



THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH AND SOCIAL WELFARE

National Integrated Community Maternal, Newborn and Child Health Guidelines



**Reproductive and
Child Health Section**
P.O. Box 9083
Dar es Salaam





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MINISTRY OF HEALTH AND SOCIAL WELFARE

National Integrated Community Maternal, Newborn and Child Health Guidelines



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FOREWORD

Working with individuals, families and communities is critical for ensuring the recommended continuum of care throughout pregnancy, childbirth and the postpartum period. The aim of working at community level is to contribute to the empowerment of women, families and communities to improve maternal, newborn and child health (MNCH) outcomes.

These *National Integrated Community Maternal, Newborn and Child Health Guidelines* aim at providing a national focus for all stakeholders in implementing community MNCH services. This document targets all organisations, groups, partners and individuals working on community MNCH in Tanzania. It is one piece of a package guiding implementation of integrated community MNCH services, which includes the following documents: Integrated Community MNCH Trainers' Guide, Integrated Community MNCH Reference Manual for Community Health Workers, Integrated Community MNCH Supervisors' Guide, Integrated Community MNCH Job Aids for Community Health Workers, and related information, education and communication materials for clients.

These guidelines address managerial and technical areas for consideration, such as content of household visits, CHW roles and responsibilities, selection of trainers, training duration, selection criteria for community health workers, logistics, management information system, supervision, and monitoring and evaluation.

The MOHSW expects that these guidelines will spearhead the implementation of high-quality community MNCH services and contribute towards reducing morbidities and maternal, newborn and child mortalities—ultimately, fostering improved health within communities at large.

Regina L. Kikuli
Ag. Permanent Secretary
Ministry of Health and Social Welfare

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Dr. Donan W. Mmbando
Ag. Chief Medical Officer
Ministry of Health and Social Welfare

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARV	Antiretroviral [medicine]
BCC	Behaviour Change Communication
CBD	Community-Based Distributor
CBO	Community-Based Organisation
CCHP	Council Comprehensive Health Plan
CHMT	Council Health Management Team
CHW	Community Health Worker
COC	Combined Oral Contraceptive
CORP	Community Owned Resource Person
CTC	Care and Treatment Centre
DMO	District Medical Officer
DRCHCo	District Reproductive and Child Health Coordinator
EPI	Expanded Programme on Immunisation
FGM	Female Genital Mutilation
FP	Family Planning
HIV	Human Immunodeficiency Virus
HTSP	Healthy Timing and Spacing of Pregnancy
IBP	Individualised Birth Plan
IEC	Information, Education and Communication
IPC	Infection Prevention and Control
IPT	Intermittent Preventive Treatment
IMC	Integrated Management Cascade
ITN	Insecticide-Treated [bed] Net
IEC	Information, Education and Communication
IUCD	Intrauterine Contraceptive Device
KMC	Kangaroo Mother Care
LAM	Lactational Amenorrhoea Method
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MNCH	Maternal, Newborn and Child Health
MOHSW	Ministry of Health and Social Welfare
MTCT	Mother-to-Child Transmission of HIV

NACP	National AIDS Control Programme
NGO	Nongovernmental Organisation
ORS	Oral Rehydration Solution
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PNC	Postnatal Care
POP	Progestin-Only Pill
PPC	Postpartum Care
PPFP	Postpartum Family Planning
RCHCo	Reproductive and Child Health Coordinator
RMO	Regional Medical Officer
STI	Sexually Transmitted Infection
TB	Tuberculosis
TBA	Traditional Birth Attendant
VSC	Voluntary Surgical Contraception
WHO	World Health Organization

CHAPTER 1: OVERVIEW

1.0 INTRODUCTION

These guidelines are for implementers of community maternal, newborn and child health (MNCH) interventions in Tanzania. The chapters included describe what should be done at the community/household level regarding MNCH, including postpartum family planning (PPFP) and prevention of mother-to-child transmission of HIV (PMTCT). These guidelines also cover how the community health worker (CHW) interacts within the community and the health system.

1.1 Overview of Maternal, Newborn and Child Health in Tanzania

The World Health Organization (WHO) estimates that worldwide, 536,000 women die every year as a result of pregnancy- and childbirth-related conditions. Most (80%) of these deaths are preventable, and more than half occur in sub-Saharan Africa—a region that accounts for only 17% of the world's population and 12% of births worldwide. The risk of maternal death in the African region is 1:16, compared to 1:3,500 in North America, 1:2,400 in Europe, 1:160 in Latin America and the Caribbean and 1:100 in Asia.¹

Tanzania's maternal mortality ratio, 454 deaths per 100,000 live births, is among the 10 highest in the world.² In Tanzania, the direct causes of maternal death include haemorrhage (28%), abortion-related complications (19%), pregnancy-induced hypertension (17%), obstructed labour (11%) and sepsis (11%).³

Tanzania's neonatal mortality rate is 26 per 1,000 live births, the infant mortality rate is 51 per 1,000 live births, and the under-five mortality rate is 81 per 1,000.⁴ The main causes of newborn mortality in Tanzania are infection (29%), asphyxia (27%) and prematurity (23%).⁵ The main causes of child mortality in the country are malaria, pneumonia, diarrhoea, and HIV/AIDS.⁶ In Tanzania, the prevalence of HIV in the general population is 5.8% and among pregnant women is 6.9%.⁷

About 50% of maternal and newborn deaths occur in the first 24 hours after birth, and 75% of perinatal deaths occur within the first week.⁸ This is further complicated by the fact that in Tanzania, only 51% of women deliver at a health facility⁹ and only 13% of women who deliver at home report to the health facility within 48 hours after delivery.¹⁰

¹ WHO/AFRO 2001

² NDS 2010

³ WHO 2005

⁴ NDS 2010

⁵ WHO 2005

⁶ MOHSW 2008

⁷ NACP 2008

⁸ MOHSW 2008

⁹ NDS 2010

¹⁰ NDS 2005

The contraceptive prevalence rate (CPR) for modern methods in Tanzania is only 27% among married women, and 25% of married women have an unmet need for family planning (FP).¹¹ Increasing contraceptive prevalence and reducing unmet need for FP would significantly reduce unintended pregnancies, abortions, and maternal and child deaths.¹²

Community-based interventions provide a vital entry point to reduce maternal, newborn and child deaths and promote health and well-being by bringing health services and information closer to mothers, families, caregivers and the community, thereby, allowing for decreased delays in seeking care and increased access to vital health promotion information and services.

1.2.1 Rationale for Community Maternal, Newborn and Child Health Care

Findings from a community assessment conducted by the MOHSW in 2009¹³ revealed a high level of awareness amongst Tanzanian women, their partners and community leaders regarding the importance of antenatal care (ANC) and HIV screening during pregnancy. In some communities, traditional birth attendants (TBAs) are actively providing delivery care. It was also found that men are usually the decision-makers about whether a woman will deliver at a facility or not; thus partner engagement in MNCH activities is key. There was limited knowledge and reported use of postnatal care (PNC) services beyond immunisation and child growth-monitoring cards. Barriers to use of MNCH services offered at facilities included lack of available transportation, costs associated with delivery in a facility and the attitudes of health providers.

Postpartum sexuality, fertility return and pregnancy risk are intertwined. According to the aforementioned MOHSW assessment, most communities did not recognise pregnancy risk before menstruation return, although they did acknowledge it was possible to become pregnant while breastfeeding. While some women reported that they had exclusively breastfed their infants through six months, the majority of community members reported that exclusive breastfeeding lasted only one to three months.

Even if a birth occurs in a health facility, in many settings, mothers and newborns are discharged within a few hours and have no further contact with a health care provider, especially in the first week when risk for maternal and newborn death is high. Births at home pose an even greater challenge for providing care to mothers and newborns during the critical hours and days after birth. This challenge can be addressed by introducing home visits as a complementary strategy to facility-based PNC to increase coverage of care and improve maternal and newborn survival.

Because mothers and newborns are often kept indoors during the postnatal period, CHW visits to the home offer an opportunity to bring support, education, counselling and referrals to the woman and baby during this culturally sensitive time. Delegating these tasks to CHWs can bring high impact at relatively low cost.

¹¹ TDHS 2010

¹² Scott Moreland 2007

¹³ ACCESS-FP 2009

Community involvement and participation contribute to the achievement of the Millennium Development Goals (MDGs), including reduction of under-five and maternal mortality and HIV transmission, and provide a stronger foundation of health services. These interventions outlined in the following Section 1.3 are in line with MDGs 4, 5 and 6, and their implementation can result in the following benefits:

- Reductions in under-five mortality
- Reductions in maternal mortality and increased access to reproductive health care
- Prevention of HIV and AIDS, sexually transmitted infections (STIs), malaria and other diseases

1.3 Community MNCH Interventions

Recommended interventions at home and in the community are as follows:

1.3.1 Antenatal care

The goals of ANC are to provide timely and appropriate care to women during pregnancy in order to reduce maternal morbidity and mortality and to achieve a good foetal outcome.

Care during pregnancy in the community should involve:

- Counselling on:
 - Early health care-seeking behaviour
 - Maintenance of a healthy and balanced diet
 - Development of an Individualised Birth Plan (IBP) and complication preparedness
 - Recognition of pregnancy danger signs and symptoms (and referral to health facility for management)
 - Importance of male involvement in reproductive health
 - Importance of knowledge and disclosure of HIV status
 - Healthy timing and spacing of future pregnancies
- Health promotion and prevention of malaria, STIs, HIV/PMTCT, tuberculosis (TB) and prevention of anaemia in pregnancy
- Encouraging early attendance at ANC, completion of all four ANC visits, and additional visits if need arises
- Identification of social, cultural and nutritional factors affecting pregnancy

1.3.2 Postpartum care

Postpartum care for the mother aims to provide support for the mother, from delivery to six weeks after delivery.

Community care for the mother during the postpartum period should involve:

- Support for exclusive breastfeeding for the first six months of life
- Self-care at home, including safe disposal of sanitary pads, washing of contaminated linens and upkeep of hygienic practices for mother and newborn
- Support for rest and reduced workload for the mother
- Maternal nutrition and maintenance of a healthy and balanced diet
- Encouraging mothers to attend all postnatal care visits at the health facility (within the first 48hrs, 3–7 days, 8–28 days and up to 42 days)
- Counselling on cervical and breast cancer screening
- Prevention and management of malaria (including use of insecticide-treated bed nets [ITNs])
- Prevention of postpartum complications, and referral to health facility if complications occur
- Counselling on return to fertility and PFP
- Recognition of postpartum danger signs for the mother and the newborn
- Counselling and support for women living with HIV/AIDS and their exposed infants, including referral to Care and Treatment Centres (CTCs) and link to social support groups
- Reporting birth and death (vital registration)
- Psychological support for postpartum women

1.3.3 Newborn care

Newborn care aims to ensure proper care-taking, health promotion and monitoring for danger signs from birth to 28 days after birth.

Community care for the newborn should include promotion of and support for:

- Exclusive breastfeeding
- Immunisation
- Thermal protection
- Infection prevention: general hygiene, handwashing before touching the newborn, cord care and safe disposal of baby's faeces
- Special care for a small/premature baby
- Recognition of danger signs, illness and timely care-seeking/referral
- Follow up of HIV-exposed and HIV-infected infant
- Routine newborn care and follow-up visits at the health facility
- Birth and death registration

1.3.4 Child care

The aim of child care is to ensure proper growth, development, health promotion and timely care-seeking as needed. In these guidelines, “child care” focuses on children younger than age five.

Child care in the community should include promotion of and support for:

- Complementary feeding starting at six months of age
- Uptake of a balanced and nutritious diet
- Completing the immunisation schedule according to Expanded Programme on Immunisation (EPI) schedule
- Dietary supplementations (vitamin A, iodine, iron)
- Regular growth monitoring and deworming
- Use of ITNs
- Care of a sick child at home
- Danger signs and need for immediate referral to health facility
- Counselling on the importance of adherence to treatment
- Personal hygiene, including safe disposal of child's faeces
- Discouraging harmful practices against children (female genital mutilation [FGM], uvulectomy, etc.)
- Prevention of childhood home accidents
- Early childhood development and psychosocial stimulation
- Early detection of HIV for HIV-exposed children and linking to CTC and support for HIV-infected children

1.4 Overview of CHW Tasks

Community MNCH services will primarily be implemented through home visits conducted by CHWs. Home visits will begin during the antenatal period, and continue until the child turns age five. The full schedule of home visits is summarized on the next page.

ANTENATAL VISITS	
First Home Visit	As early as CHW identifies a pregnant woman
Second Home Visit	At six months of pregnancy
Third Home Visit	At eight months of pregnancy
POSTPARTUM MATERNAL AND NEWBORN/INFANT HEALTH VISITS	
First Home Visit	Within 24 hours of delivery, after discharge from the health facility
Second Home Visit	Third day after delivery or discharge from the health facility
Third Home Visit	Eighth day after delivery or discharge from the health facility
Fourth Home Visit	Third week after delivery
Fifth Home Visit	Fifth week after delivery
Sixth Home Visit	Third month after delivery
Seventh Home Visit	Fifth month after delivery
FOLLOW-UP VISITS	
Follow-Up Visits	Once every three months, up to five years of age

CHAPTER 2: ROLES OF COMMUNITY HEALTH WORKERS IN THE COMMUNITY

2.0 INTRODUCTION

A community health worker, or CHW, is a member of a particular community whose task is to assist in improving the health of that community in cooperation with the health care system, public health agencies and the broader community.

2.1 Selection Criteria for CHWs

CHWs will be selected based on the following criteria:

- Nominated from the community by the village government in collaboration with the health facility (those who are interested will apply)
- Accepted by community members through village meeting
- Resident of the specific area (preferred)
- Willing to volunteer
- Age above 18 years
- Role model in reproductive and child health issues
- Completed at least form four level of schooling (added advantage)
- Can be male or female

2.2 Roles and Responsibilities of CHWs

The role of the CHW focuses on reaching mothers and those who support them in their homes and communities to promote healthy maternal, newborn, child and reproductive health practices, as well as to facilitate service use. The CHW is responsible for conducting activities that encourage the desired healthy behaviours and collaborating with communities to create a supportive environment for the use of services and practice of those behaviours.

Roles of CHWs include:

- Planning MNCH activities in the respective catchment area
- Conducting annual community surveys and regular mapping of the catchment area
- Providing information, education and basic counselling on maternal, newborn and child health in the community, primarily through home visits
- Providing referrals for clients for MNCH services
- Participating in village health meetings and linking with partners
- Monitoring of community MNCH services

2.3 Catchment Area of the CHW

Each CHW should be responsible for approximately 60 households in their respective catchment area.

2.4 Training for CHWs

CHWs will be trained according to the National Integrated Community MNCH Training Package. They will be trained by trainers selected by the Council Health Management Team (CHMT). The training will be two weeks of classroom training and one week of practical training at community level. The following standardised training materials and documents in their most current edition should be used:

- National Integrated Community MNCH Guidelines
- Integrated Community MNCH Trainers' Guide
- Integrated Community MNCH Reference Manual for Community Health Workers
- Integrated Community MNCH Supervisors' Guide
- Integrated Community MNCH Job Aids and information, education communication (IEC) materials

After completing the initial training, CHWs will receive an official certificate. CHWs will also receive follow-up after training to refresh and update skills.

2.5 Supervision of CHWs

Supervision of CHWs will be implemented through the Integrated Management Cascade. Refer to Chapter 11.

2.6 CHW Working Tools

After training, CHWs will be provided a reference manual, job aids, IEC materials, a bag and reporting forms. The CHW is responsible for the maintenance and safekeeping of these tools.

2.7 Overcoming Challenges to Service Utilisation and Provision

Members of the community may face challenges in utilising health services, just as CHWs may face challenges in providing services. It is important for the CHW to be aware of these challenges, and take proactive steps to reduce barriers wherever possible.

To overcome challenges to **utilisation** of services by community members, the CHW should consider the following strategies:

- Work in partnership with community stakeholders to identify culturally sensitive solutions to address challenges related to culture and traditions and harmful traditional practices.
- Educate communities about the value of MNCH and PFP services.

- Advocate for increased availability of resources through linkages with community leaders, organisations and institutions.
- Encourage gender equity.
- Work to improve livelihoods of mothers and access to quality services (such as through social clubs and income-generating activities).

To overcome challenges that the CHW might face in **providing** services, the following measures should be considered:

- Incentives/motivations (from the community or supervising agency), based on such measures as time committed, households visited, activities conducted, etc.
- Supportive supervision, follow-up and feedback on performance
- Clear and effective chain of command for decision-making
- Clear and effective communication channels
- CHWs understanding their job description and expectations
- Capacity-building for CHWs through training to acquire and maintain necessary skills for the job.
- Materials for CHW are in place and are easily accessible

CHAPTER 3: BEHAVIOUR CHANGE COMMUNICATION, INTERPERSONAL COMMUNICATION AND COUNSELLING

3.0 INTRODUCTION

The concepts of behaviour change communication (BCC), interpersonal communication and counselling are intertwined. It is critical for the CHWs to develop skills in these areas, to enable them to work effectively on issues related to MNCH in the community.

3.1 Behaviour Change Communication

Behaviours are actions and practices that are influenced by various factors, such as culture, social norms, knowledge and access to resources. BCC involves the strategic use of communication to shift the ways in which people perceive, think, feel and act, encouraging behaviours that will lead to positive health outcomes,

It takes more than a message to bring about behaviour change, especially for practices that have deep cultural roots. Women of childbearing age and other members of the community may have genuine reasons from their perspective for not adopting a particular behaviour. Thus, addressing their concerns and barriers to behaviour change facilitates the adoption of the appropriate behaviour. CHWs should apply principles of BCC in the process of providing services in their catchment areas.

3.2 Concept of Interpersonal Communication

Interpersonal communication is an exchange of information, ideas, thoughts or feelings that is face-to-face, both verbal and non-verbal, between two or more people. Interpersonal communication skills are very important for the CHW in order to provide appropriate health promotion messages within the community. The information given by CHWs should be provided in a way that is easy to understand, culturally acceptable and easy to follow. By using good interpersonal communication skills, the CHW can talk with families and help them provide the best care possible to mothers, newborns and children.

3.2.1 Effective interpersonal communication

All CHWs will be trained to use effective interpersonal communication skills. CHWs should be able to demonstrate active listening, asserting, influencing, persuading, empathising, showing sensitivity and using diplomacy. The CHW should be familiar with interpersonal communication concepts and utilise the skills involved to effectively communicate with members of the community in which he/she serves.

3.3 Definition and Purpose of Counselling

Counselling is an interactive process in which the counsellor sits with the client and helps him/her to decide what he/she wants, recognise individual needs, choose or accept appropriate management and practice the chosen management properly. Counselling is a type of interpersonal communication that can bring about behaviour change. During CHW home visits, mothers and families will receive information and education specific to their needs, which will enhance learning of new attitudes or behaviours. CHWs will be trained in basic counselling skills to help mothers and families make decisions that support MNCH care and FP use.

3.3.1 Qualities of an effective counsellor

CHWs should know and exhibit the qualities of a successful counsellor, which include maintaining confidentiality and being:

- Non-judgemental
- Trustworthy
- Respectful
- Flexible
- Non-dominant
- Empathetic
- Patient

3.4 Ways to Overcome Communication Barriers

The CHW should be able to overcome common communication barriers. Some of the recommended strategies include:

- Identifying culture, norms and values of the community
- Composing simple and clear messages
- Using simple language understandable to the receiver
- Identifying appropriate time and channel/media for message delivery
- Selecting appropriate audience
- Selecting appropriate venue
- Making the message meaningful to the audience
- Checking understanding by asking appropriate questions
- Asking for feedback from clients and supervisors

3.5 Importance of Communication Skills

By communicating messages effectively, the CHW can:

- Gain the trust of people in the community.

- Strengthen relationships among CHWs, clients and health facilities.
- Share information and resources.
- Facilitate empowerment and ownership.
- Shift attitudes and behaviours to improve the health status of the community.

CHAPTER 4: CARE DURING PREGNANCY

4.0 INTRODUCTION

The CHW will work with community leaders and the community at large to regularly identify pregnant women in the community, and conduct home visits to provide appropriate information and support. The CHW will keep and maintain a record of all pregnant women in his/her catchment area, which will help to facilitate close follow-up.

4.1 Advice for Pregnant Women and Community Members

The CHW should advise and encourage pregnant women to attend ANC according to the recommended schedule.

CHWs should also advise the community on the following:

- Importance of the woman's involvement in health-related decision-making in the household
- Importance of early antenatal booking and subsequent antenatal and postnatal visits
- Importance of facility delivery with the help of skilled birth attendants
- Importance of maternal nutrition during pregnancy and postpartum periods
- Importance of early reporting of illnesses
- Discouragement of the use of local herbs and non-prescribed medicines during pregnancy
- Development of an individualised birth plan (IBP), including complication readiness
- Recognition of danger signs and immediate care-seeking
- Postpartum family planning (PPFP) and healthy timing and spacing of pregnancy (HTSP)
- Importance of HIV testing, knowing their serostatus and disclosure, and partner testing
- Adherence to antiretroviral (ARV) prophylaxis and safer sex practices
- Optimal breastfeeding practices and benefits of exclusive breastfeeding (including the Lactational Amenorrhoea Method [LAM] of family planning and transition to other modern FP method)
- Support for rest and reduced workload for pregnant women

4.2 Recognition of Danger Signs

The CHW should advise the community on recognition of danger signs in pregnant women and the importance of going to a health facility for management. Critical danger signs for the antenatal period are:

- Vaginal bleeding during pregnancy
- Severe headache and blurred vision
- Swelling of face or hands
- Fever

- Severe upper-abdominal pain
- Foul-smelling vaginal discharge
- Leaking of amniotic fluid from the vagina
- Pre-term labour
- Pallor (palms, tongue and conjunctiva)
- Loss of consciousness/fits
- Reduced or no foetal movement

4.3 Prevention of Malaria, STIs/HIV, Malnutrition and Anaemia

Prevention of various diseases and conditions is important during pregnancy. For this reason, the CHW should advise and encourage the pregnant woman on the following:

- Prevention of malaria by use of ITN, intermittent preventive treatment (IPT), control of mosquito breeding sites and household spraying of insecticide
- Screening, prevention and management of HIV and STIs including partner testing, safer sex practices and adherence to treatments as prescribed
- Prevention of malnutrition and anaemia through dietary advice, emphasising the importance of taking iron and folic acid supplementation

4.4 Birth Preparedness

The CHW should assist pregnant women and partners to develop an IBP and complication readiness plan. The CHW should work with other members of the household and community to ensure that the mother has the support needed, such as transport for delivery.

4.5 Identify Social Factors That Negatively Influence Pregnancy, Pregnancy Outcomes and Parenting

CHWs should assist in identifying social factors, including domestic and sexual violence, which may have a negative influence on the woman's health and pregnancy outcomes. CHWs should discourage these practices and link survivors to institutions dealing with these issues.

4.6 Postabortion Care

In Tanzania, abortion is defined as the termination of pregnancy (either spontaneous or induced) before 28 completed weeks of gestation or below 1,000 gm foetus. Nineteen percent of maternal deaths in Tanzania are attributed to abortion-related complications.¹⁴ Action can be taken to avert death and disability and promote healthy spacing of future pregnancies. CHWs should counsel on the following:

- If a woman experiences bleeding during pregnancy, it is important to attend the health facility as soon as possible for proper management.

¹⁴ National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania: 2008–2015.

- Provision of psychological support from partner and family members should be encouraged.
- Women who have experienced an abortion should wait at least six months before attempting another pregnancy (for her health and the health of the baby).
- A woman's fertility can return as early as 11 days following abortion. She should visit the health facility for FP in order to prevent another pregnancy too soon.

4.7 Home Visit Schedule and Activities

With support of community leaders, the CHW will plan and organise feasible schedules for home visits to see pregnant women in the community. This schedule should include key activities to be performed at each visit.

The CHW will conduct three home visits for each pregnant woman during the antenatal period: the first one as soon as the CHW identifies a pregnancy (after disclosure or physical signs), the second at six months and the third at eight months of pregnancy. The CHW will also keep and maintain appropriate records for each visit, including key decisions made and next steps for follow-up in subsequent home visits.

Additional home visits may be needed depending on the health of the mother and to follow up on referrals. CHWs will be trained to identify when additional visits are needed.

4.8 Home Visit Schedule and Key Topics Covered during Pregnancy

The schedule of home visits and key topics for the CHW to discuss at each visit are described in Appendix A.

CHAPTER 5: CARE OF THE POSTPARTUM MOTHER

5.0 INTRODUCTION

The postpartum period (pueperium), as defined by WHO, is the period that begins immediately after delivery of the placenta and lasts up to 42 days (six weeks). WHO further includes the first six postnatal months as a very important period of time to continue monitoring the mother and baby on issues of breastfeeding, FP, immunisations, HIV testing and treatment, and management of any complications that arise. PPFPP programmes encourage the use of family planning services during the first year postpartum (the extended postpartum period) to ensure healthy timing and spacing of pregnancies. Reaching postpartum mothers as early as possible and throughout the extended postpartum period is of paramount importance to ensure that mothers and infants receive a full continuum of care.

5.1 Physiological and Psychological Changes in a Woman during Postpartum Period

The CHW should educate the mother on the normal physiological and psychological changes that occur during the postpartum period. During this period, women experience changes related to:

- Uterine size
- Body weight
- Breasts
- Lochia
- Urinary bladder
- Psychological state

Changes in these areas are normal and the mother should be given reassurance by the CHW. CHWs should be able to easily distinguish these changes from danger signs. They should assist the mother to distinguish danger signs from normal changes and encourage immediate care-seeking at facility level when danger signs appear.

5.2 Counselling and Support

CHWs should support the building of the mother-newborn relationship, encouraging bonding and offering praise and reassurance that the mother is capable of good care for her newborn. Women's attitudes, beliefs, culture and particular circumstances are to be fully respected. Counselling is to be offered in a kind, respectful manner. The mother needs strong encouragement and support to follow through with postpartum appointments at the health facility.

CHWs will counsel postpartum women, partners and family members on the following important points:

- Hygiene and infection prevention: including appropriate handwashing, body hygiene, safe disposal of sanitary pads, washing of contaminated linens, observing hygienic principles when handling the newborn baby and providing safe cord care
- Exclusive breastfeeding: provides all essential nutrients for the baby for the first six months and can act as a short-term FP method (when all three LAM criteria are met)
- Cervical and breast cancer screening at three months
- Good maternal nutrition: emphasis on balanced diet and increased frequency of taking meals due to increased demand for nutrients on the part of the mother and the baby
- Adequate rest: helps the body return to a pre-pregnancy state, and allows the mother to heal and re-gain strength
- Postpartum family planning:
 - Emphasis on the importance of healthy timing and spacing of pregnancy (two-year birth-to-pregnancy interval at minimum), return to fertility and importance of selecting a contraceptive method (taking breastfeeding status into account) to prevent unintended, closely spaced pregnancies.
 - For mothers who choose LAM, emphasis on the three criteria required for LAM to be an effective contraceptive method and the importance of transitioning to other modern methods by six months or sooner if any of the three criteria change.
 - Emphasis on safer sex and dual protection for HIV infected individuals.
- Health care-seeking behaviour: go to a health facility for routine postpartum care (PPC) appointments, and seek care as early as possible in the event of reported illness, postpartum danger signs and other abnormal conditions of the mother and the infant
- Importance of going for HIV testing and counselling
- Adherence for mothers on ARV and link to social support groups
- Malaria prevention: use of ITNs every night to protect the woman, infant/child and family against mosquito bites
- Postpartum exercise: to strengthen pelvic floor muscles and body posture, increase stamina and improve self-esteem
- Postpartum danger signs: help the mother to be able to recognise the danger signs and advise mother to seek help immediately if the following signs and symptoms occur:
 - Vaginal bleeding (heavy or sudden increase)
 - Fever
 - Severe pain in the genitalia
 - Severe abdominal pain
 - Pain in the calf muscles
 - Breathing difficulty
 - Leakage of urine

- Severe headache/blurred vision
- Loss of consciousness/fits
- Foul-smelling discharge from vagina or perineal tear
- Abnormal behaviour (depression, psychosis)
- Pallor (palms, tongue and conjunctiva)
- Painful, red and hot breast, cracked nipples

5.3 Ongoing Social Support

CHWs should ensure that the postpartum mother receives family support during the postpartum period. This may include having one or more caretakers to provide assistance necessary during the first week and throughout the postpartum period. Similarly, partner/male involvement and support are critical, and the community at large also has a role to play in providing support for postpartum women. The CHW should assess the availability of food and basic commodities for the postpartum mother and mobilise the community to assist, if needed.

5.4 Encouraging Postpartum Visits at the Health Facility

CHWs will encourage the mother to attend postpartum appointments at the health facility according to the following schedule:

- Within 48 hours in case of home deliveries
- Within seven days postpartum
- At 28 days postpartum
- At 42 days postpartum
- At six months postpartum

During each visit, the mother should go to the facility with her baby. The mother should be prepared by the CHW on what to expect during these visits. Prior to the 42-day visit, the CHW should help prepare the mother for PFP counselling and choosing a method if she is not already using LAM. The CHW should discuss with the mother the support she may need and provide assistance as necessary.

5.5 Home Visits during Postpartum Period

CHW home visits to the mother and baby during the postpartum period will be conducted according to the following schedule:

- Within 24 hours after discharge from health facility or home delivery
- Third day after discharge from health facility
- Eighth day after discharge from health facility
- Third week after delivery

- Fifth week after delivery
- Third month after delivery
- Fifth month after delivery
- Follow-up visits every three months until the child reaches age five

Refer to Appendix B: Key Counselling Topics for Postpartum Visits.

CHW home visits will complement postnatal visits to the health facility, so as to ensure continuum of care after the mother and baby leave the health facility and to reinforce advice and instructions given by health providers at the facility. The CHW has an important role to play in order to ensure relevant maternal and newborn care is provided at the community level. The CHW can also help ensure that unresolved problems and complications are referred to a health facility for attention.

Additionally, CHWs will be responsible for identifying women who have just delivered and linking them with service providers at the health facility. Then, the CHW should prepare a schedule of visits, and for each visit, outline specific activities.

CHAPTER 6: NEWBORN AND CHILD CARE

6.0 INTRODUCTION

The majority of newborn mortality occurs within the first few days after delivery, and more than 75% of under-five deaths are due to preventable diseases such as malaria, pneumonia, diarrhoea, measles and malnutrition. Therefore, community child health interventions should focus on **prevention and timely action** to reduce newborn and child morbidity and mortality. The CHW will help to promote health and wellbeing for newborns, infants and children in the community.

6.1 Newborn Care

During home visits, the CHW will counsel the mother, partner and family on the information below:

6.1.1 Care of the newborn in the first 24 hours

During the first 24 hours after birth, CHWs will assist the mother to initiate breastfeeding, and counsel on how to keep the newborn warm and the cord stump clean and dry. If the baby is born at home, the mother should also be advised to go to the health facility within 48hrs for routine care including relevant immunisations. Mothers should know newborn danger signs and be counselled to report to a health facility if any appear. In case of preterm birth/low birth-weight babies, the CHW should advise the mother on special needs, including referral to the health facility, where the mother will be trained on Kangaroo Mother Care (KMC).

6.1.2 Immunisation

CHWs will advise on the importance of having the baby immunised according to National EPI Guidelines, including BCG and Polio-0 at birth, and completing the full immunisation series according to schedule.

6.1.3 Danger signs for the newborn

Mothers, partners and family members should be aware of the danger signs for newborns and that they should report to the health facility immediately if any of these signs occur. The following are some key danger signs for the newborn:

- Fever
- Feels cold/low temperature (hypothermia)
- Redness around the umbilical cord, foul-smelling discharge from the umbilical cord
- Skin rashes/pustules
- Unable to breastfeed
- Excessive crying
- Convulsions
- Non-response to sensory stimulus
- Pale or jaundiced

- Lower chest wall in-drawing (fast breathing)
- Cyanosis (blueness of lips)
- Failure to pass urine or stool

6.1.4 Basic care of the newborn

During newborn home visits, the CHW will promote and provide support for early initiation of breastfeeding (within the first hour of birth if the baby is delivered at home), exclusive breastfeeding, keeping the newborn warm, hygienic umbilical cord care and skin care. In addition, the CHW should assess for general danger signs and refer those with danger signs to a local health facility. The mother should be informed on the importance of birth registration and timely vaccination according to the National EPI Schedule. The CHW should also counsel on the importance of ITN use for baby, mother and family to prevent malaria.

6.2 Infant and Child Care

The CHW will counsel the mother, partner and family on the information below:

6.2.1 Completing immunisation schedule according to EPI

Mothers, partners and families should be advised on the importance of completing immunisation according to EPI schedule.

6.2.2 Regular growth monitoring

CHWs will advise on the importance of regular growth monitoring for the child including weight and height. CHWs should assist the mother to understand and interpret the growth graph of her child.

6.2.3 Use of insecticide-treated bed nets

Mothers, partners and families should be educated on the importance of using ITNs as an effective way of protecting children from malaria.

6.2.4 Danger signs for the infant and child

Mothers, partners and family members should be informed on which symptoms require early attendance at the health facility, such as:

- Cough
- Fever
- Diarrhoea or blood in stool
- Ear pain
- Fast breathing and difficulty with breathing

The following danger signs indicate that the child is very sick and requires **urgent** attendance at a health facility:

- Convulsions
- Continued vomiting
- Lethargy
- Unconsciousness
- Inability to suck or drink

6.2.5 Importance of adherence to treatment

CHWs should explain the importance of correct use of medicines prescribed at the health facility (including correct dose, frequency and duration), when to return to the facility if the child is not improving or deteriorates, and the importance of adhering to follow-up appointments and completion of dosage.

6.2.6 Care of sick child at home

Mothers and family members should be educated on how to care for a sick child at home, including feeding frequency, use of oral rehydration solution (ORS) and zinc for a child with diarrhoea, and care of the child with fever.

6.2.7 Safe disposal of child's faeces and handwashing

CHWs should counsel the mother on the importance of disposing the child's faeces into the latrine, and correct handwashing with soap and running water after disposing of waste and before breastfeeding or preparing food.

6.2.8 Safe drinking water

Drinking water for the household should be boiled (or use water guard) and stored in a clean, covered container.

6.2.9 Harmful practices against children

Mothers, partners and family members should be informed and counselled on harmful practices such as: uvulectomy, removal of dental cyst (plastic teeth) and Female Genital Mutilation (FGM). Disabled children should be given special care depending on the severity of their disability.

6.2.10 Causes, prevention and care of childhood home accidents

The CHW should counsel the mother, partner and family members on prevention of home accidents, such as keeping the child away from fire, medicines, chemicals, sharp and small objects, deep pits and wells.

6.2.11 Early childhood psychosocial development

CHWs should counsel the mother, partner and family members on how to promote interaction that improves child development and psychosocial stimulation.

6.2.12 CHW home visit schedule for newborn and child care

The schedule for CHW home visits for provision of newborn and child care is the same as for the postpartum mother described in Chapter 5. Refer to Appendix B: Key Counselling Topics for Postpartum Visits.

Extra home visits for preterm/low birth weight baby should be done on day two and day 14 after delivery.

CHAPTER 7: INFANT AND YOUNG CHILD FEEDING

7.0 INTRODUCTION

It is important to be sure that women are prepared psychologically and physically for breastfeeding, and to have social support for breastfeeding continuation and introduction of complementary foods at six months. Counselling to encourage optimal breastfeeding practices should begin during pregnancy and be reinforced during the postnatal period.

7.1 Breastfeeding

Early and exclusive breastfeeding is beneficial for the health of the mother and baby. It is recommended that women initiate breastfeeding within one hour after delivery and breastfeed exclusively for six months. After six months and up to 24 months, the mother should continue to breastfeed in addition to introducing complementary foods. HIV-positive mothers should be counselled according to current National PMTCT Guidelines.

CHWs should provide counselling and support in the following areas:

- Advantages of exclusive breastfeeding and the disadvantages of artificial feeding
- Initiation of breastfeeding and benefits of colostrum
- Breastfeeding maintenance
- Support for proper positioning and attachment
- Prevention of common breast conditions
- Special considerations for feeding preterm, low-birth-weight and sick babies
- Introduction of complementary feeding
- LAM as a natural FP method, which includes exclusive breastfeeding as one of three criteria

7.1.1 Benefits of breastfeeding

During home visits before and after birth, CHWs should discuss the benefits of breastfeeding for the mother and the baby.

Benefits for child:

- Decreases exposure to contaminants in water, other milk or formulas, or on utensils
- Meets needs of growing infant
- Is more easily digested than other milk or formulas
- Promotes optimal brain development
- Provides passive immunity and protects against infections
- Provides some protection against allergies
- Strengthens mother-baby bond

Benefits for mother:

- Stimulates uterine contractions in early postpartum and may reduce postpartum blood loss
- Lessens iron depletion by suppressing menses
- Promotes involution (return of uterus to pre-pregnancy state)
- Reduces fertility (decreases risk of pregnancy) without side effects, as long as the LAM criteria are met
- Is economical

NOTE: *Exclusive breastfeeding for six months is recommended both for mothers living with HIV and those who are not.*

7.1.2 Initiation of breastfeeding and benefits of colostrum

CHWs should encourage the mother to initiate breastfeeding within one hour after delivery. The CHW should explain that colostrum is the first milk, yellow in colour, which protects against infection and helps the baby to clear out meconium. Although small in amount, the colostrum is sufficient for the nutritional needs of the newborn until the milk comes in on day three or four postpartum.

7.1.3 Maintenance of breastfeeding

CHWs should counsel and help the mother maintain optimal breastfeeding. This includes an emphasis on the importance of giving the baby **only** breast milk for the first six months.

Optimal breastfeeding means:

- Feed newborn on demand, day and night.
- Breastfeed exclusively for the first six months (baby is given only breast milk, no water, liquids or solid foods except prescribed medicines).
- Introduce complementary foods after six months and continue breastfeeding until the child is two years and beyond.
- Avoid using bottles, pacifiers or any other artificial nipples (cup feeding is recommended).

7.1.5 Positioning and attachment

In addition to counselling, during home visits the CHW should provide support to help the mother with correct positioning and attachment of the baby during breastfeeding.

7.1.6 Prevention of common breast conditions

CHWs should help the mother understand how to prevent and manage common breast conditions including; breast engorgement, sore or cracked nipples, blocked ducts, mastitis and flat nipples. Counselling on prevention of breast conditions should focus on breastfeeding on

demand (day and night) and proper positioning and attachment. The CHW should encourage the mother to report to a health facility if any breast conditions appear.

7.1.6 Support for feeding of preterm, low birth weight and sick babies

CHWs should give special support to mothers who are breastfeeding preterm, low birth weight and sick babies. The CHW should encourage the mother to breastfeed more frequently (every two to three hours) and reassure the mother that she can breastfeed her small baby and she has enough milk. CHWs should also explain to the mother that a small baby does not feed as well as a full-term baby, because small babies suck weakly, have long pauses between suckling, fall asleep during feeding, become tired easily and do not always wake up for feeds.

7.2 Complementary Feeding

Proper infant feeding practices are essential for the baby's growth and development. Mothers and caretakers often need guidance and support on how and when to introduce foods. CHWs should provide guidance and support.

7.2.1 How and when to introduce foods

Complementary feeding for all infants (including infants who continue breastfeeding) requires nutritious foods beginning at six months of age. Types of foods and methods of complementary feeding should be based on locally available foods and feeding practices. These recommendations should include specific guidance on the best nutrition for the baby from 6–9 months, 9–12 months, 12–24 months, and 24 months and beyond. In addition to the complementary feeding, the woman should continue also to breastfeed for the first 24 months. For mothers with HIV, they can continue to breastfeed through 12 months as long as the baby is on antiretroviral (ARV) medicine. Mothers who are living with HIV and their infants should seek guidance on infant feeding at the local health facility.

Caregivers should begin introducing complementary foods in small amounts at six months of age, gradually increasing the amount and variety of foods as the infant gets older, adapting to the infant's nutritional requirements and physical ability. They should be encouraged to introduce additional food slowly and patiently, encouraging the child to eat, not force feeding, and avoiding giving the baby drinks, such as tea and soda, with no nutritional value.

7.2.2 Food preparation and hygienic practices

Mothers and caretakers should be counselled on food preparation based on locally available foods. It is recommended that foods be well-cooked, mashed or ground so that they are smooth and easy for the infant to swallow. Proper hygiene and handling practices when preparing and storing foods should be explained and demonstrated, including handwashing before food preparation and feeding the baby, safe storage of foods, serving foods immediately after preparation, and proper cleaning of utensils used to prepare and serve food.

7.2.3 Age-appropriate feeding recommendations

The following are age-appropriate feeding recommendations:

BIRTH–6 MONTHS	6–9 MONTHS	9–12 MONTHS	1–2 YEARS	2–5 YEARS
<ul style="list-style-type: none"> Exclusively breastfeed on demand, day and night (not less than 10 times per 24 hr). Give no liquid or other foods. 	<ul style="list-style-type: none"> Breastfeed on demand, day and night. Introduce other foods (thick porridge, smashed banana, potatoes, minced meat, fish, beans, ground nuts). Start with 2–3 tablespoons 2 times a day. At seven months, increase gradually to 2/3 of 250 mL cup, 3 times a day. Add 1 spoonful of oil to each feed and use iodized salt. If not breastfeeding, give 1–2 cup of 250 mL fresh milk/day and 2 more extra meals. 	<ul style="list-style-type: none"> Breastfeed on demand day, and night. Continue to give thick porridge, smashed banana, potatoes, minced meat, fish, beans, ground nuts. Increase gradually to ¾ of 250 mL cup, 3 times a day. Give snacks in between meals (milk, juice or bite). Add 1 spoonful of oil to each feed and use iodized salt. Give fruits such as paw-paw, avocado, ripe banana. If not breastfeeding, give 1–2 cup of 250 mL fresh milk a day and 2 more extra meals. 	<ul style="list-style-type: none"> Continue breastfeeding on demand. Give family foods that are smashed, 3 meals per day (250 mL per feed). Give snacks in between meals (milk, juice or bite). Give fruits such as paw-paw, avocado, ripe banana. 	<ul style="list-style-type: none"> Give 3 family meals a day. Give snacks in between meals. Give fruits such as paw-paw, avocado, ripe banana.

7.3 Nutritional Supplementations

Mothers, partners and families should be informed on the importance of nutritional supplementations, including:

- Vitamin A at nine months, repeated every six months up to age of five years
- Use of iodized salt at six months
- Foods rich in iron after six months

Mothers and caretakers should be advised on regular deworming of their children, beginning at the age of one year, repeated every six months up to the age of five years.

CHAPTER 8: COMMUNITY-BASED FAMILY PLANNING

8.0 INTRODUCTION

Family planning involves individuals, couples or partners making voluntary and informed decisions on when to have children, the number of children they want to have and the interval between pregnancies using FP methods of their choice. All people irrespective of their parity and marital status have a right to access FP information, education and services. Family planning can help mothers and couples determine the family size they want and have their babies when they choose and not just because it happens.

CHWs should be able to counsel clients on the benefits of FP, and the wide range of contraceptive methods available to them (including short-acting, long-acting and permanent methods). They should be able to refer clients to health facilities for FP services, where they can obtain family planning methods, in-depth counselling, and can seek management for any complications.

8.1 Counselling on FP

During antenatal and postpartum home visits and other community events, the CHW will counsel and provide health education on family planning. Women, partners, and families should be advised that regulated childbearing through use of FP methods reduces health problems associated with the following:

- Early pregnancies (less than 20 years of age)
- Closely spaced pregnancies (less than two years between birth and start of next pregnancy)
- High parity (more than four pregnancies)
- Pregnancy at late age (more than 35 years of age)
- Unwanted pregnancies
- Abortions
- Maternal/infant/child illness and death

8.2 Family Planning Methods Available in Tanzania

The CHW should inform women and their partners about the range of modern FP methods available and suitable for postpartum women in Tanzania. CHWs will refer women to the health facility for more in-depth counselling on specific methods suitable to their needs.

Available FP methods in Tanzania include:

- Short-acting methods:
 - Natural methods: LAM
 - Oral pills: combined oral contraceptives (COCs) and progestin-only pills (POPs)

- Injectables: Depo-Provera
- Condoms: female and male condom
- Long-acting methods:
 - Implants
 - Intrauterine contraceptive device (IUCD)
- Permanent methods:
 - Voluntary surgical contraception (VSC): vasectomy, tubal ligation

Not all FP methods listed above are suitable for postpartum women. CHWs should be able to counsel postpartum women on LAM and the transition to another modern family planning method, and refer women to the health facility as early as six weeks postpartum for more in-depth FP counselling and service provision.

8.3 Benefits of Healthy Spacing of Pregnancy

CHWs should explain to the mother, partner and family the importance of waiting at least two years from the birth of a baby before attempting the next pregnancy. The benefits of pregnancy spacing are:

- For the health of the mother: her body will be stronger when taking care of her family; helps reduce problems during pregnancy; she will experience less work burden.
- For the health of the baby: helps prevent babies from coming early and small; helps the baby grow stronger; allows longer period of breastfeeding and more mother/infant bonding.
- For the health of the family: more money and time to extend care to everyone in the family.
- For the health of the country: strong, healthy workers; greater financial and other resources available to more people.

8.4 Return to Fertility

The mother should be made aware of when she can become pregnant after delivery. She should be informed about the following:

- The return to fertility is not predictable. Women may become pregnant before their menses returns.
- To protect against pregnancy, mothers need to use a family planning method:
 - Within six weeks after birth if breastfeeding
 - Within three weeks after birth if not breastfeeding

8.5 Lactational Amenorrhoea Method

CHWs should emphasise the importance of LAM as a family planning method for breastfeeding mothers. LAM is a temporary method of contraception for postpartum mothers that uses exclusive breastfeeding to prevent pregnancy. It is based on the natural effect of breastfeeding on fertility.

To be effective, CHWs should explain that LAM requires all three of the following criteria:

1. Menses has not returned.
2. Exclusively breastfeeding day and night, on demand.
3. The baby is less than six months old.

LAM is consistent with recommended exclusive breastfeeding practices, and has the following advantages:

- Is effective, safe, non-hormonal
- Is non-invasive, suitable for most women
- Is immediately available, no supplies or procedures needed
- Has no medical appointment required
- Has no cost
- Can be used by mothers with HIV
- Allows time for the couple to decide on another contraceptive method
- Generates effective breastfeeding practices
- Promotes infant nutrition and protects baby from diseases
- Promotes mother-infant bonding

8.6 The Transition from LAM to Other Modern FP Methods

It should be emphasised that LAM is a short-term method and can protect against pregnancy only for as long as the three criteria are met. As soon as one of the three criteria changes, the couple should switch to another method. Women who are not practicing LAM or whose LAM criteria are no longer met should switch to another appropriate FP method after consulting with a health care provider.

8.7 Male Involvement in Family Planning

CHWs should encourage partners to participate in FP counselling sessions and to share in decision-making about FP choices. If a woman feels that including her partner is a barrier to FP use, the choice of the woman should be respected. However, reliable FP will be more successful if both partners are informed and in agreement regarding their contraception choices.

8.8 Postpartum Family Planning Counselling and HIV/STIs

During PFP counselling, CHWs should emphasise HIV/AIDS and STI prevention. Information must include that the condom is the only method that can provide prevention against HIV transmission, STIs and unintended pregnancy simultaneously. People with HIV have the right and need for counselling, care and access to FP methods. They also have the right to know their HIV status and make informed decisions about infant feeding. CHWs should explain that when ARVs are used, HIV-positive women can also use LAM.

8.9 Follow-Up Visits

The postpartum mother should be informed by the CHW to return to the health facility:

- For re-supply of her method before it is finished or effectiveness has expired.
- If she experiences side effects or complications.
- When she wishes to change or stop her method.
- When or if she wishes to conceive.

CHAPTER 9: PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV IN THE COMMUNITY

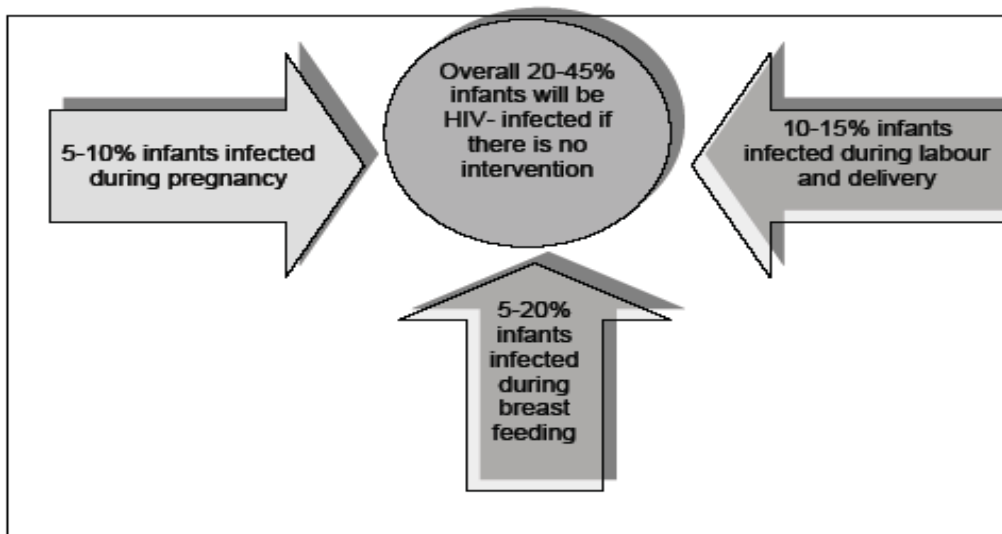
9.0 INTRODUCTION

Mother-to-child transmission of HIV (MTCT) is responsible for more than 90% of childhood HIV infections worldwide.¹⁵ The risk of transmission of HIV from the mother to the baby during pregnancy, labour, delivery and breastfeeding should be explained by the CHW during home visits. CHWs should also counsel on strategies for PMTCT and resources for follow-up care, treatment and support. If the mother discloses her positive serostatus, CHWs should facilitate referrals and linkages to HIV treatment, care and support to ensure that the mother and child receive ongoing care.

9.1 Risk of Mother-to-Child Transmission of HIV without Interventions

Most MTCT occurs during labour and delivery, but depending upon breastfeeding practices and duration, there is also risk of HIV transmission to the infant during breastfeeding. Without intervention, 20–45% of infants born to mothers infected with HIV can acquire HIV during pregnancy, labour, delivery and breastfeeding.

Figure 9.1 Estimated HIV outcomes of infants born to women infected with HIV



Source: Tanzania National PMTCT Guidelines 2012

Note: The figure gives an overall picture of possible outcomes. There will be variability among different populations nationally.

¹⁵ MOHSW 2011

9.2 Transmission of HIV

The community should be informed that HIV can be transmitted through: unprotected sexual contact; infected blood and blood products; unsterilized/contaminated instruments including needles; and MTCT (which can occur during pregnancy, delivery and breastfeeding).

9.2.1 Risk factors

The CHW should explain the risk factors for HIV infection, such as having multiple sexual partners, unprotected sex, alcoholism, drug abuse, gender-based violence, and handling of contaminated linen and body fluids without protective gear.

9.2.2 Misconceptions about HIV transmission

The CHW should seek to dispel misconceptions about HIV transmission. HIV is **not** transmitted through handshaking, insect bites, coughing, sneezing, hugging, sleeping or eating together, or sharing utensils and toilets.

9.3 Testing Process and Confidentiality

CHWs should counsel about what to expect if one decides to go for HIV testing. Clients should be made aware that HIV is tested by taking blood, and the results will be confidential and given on the same day. The test can be done on an individual basis or as a couple.

9.3.1 Advantages of counselling and testing for HIV

CHWs should counsel mothers and partners on the importance of HIV testing, which will enable them to learn their HIV status, help them take necessary precautions to avoid transmission to the baby, and support women in disclosure decisions.

9.3.2 HIV-related stigma and discrimination

CHWs should avoid stigmatising people living with HIV (PLHIV) and should be aware that stigma can discourage mothers/couples from getting tested for HIV, disclosing their test results, taking ARV treatment or prophylaxis, and accepting safer infant-feeding practices, resulting in social exclusion and continued spreading of HIV.

9.4 Interventions for PMTCT

CHWs will advise mothers, partners and families about the interventions which can reduce transmission of HIV from mother to child, including:

9.4.1 Interventions during ANC

CHWs should counsel mothers that all women, regardless of their serostatus, should receive the same basic services. However, obstetric and medical care is expanded to address the specific needs of women living with HIV. In addition, HIV-positive pregnant women should receive ARV prophylaxis at the facility from 14 weeks of pregnancy.

9.4.2 Interventions during labour and delivery

Most HIV transmission to infants occurs during labour and delivery. There are medical interventions that can help prevent transmission during this time. Therefore, the CHW should emphasise the importance of health facility delivery, where mothers can receive additional ARV prophylaxis.

CHWs should inform the mothers who have not been tested for HIV that HIV testing can be done during labour and after delivery at the health facility. Women whose HIV status is positive should be provided with ARV prophylaxis for PMTCT.

9.4.3 Intervention during the postpartum period

CHWs should encourage postpartum mothers living with HIV (who have disclosed their serostatus) to attend postnatal services as scheduled, and provide social and psychosocial support and home-based care services as needed.

Women living with HIV should also have access to FP counselling and services, and should be educated on the benefits of healthy timing and spacing of pregnancies. Women living with HIV who are on ARVs and exclusively breastfeeding can use LAM as their FP method for up to six months if all three LAM criteria are met.

Through visits during pregnancy and postpartum periods, CHWs should also be able to identify some symptoms and signs of common opportunistic infections and refer to the facility as needed.

9.4.4 ARVs for mother and infant

CHWs should explain that ARV medication does not cure HIV infection. The medication does, however, slow the reproduction of HIV, thus reducing viral load. ARVs given to the pregnant woman and/or her newborn greatly reduce the risk of MTCT for HIV-infected mothers and HIV-exposed infants. CHWs should inform the mother and the family members that ARV prophylaxis is provided at the facility, from the gestational age of 14 weeks, and additional ARV prophylaxis will be provided during labour and delivery according to the National PMTCT Guidelines. Emphasis should also be given to the importance of adherence to ARV prophylaxis/treatment and follow-up for both mothers and infants.

9.4.5 Follow-up of HIV-exposed infant

HIV can progress very rapidly in children infected in utero. Therefore, the CHW should encourage mothers with HIV-exposed infants to have regular follow-up visits at the health facility for close monitoring according to the schedule.

Exposed children should be referred to a health facility where they can be tested for HIV at four weeks. All HIV-exposed infants should receive cotrimoxazole prophylaxis according to the National PMTCT Guidelines. CHWs should follow up with HIV-exposed infants and encourage families to take them to the health facility according to the schedule given by the health care provider until their serostatus is confirmed.

CHAPTER 10: COMMUNITY INVOLVEMENT AND PARTICIPATION

10.0 INTRODUCTION

CHWs will work to mobilise communities to be involved and participate in implementing interventions that will contribute to their own community's health.

10.1 Community Involvement

Community involvement is the process whereby community members are called to participate in various aspects of activities, including planning, implementation and monitoring of community MNCH services. Community involvement is considered an essential element of most health and development programmes in the community. Involvement creates a more supportive environment and sense of community ownership that enables individuals to adopt and maintain new behaviours, extends the reach and scope of interventions, and shortens delays for seeking care. More broadly, increasing community participation in MNCH activities can help the community to develop an increased awareness and sense of shared community responsibility for MNCH.

10.2 Community Empowerment

Community empowerment is a process of enabling the community to make decisions and take appropriate actions on matters affecting them. Communities should be able to:

- Identify priority problems and **possible solutions**.
- Identify available resources and plan for increased resource generation to enhance an improved resource base.
- Facilitate provision of education and sensitisation activities.
- Initiate interventions independent of external support.
- Make contact with partners for technical support and resource mobilisation, while at the same time retaining control over the use of certain resources.
- Develop mechanisms for transparency and accountability of resources and delineation of responsibilities for implementation of activities.
- Develop mechanisms for shared responsibility in MNCH activities.

10.3 Potential Community Partners

CHWs should consider involving the following members of the community to support MNCH care in the community:

- Community-based distributors (CBDs)
- Religious leaders
- Influential people/advocates
- Extension workers

- Village health committees
- TBAs and traditional healers
- Community-based organisations (CBOs)/nongovernmental organisations (NGOs)
- Other local groups and clubs including sports clubs, drama groups, etc.
- Representative of youth groups
- Local government council
- Other public institutions including schools, hospitals, banks, police, etc.
- Private institutions such as private clinics, schools, mass media, etc.
- Other non-health-related community owned resource persons (CORPs)

10.4 Ways to Involve Men in MNCH

Men are often decision-makers in the household, so it is critical to determine how they can be involved to support MNCH care.

The CHW should consider involving men in:

- Educating other men through community dialogue and advocacy
- Providing support for MNCH care
- Participating in FP Counselling and decision-making (as appropriate)
- Going with women to their health facility appointments
- Raising awareness of danger signs
- Testing and counselling for HIV

10.5 Roles of Different Levels in Supporting Community MNCH

10.5.1 Household level

- Ensure shared responsibility for MNCH in the family.
- Empower women to have decision-making power and resource ownership.
- Promote health-seeking behaviour and birth preparedness, including MNCH care and referral.
- Promote positive health behaviours in the home, including those related to maternal, newborn and child health, PMTCT, and healthy timing and spacing of pregnancies.

10.5.2 Village government

- Enable community sensitisation, mobilisation and organisation.
- Strengthen village health committees.
- Participate in selection of CHWs.

- Develop mechanism for supporting CHWs including motivation and retention.
- Provide health education and promotion with support from CHWs.
- Identify and discourage risky behaviours.
- Promote and support early attendance at ANC, birth preparedness and importance of facility delivery and follow up after delivery.
- Implement community management information system.
- Support immunisation services.
- Ensure registration of pregnancies, births and deaths.
- Establish and use maternal waiting homes and timely referral.
- Provide support for referrals to health facilities in case of emergencies.
- Plan and implement village health days.

10.5.3 Health facility

- Provide technical support and supportive supervision to CHWs.
- Ensure availability of CHW supplies and tools.
- Monitor and supervise CHWs.
- Ensure continuous availability of high-quality services.
- Ensure continuum of care from the facility to the community.
- Provide timely response to emergencies and outbreaks in the community.
- Collaborate with village government in selection of CHWs.
- Follow up on CHW referrals.
- Collect and compile CHW monitoring reports.
- Share information and feedback with village government leaders and CHWs.
- Act as a link amongst the health management team, the facility and CHWs.

10.5.4 Council Health Management Team (CHMT)

- Conduct participatory planning for MNCH interventions.
- Advocate and provide sensitisation amongst various stakeholders MNCH issues.
- Collect and analyse data for planning purposes.
- Train various actors on MNCH.
- Coordinate implementation and link with different stakeholders implementing MNCH interventions.
- Facilitate care-seeking through provision of transport for referral.
- Ensure availability of CHW supplies and tools.

- Incorporate community activities within the Council Comprehensive Health Plan (CCHP).

10.5.5 CBOs and other partners

- Link with CHWs for the following:
 - Organise and participate in community sensitisation events.
 - Advocate for MNCH with village government leaders, health facilities and other groups.
 - Provide support for most vulnerable children and PLHIV.

10.5.6 Regional level

The regional level is the operating arm of the central government and links with the local councils in implementing the following strategies:

- Coordinate and interpret national health policy, guidelines and directives.
- Coordinate and link the NGOs and other partners working in the region.
- Ensure capacity-building for districts/councils on MNCH.
- Provide quality assurance.
- Collect and analyse data for planning purposes and mobilize resources, supplies and human resource for health.
- Provide technical support.
- Facilitate networking amongst different partners in health.

10.5.7 Central level

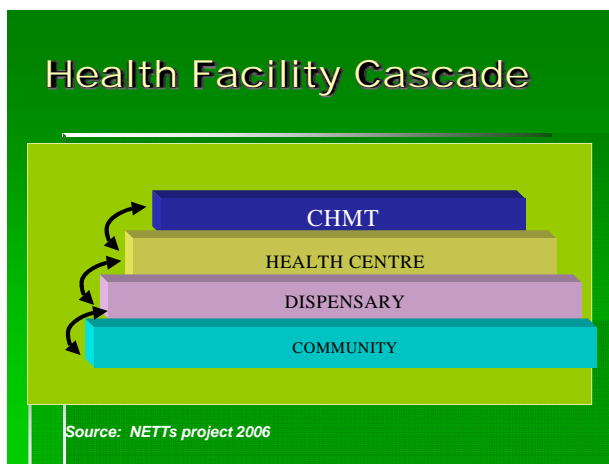
- Formulate and review the guidelines in line with national health policies.
- Provide capacity development to regions and districts/councils for participatory needs assessment and planning.
- Liaise with other sectors and donors in community-related interventions.
- Allocate resources.
- Ensure that community management information system is part of health management information system.
- Implement monitoring policy.
- Ensure equity of health services.
- Provide quality assurance.
- Provide technical support and feedback.
- Advocate for community health issues.

CHAPTER 11: INTEGRATED MANAGEMENT CASCADE AND SUPPORTIVE SUPERVISION

11.0 INTRODUCTION

Management and supervision systems are essential to the successful, ongoing implementation of community MNCH activities. Community MNCH activities will be implemented through the Integrated Management Cascade (IMC).

IMC is focused largely on increasing capacity for the downwards delegation of administrative duties to community-level workers (so that those workers become more engaged in the process of improving health care delivery). IMC was designed to ensure the smooth operation of the health system by improving the links between CHWs and supervisory personnel. This strategy aims to enhance and improve self-sufficiency, decision-making, communication, advocacy and involvement within district health facilities, and to promote the participation of frontline health workers in district health plan activities and health sector reform implementation.



11.1 Clinic-Based CHW Supervisors

The immediate supervisors of the CHWs are based at the local health facility. Where cascades are already in place, CHWs will be supervised by cascade supervisors.

Selection criteria:

- CHW supervisors should be recruited from health facilities within the CHW catchment areas.
- CHW supervisors should have prior knowledge of and experience with MNCH.
- They should have successfully completed a course in supervision of CHWs on MNCH.
- They should be willing to support and mentor CHWs.

Training:

CHW Supervisors will be trained using the standard Community MNCH Training Package. The following standardised training materials and documents in their most current edition should be used:

- National Integrated Community MNCH Guidelines
- Integrated Community MNCH Trainers' Guide
- Integrated Community MNCH Reference Manual for Community Health Workers
- Integrated Community MNCH Supervisors' Guide
- Community MNCH job aids and information, education communication (IEC) materials

11.2 Roles and Responsibilities

Roles and responsibilities of the CHW supervisors will include:

- Maintain a record of CHWs working in their catchment area.
- Develop a supervision plan.
- Provide technical support to CHWs to facilitate community mapping and household census.
- Provide technical support to CHWs in the process of conducting household visits and other sensitization activities for community members on MNCH services.
- Provide support for CHW in planning monthly activities and organizing community education.
- Conduct quarterly meetings to discuss implementation of planned activities by CHWs and provide technical support accordingly.
- Collect and submit data collected at community level.
- Manage referrals made by CHWs to health facilities.
- Coordinate and collaborate with village government, district level and partners and develop an inventory of stakeholders within the Service Area.

11.3 Supportive Supervision

Supervisors are expected to practice supportive supervision of CHWs. Supportive supervision promotes high-quality health services at all levels by strengthening the CHW relationship with the health system, focusing on the identification and resolution of problems, and helping to optimise the allocation of resources. CHW supervisors should provide support to CHWs as needed, in order to facilitate provision of high-quality community MNCH services in CHW catchment areas.

CHAPTER 12: MONITORING AND EVALUATION

12.0 INTRODUCTION

Monitoring is the routine tracking of key activities, so as to compare actual performance against expected outcomes. Evaluation is the periodic assessment of activities/services in line with set objectives to assess quality of service, outcomes and impact. A monitoring and evaluation (M&E) system will help to track accomplishments, monitor CHW performance and identify areas where more support or resources are needed.

This chapter provides an overview of the M&E strategy for community MNCH activities. It presents an overview of the tools to be used, the data collection and reporting processes, and the indicators that will be tracked.

12.1 Goals for M&E

Information gathered through M&E can be used to evaluate progress towards national targets and for programme planning.

M&E goals for community MNCH activities are to:

- Record utilisation of MNCH services at community level.
- Track the progress of implementation against national targets.
- Ensure continuous improvement in quality of services.
- Facilitate evidence-based programme planning.
- Provide feedback (successes and shortcomings) to the implementers, community and other stakeholders.

12.2 National Targets for Community MNCH

Community MNCH services will be implemented as part of the national vision for improving MNCH outcomes. The table below shows how the community MNCH activities can contribute to improving national targets for maternal, newborn and child health, as articulated in the *National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania, 2008–2015*.

NATIONAL TARGETS
<ul style="list-style-type: none">• Increased coverage of births attended by skilled attendants from 46% to 80%.• Increased immunization coverage of DTP-HB 3 and measles vaccine to above 90% in 90% of the districts.• Reduced stunting and underweight status among under-fives from 38% and 22% to 22% and 14%, respectively.• Increased exclusive breastfeeding coverage from 41% to 80 %.• PMTCT services provided to at least 80% of pregnant women, their babies and families.• Increased coverage of under-fives sleeping under ITNs from 47% to 80%.• 75% of villages have community health workers offering MNCH services at community level.

NATIONAL TARGETS

- Increased modern contraceptive prevalence rate from 20% to 60%.
- Increased antenatal care attendance for at least 4 visits from 64% to 90%.

12.3 Indicators for Community MNCH Activities

The table below presents the indicators for the community MNCH activities.

S/N	INDICATOR	DEFINITION
1	Number of women of reproductive age (15–49 year) within the village	Number of women living in the village in the age group 15–49 years
2	Number of children in the village under five years	Number of children living in the village who are from 0 to five years of age
3	Number of children in the village under one year	Number of children living in the village who are under one year of age
4	Number of women visited	Number of women visited by a CHW provided with at least one home visit
5	Number of women delivering at home	Number of women visited by a CHW who have delivered at home
6	Number of women visited during pregnancy by CHW	Number of home visits during pregnancy (Visit 1, Visit 2, Visit 3, Other visits) conducted by a CHW; a visit is counted only when a service is provided
7	Number of women visited after delivery conducted by CHW	Number of home visit after delivery (Visit 1, Visit 2, Visit 3, Visit 4, Visit 5, Visit 6, Visit 7) conducted by a CHW; a visit is counted only if a service is provided
8	Number of children under one year visited by a CHW	Number of home visit after delivery (Visit 1, Visit 2, Visit 3, Visit 4, Visit 5, Visit 6, Visit 7) conducted by a CHW; a visit is counted only if a service is provided
9	Number of children vaccinated with BCG	Number of children under one month vaccinated with BCG
10	Number of children vaccinated with Polio-0	Number of children under one month vaccinated with Polio-0
11	Number of children vaccinated with DTP-HB+Hib vaccine = PENTA-3	Number of children under one year vaccinated with all three doses of PENTA-3
12	Number of children vaccinated with measles	Number of children under one year vaccinated with measles
13	Number of newborns who were breastfed within first hour after childbirth	Number of new born babies who were breastfed within the first hour after childbirth
14	Number infants reported to have been exclusively breastfed for three months	Number of children from one month up to one year old, reported to have been exclusively breastfed for three months <i>Exclusive breastfeeding covers feeding using breast milk only, on demand day and night, without giving any other foods, not even water.</i>

15	Number of infants reported to have been exclusively breastfed for six months	Number of children from one month up to one year old, reported to have been exclusively breastfed for six months <i>Exclusive breastfeeding covers feeding using breast milk only, on demand day and night, without giving any other foods, not even water.</i>
16	Number of postpartum mothers using modern FP method at six weeks post-delivery	Number of women visited by a CHW after delivery who are using a modern method of FP six weeks after having delivered
17	Number of postpartum mothers using modern FP method at five months post-delivery	Number of women visited by a CHW after delivery who are using a modern method of FP five months after having delivered
18	Number of maternal deaths at community level	Number of women who have died due to pregnancy-related complications, delivery and up to 42 days after delivery in the community
19	Number of mothers with abortion before 28 weeks gestation	Number of mothers who have miscarried 28 weeks of pregnancy
20	Number of neonatal deaths occurring in the community	Number of children up to 28 days old who have died in the community
21	Number of infants deaths within the community	Number of infants, includes children up to one year of age, who have died in the community
22	Number of deaths of children under-fives years in the community	Number of children from between birth and five years who have died in the community
23	Number of confirmed referrals given by CHW during pregnancy	Number of confirmed referrals given during home visits during pregnancy given by CHW
24	Number of confirmed referrals given by CHW after delivery	Number of confirmed referrals given during home visits after delivery given by CHW
25	Number of confirmed referrals for immunization	Number of confirmed referrals on immunization given by CHW
26	Number of confirmed referrals for FP	Number of confirmed referrals on FP given by a CHW
27	Number of confirmed referrals for PMTCT	Number of confirmed referrals for PMTCT given by a CHW

12.4 Reporting System Overview

Community MNCH activities will require data collection at various levels and at various points in time using a series of standardized data collection tools.

The main data that the CHWs collect will be recorded in the CHW Home Visit Register. The CHW register contains information on all of the basic components of their work, including:

- Demographic information of the client
- Visits completed and timing of visits
- Services provided at each visit

Forms in CHW Reporting System

CHW Level:

Home Visit Register
Referral Form
Monthly Tally Sheet
Monthly Summary Form

Facility Supervisor Level:

Village Monthly Summary Form

District Level (DRCHCo for DMO's office):

Quarterly District Summary Form

- Number of referrals for mother during pregnancy and postpartum periods
- Number of newborns and children referred
- Maternal and child mortality

CHWs will use the Referral Form to track and follow-up on referrals made at community level.

On a monthly basis, the CHW will compile the information from the register into the Monthly Summary Form.

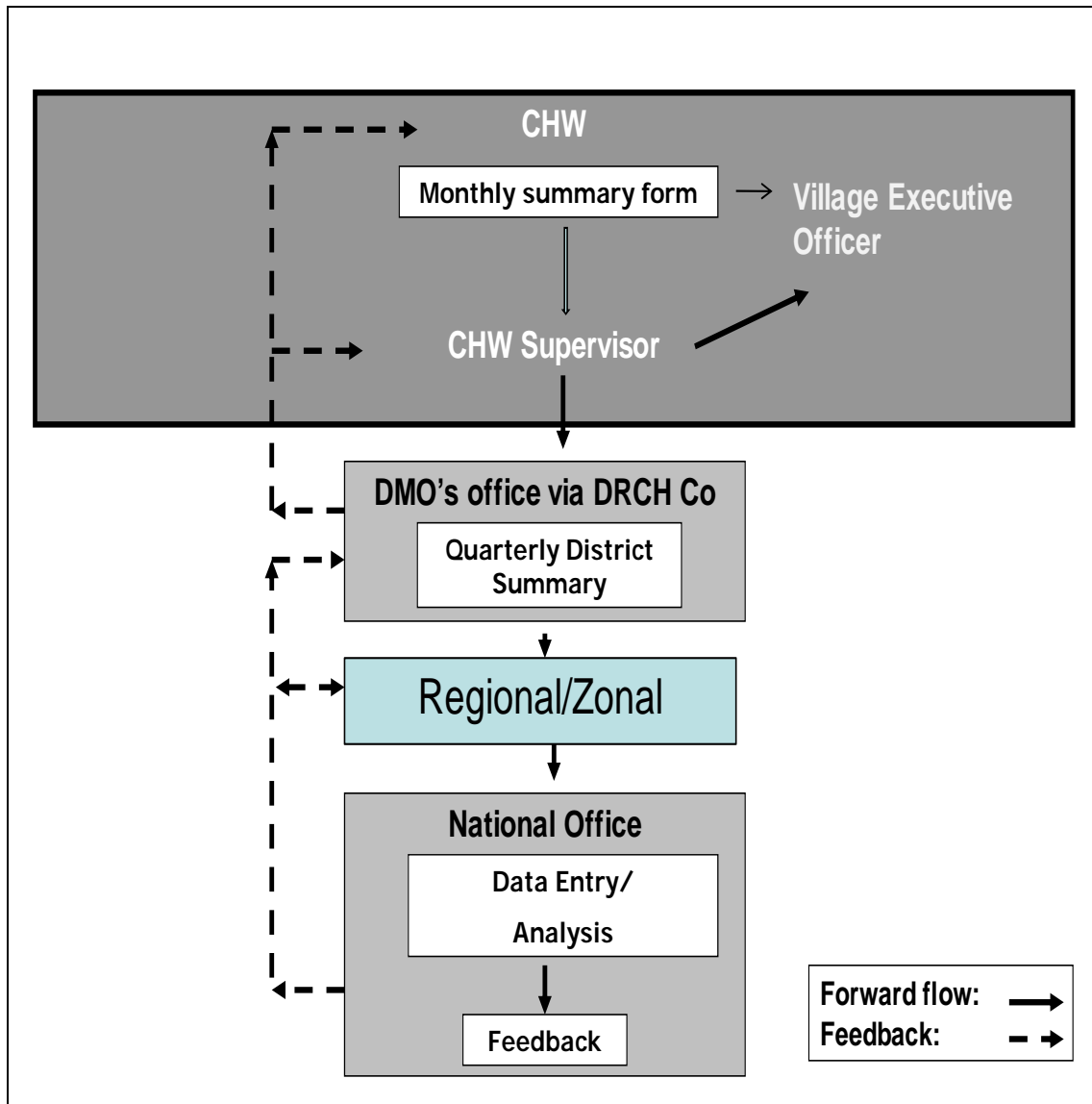
Three copies of the Monthly Summary Form will be shared: one for the village government authorities (Village Health Secretary), one for the CHW supervisor, and one for the CHW's own records. The CHW will deliver the Monthly Summary Form to his/her supervisor by the third day of the month following the service delivery.

The CHW supervisor based at the health facility will combine all of the CHW Monthly Summary Forms for each village into the Village Monthly Summary Form. He or she will take the form by the 5th day of the month following the service delivery to the District Reproductive and Child Health Coordinator (DRCHCo) and provide a copy to the village government authorities (Village Health Secretary).

The DRCHCo will aggregate the information from the Village Monthly Summary Form, into the Quarterly District Summary Form on a quarterly basis, to be reported to the RMO's office through the Regional Reproductive and Child Health Coordinator (RRCHCo). The RMO will report quarterly to central level.

This data flow is illustrated in Figure 12.1.

Figure 12.1 Hierarchy of reporting system



APPENDIX A: KEY COUNSELLING TOPICS FOR ANTENATAL CARE VISITS

Make at least three home visits to each pregnant woman in the community:

VISITS	TOPICS COVERED
<p>FIRST VISIT As early as the CHW identifies a pregnant woman</p>	<ul style="list-style-type: none"> • ANC Booking • Pregnancy Danger Signs • Nutrition during Pregnancy • Individualized Birth Preparedness • Malaria Prevention • HIV/AIDS General Information • PMTCT for the Mother • Gender Issues
<p>SECOND VISIT About six months of pregnancy</p>	<ul style="list-style-type: none"> • ANC Booking • Pregnancy Danger Signs • Nutrition during Pregnancy • Individualized Birth Preparedness • Breastfeeding • Malaria Prevention • PMTCT for the Mother
<p>THIRD VISIT About eight months of pregnancy</p>	<ul style="list-style-type: none"> • Pregnancy Danger Signs • Individualized Birth Preparedness • Postpartum Danger Signs • Immediate Newborn Care • Breastfeeding • LAM • Postpartum Family Planning • Newborn Danger Signs • Infection Prevention and Control • PMTCT for the Mother • Follow-Up for the HIV-Exposed Infant • Postpartum Physiological Changes

APPENDIX B: KEY COUNSELLING TOPICS FOR POSTPARTUM VISITS

Make at least seven home visits to all postpartum women in the community:

VISITS	TOPICS COVERED
<p>FIRST HOME VISIT Within 24 hours after discharge from the health facility or home birth</p>	<ul style="list-style-type: none"> • Maternal Nutrition • Postpartum Danger Signs • Immediate Newborn Care • Breastfeeding • Care of the Normal Newborn • Care of the Premature Baby • Newborn Danger Signs • Malaria Prevention • Immunization • Infection Prevention and Control • HIV/AIDS General Information • Postpartum Care for the Mother • Postpartum Physiological Changes
<p>SECOND HOME VISIT Third day after discharge</p>	<ul style="list-style-type: none"> • Postpartum Danger Signs • Breastfeeding • Care of the Normal Newborn • Care of the Premature Baby • Newborn Danger Signs • Follow-Up of HIV-Exposed Infants • Postpartum Care for the Mother • Postpartum Physiological Changes
<p>THIRD HOME VISIT Eighth day after discharge</p>	<ul style="list-style-type: none"> • Maternal Nutrition • Postpartum Danger Signs • Care of the Normal Newborn • Care of the Premature Baby • Newborn Danger Signs • Malaria Prevention • Postpartum Care for the Mother
<p>FOURTH HOME VISIT Third week after delivery</p>	<ul style="list-style-type: none"> • Maternal Nutrition • Breastfeeding • LAM • Postpartum Family Planning • Newborn Danger Signs • Immunization • Follow-Up of HIV-Exposed Infants

VISITS	TOPICS COVERED
<p style="text-align: center;">FIFTH HOME VISIT Fifth week after delivery</p>	<ul style="list-style-type: none"> • Breastfeeding • LAM • Postpartum Family Planning • Malaria Prevention • Immunization • Infection Prevention and Control • Follow-up of HIV-exposed Infants • Birth Registration
<p style="text-align: center;">SIXTH HOME VISIT Third month after delivery</p>	<ul style="list-style-type: none"> • Breastfeeding • LAM • Postpartum Family Planning • Malaria Prevention • Immunization • Child Danger Signs • Gender Issues • Birth Registration
<p style="text-align: center;">SEVENTH HOME VISIT Fifth month after delivery</p>	<ul style="list-style-type: none"> • Breastfeeding • LAM • Postpartum Family Planning • Malaria Prevention • Immunization • Complementary Feeding • Child Danger Signs • Infection Prevention and Control • Prevention of Accidents • Growth and Development
<p style="text-align: center;">FOLLOW-UP VISITS Once every three months up to age five years</p>	<ul style="list-style-type: none"> • Postpartum Family Planning • Malaria Prevention • Immunization • Complementary Feeding • Child Danger Signs • Infection Prevention and Control • Prevention of Accidents • Growth and Development • HIV/AIDS General Information • Gender Issues

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