) AND • No edema of both feet	**No Acute Malnutrition**	Congratulate and Counsel on CNP **(CARE PLAN A)**

Enabling Objective 3: Explain complementary feeding

Training Methods: class exercise(10 min), Demonstration and group discussion (40 min)

Class exercise

- Distribute piece of paper with table depicting types and groups of food leaving the " sources column" empty (see table 13 below).

Table 13: Types of nutrients and their food sources

Nutrient	Food group	Examples of food/sources (see facilitator note below)
Sugar and starch fiber	Carbohydrate	
Fats/oils	Fat	
Protein	Proteins	
Vitamins and minerals	Micronutrients	
Water	Water	

- Ask the participants to fill individually the sources of food for each food group
- Ask one participant per nutrient type to read to the larger group the sources of food
- Select two participants to describe how a mother should prepare a meal for a child (using the types of food mentioned above)
- Ask participants to comment on the description given by the two participants.

Demonstration of nutrition counseling

- Select four participants and ask them to demonstrate how they can provide counseling for mothers/guardians/family in feeding
    - Babies under 6months,
    - Babies 6-12 months,
    - Children 1–5 years old,
    - School aged children
- Ask the participants to comment on the demonstrations

Facilitator's note

The UHE-Ps can assist families in choosing foods with diversified composition that keeps energy intake within reasonable bounds, while maximizing intake of nutrient-rich foods such as vegetables, fruits, legumes, whole grains, exclusive breast milk and other foods and fluids. Start optimal complementary feeding (giving solid or semi-solid food to a child in addition to breast milk) at six months with continuation of breast feeding for the first two years and above. School aged children needs at least two to three mixed meals and some snacks per day.

Children 1-5 years old need breast milk until they are at least two years old. They need at least three mixed meals and two snacks each day. They cannot eat large bulk meals. It is especially important for the meals to be clean and free from biological and chemical contaminations.

Babies 6-12 months need breast milk eight to ten times or more per day. They need small meals,

which are not bulky, three to five times a day.

When you are advising mothers and caregivers about optimal complementary feeding, there are a number of key messages you can give.

- When the infant is six months old the mother must give the infant complementary foods in addition to breastmilk to help the infant grow strong and healthy. At this age, breast milk alone cannot meet all the nutritional requirement for growth and development of the infant.
- The mother should continue giving breastmilk as the main food throughout the infant`s first year. Breastmilk will continue to protect the child against illness.
- The mother or caregiver should begin complementary feeding by adding available and affordable local foods. Vegetables, fruits, eggs, milk and meat should be mixed with cereals and legumes. Increase the amount of food given per day as the child grows.

Enabling Objective 4: Demonstrate vitamin A supplementation and de-worming

Method: Demonstration (30 min)

Explain to the participants on how Albendazole and vitamin A are administered to children of different age groups. Make sure that all the participants have understood correctly.

- Divide participants in to three groups.
- Ask them to administer Albendazole and Vit A for different age groups. Tell participants to create their own case. Ensure that all types of eligible children are included in their cases.
- While one group demonstrates the other group participants will rate the demonstration based on the checklist described below.

Checklist for rating Albendazole administration

Activity	Rate (yes, partly, no)			Remark
	1	0.5	0	
Communicate the client – what the child/client received, importance of deworming, etc				
Dosage checked				
Expiry date checked				
Proper administration of de-worming				
Total				

Following demonstration and rating exercise, facilitate discussion by asking the following questions.

Make sure that the participants clearly understand the dose of deworming according to the Ministry of Health guidelines.

Encourage participants to ask additional questions. Ask the following questions:

1. What was going well?
2. What were the main mistakes or missing pieces of information in the demonstrations?
3. Why do you think it is easy to make such mistakes or miss those points?

4. What can UHEP do if they realize that they have made a mistake or missed an important information item?

Ask one or two participants to summarize the main learning points from the activity.

Facilitator's note

Schedule for Vitamin A supplementation

Target for vitamin A for treatment	Immediately on diagnosis	Next day	Follow-up
Infants less than 6 months old			
Infants aged 6–11 months			
Children aged 12 months and over			

Target for vitamin A as EPI plus	Immunization contact	Vitamin A dose
Infants 6–11 months Children 12 months and older		
Children 12–59 months		

Session Assignment

1. What are the possible methods of assessing nutritional status among children?
2. What is the difference in taking measurement of height among children below the age of two and above the age of two?

Answer

1. MUAC measurement, assessing weight for age, weight for height for age.
2. Those who are below the age of two should be measured while lying on their back while older children can be measured while standing

References

1. Federal Ministry of Health. Family planning. Blended Learning Module for the Health Extension Program, Health Education and Training HEAT in Africa, 2011, Ministry of Health, Addis Ababa, Ethiopia

2. Federal Ministry of Health. HEAT in Africa, 2011, Ministry of Health, Addis Ababa, Ethiopia

3. National Center for Chronic Disease Prevention and Health Promotion. Family planning methods and Practices: Africa, 2nd edition, 2000, Center for Disease control and prevention, National Center for Chronic Disease Prevention and Health Promotion Division of Reproductive Health, Atlanta, Georgia 30333, USA

4. Federal Ministry of Health. National Guideline for Family Planning Services in Ethiopia; FMOH, October 2011

5. Johns Hopkins Bloomberg School of Public Health. The Essentials of Contraceptive Technology, A hand book for Clinic Staffs, Population Information Program Center for Communication Programs, Johns Hopkins Bloomberg School of Public Health, 111 market place, Baltimore, MD21202, USA

6. UNFPA. The Power of 1.8 Billion: Adolescents, Youth and the Transformation of the Future, the State of World Population 2014. UNFPA

7. Federal Ministry of Health. Integrated Management of Newborn and Childhood Illnesses, part I and II. Blended Learning Module for the Health Extension Program, Health Education and Training HEAT in Africa, 2011, Ministry of Health, Addis Ababa, Ethiopia

8. Federal Ministry of Health. Antenatal Care, part I and II. Blended Learning Module for the Health Extension Program, Health Education and Training HEAT in Africa, 2011, Ministry of Health, Addis Ababa, Ethiopia

9. Federal Ministry of Health. Postnatal Care. Blended Learning Module for the Health Extension Program, Health Education and Training HEAT in Africa, 2011, Ministry of Health, Addis Ababa, Ethiopia

Appendices

Appendix 1:Pre and post-test questions

Read the following statements carefully. Answer “T” if the statement is true and answer “F” if the statement is false in the provided space

No	Question	Answer T/F
1	Young people are not among the priority target groups for reproductive health services	
2	Adolescents and youth get a lot of information from different sources and can keep themselves safe. There is no need to worry about their sexual and reproductive health issues	
3	Parents should always be informed when their adolescent children encounter reproductive health problem?	
4	Showing confidence during adolescent counseling will help to establish trust	
5	Excessive eye contact during counseling will scare adolescents	
6	You should avoid telling young people disapproval of their action to ensure good Counseling	
7	Condom is one of the effective methods to prevent HIV and other STIs	
8	Family planning is having small number of children for the wellbeing of the family	
9	It is the responsibly of women to use contraceptive methods and avoid unwanted pregnancy	
10	Family planning has benefit for the mother, children, family as well as the economy.	
11	Understanding and analyzing the social ecology factors for family planning use will help providers give tailored family planning services based on the individual need	
12	Natural methods of contraception are as effective as artificial methods	
13	All hormonal methods are recommended for all women as long as their breastfeeding practice is taken into consideration and the women are advised properly	
14	All barrier contraceptive methods are effective in the prevention of HIV and STIs	
15	A woman can use oral contraceptive method throughout her reproductive life	
16	Oral contraceptive pills do not cause birth defects or multiple birth	

No	Question	Answer T/F
17	Informed choice of family planning is when a woman/ couples make their choice after getting information on all possible methods including benefits and side effects	
18	Anemia during pregnancy is among the major cause of maternal mortality	
19	UHE-ps have significant role in identification and prioritization of households with pregnant mothers and neonates	
20	Interventions to reduce neonatal mortality often seen high level technology and are expensive	
21	The best time to start ANC is as soon as the woman suspects pregnancy	
22	In FANC there are 4 essential visits recommended that the woman can make whenever she has time	
23	Blurred vision is one of the danger signs of pregnancy	
24	The nutritional status of a girl child will be always reflected on her future children	
25	MUAC is one of the simplest ways of assessing nutritional status of pregnant women.	
26	Pregnant and lactating mothers with MUAC less than 23.5cm are considered as malnourished.	
27	UHEPs do not have any contribution in the national PMTCT program	
28	PMTCT care and treatment services decrease the transmission of HIV from mother to child significantly	
29	Primary prevention of HIV is the key for prevention of mother to child transmission of HIV	
30	Like any other women in the reproductive age, women living with HIV have the right to decide on her fertility related issues	
31	All women should be advised on replacement feeding regardless of their contexts for the sake of the child	
32	During child birth, if the placenta is removed safely we can consider the mother to be safe and focus our attention on the child only	
33	It is important to discuss about family planning as soon as possible after a woman gives birth	
34	Keeping the baby in the skin-to-skin contact with the mother protect the newborn form hypothermia	
35	Women with low education can't really understand the importance of good newborn care.	
36	Men can't be expected to share responsibility for newborn care	
37	Sometimes babies get trusty and it is ok to give them some drops of boiled water	

No	Question	Answer T/F
38	We should limit the number of times the baby is breast-feed as excessive feeding may cause obesity	
39	Both high and low body temperatures are danger signs among newborns and should lead to immediate referral for care at health facility	
40	Currently in Ethiopia a total of 10 childhood illnesses are targeted by the national EPI program	
41	Tetanus is one of the EPI targeted diseases globally targeted for eradication	
42	Convulsion is one of the general danger signs of a sick child	
43	A child with danger sign should be managed at home before referral	
44	A child with MUAC measurement of 11.2 cm is in good nutritional status	
45	Weight for age is the most common index used in growth monitoring	
46	All under five children should be measured for their length while lying on their back	

Answers

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
F	F	F	T	F	T	T	F	F	T	T	F	T	F	T	T	T	F	T	F	T	F	T

24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46
T	T	F	F	T	T	T	F	F	T	T	F	F	F	F	T	T	F	T	F	F	T	F

Appendix 2: **A check-list for daily evaluation**

- **How useful is this training to help you reflect on your current knowledge and experience to identify how you can improve what you do in your work?**

  Very useful **Useful** **Partially useful** **Not useful**

- **How useful is this training to help you identify how to re-orient your attitudes to better do your job?**

  Very useful **Useful** **Partially useful** **Not useful**

- **How useful is this training to help you identify and analyse broader social factors that may affect different clients and**

  groups you are meant to reach?

  Very useful **Useful** **Partially useful** **Not useful**

- **How useful is this training to help you expand knowledge and identify how to use it with different clients and groups you are meant to train?**

  Very useful **Useful** **Partially useful** **Not useful**

- **How useful is this training to help you improve your skills to apply CBT approach in providing services to your clients?**

  Very useful **useful** **Partially useful** **Not useful**

- **How relevant are the methods in addressing ASK and ELC?**

  Very relevant **relevant** **Partially relevant** **Not relevant**

- **other comment**

  _____

  _____

  _____

  _____

  _____

Appendix 3: **A check-list for end-course evaluation**

- **How useful is this training to help you reflect on your current knowledge and experience to identify how you can improve what you do in your work?**

  Very useful **Useful** **Partially useful** **Not useful**

- **How useful is this training to help you identify how to re-orient your attitudes to better do your job?**

  Very useful **Useful** **Partially useful** **Not useful**

- **How useful is this training to help you identify and analyse broader social factors that may affect different clients and**

  groups you are meant to reach?

  Very useful **Useful** **Partially useful** **Not useful**

- **How useful is this training to help you expand knowledge and identify how to use it with different clients and groups you are meant to train?**

  Very useful **Useful** **Partially useful** **Not useful**

- **How useful is this training to help you improve your skills to apply CBT approach in providing services to your clients?**

  Very useful **useful** **Partially useful** **Not useful**

- **How relevant are the methods in addressing ASK and ELC?**

  Very relevant **relevant** **Partially relevant** **Not relevant**

- **other comment**

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REPRODUCTIVE, MATERNAL, NEW BORN AND CHILD HEALTH

Facilitator's Guide