FutureGenerations

Empowering Communities to Shape Their Futures

EMPOWERING COMMUNITY HEALTH WORKERS

TO TEACH MOTHERS FOR BETTER MATERNAL & CHILD HEALTH

'HOW-TO' GUIDE

FOR THE

Learning/Teaching Method "SHARING HISTORIES"

AND THE

Modular Training Program in Maternal, Neonatal, Child, and Adolescent Health for Community Health Workers

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If you are an outsider working with communities, as a government primary health care provider, private NGO staff, consultant, or volunteer, you have seen the challenges of helping each community get on its own path to development. Some communities are distrustful of outsiders due to previous promises that were made and broken. Other communities have become accustomed to receiving help that arrives on their doorstep, but when the help stops, despondency soon sets in. On the other hand, evidence from global research shows that when communities are empowered to move forward on their own path to development, they will usually do so in an equitable and sustainable way. That is an important goal globally.

But what are the best practices to achieve and scale up community-based social change that is equitable and sustainable? This is the big question that we are always searching to answer. Future Generations University (www.future.edu) and its global family of organizations (www.future.org) seeks a global shift in practice that promotes partnerships between communities, governments, and organizations to achieve community change in health, conservation, peace-building, and action that builds from successes in every community guided by evidence. The focus of action is on changing behaviors as the outcome *to achieve just and lasting futures* for these communities. Effective practices that fit the local ecology, culture, and economy, that respect the dignity of every human being, and that focus on the well-being of families, children, and community will contribute to a better world for present generations and generations yet to come.

This "How-To" Guide is about the process of empowering women to practice healthy behaviors. The focus is on achieving better home-based knowledge and behaviors for maternal, newborn, and child health. To do this, policy commitments, organizational arrangements, methods, and tools are needed to train and support high-performing community health workers (CHWs) who are empowered to use the same methods to reach mothers. The training program seeks to develop positive attitudes towards CHWs as key change agents in communities. Guidance is provided here on the basis of experience in several countries as to how the public health sector and local government can work with communities to improve the health of women, infants, children, and adolescents.

Part One of this "How -To" Guide presents details of the method which can be used by government primary health care providers to teach CHW, which CHW in turn can use for teaching mothers. This transformative teaching/learning method called "Sharing Histories" has been validated in field trials in Afghanistan, India, and Peru.

Part Two of this "How-To" Guide describes how to implement the Modular Training Program in Maternal, Neonatal, Child, and Adolescent Health for Community Health Workers, including how to engage stakeholders, organize health services, strengthen the health workforce, develop or adapt training and educational materials, how to organize a modular training program for CHW, and how to implement and monitor a health promotion program for mothers, infants, children, and adolescents.

Future Generations values respect for all life and the conditions for harmonious coexistence. This "How-To" Guide adopts a holistic and ecological approach to community and behavioral change. It emphasizes equity, empowerment, and self-confidence, especially among women and other marginalized members of the community.

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LIST OF TABLES

ACRONYMS

ANC	Antenatal (prenatal) care
CS	Community supervisors
CHW	Community Health Worker
DIRESA	Regional Health Directorate
G&D	Growth and development
H.C.	Health center
H.F.	Health facility
MAM	"Salud en Manos de Mujeres" ("Health in the Hands of Women" Project)
MNCAHN	Maternal, neonatal, child, and adolescent health
MOH	Ministry of Health
SDG	Sustainable Development Goals
USAID	United States Agency for International Development
WHO	World Health Organization

HOW TO USE THIS GUIDE

PART ONE
"How-To" Guide for Sharing Histories

GUIDELINES FOR USING A LEARNING/TEACHING METHOD CALLED 'SHARING HISTORIES' This new method for training community health workers (CHWs) has been shown to energize, engage, and empower CHWs to change their own knowledge and behavior. CHWs then use the method as a useful way to approach mothers in the community to help them learn and adopt health behaviors that will lead to better family and child health. Sharing Histories was originally piloted and tested in indigenous villages of Afghanistan, then in remote Himalayan valleys of Tibet and eastern India, and finally in the high Andes of Peru.

PART TWO
"How-To" Guide for Implementing a Modular Training Program in Maternal, Neonatal, Child, and Adolescent Health for Community Health Workers

STAGE 1 ENGAGING STAKEHOLDERS Reaching mothers and families in the home for health behavior change begins with the understanding and commitment of high level government and health authorities at the national, regional or provincial, and district levels, and leaders and members of communities. Participatory planning meetings at all levels are held to inform and motivate local partners to commit political and budgetary support to actions for community-based health promotion.

STAGE 2 ORGANIZING HEALTH SERVICES TO PROMOTE HEALTH IN COMMUNITIES Successful and sustained community-based health promotion is possible when health services are linked with organized communities and other local public and private institutions, with collaborative management that allows for social accountability and empowerment of the community. This includes reassignment of tasks with development of health facility management teams, community committees to co-manage health services, and agreements with local government to complement financing of community health work.

STAGE 3 STRENGTHENING THE HEALTH WORKFORCE Health promotion in the community needs prepared and committed people at different levels that share a common vision and carry out tasks in a coordinated manner. Health providers in primary health care services can serve as Trainers. Local women who volunteer as CHWs learn and share information with neighbors. Experienced CHWs are selected to support and supervise newer CHWs. Definition of

personnel profiles, selection processes, responsibilities, functions and tasks are needed for each category of personnel for health promotion.

STAGE 4 DEVELOPING OR ADAPTING MANUALS AND MATERIALS FOR COMMUNITY HEALTH PROMOTION Promotion of health behavior change in women and families of low educational attainment is helped by "job aids" that have colorful illustrations (teaching cards) and pictographs (checklists) that do not rely on the written word. A series of teaching manuals, flipcharts, home monitoring checklists, and other tools complement the new learning/teaching method for CHWs and mothers described here.

STAGE 5 ORGANIZATION OF THE MODULAR PROGRAM FOR TRAINING IN MATERNAL, NEONATAL, CHILD, AND ADOLESCENT HEATH FOR COMMUNITY HEALTH WORKERS The organization of a training program for CHWs in maternal, neonatal, child, and adolescent health will depend on an analysis of the health situation in your program area to determine the priority areas in which CHWs will be trained. The key knowledge, skills, and behaviors that mothers need to practice are based on global evidence regarding which have the greatest influence on health of mothers, newborns, children, and adolescents to reach health goals.

STAGE 6 IMPLEMENTING AND MONITORING HEALTH PROMOTION FOR MOTHERS, NEWBORNS, CHILDREN, AND ADOLESCENTS Each health facility jurisdiction will determine the logistics of its health promotion program depending on the size and dispersion of its population. Here we provide guidelines for determining the numbers of Trainers, community supervisors, and CHWs are needed to provide coverage of monthly home visits to all pregnant women, new mothers and infants, children, and adolescents.

TEACHING COMMUNITY HEALTH WORKERS TO TEACH MOTHERS FOR BETTER CHILD AND ADOLESCENT HEALTH

The most cost-effective and sustainable key to improving health and development globally could be *mothers adopting healthy home practices.* Benefits could be many. Improved nutrition, sanitation, and hygiene practices could lead to prevention of illness and better physical and cognitive growth of children. Increased engagement with formal health services can lead to better illness care. In addition, home health and household behavior could produce ancillary benefits, including better school achievement and greater productivity in adulthood. Mothers adopting healthy home practices can be an entry point for healthier whole lives for families and healthier communities. In addition to these health benefits there also could be positive consequences for household income and household food security.

COMMUNITY HEALTH WORKERS AND EFFECTIVE MATERNAL BEHAVIOR CHANGE

The challenge is how to effectively support mothers to change behaviors in communities where access to health information is limited, educational levels are low, and traditional beliefs are strong, even in places where there is access to health services. Community health workers (CHWs) are now recognized as essential to close gaps between formal health systems and communities to achieve universal health coverage and to meet Sustainable Development Goals (SDGs) [1]. CHWs are part of the Global Strategy for Human Resources of the World Health Organization (WHO) [2]. Accordingly, advancing effective CHW education that is grounded in the reality of the local community is a rising global priority.

We often assume that teaching CHW new practices will equip the CHW to be effective agents of behavior change with mothers in the communities, but it is not that simple. Many studies on behavior change have shown that just increasing knowledge and awareness of correct health

practices does not lead to the sustained behavior change needed to improve health [3]. The big challenge is finding the best methods to teach CHW so they become effective change agents.

To expand CHW programs from small demonstration projects to national-level government-sponsored programs, a key aspect is how well health providers in primary health care services can serve as Trainers to facilitate CHW learning. Such personnel are in-place, are salaried, and have basic health knowledge. However, health care providers are generally not educators. They tend to rely on medical terminology and use simplified facts, instructions, and information to train CHWs, often without the help of training tools or materials. This medicalized orientation can result in significant limitation of their effectiveness as Trainers.

Health providers are often not from the area where they are working, and do not necessarily understand the cultural underpinnings of local health beliefs and practices. There are also areas where indigenous languages or dialects are spoken, and health providers may speak the language poorly or not at all, so it is a further limitation to those mentioned above. Different types of participatory methods are often used for teaching CHWs to accommodate to their educational level. Even if participatory methods are used, changing the knowledge of CHWs on health topics does not necessarily signify that the CHW has changed her own health practices, nor that the CHW is able to effectively teach mothers the same information. Nor does it mean that mothers will adopt the new behaviors that are being taught by the CHW. *A dysfunctional gap exists: health knowledge to adopt healthy home practices needs to be delivered, but the in-place, salaried, knowledgeable health care providers are often not able to connect beneficially to CHW nor to mothers*.

NEW TRAINING METHOD FOR COMMUNITY HEALTH WORKERS

This manual provides guidelines for a new method for training CHWs, called "Sharing Histories," that energizes, engages, and empowers CHWs to change their own knowledge and behavior. The method also provides CHWs with an effective way to approach mothers in the community to help them learn and adopt optimal maternal, newborn, child, and adolescent health and nutrition (MNCAHN) behaviors that will lead to better family and child health.

The Sharing Histories learning/teaching method was originally piloted and tested in indigenous villages of Afghanistan [4] [5], in remote Himalayan valleys of eastern India [6], and in the high Andes in Peru [7] [8] [9] (see Annex 1 for more detail). The training approach begins

with and builds on the sharing by CHWs, who are preferably somewhat older women from the community, of their personal experiences during pregnancy, birth, postpartum, and newborn, as well as with care and feeding of their own children, and of events leading to a child's sickness and death. The method is supported by psychological, communications, and neuroscience research on autobiographical memories [8].

The effectiveness of Sharing Histories for teaching CHWs was tested in rural Peru in a cluster randomized controlled study in which half the CHWs were trained with Sharing Histories, and the others were trained with a standard CHW training method. The results of the study showed improvements in maternal behaviors with a significant effect on growth in young children when mothers were taught by CHWs trained in this method, as compared to mothers taught by standard-trained CHWs [9]. The purpose of this manual is to provide details on how to implement this training method.

PRIMARY HEALTH CARE SYSTEM FOR TRAINING AND SUPPORT TO CHW

While the innovative method to train CHWs is a key component of an integrated educational strategy to improve maternal, neonatal, child, and adolescent health (MNCAH) and is the focus of this manual, the surrounding structure of the health system, local government, and communities must also be strengthened if a community-based health program is to be sustainable and effective for getting mothers to adopt healthy home practices. An effective system should ensure that pregnant women and mothers of young children are visited at home at least monthly for purposes of receiving health behavior change education, monitoring and referral from a CHW who is a peer. We assume that mothers will receive prenatal and postnatal care at a health facility, and that children will attend well-baby visits for immunizations and growth monitoring at this facility. The gap to fill is the need of mothers for more intensive and individually focused peer education at home.

Health services must have a system to train and support health providers as Trainers of CHWs. This is referred to as training of trainers (TOT) which helps to ensure that CHWs receive quality training and on-going support. CHWs must receive support including educational tools to teach and monitor mothers in home visits and other types of support which also serve as incentives.

The system-strengthening strategies presented in this manual were tested and validated by two major projects in Peru implemented by Future Generations. The goal of these projects was to

contribute to the sustainable improvement of maternal, neonatal, child, and adolescent health and nutrition in rural communities. See the Annex for project details.

The behavior change strategy of these projects was centered on implementation of the *Modular Program for Training in Maternal, Neonatal, Child, and Adolescent Health for Community Health Workers*.

Table 1: Topics for the first 1,000 days of life

Pregnancy
Birth and postpartum
Newborn
Exclusive breastfeeding
Infant growth, nutrition, and micronutrients
Child diarrhea
Child pneumonia
Others (e.g., malaria)

The training program focuses on three areas of knowledge and skills for the CHW regarding the first 1,000 days of life (from conception to two years of age). These are: (1) learning and practicing how to teach mothers the key knowledge and home health and nutrition behaviors during the first 1,000 days of life; (2) identification of early danger signs during the first 1,000 days of life; and (3) timely referral of mothers and children to the nearest government primary health care facility for preventive and curative care services.

The primary agent for teaching, monitoring, and referral of mothers and children at the household level is the female CHW [10]. In this manual, CHWs are defined as female members of the community who are selected by fellow community members to receive training and to serve the community for promotion of healthy behaviors and lifestyles for health of mothers and children.

MODULAR PROGRAM FOR TRAINING IN MNCAHN FOR CHW

The teaching and promotion of MNCAHN in the community is a complex activity that requires coordination and collaboration of multiple actors and institutions in order to ensure effective and sustainable behavior change in the community that will measurably improve the health status of mothers, infants, and children.

The *Modular Program for Training in Promotion of MNCAHN* specifies the responsibilities and tasks of each type of human resource at each level, from the community to various levels of government in the process of the promotion of MNCAH. It details the skills profile that each actor, from Trainer to learner, should develop during the training. As well, it

describes methodological strategies used by Trainers and the training contents provided to CHWs. The training program provides guidance to define the responsibilities of each CHW as teachers and monitors of mothers, newborns, children, and adolescents in the home.

This training program has been developed on the basis of successful experiences and lessons learned from: (1) various maternal, neonatal, child, and adolescent health projects implemented by Future Generations in Peru in the past ten years; (2) other community-based primary health care pilot projects implemented in Peru in the last two decades; and (3) successful aspects of other community-based primary health care projects implemented globally, such as the SEARCH Project in India (e.g., their check-list format for home monitoring of the newborn by CHWs). Throughout the training program, we make use of participatory teaching/learning methodologies and principles for adult learning. Technical training content and operational aspects should be based on national protocols and adapted into public sector health policies, procedures, and regulations of the Ministry of Health (MOH).

One of the most important aspects of the modular curriculum is the introduction and evaluation of a simple-to-learn teaching/learning method that Trainers can use for training CHWs, called "Sharing Histories." This is an innovative educational method based on the sharing of personal experiences that CHWs have had with all of their pregnancies, births, and the feeding, caring for, and parenting of their children. Shared histories are followed by group analysis of cultural beliefs and practices that are identified from the histories, on which subsequent training is built. This teaching/learning method has been shown to increase the self-esteem and self-confidence of CHWs, empowering them to change their own beliefs, practices, and maternal capabilities, thus improving their ability to convince other mothers to make the same behavioral changes.

PART ONE

"How-To" Guide for Sharing Histories

METHODOLOGICAL GUIDELINES FOR THE TEACHING/LEARNING METHOD "SHARING HISTORIES" TO UTILIZE FOR THE TRAINING OF COMMUNITY HEALTH WORKERS

A. WHY "SHARING HISTORIES" WORKS

The training methodology that is applied to the training of community health workers (CHWs) is very important because, if it is effective, it can help to establish good communication channels and a productive learning relationship between Trainers and CHWs trainees. Sharing Histories encourages the recounting of personal experiences of CHW trainees with their own pregnancies, births, and the feeding and care of their children. With guided analysis of their experiences, CHWs trainees are able to identify and learn from their own cultural beliefs and practices. This learning method can increase the self-esteem and self-confidence of CHWs, empowering them to change their own beliefs and practices, and helping them become more capable and convincing promoters of the same key behavioral changes with mothers in their communities. In community work following their training, CHWs use the pedagogical method of Sharing Histories to establish relationships of trust and learning with mothers in the home.

The learning/teaching method Sharing Histories is corroborated by research evidence on autobiographical memory and narrative communication. The act of remembering and sharing personal experiences and then analyzing them prior to learning new knowledge results in a more sustainable up-take of new knowledge and key behaviors that influence the health of children, mothers, and families [8].

This process of telling and sharing personal stories has several consequences such as the following:

(1) Sharing Histories provides practice in verbal expression by CHWs who may be timid to speak in a group among other persons with whom they may not be well acquainted;

(2) Sharing Histories increases the self-esteem and confidence on the part of CHWs, who recall, recognize, and begin to accept their own personal experiences, even if the experiences were painful;

(3) Sharing Histories improves the relationship and positive learning relationship of CHWs with Trainers and other health care providers when CHWs feel they are listened to and treated more as equals with the shared goal to help the community.

(3) Sharing Histories helps to create empathetic bonds among women when they listen to each other's experiences;

(4) Sharing Histories helps to establish a social support group among CHWs that in future will help to sustain their new knowledge and behaviors;

(5) Sharing Histories provides CHWs with an effective method that they can use to approach mothers and develop an effective interpersonal social relationship with them in the home. The sharing process helps mothers to become engaged, with greater interest in the subject, better understanding and learning, and more sustainable behavior change by the mother;

6) Through Sharing Histories, an atmosphere of interpersonal trust between Trainers and CHWs and mothers is created that facilitates more change in behaviors as well as greater confidence in health services, improving access and use. Better health is the result.

The teaching/learning method, Sharing Histories, is incorporated into each teaching session of each of seven Facilitator Manuals which form an essential part of the *Modular Program for Training in Maternal, neonatal, child, and adolescent Health for Community Health Workers* with seven technical topics. Each topic is divided into ten or more sessions. The methodology applied in each session generally consists of five components: sharing histories; identifying and understanding cultural beliefs and practices; strengthening knowledge; practicing skills; and evaluating what was learned.

B. STRUCTURE OF LEARNING SESSIONS WITHIN EACH TRAINING MODULE – FIVE PHASES

Phase I – How to share histories

Sharing Histories is a participatory training technique that we describe in detail in this section. During a training workshop, CHW trainees will recall and share their personal experiences with the birth and rearing of each of their children, depending on the training module topic of the workshop being conducted that day. Each Facilitator Manual explains in detail how to carry out the process of sharing stories, and provides a format (found in the annex of each Facilitator Manual) to guide and document the key points of the stories. Table 2 provides a list of the steps to share histories, followed by a how-to description of each step.

Table 2: Steps to share histories (Phase I)

i.	Preparation for the first round of Sharing Histories.
ii.	Organization of the CHW trainees for Sharing Histories.
iii.	Process to initiate Sharing Histories.
iv.	Use of the "Histories Format" to guide sharing and to note down key information.
v.	Maintaining the confidentiality of histories that are shared.

Steps to Share Histories (Phase I)

i. Preparation for the first round of Sharing Histories

Prior to the first round of Sharing Histories, the Trainer should identify one volunteer from among the CHW trainees who is not timid and who accepts the challenge of being the first CHW to share the history of her pregnancies in front of the entire group of CHW trainees. If necessary, the chosen CHW could practice ahead of time in private with the Trainer, providing the narration of her pregnancies with help from the Trainer who assists by asking the CHW probing questions from the "Histories Format: Pregnancy." Sometimes the Trainer needs to be the first person to tell

about her experiences with her own pregnancies, and then some trainees will be encouraged to tell theirs.

This special preparation will not always be necessary. Frequently there are CHW trainees who easily begin to share their experiences. Once the first few CHWs share their experiences, the more timid CHWs begin to feel more comfortable and soon will also be willing to share their own experiences.

Prior to beginning the sharing histories session, there should always be a pre-test of knowledge on the module topic and an ice-breaker exercise, using a game to have fun while the CHW trainees become acquainted and get to know each other better.

ii. Organization of CHW trainees for Sharing Histories

Once the CHW trainees are warmed-up with ice-breaker games, the Trainer says to them, "First we are going to form a closed circle and I am going to ask each one of you to share with all of us about your experiences with all your pregnancies, one by one, starting with your first pregnancy. Tell us how each of your pregnancies were, how you prepared for the birth, what prenatal visits you had, where you went for care, how your prenatal visits were, how you took care of yourself at home, what you ate, what problems or complications you had, what you did about those problems, who helped you, and how you felt about having had those problems."

iii. Process to initiate Sharing Histories

The CHW who was previously identified is the first to share the history of her pregnancies. Alternatively, the Trainer can be the first to share her own histories.

During the history sharing, no feedback is given to the CHW who is sharing, and no comments or opinions are expressed by the Trainer or other CHWs. All histories are shared in an atmosphere of acceptance and trust. When difficulties such as birth complications or child deaths are shared, in many cases there are tears shed and emotions shared among participants. Sympathetic responses from other CHWs are encouraged, though without commenting on the specific situation that occurred. The CHW is encouraged to share details about those difficult experiences to the extent she is willing to share them.

Once the first CHW trainee finishes sharing her histories, the next CHW to share can be a volunteer from the group. Otherwise, the Trainer can call on another less-timid CHW trainee to

share her histories. By the time most of the CHW trainees have shared their experiences, the more timid CHW trainees have lost their fear to speak out and are more willing and able to share their experiences.

iv. Use of the "Histories Format" to guide the sharing and to note down key information

A "Histories Format" is found in the annex of each Facilitator Manual. These formats provide a list of questions that can be used to guide the history-telling, to probe into details of experiences, and to provide space to note down key aspects of the histories told on each child born to the CHW trainee who is sharing her history. The Trainer or a Trainer´s helper will write down the relevant information expressed by each CHW Trainer in turn, registering the information on the "Histories Format." A copy of this format should be available for each CHW trainee so that individual information can be noted on each one.

The Trainer should probe into more details in the shared histories, according to how thoroughly each CHW trainee is telling her stories. Each CHW trainee should be encouraged to explain in detail about what happened, what she thought, what she did, how she felt, who she was with, who helped her, etc. in relation to the experiences that she is sharing on each of her children.

If training groups are very large, there may be less time available for all CHW trainees to share experiences on each of their children. However, it is important that each CHW recall each of her pregnancies so that all practices and situations can be put forward for later discussion. For this reason, and to ensure better learning, CHW training groups should be limited ideally to 10-15 trainees. If there are many CHW (more than 10-15) who work in the area of one health facility, that facility may need to hold more than one CHW workshop per month, and/or add Trainers so that parallel workshops can be held on the same day.

v. Maintaining the confidentiality of histories that are shared

Each CHW trainee should promise to preserve the confidentiality of information shared in these group sessions of Sharing Histories. Trainers need to continually reinforce the importance of confidentiality. Sensitive information should not be shared freely with the group if CHW trainees feel their personal experiences may be shared outside of the training circle. The building of trust among CHW and with Trainers is an essential goal of CHW training. This trust will then extend

to the relationship of trust that will be built between the CHW and the women under her care in the community.

Phase II – How to identify and understand cultural beliefs and practices

Based on the histories shared by all CHW trainees and using a chalk board or large blank paper mounted on an easel or on the wall, the Trainer first makes a list of the beliefs, myths, and cultural practices that were shared by the CHW trainees in the first phase of history sharing. This listing generally identifies practices that are common to many CHW trainees, reflecting general belief and practice in the community. Some practices may have been mentioned only once or twice in the history sharing, but those should also be listed. It is important to point out that this process should avoid identification of specific CHW trainees in relation to specific practices in order to avoid any embarrassment or shame of the CHWs.

When the list is complete, the Trainer leads a group analysis and discussion of each cultural belief, myth, and practice on the list to understand how and why it has an effect on health of the mother, newborn, or child. Colored markers are used to identify each belief, myth, and practice as beneficial to health (green), neutral or having no effect on health (blue), or possibly dangerous effect on health (red).

Discussing and understanding why each practice is beneficial, neutral, or possibly dangerous leads then to a new understanding among CHW of their own cultural belief systems.

Trainers should leave these lists posted on the chalkboard or wall during the remainder of the training session(s) on that topic, so that the list can be added to during further discussion and so the list of cultural beliefs and practices can be taken into account in teachings during the course of the workshop.

Table 3: Steps to identify and understand cultural practices (Phase II)

i.	Make a list of beliefs and practices based on histories shared in Phase I.
ii.	Identify each point on the list as beneficial, neutral, or possibly dangerous to health of the mother, newborn or child.
iii	Discuss and analyze each point on the list to arrive at an understanding of why and how it effects health.

Phase III – How to strengthen knowledge

This phase involves the review and analysis of the Flipchart messages on the topic at hand. Each page of the Flipchart has a color drawing that graphically displays a message related to a key behavior or danger sign. Key messages are listed on the back of each flipchart page in a box at the top of the page. Below that appear questions and answers to ask and discuss in the workshop with CHWs or in the home with mothers. The how-to steps for this phase are summarized in Table 4 and are each presented in more detail below.

Table 4: Steps to strengthen knowledge (Phase III)

Before viewing the Flipchart images i. The Trainer first leads a round of history sharing by each CHW trainee on the topic of a specific drawing and message on the flipchart on the topic at hand, using questions in the Facilitator Manual. Review and discussion of Flipchart images and messages ii. CHW trainees take out their Flipcharts and turn to a specific drawing and message. iii. CHW trainees are asked to view the drawing and then to express what they see and what they think about the scene in the drawing. iv. Trainers reinforce the main message of the drawing and discuss the question(s) posed on the back of the Flipchart drawing in the context of cultural beliefs, myths, and practices shared by CHW trainees. v. Trainers add other knowledge to the discussion to accompany and expand a message.

Before the Flipchart is viewed, the sessions on knowledge strengthening begin with an in-depth round of Sharing Histories on the experiences of CHW trainees in relation to the specific knowledge or behavior that is shown on the Flipchart drawing that will soon be viewed.

For example, if Session 6 of the training module on Pregnancy is being taught that day, which covers the topic of food consumption during pregnancy, the Trainer would start asking

CHW trainees to recall and share their memories, using a brainstorming technique, of how and what they ate during their pregnancies, how much they ate, if they ate any special foods or avoided certain types of foods, and other aspects of their experiences with food consumption during their pregnancies. A list of suggested questions for sharing histories on this topic is listed in the Facilitator Manual under Session 6. After these histories have been shared by CHWs, the Trainer notes down on the blackboard, white board, or a large paper on the wall the cultural beliefs and practices that were expressed by the CHW trainees in relation to food consumption during pregnancy. At this point, no feedback is given to the CHW on the cultural beliefs and practices mentioned.

Next, CHW trainees are asked to take out their Flipcharts and turn to the drawing on a certain page. In our example of Session 6 in the pregnancy module, they will turn to page 8 of the Pregnancy Flipchart. CHWs are asked to view the drawing and to describe what they see. They are asked to comment on, analyze, and interpret the scene(s) in the drawing.

Following this, and building on the CHWs' interpretations of the drawing on page 8, the Trainer reinforces the main message of the drawing, and leads a discussion of the questions (and correct answers) provided on the back of page 8 of the Pregnancy Flipchart. Cultural beliefs and practices that were identified on the previous step are discussed again by the Trainer in the context of the new knowledge portrayed on the flipchart page. The Trainer reinforces the positive practices and facilitates the understanding and internalization of them. The Trainer provides the correct answers to reinforce and supplement those provided by the CHW trainees, while also emphasizing the negative practices as shared beliefs that are now better understood and to be avoided in the future.

Depending on the session in progress, the Trainer can then add supplementary knowledge to the discussion according to information provided in the Facilitator Manual to accompany and expand a message. This may include additional facts, as well as the introduction of tools, formats, visualizations, and others. For example, Session 6 of the pregnancy module includes showing and discussing pictures of different types of foods and their grouping into food groups by how each can improve health. Other examples of supplementary knowledge could include how to use a community birth plan, when and how to wash hands properly, how to prepare oral rehydration solution (ORS) and many others.

Phase IV – How to practice skills

For the comprehension and internalization of important skills, each training session involves time for practice of a skill. Practice means doing the skills that are learned, whether that be a specific activity or else practice using the flipchart to teach the mother. For example, CHWs practice proper handwashing, proper breastfeeding techniques, or preparation of appropriate foods for children (for example, participating in a demonstration of the content, consistency, and quantity of a meal for children from 6-23 months of age). They also practice how to demonstrate and teach that skill to mothers and families.

CHW trainees participate in socio-dramas to practice using the method "Sharing Histories" with mothers in home visits helps them acquire skills to establish a relationship of trust with the mother. CHW trainees also use socio-dramas to practice skills in use of the flipchart to teach mothers and in use of monitoring formats during home visits. In these socio-dramas, CHW trainees alternate playing the role of CHW who teaches the mother, and playing the the mother as she is being visited by the CHW. At the end of each practice session, the CHW trainees are asked to say how they felt during the practice session, and to express their opinions about the positive aspects of the practice as well as to analyze the negative aspects that should be improved.

Participatory practice sessions on many skills are suggested in the various Facilitator Manuals. Trainers use the practice sessions to observe how well CHW trainees can perform the skills as well as the appropriateness of their attitudes.

Table 5: Steps to practice skills (Phase IV)

i.	The Trainer organizes the CHW trainees into a circle and explains to them what skill will be practiced, the importance of the skill, and how they will practice the skill.
ii.	The Trainer demonstrates de skill.
iii.	The Trainer organizes the practice session so that each CHW trainee is able to practice the skill.

iv.	The Trainer observes each CHW trainee and assesses the CHW´s skills and attitudes while performing the skill. More practice time and/or instruction are given to CHWs who need to improve their skills and/or attitudes.
v.	The Trainer notes down her assessment of each CHW on the assessment sheet.
vi.	Each practice session is followed by a group discussion of the positive aspects of how good the CHW skills were shown to be during the practice, with group identification and analysis of what needs improvement in the skill by CHW trainees.

Phase V – How to review and assess learning

At the end of each learning session on a key message, CHW Trainers are led through a variety of different participatory technique to review the material just learned. Games such as musical chairs, tossing a ball, sitting on balloons until they break, dressing up a volunteer with items of clothing, and many other fun activities are used to allow Trainers to ask questions and CHW trainees to provide answers. This allows CHW trainees to review the material just learned. Trainers can determine if participants have appropriately understood and learned the main concepts from the learning session. If not, the messages are reinforced. Table 6 lists the steps to review and assess learning.

Table 6: Steps to review and assess learning (Phase V)

i.	The Trainer organizes the CHW trainees into a circle and explains to them how they will review the lesson.
ii.	The Trainer organizes the review session so that each CHW trainee is able to answer at least one or two questions.
iii.	The Trainer observes each CHW trainee and assesses the CHW´s knowledge and attitudes while responding to questions. Positive reinforcement is given when a correct answer is given. If one CHW cannot answer a question correctly, another CHW is asked to provide an answer. The correct answer is provided by the Trainer

if no CHW knows the correct answer. More review time and/or instruction are given to CHWs who need to improve their knowledge and/or attitudes.

iv. The Trainer notes down her assessment of each CHW on the assessment sheet.

v. Separately, overall learning on the module topic is assessed with an individual pre- and posttest with 10 questions that applied verbally to each CHW and CS at the beginning and at the end of each training module topic.

In addition to learning assessment exercises after each learning session, overall learning on a module topic is assessed with a pre- and post-test that is applied before and after each training module topic. The format for the pre- and post-test is found in the annex of each respective Facilitator Manual.

SECTION II

"How-To" Guide for Implementing a Modular Training Program in Maternal, Neonatal, Child, and Adolescent Health for Community Health Workers

STAGE 1 ENGAGING STAKEHOLDERS

Reaching mothers and families in the home for health behavior change begins with the understanding and commitment of high-level government and health authorities at the national, regional or provincial, and district levels, and leaders and members of communities. Participatory planning meetings at all levels are held to inform and motivate local partners to commit to moral and budgetary support to actions for community health.

In any country health system, the involvement and approval of MOH officials are key to a successful program for training and support of CHWs. Typically, these officials should include the minister of health and, at minimum, the offices of human resources management, primary health care services, and health promotion or similar.

At sub-national levels, regional, provincial, health service management networks, district health officials, and/or other local government officials depending on the specific country, must be fully engaged in the CHW training and support program from the planning stages, playing an important role in the incorporation of CHW program activities in their annual planning and budgeting for primary health care services. Steps for engaging stakeholders are described. These are followed by specific proposed roles and functions the district management and coordination committee or health service network which are listed in Table 7.

1. *Meet with officials in the Ministry of Health*. At a meeting or series of meetings, you will want to review the rationale for why a special effort is needed to reach mothers in the home to change their health behaviors, and why it is important to work with CHWs to support this effort. You will want to present them with information on health and hygiene practices in vulnerable communities, and with evidence on how health promotion with CHWs can help to improve these practices. They will need to be convinced with feasible plans and costs for implementing this effort. Policies and budgets need to be developed if they are not already. In countries where community participation and CHWs are a general part of public policy, though without full adherence, the challenges are to sensitize government officials to the cost-effectiveness of the methodology and to develop specific normative documents to guide implementation by decentralized levels. Finally, this innovative approach will be used as a systemic application of interactive, theory-based, and research-

driven processes not only to address but also support the adoption of optimal behavior change at the individual, community, and societal levels.

2. *Meet with officials at the regional/provincial and district levels (both governors and health sector leaders)*. These officials need convincing of the value of community-oriented health programs that train and support CHWs, and how this approach can help the health sector and local government meet their goals for coverage, impact, and budget execution. In decentralized systems, these officials have key roles in programming and budgeting to orient resources to community-based health programs.
3. *Create a management and coordination committee in each district or health service network management center*. This management and coordination committee should be multidisciplinary and should receive training in organizing, implementing, and sustaining a community-based program for health promotion. The best place for this training to occur is in a district or health service network management center that has already implemented the program. The program there can serve as a demonstration training site for others to see in action.
4. *Plan for local adaptation of the program*. The management and coordination committee in each district or health service network management center should adapt the community-based program for health promotion to their own local realities.

Table 7: Roles and functions of the district management and coordination committee or health service network management center

1. Lead the coordination of initiatives related to promotion of MNCAHN in the local area. 2. Subscribe to agreements with public and private organizations that implement local initiatives in MNCAHN, with emphasis on health prevention and promotion. 3. Coordinate with health facilities in the district to implement actions for MNCAHN, with emphasis on prevention and promotion. 4. Coordinate the work of existing public and private entities on issues related to health promotion and local multi-sectoral development. 5. Establish public policies that will institutionalize processes for improving the quality of life of families and communities in the district. 6. Participate in the evaluation of health services management in the district.

7. Finance, with municipal funds, initiatives in MNCAHN that are presented by communities through participatory budgeting processes or through community work plans.
8. Finance, with municipal funds, monetary and non-monetary incentives for active CHWs in the district.
9. Finance, with municipal funds, training activities for CHWs.
10. Finance, with municipal funds, quality improvement of health services in the district, including construction and improvement of infrastructure, equipment, and contracting of health providers.
11. Coordinate with health facilities, community leaders, and community health workers the actions needed to meet the goals established in national and local health plans.

STAGE 2 ORGANIZING HEALTH SERVICES TO PROMOTE MATERNAL, NEONATAL, INFANT AND ADOLESCENT HEALTH AND NUTRITION IN COMMUNITIES

All health staff in each primary health care facility must be fully oriented and committed to the CHW training and support program for community-based promotion of MNCAHN. Health facility leadership for the program should be identified and trained to take responsibility for leading the program and to oversee accountability for its implementation. Clear roles and functions should guide this work to ensure the means for accountability.

1. *Form management teams in each health facility*. The management committee in each district or health service network management center helps to form a management team in each primary health care facility. This team should be multidisciplinary and have the head of the health facility as the management committee leader.
2. *Train management teams in each health facility*. The district or network management committee trains the management team in each health facility in the community-based health promotion strategy. Prior to this, ideally, the district or network management committee members visit a health facility that is successfully implementing the community-based health promotion strategy so they can better teach others.
3. *Support health facility staff to do a self-evaluation*. The district or network management committee supports each health facility staff to conduct a self-evaluation regarding their health facility organization and management for implementation of community-based health promotion.
4. *Plan how to organize to implement community-based health promotion*. Based on their self-evaluation of organization and management, the health staff makes a plan that will strengthen their capacities to implement community-based health promotion.
5. *Designate the staff person or team responsible for health promotion in a health facility.* Community-based health promotion is a common task of all staff in a primary health care facility. However, there should always be one person or team that is responsible for its operation in each health facility, and this person should have clearly defined roles and functions.

Table 8: Who is responsible for community-based health promotion in a health facility?

The responsibility for community-based health promotion in a health facility should be any one or more of the following: i. The medical chief of the health facility. ii. The staff person in charge of health promotion. iii. The management team of the health facility. iv. A specially-formed team for community-based health promotion.

Table 9: Roles and function of the staff person or team responsible for community-based health promotion

Roles and functions of the health facility staff or team responsible for community-based health promotion: i. Lead the program in their jurisdiction. ii. Periodically accompany Trainers and Community supervisors in the completion of their tasks. iii. Support the development of a plan for monthly training activities from Trainers and post it in a visible place in the health facility. iv. Convoke monthly meetings with Trainers to evaluate progress and analyze work in communities. v. Receive, consolidate, analyze feedback, and archive monthly reports from Trainers, Community Supervisors, and CHWs. vi. Articulate community-based health promotion activities with those of community health committees and with the district municipality. vii. Generate internal memos or administrative procedures (including incentives and sanctions) that facilitate achieving the objectives of community-based health promotion. viii. Support the Trainer to program and convoke training workshops for Community supervisors and community health workers. ix. Inform the chief officer of the health facility on progress and difficulties in the implementation of community-based health promotion, and propose alternative solutions.

STAGE 3 STRENGTHENING THE HEALTH WORKFORCE FOR HEALTH PROMOTION IN THE COMMUNITY

At the level of primary health care facilities, *Trainers of MNCAHN Promotion* are specially selected or self-selected government primary health care professionals. They are the key training resource who oversee, coordinate, and implement the training and follow-up of CHW and Community Supervisors (CSs) in their health facility jurisdiction.

At the community level, there are two categories of human resources for health promotion. CHWs are female community members who make home visits to mothers for promoting an enabling environment in which mothers will be supported with education on best practices, monitoring, and referral. CSs are tasked with monitoring and supporting CHWs. CSs are a new type of community asset who are from the same communities as CHWs. The following table summarizes the main actors for community health promotion within the context of the *Modular Program for Training in Promotion of MNCAH*.

Table 10: Roles of the main actors for community-based health promotion

Type of actor	Where from?	Who are they?	What roles?
Trainers of MNCAHN promotion	Primary Care Center	Health Promotion Managers Professional Nurses Professional Midwives	Responsible for organizing, implementing, overseeing, and monitoring the training of CSs and CHWs.
Community Supervisors	Community	Community members who are selected by open competition in a bidding process typical of hiring for a new job.	Responsible for supervising, accompanying, and reinforcing the training and practice of CHW in use of the flip charts and monitoring formats that CHWs will use with mothers in the home.
Female CHWs	Community	Community members who are (ideally) selected by other women in their community.	Responsible for raising awareness, teaching and monitoring mothers, children, and families in the home, and referring cases to the nearest primary health care facility for preventive and curative care.

A. TRAINERS FOR PROMOTION OF MATERNAL, NEWBORN, CHILD, AND ADOLESCENT HEALTH AND NUTRITION

Trainer profile

Ideal characteristics of the primary health care worker selected to serve as a Trainer for Promotion of MNCAHN include: (1) being a health professional (preferably a licensed or registered nurse or midwife), (2) being female, (3) having technical capacity in some or all aspects of MNCAHN and nutrition, and (4) having prior experience and/or interest in training CHWs and in promoting health behavior change of mothers and families in the community.

A preference for female Trainers helps to ensure effective facilitation of training using the methodology "Sharing Histories", since female Trainers would have a greater ease and capacity to establish a relationship of trust between themselves and female CHWs. It is recognized that in some circumstances female health workers will not be available to take the role of Trainer. In those cases an experienced male health worker will have to fill the role.

Process for Trainer selection

Ideally, the Trainer is self-selected based on a strong personal interest in serving as a CHW Trainer. The ideal candidates for this role will also have the approval, support, and formal designation by the medical director of the health facility.

The number of Trainers selected from each health facility depends on the number of inhabitants in the health facility catchment area, which determines the number of CHW needed, and thus the number of monthly training workshops given by the Trainer(s). Each workshop should have no more than 10 to 15 CHWs for optimal learning.

Trainer responsibilities

Table 11: Main responsibilities of a Trainer

i.	Receive training as a Trainer.
ii.	Plan, schedule, organize, and facilitate monthly training workshops for CHWs and CSs.
iii.	Ensure quality of trainings according to the manual.
iv.	Be responsible for CHW/CS training materials.
v.	Prepare, adapt the materials ahead of time for each workshop.
vi.	Apply the “Sharing Histories” methodology for teaching.

vii.	Utilize Facilitator Manuals and Flipcharts for teaching CHWs and CSs
viii.	Apply the Pre- and Post-Test with CHWs and CSs for each training module.
ix.	Conduct continual evaluation of the training.
x.	Keep detailed records of attendance and test scores on each CHW and CS trainee.
xi.	Encourage and ensure active participation of all trainees.
xii.	Monitor the knowledge and skills of the CHWs and CSs, identifying problems and helping them find solutions.
xiii.	Report on the completion of each workshop.
xiv.	Identify the lessons learned to be used for future trainings.
xv.	Obtain certification as a Trainer.

Description of each responsibility of Trainers

i. Receive training as a Trainer

Trainers have a first responsibility to participate in workshops to receive training as a Trainer for Promotion of MNCAHN. Such workshops will be convened by the subnational Ministry of Health office in collaboration with health facility network managers and the chief of the health facility where the Trainer works. Suggested training time could include a three-day workshop on responsibilities, adult-learning theory, and participatory techniques for adult learning; a three-day workshop on the "Sharing Histories" methodology; and one day of orientation and practice for each of the eight learning modules. This and other suggested content is found in Table 12.

Table 12: Content of workshops for training of Trainers

- Responsibilities of Trainers.
- Adult learning theory.
- Becoming familiarized with the Facilitator Manuals and the Flipcharts for each theme of the first 1,000 days of life (8 learning modules).
- How to teach CHWs and CSs using the "Sharing Histories" methodology.
- How to teach CHWs and CSs using other participatory methodologies for adult learning.

- Operational systems for training and support to CHWs and CSs linked to health facilities.
- Review of technical content of the specific knowledge and practices that CHWs and CSs should learn in order to then teach the same to mothers in the home, on themes covered in the seven modules of the training program.

i. Plan, schedule, and organize monthly training workshops for CHWs and CSs

Once trained, the Trainer is responsible for planning, organizing, and facilitating monthly training workshops in one´s own health facility for CHWs and CSs from their health facility jurisdiction. Training activities should be included in the training plans and general operational plans of their respective health facility. Training workshop dates and the convening of CHWs should be coordinated by the Trainer with the CSs.

ii. Ensure quality of the trainings according to the Trainers´ manual

Trainers should follow a systematic process to facilitate the implementation of training workshops. As presented in the manuals, each (approximately) one-hour learning session during the workshop follows a systematic process of sharing histories/experiences, strengthening knowledge through pictures, practicing skills, and evaluating learning.

iii. Be responsible for CHW/CS training materials

Trainers are responsible for storing and maintaining all materials used for CHW and CS training, ensuring their proper use and care, and their correct distribution to target groups.

iv. Prepare materials ahead of time for each workshop

Trainers prepare materials for teaching according to the list of needed materials described in the Facilitator Manual at the beginning of each new teaching session. These materials are for presenting new information, such as "visualizations" in which a design is created with colored paper forms on the wall as information is gradually presented to participants. See photo. Other materials are prepared and used for practice activities and participatory evaluation activities (such as balls, string, balloons, colored paper, and other) which are held at the end of each learning session.

[Include photo of a visualization]

v. Apply the "Sharing Histories" methodology for teaching

Trainers should follow the instructions in this manual, in addition to the session guidelines and questions for discussion that are provided in the Facilitator Manuals. The "History Formats" in the annex of each Facilitator Manual should be used to record details of the histories told by each participant.

vi. Utilize Facilitator Manuals and Flipcharts for teaching CHWs and CSs

Trainers should promote continual dialogue and analysis of the themes in each workshop, following the session guidelines in the Facilitator Manuals, as well as utilizing the drawings in the flipcharts to stimulate discussion. The Facilitator Manuals also provide ideas for active learning exercises and games for practice and evaluation of learning that facilitate the effectiveness of the training. It is important for CHW and CS to become fully oriented to each drawing (picture card) in the Flipcharts along with the key messages associated with each drawing, so that the CHW and CS can use the Flipcharts to teach mothers in the home. Considerable practice in teaching mothers with the Flipcharts should be gained by CHW and CS during their training program. If information technology becomes available in a setting so that CHW and CS can have access to an electronic tablet or smart phone, it is possible that these can be used in the place of flipcharts for teaching mothers and families in the home.

vii. Apply the Pre- and Post-Test with CHW and CS for each learning module

Trainers use the pre- and post-test questions provided in the annex of each Facilitator Manual. Each CHW and CS training participant is evaluated with these questions both at the beginning and at the end of each learning module. The test questionnaires should be photocopied from the Facilitator Manual on a double-sided page with enough copies for each CHW and CS participant. Tests are verbal, so the tester and participant must go to a secluded place to take the test to ensure that the questions and answers are not overheard by other participants. Each test has ten questions that are asked verbally in an open-ended format, and the responses provided by the participant, if correct, are marked on the sheet. Test questions are either yes/no or else a list of correct possible answers to check off, such as a list of danger signs during pregnancy. For grading the tests, each question is marked as "correct" if the minimum number of correct responses to each question were

provided spontaneously by the participant. For example, the answer would be correct if the CHW spontaneously mentions three or more correct danger signs during pregnancy. The final score is on a scale of one to ten "correct" answers.

viii. Conduct continual evaluation of the training

Trainers should utilize games and participatory activities to evaluate learning at the end of each session. Evaluation activities are proposed and described for each learning session in the Trainers´ manual.

ix. Monitor the skills of the CHW and CS, identifying problems and helping find solutions

During monthly training workshops, Trainers should take time for sessions of "user reflection" to discuss the experiences of CHWs and CSs with mothers and families in their visits. These sessions should identify and discuss successes as well as any problems, and solutions should be sought among the participants themselves. Trainers should observe how well each CHW and CS participant is participating during learning sessions, practice sessions, and evaluation sessions. When learning problems are identified, the Trainer should help the CHW or CS to find solutions through further discussion of cultural beliefs and new knowledge or practice of skills.

x. *Keep records on attendance and test scores of each CHW and CS training module*

It is important that Trainers keep written records on each CHW and CS regarding: (a) their participation at each training workshop, and (b) their scores on each pretest and posttest. In the first case, it is important to be able to follow-up with repeated sessions by Trainers for CSs who missed workshops. CHWs who miss workshops should receive a repeat training session from her CS supervisor. In the second case, the pre- and post-test scores are important for later evaluation of the effectiveness of the training workshops. Pre-test scores should also be used to identify areas of especially weak knowledge that can be emphasized during the training workshop.

xi. Encourage and ensure active participation of all trainees

Trainers should always be aware of how each trainee is participating, and if she needs encouragement to speak out. This is especially important during the Sharing Histories sessions,

when each trainee needs to be encouraged to share their own experiences, in order to maximize their own learning when new information is provided on best practices.

xii. Report on completion of each workshop

Trainers should fill out a simple report upon completion of each training module, and submit it to the person responsible for training or human resources in the health facility. The report should include the topic of the module, the attendance record of each CHW and CS participant, the pre-test and post-test scores of each CHW and CS participant, and any observations. This report should be collected, collated, and filed by the health service network manager and/or the health promotion office of the subnational/provincial or district health office. The information from these reports should be used for program evaluation and research.

xiii. Identify the lessons learned to be used for future trainings

Each workshop will provide new lessons that should be recorded so that future training efforts can be improved. Ideas on new things learned should be written down in a notebook by the Trainer during the workshop so that she does not forget them. Reflections by the Trainer following the training should also be captured as lessons learned, and included in the workshop report.

xiv. Obtain certification as a Trainer

Ideally, the Ministry of Health should award a "certification" to Trainers who adequately fulfill their duties at the required level of competence based on evaluation criteria. Certification is an important component of incentives given to Trainers who may or may not receive additional remuneration for their role in training CHWs and CSs.

Trainer functions, tasks, and skills & attitudes

For fulfillment of their duties as Trainers, Trainers should ideally comply with the profile of functions, task, skills, and attitudes shown in Table 8. These are transmitted through a series of TOT workshops on 1) principles of adult learning and education, and 2) understanding and handling the Facilitator Manuals for teaching CHWs.

During their TOT training, Trainers can be evaluated on the skills and attitudes listed in the following table during practice sessions on teaching CHWs using the learning sessions outlined in the Facilitator Manuals. Following the TOT workshops, Trainers can be evaluated by supervisors who attend CHW training workshops in which Trainers are applying the Sharing Histories methodology to train CHWs and CSs.

To evaluate the Trainers, supervisors can use a checklist with some or all of the suggested skills and attitudes that can be graded on a scale of 1 (low) to 5 (high) as follows.

Table 13: Suggested checklist for evaluation of Trainer skills and attitudes

Trainer Functions	**Trainer Tasks**	**Trainer Skills & Attitudes**	**Evaluation score** 1 (low) to 5 (high)
Communicate effectively with CHWs, CSs, and mothers	Establish effective interpersonal relationships and communication with CHWs, CSs, and mothers	Values the importance of a good inter-personal relationship in Trainer-participant processes.	
		Can establish an empathic relationship with each CHW and CS.	
		Can use teaching methodologies that are mainly participatory.	
		Values and applies creativity and innovation during teaching sessions.	
Apply the methodology of "Sharing Histories" and concepts of participatory adult education	Manage the use of "history formats" to facilitate the telling of personal histories	Can listen carefully to each CHW history that is shared.	
		Can encourage CHWs to provide details of their personal experiences using the respective "history format".	
		Can record relevant details of each history in the respective "format of history" according to the story being told.	
Analyze the cultural beliefs and practices of CHWs and mothers	Facilitate discussion of the beliefs and practices of the CHWs and mothers	Can identify beliefs and practices that are expressed in histories told by CHWs.	
		Can distinguish whether cultural beliefs and practices have positive, neutral or negative effects on health.	
		Can clearly discuss with and explain to CHWs in what way cultural beliefs and practices have either positive, neutral or negative effects on health.	
Transmit and reinforce the messages on key behaviors and knowledge	Has proficient background technical knowledge related to key health behaviors	Uses a creative and innovative participatory methodology for the presentation and discussion of each one of the key messages.	
		Can ask probing questions on CHW experiences on the messages transmitted	

in the first 1000 days		by drawings on each page of the flipcharts provided.	
		Can correctly explain the key messages on each page of the flipcharts provided.	
		Can emphasize the key messages of each page of the flipcharts provided.	
		Manages and enhances the spaces in the Trainer – participant process.	
Continually apply the rules of good teaching and learning	Promote effective communication based on interpersonal empathy	Uses language that is clear, understandable, and empowering to the learner.	
		Uses questions, clarifies, focuses and re directs new perceptual and behavioral options.	
	Manage processes of collective construction of ideas	Stimulates the active and focused participation of each participant	
		Can identify common themes of cultural beliefs and practices and brings them to discussion in light of their effect on health.	
	Establish a relationship of trust and confidence in learners	Can project warmth, understanding, trust, and confidence in herself and within participants in the group.	
		Can foster a an enabling environment which can motivate and support motivation and optimism in the group	
		Can maintain physical, psychological, and emotional participation of all members of the training group.	
	Effectively manage available teaching resources	Can optimize the time available with the group.	
		Can keep a varied and appropriate rhythm that optimizes the energy of the group.	
		Can effectively manage the logistics and physical spaces according to needs and objectives of the group.	
		Designs and choose the materials, dynamics and audiovisual resources to achieve the objectives.	
	Stimulate and enhance creativity in learners	Recognizes and encourages the expression of different experiences, knowledge, and personal perceptions of participants.	
		Values and leverages the diversity of the group.	
Evaluate learning	Evaluate knowledge of participants before and after training	Uses appropriate verbal testing techniques and questions to evaluate each participant.	
		Can analyze the results of evaluations. Records scores.	

		Can use pretest results to improve the training, placing greater focus on weak areas of knowledge.	
	Collect, classify, order, and share information	Produces quantitative and/or qualitative reports as requested based on information collected during training workshops for CHW and CS.	

B. COMMUNITY SUPERVISORS FOR PROMOTION OF MATERNAL, NEONATAL, CHILD, AND ADOLESCENT HEALTH AND NUTRITION

Community Supervisor profile

As the principal supervisor and supporter of CHWs in the community, the Community Supervisor (CS) role is an adaptation from the Care Group Model in which the person in this role is called a "promoter" who trains and supervises "volunteers" [11]. This is a key role that is often absent or ineffective in CHW and community health promotion programs. By using a member of the community who has previous training and experience as a CHW, or has training as a health technician or auxiliary nurse and lives in the community, the CS is more likely to remain in her role and provide sustainability to CHW supervision and support.

A CS is a member of the community who has had five years or more of previous experience as a CHW, or has had professional or technical training in health such as for an auxiliary nurse or health technician. To be most effective, the CS is a woman who has already raised one or more children who are now grown, which gives them greater credibility with younger mothers in the process of teaching them for behavior change in MNCAH. CSs whose children are grown also have a greater availability of time to serve as a CS.

CSs should be able to read and write. They should have a level of maturity to be responsible for completing their responsibilities, functions, and tasks with appropriate skills and attitudes.

Community Supervisor workload

In general, we have found that each CS can be in charge of supporting, mentoring, and supervising about 15-20 CHWs if the tasks to be performed by the CS are to take an average of about 20 hours a week (half-time).

The CSs and CHWs should be trained together so they both have the same training experience and get to know each other on a horizontal plane through sharing histories together. The difference between the CSs and the CHWs is the time commitment, for which the CSs should receive a nominal stipend. CSs generally need to commit about 50% of the time-effort of a full-time job to supervise and support 10-15 CHW according to their assigned tasks. CHWs, on the other hand, would spend approximately 5-6 hours a month to visit their caseload of mothers and children.

Process for Community Supervisor selection

In order to begin the selection process, it is first necessary to determine how many CSs are required in the area of the health facility. If it is determined that one CS will support and monitor about 15 to 20 CHWs, the number of CSs will depend on the number of CHWs in the same health facility area. See the section on "CHW Selection" for information on calculating the number of CHWs in a health facility area. The number of CSs required in each health facility area should be coordinated and agreed on with the district municipality (local government) or other public or private entity that, ideally, will be financing the stipends and incentives of the CSs in addition to the incentives for CHWs.

CSs can be best selected through an open competition organized by each health facility in order to avoid favoritism or clientelism that could result in less sustainability over time that would occur if local leaders choose them, if these leaders are not then reelected. The competition is organized by the chief of the health facility or a management committee of health facility staff that oversees community health work. First, a small CS Selection Committee is formed to be in charge of the open competition for the selection of CSs. The CS Selection Committee is formed by one or more staff of the health facility, one representative of the local district government, and if possible, one representative from a civil society organization working in the area.

The open competition begins with preparation and local publication of a public notice about the competition. The notice should provide details on the desired profile characteristics of CSs

and the roles and responsibilities of the position. Applicants should be asked to submit a letter of intent to the Selection Committee along with a curriculum vitae or written description of training and experience. From among the applicants, the Selection Committee invites a short list of applicants to be interviewed in person. After all interviews have been conducted, the Selection Committee serves as a panel of judges to select and notify those who will serve as CSs.

Community Supervisor responsibilities

CSs have the overall goal to monitor and support CHWs in the community. Each CS could have, for example, an average of 15-20 CHW to support, though this ratio can vary according to the workload given to the CSs in terms of their time commitment and also by geographic dispersion of CHWs and distances to travel for supervision and support visits. The fulfillment of responsibilities for promotion of MNCAHN implies that CSs will need to:

- Understand clearly the four responsibilities of CSs and how to document their completion, as in Table 14.
- Familiarize themselves with the flipcharts, checklists, and other forms for teaching and monitoring mothers and families.
- Familiarize themselves with the key knowledge, skills, and practices in MNCAHN to be promoted to mothers and families through home visits by CHWs.
- Fill out and submit a reporting form to document the completion of their four main responsibilities to receive their full stipend, which is based on task completion (product-based payment).
- Report to the Trainer of MNCAHN Promotion in their health facility as required.

Table 14: Four main responsibilities of Community Supervisors

i. Convene their assigned CHWs to make sure all CHWs attend the monthly training workshop in the health facility. ii. Attend, together with their CHWs, the monthly training workshops. iii. Organize and meet in smaller decentralized groups of 5-6 CHWs in the community, once or twice a month to conduct the following activities: a. Review and reinforce with CHWs the training content received in the workshop monthly with the Trainer, b. Help CHWs to practice using Flipcharts for the education of mothers,

c. Strengthen the capacities of CHWs to utilize monitoring checklists for observation and monitoring of pregnant/lactating mothers, newborns, and children under age two years.
d. Collect information on the activities of CHWs.
e. Help CHWs share experiences of home visits to identify and resolve doubts or problems.
f. Identify with CHWs the mothers and children at risk who have a special need for referral or for a home visit by a professional health provider. Help to organize special care for those families.

iv. Accompany each CHW individually in home visits to model the performance of home visits and interactions with mothers to teach and monitor them for health behavior change.

Community Supervisor incentives

As a feasible strategy, incentives for CSs can include a part-time stipend equivalent to a half-salary of an auxiliary nurse considering the workload and time commitment. In some cases this could be a part-time salary with benefits and job security. Local government or another public or private entity could pay these stipends. If a monetary incentive is not possible, CSs should be provided with non-monetary incentives in their supervisory role, such as an official identification badge, a letter of recognition from local authorities, an occasional food basket, and/or clothing items such as a simple vest or rain poncho that identifies them as CSs who work in collaboration with the health facility and/or local government. Other effective incentives can be celebration of an annual day to commemorate CSs and CHWs.

Functions, tasks, skills, and attitudes of Community Supervisors

To fulfill their duties, CSs should be able to comply with the profile of functions, task, skills, and attitudes, as shown in Table 15. This profile is learned and practiced through a series of training workshops they will attend on a monthly basis along with CHWs. During their training, CSs are evaluated on the skills and attitudes listed in the following table during practice sessions that are facilitated by Trainers using the learning sessions outlined in the Facilitator Manuals. CSs are evaluated on the required skills and attitudes by Trainers who observe them while they practice applying the Sharing Histories methodology to train CHWs.

To evaluate CSs, Trainers can use this suggested evaluation checklist of skills and attitudes that are graded on a scale of 1 (low) to 5 (high) as follows.

Table 15: Suggested checklist for evaluation of Community Supervisor skills & attitudes

CS Functions	CS Tasks	CS Skills & Attitudes	Evaluation score 1 (low) to 5 (high)
Communicate effectively with CHWs and mothers	Establish effective interpersonal relationships and communication with CHWs and mothers	Values the importance of good interpersonal relationships to support and teach other women.	
		Can establish an empathic relationship with CHWs and mothers.	
		Can use the "Sharing Histories" method to talk to mothers during home visits.	
		Can help CHWs use the "Sharing Histories" method to talk to mothers during home visits.	
Reinforce the trainings by Trainers on promotion of MNCAHN	Help CHWs to review and practice using the Flipcharts and monitoring forms	Can help CHWs identify and explain the key messages on each picture card that CHWs must convey to mothers	
		Can explain how to use and fill out the checklist forms to monitor pregnant women, newborns, children and adolescents in home visits.	
Apply on a continuous basis effective methods of supportive supervision to CHWs' learning and performance	Establish an effective learning environment with CHWs based on trust	Projected warmth, understanding and confidence in herself and the group.	
		Fosters a climate of motivation and optimism in the group of CHWs.	
	Stimulate and enhance the recall of personal memories by the CHWs and by mothers	Recognizes and stimulates the expression of the different experiences, knowledge and personal perceptions of the CHWs.	
		Values and leverages the diversity of cultural beliefs and practices	
Information reporting	Collect, collate, and report information on CHWs under their supervision and completion of their own tasks	Can obtain information from CHWs on the activities carried out in home visits.	
		Can tabulate information collected from their CHWs and registers the information on reporting forms.	
		Can support CHWs in the identification of health risks and educational needs of mothers, using the checklist guides for observation and monitoring of pregnant/ lactating women, newborns, children, and adolescents.	

C. COMMUNITY HEALTH WORKERS FOR PROMOTION OF MATERNAL, NEWBORN, CHILD, AND ADOLESCENT HEALTH AND NUTRITION

Community Health Worker profile

The CHWs that we refer to in this guide are female community members. CHWs may or not be literate and are culturally similar to the rest of their community. Somewhat older women work best as CHWs especially when they have had their own experiences with childbearing and childrearing upon which to learn. Older women are more likely to have the respect of younger women in the community, and are likely to have more free time if their children are already grown. CHWs may have received previous training as a community health promoter, or they may be novices. Women are the preferred gender to serve as CHW due to their affinity and access to mothers. Female CHWs are more able than men to visit other women in their homes and discuss topics relevant to health of women and children. Female CHWs also have a greater potential to develop a deep level of trust with mothers that helps empowers them to change health-related behaviors. The process of developing trust and confidence with mothers is facilitated through the innovative teaching methodology Sharing Histories which is the focus of this manual.

Community health worker workload

The number of CHWs selected from each community is estimated at a rate of one CHW for each 30 households (ratio 1:30) for a relatively dispersed rural area. Among 30 households, there are on average five or six 'high-risk' households – meaning that there is a pregnant woman or a child under two years of age. The CHW visits each of these 5 or 6 families at least once per month. For denser urban neighborhoods with shorter travel time to each household, CHW may be able to cover up to 50 families. This is not a strict prescription, but the workload needs to be carefully calculated to not overload while remaining sustainable.

Careful calculation of a volunteer CHW's workload is essential so she is able to make the appropriate number of home visits as well as attend monthly training sessions and monthly or bimonthly refresher sessions with her CS. The workload should be such that a CHW has enough

free time to visit each mother monthly. The goal is that 100% of pregnant women and mothers or guardians of children younger than two years of age be visited at least once per month.

Process for community health worker selection

Preferably, the CHW should be nominated and selected by other mothers who are neighbors in her immediate community to ensure that the CHW is acceptable to the women she will serve. The selection of the CHW should also be acceptable to and approved by community leaders.

Community health worker incentives

Incentives to serve in the role of CHW are usually non-monetary and can include various mechanisms. A very effective substitutive non-monetary incentive is the recognition by the community of the work done by the CHW through the exoneration of her participation in other communal labor activities such cultivating community lands, joint house-raising, and other similar activities. These can be, for example, an official identification badge, a letter of recognition from local authorities, an occasional food basket, and/or clothing items such as a simple vest or rain poncho that identifies her as a CHW working in collaboration with the health facility and/or local government.

Other effective non-monetary incentives can include providing preferential attention for health care for CHWs and their immediate family at the primary health care facility (bypassing long waiting lines), the designation of an annual day to commemorate CHWs (i.e. a national CHW Day), and the organization of CHW group celebrations during special holiday seasons.

Community health worker responsibilities

To guide their work, it is important for CHWs to have a clear delineation of their responsibilities. The proposed five main responsibilities of CHWs are listed in Table 16 and are then described in more detail following the table.

Table 16: Five main responsibilities of CHWs

i.	Actively participate in continuous training workshops on a monthly basis.
ii.	Be well-familiarized with messages in flipcharts and checklists to use in home visits.
iii.	Make at least one home visit each month to every home in her neighborhood with a pregnant woman or mother with a child younger than two years of age and complete the five main tasks in each home visit.
iv.	Attend small group training sessions with her community supervisor (CS) at least once per month.
v.	Fill out and submit monthly activity reports and birth or death notification forms.

Description of each responsibility of community health workers

i. *Actively participate in continuous training workshops on a monthly basis.*

One of the key contributors to good performance of CHWs is provision of continuous training. For that reason, it is recommended that a standard monthly training session for CHWs is organized in the health facility by the Trainer. This monthly training workshop can be a half-day or full-day in length, depending on local decisions and the especially the choice of the CHWs.

ii. *Be well familiarized with messages in flipcharts and checklists to use in home visits*

To be able to comply with their responsibilities, CHWs should be provided with educational material for teaching and monitoring mothers in the home. These materials include the flipcharts on each of seven key themes of the first 1,000 days of life and checklist guides to use during home visits to monitor pregnant and lactating mothers, newborns, and children under two years of age. See lists of materials on Tables 16 and 17. CHWs need to be fully familiarized with the key behaviors and practices in MNCAHN that are represented by each flipchart picture card and be able to use the picture cards to explain things to and teach mothers and families.

iii. *Make at least one home visit each month to every home in her neighborhood with a pregnant women and mothers with a child under two years of age and complete the assigned tasks.*

CHWs should consider five main tasks that she needs to carry out on each monthly visit to pregnant women and mothers with a child under two years of age. These tasks are listed in Table 17.

Table 17: Five main tasks of CHWs in each home visit

a. Share Histories with mothers to build the relationship and to identify how mothers think and act, according to the method described in Section .
b. Use flipcharts to educate mothers and families on key practices for MNCAHN.
c. Use checklists to observe that the mother is practicing the key behaviors to optimize MNCAHN and to prevent chronic child malnutrition chronic child and anemia.
d. Use checklists to look for danger signs in the mother, newly born and children under two years of age.
e. Use the referral form to make timely referrals of mothers and children to the health facility for preventive care and curative services.

iv. Attend small group training sessions led by the CS at least once per month

Each CHW should attend one or two small-group monthly meetings in a decentralized location with the facilitation of the CS. To facilitate participatory learning, the number of CHW in each small group should be between five and seven. Where possible, these decentralized meetings are also supported by the Trainer and/or other staff from the health facility who may be assigned to support that community. In this monthly meeting with the CS, the small group of CHWs should be able to participate in the activities listed in Table 18.

Table 18: Purposes of the small group training sessions led by CS for CHW

a. CHWs receive reinforcement from the CS to strengthen learning from the last training workshop with the Trainer in the health facility,
b. CHWs practice using the flip chart for education of mothers, guided by the CS,
c. CHWs receive reinforcement and practice using checklists for home observation and monitoring,
d. CHWs provide information on their community activities to the CS,
e. CHWs share experiences on their home visits with the group of CHWs and discuss them to learn new things from each other and to resolve any doubts or problems.

CSs should monitor attendance at meetings of their small groups of CHWs. If attendance is faltering, this could indicate errors in the program methodology or in the attitudes or personal situation of the CHWs or the CSs. It is necessary to identify these problems immediately so that Trainers and other health staff from the nearest health facility can take corrective action.

v. Fill out and submit monthly activity reports and birth or death notification forms

CHWs should meet monthly in small groups with their CS to fill out monthly activity reports on their home visits for education, monitoring, and referral activities. CHWs should also fill out reporting forms on any births and deaths that occurred in their community.

Community health worker functions, tasks, skills, and attitudes

To fulfill their duties ideally, CHWs should be able to comply with the following profile of functions, task, skills, and attitudes, as shown in Table 19. This profile is learned and practiced through a series of training workshops they will attend on a monthly basis along with CHWs. During their training, CHWs can be evaluated on the skills and attitudes listed in the following table during practice sessions that are facilitated by Trainers using the learning sessions outlined in the Facilitator Manuals.

CHWs can be evaluated on a scale of one (low) to three (high) on the suggested skills and attitudes by Trainers who observe them while they share and discuss their own histories, and practice using the learning method to talk to mothers in the home.

Table 19: Suggested checklist for evaluation of community health worker skills and attitudes

CHW Functions	CHW Tasks	CHW Knowledge, Skills, & Attitudes	Evaluation score 1 (low) to 3 (high)
CHWs carry out home visits to mothers and families to promote MNCAHN	Teach mothers the key health knowledge and practices.	Asks the mother to tell her experiences about aspects of the first 1,000 days in the life of her children.	
		Uses flipcharts to teach key health knowledge and practices to mothers and families.	
	Monitor the practice of behaviors and the warning signs	Applies a checklist observation guide to observe that the mother is practicing the key behaviors.	

	Refer pregnant women, postpartum women, infants and children to the nearest health facility for preventive care and for timely attention timely for signs of danger	Identifies signs of danger that requires medical attention.	
		Fills out a community referral and cross-referral form and accompanies the mother and child to the health facility.	
CHWs apply on an ongoing basis the following rules of all Trainers	Use and promote effective communication	Asks questions, clarifies, focuses, and redirects the new perceptual and behavioral options.	
	Establish a relationship of trust and confidence with the mother and family	◆ Projects warmth, understanding and confidence in herself. ◆ Fosters a climate of motivation and optimism with the mother. ◆ Applies the methodology of "sharing histories" with mothers in the home	
CHWs collect information for monitoring and reporting	Collect and classify information on mothers and children	◆ Supports the collection of information for monitoring the change of knowledge, skills, and attitude for MNCAHN of mothers and families, using the relevant checklist. ◆Notifies the health facility of births and deaths occurring in homes.	
	Report on monthly activities	◆Submits a monthly checklist report to her CS and Trainer. ◆Informs her CS and Trainer of any difficulties encountered in her work and coordinate actions to resolve them.	

STAGE 4 PREPARING OR ADAPTING THE MANUALS AND MATERIALS TO BE USED FOR MATERNAL, NEWBORN, CHILD, AND ADOLESCENT HEALTH AND NUTRITION PROMOTION

The *Modular Program for Training in Maternal, Neonatal, Child, and Adolescent Health and Nutrition (MNCAHN) for Community Health Workers* has been designed with a structure of eight learning modules. Additional modules can be added as time goes on and according to health needs of each locality. Each of the seven learning module topics to date has a set of two materials:

(a) Facilitator Manual for use by Trainers for Promotion of MNCAHN (professional health providers who work in primary health care facilities) to guide them in the training of female CHWs and CSs (see learning topics in Table 20);

b) Flipchart for face-to-face education of mothers in the home by community health workers (CHWs) and community supervisors (CSs), and also in primary health care clinics by government health workers (see topics in Table 21).

A set of monitoring and supervision checklists and reporting forms also form part of the materials for MNCAHN Promotion.

Of the eight learning modules, the first is introductory and provides an overview of the training program with initial exercises to sensitize CHW and CS trainees to understanding one´s own community, identifying the most vulnerable groups in the community, and learning characteristics of leadership and empowerment in the community. Following the introductory module, there are seven modules that each deals with a technical theme of importance during the first 1,000 days of life. Key messages for each module are based on evidence-based best practices that contribute to preventing chronic child malnutrition and anemia, and maximizing brain development of the child.

Table 20: List of Facilitator Manuals for training community health workers

Module	Learning Module Title	Who uses this material?
I	Facilitator Manual for Training Community Health Workers – Module I: Empowerment, equity and leadership in the community	Trainers who teach CHWs and CSs
II	Facilitator Manual for Training Community Health Workers – Module II: Pregnancy	
III	Facilitator Manual for Training Community Health Workers – Module III: Birth and Postpartum	
IV	Facilitator Manual for Training Community Health Workers – Module IV: The Newborn	
V	Facilitator Manual for Training Community Health Workers – Module V: Exclusive Breastfeeding	
VI	Facilitator Manual for Training Community Health Workers – Module VI: Diarrhea	
VII	Facilitator Manual for Training Community Health Workers – Module VII: Child Growth, Nutrition and Micronutrients	
VIII	Facilitator Manual for Training Community Health Workers – Module VIII: Pneumonia	

Table 21: List of Flipcharts for the education of mothers and families

Module	Flip Chart Title	Who uses this material?
I	(Introductory Facilitator Manual)	Trainers who teach CHWs and CSs CSs who reinforce the teaching of CHWs
II	Pregnancy	
III	Birth and Postpartum	
IV	The Newborn	
V	Breastfeeding	
VI	Diarrhea, Hygiene and Sanitation	

VII	Child growth, Nutrition and Micronutrients	CHWs who teach mothers
VIII	Pneumonia	

A set of 11 monitoring checklists, supervision forms, reporting formats, and other forms for use by CHWs, CSs, Trainers, or Supervisors of Trainers is shown in Table 22.

Table 22: List of monitoring checklists, supervision, reporting and other forms

Nº	**Name of checklist or form**	**Purpose**	**Who uses this material?**
1	Guide for observation and monitoring of pregnant and lactating woman	Simple checklist with pictorial drawings to use in monthly home visits to observe and monitor key health practices and danger signs	CHWs
2	Guide for observation and monitoring of newborns	Simple checklist with pictorial drawings to use in home visits from 0-28 days after birth to observe and monitor normal characteristics, danger signs, and key health practices	CHWs
3	Guide for observation and monitoring of the child under two years of age	Simple checklist with pictorial drawings to use in monthly home visits to observe and monitor key health practices and danger signs	CHWs and health providers
4	Referral and counter-referral	Simple form for referrals from the community to the nearest health facility if danger signs are noted or for regular preventive visits.	CHWs
5	Community Birth Plan	Simple form with drawings to help mothers and families plan for preparing for a birth and for where to go to attend the birth.	CHWs and health providers
6	Birth and death reports	Form for reporting births and deaths that occur at home or in the community	CHWs

7	CHW activity reporting form	Simple reporting form on CHW activities according to tasks assigned	CHWs
8	CS activity report	Simple report of monthly CS activities	CSs
9	Community census	Simple family register to identify risk groups (pregnant women, children under age two, chronic illnesses, elderly)	CHWs and health providers
10	Three-question survey	Three simple questions to ask a family to understand the health and health information preferences of each member of the family	CHWs and health providers
11	Community work plan	Simplified format for a community to make iterative plans for its own development	CHWs and health providers
12	Supervision of primary health care facilities	Organization of primary health care facilities to work in communities, and performance of health providers in community health work	Health facility supervisors

The above educational resources focus on the high-impact area of MNCAH. With these topics emphasized to produce results at the beginning, subsequent educational engagement can follow, building on the MNCAHN foundation to promote holistic healthy families and communities. Further educational engagements can include other health and development-related areas such as early infant stimulation, hygiene and sanitation, safe water, and malaria prevention and control. Home gardens, food security, home budgeting, literacy, environmental conservation, production, and other topics can be added according to the interests of the local population.

STAGE 5 ORGANIZATION AND IMPLEMENTATION OF THE MODULAR PROGRAM FOR TRAINING IN MNCAHN FOR CHW

The program of training Trainers in promotion of MNCAHN is organized in modular form with eight modular topics that include: Introduction (Empowerment, Equity, and Leadership in the Community); Pregnancy; Birth & Postpartum; Newborns; Exclusive Breastfeeding; Diarrhea; Growth, Nutrition, and Micronutrients; and Pneumonia. Modules can be presented in any order, according to local needs and priorities. For example, if your area has high rates of child stunting, you may want to begin the CHW training program with the breastfeeding, diarrhea and infant growth, nutrition, and micronutrient modules. If maternal morbidity and mortality is high, and/or if low birth weight is prevalent in your area, you may want to begin with pregnancy and birth & postpartum modules.

Trainers organize and implement workshops on a monthly basis at one´s own primary health care facility, inviting the CS and CHW, following the order of topics according to health priorities in communities and in the health sector.

Eight Trainer´s Manuals and seven Flipcharts have all the detail on each of the seven modular topics of the training system for promotion of MNCAHN in the community. Each module includes a number of themes that are organized into sessions, as shown in Table 23, according to the sessions presented in the series of eight Facilitator Manuals and based on the contents and key messages of the seven Flipcharts. Each page of each Flipchart focuses on a key knowledge, skill, or practice with a color picture on one side, and on the reverse side, text with the main message and questions & answers to draw the learner into a conversation to explain the picture.

Table 23: Contents of each Facilitator Manual – main messages of each learning session

TITLE OF TRAINER MANUAL		NAME OF THE SESSION	MAIN MESSAGES OF THE LEARNING SESSION
I	EMPOWER-MENT, EQUITY, AND LEADERSHIP IN THE COMMUNITY	SESSION 1: Knowing what to expect from the Modular Program on Teaching/Learning for Promotion of MNCAH.	--Welcome to the training. --Creating an environment of confidence and trust. --What are the goals, objectives, and desired results. --What are the topics they will learn about in the training. --What types of learning activities will they have.
		SESSION 2: Identifying the positive aspects (resources) of the community, and the needs of the community	--CHWs identify the positive aspects, achievements, and resources of their own community. --CHW identify needs of their community.
		SESSION 3: Identifying the 10 most common illnesses in the community. Identifying who are the most vulnerable community members and what they need	--CHW identify the most common health problems in their communities and which group they most affect (mothers, newborns, young children, adults) --CHW identify who in their community are more vulnerable and that need more care.
		SESSION 4: Identifying desired changes in the community - Vision	--CHW identify what they would like to be doing in 10 years. --CHW identify what changes they would like to see in their communities in 10 years.
		SESSION 5: Identifying the qualities of a Women Leader (CHW)	--What is a Women Leader (CHW)? --What characteristics/qualities does a CHW have? --What does the community need and what can the CHW do to change the situation?
II	PREGNANCY	SESSION 1: Welcome and pre-test.	
		SESSION 2: Sharing histories of pregnancy	--All trainees share experiences with each of their children.
		SESSION 3: Identifying cultural knowledge and practices on pregnancy	--CHW and CS experiences are analyzed through a cultural lens.
		SESSION 4: History of Teodora: The road to the death and the road to life	--Complications can lead to death of the mother. --Knowing danger signs and how to seek care can save the life of the mother.

		SESSION 5: Birth planning	--Have a birth plan and know danger signs to save a mother´s life, with help from family and community. --Attend prenatal care for counselling, lab tests, iron tablets, and anti-tetanus vaccine.
		SESSION 6: Eating during pregnancy	--Eat a balanced meal 4 times a day and take iron tablets.
		SESSION 7: Self-care by women during pregnancy	--Ensure personal hygiene and clean home environment.
		SESSION 8: Identifying danger signs during pregnancy	--Recognize these danger signs to seek timely care.
		SESSION 9: Knowing how female CHW and the community should help when labor begins and when a pregnant woman has danger signs	--Recognize signs of labor to seek timely birthing services. --Make sure the community is organized to help a pregnant woman seek care if she is in labor or has danger signs.
III	**CHILDBIRTH AND POST-PARTUM**	SESSION 1: Welcome and pre-test.	
		SESSION 2: Sharing histories of childbirth and postpartum	--All trainees share experiences with each of their children.
		SESSION 3: Identifying cultural knowledge and practices on childbirth and post-partum.	--CHW and CS experiences are analyzed through a cultural lens.
		SESSION 4: Knowing the signs and symptoms of the onset of labor. Avoiding dangerous situations.	--Recognize signs of labor to seek timely birthing services. --Avoid specific actions that put a mother in danger during labor. --If a mother was not able to give birth in a health facility, an organized community should take her immediately.
		SESSION 5: Learning about the importance of the birth of the baby in health facilities and the immediate care of the newborn. Delayed cutting and care of the umbilical cord.	--Why a baby should be born in a health facility. --Dry and wrap a baby immediately after birth and place with the mother. --Cutting the umbilical cord needs special care to avoid dangerous infections.
		SESSION 6: How to organize the community to help when a delivery is imminent in the community. Prevention of abundant bleeding.	--After birth, the family and community are prepared if the mother presents danger signs. The family helps the mother with danger signs while she is transported to a health facility. --If a mother was not able to give birth in health facility, you can help her avoid abundant bleeding until she is transported to a health facility.

			--In the health facility, abundant bleeding after birth can be treated.
		SESSION 7: Learning about the importance of giving the breast to the baby in the first hour after birth, and of the first visit to the mother and baby after delivery.	--Mothers begin to breastfeed in the first hour after birth. --Mother and baby receive a checkup at home within two days of discharge.
		SESSION 8: How to feed the mother and her baby after the birth. Risk prevention in the home.	--After birth, the mother eats well 5 times a day and takes iron pills. --After birth, the mother helps to prevent dangers (massage the uterine fundus, breastfeed frequently, bathing baby after the first day)
		SESSION 9: Learning about the support of the family if the mother has danger signs at home after the birth.	--Family and community know the danger signs after birth. --Family is prepared and knows how to support the mother in danger while she is being transported to a health facility.
		SESSION 10: Knowing the importance of giving only milk breast until six months of age. Importance of starting a family planning method	--In the first six months, feed the baby only breastmilk, then continue breastfeeding for up to two years. --Mother and spouse should start to use a family planning method after birth.
IV	**THE NEWBORN**	SESSION 1: Welcome and pre-test.	
		SESSION 2: Sharing histories of newborns	--All trainees share experiences with each of their children.
		SESSION 3: Identifying cultural knowledge and practices in the care of the newborn	--CHW and CS experiences are analyzed through a cultural lens.
		SESSION 4: Importance of drying the baby immediately after birth. The baby should cry and breathe right after birth.	--As soon as the baby is born, dry, wrap, warm, and put the baby to breast in skin contact with the mother. --Baby should cry and breathe immediately after birth. Babies born at home who cannot breathe can die. Give birth in a health facility where they can help baby breathe.
		SESSION 5: Learning why not to bathe the baby immediately after birth	--Do not bathe the baby the first day after birth. He/she should stay warm next to the mother.
		SESSION 6: Importance of giving breast milk immediately to the newborn	--Mother should begin to breastfeed immediately after birth. Why and how to put the baby on the breast.

		SESSION 7: Control of the newborn in the health facility. Special care of the underweight or premature newborn.	--The baby should be examined and weighed periodically to see if he/she is growing and developing well. --If the baby is born with low weight, put him/her near the breast to avoid chill and to feed frequently.
		SESSION 8: Learning about danger signs in the newborn	--Recognize these danger signs and seek care (does not want to feed, vomits 3 times after feeding, is flaccid or doesn´t wake up, rapid breathing, skin is cold, purple, or yellow, umbilicus is red or has pus)
		SESSION 9: Prevention of diseases through the vaccination of the newborn. Care of the baby for good development.	--Vaccinate the baby at birth and each time it is indicated. --Baby will be healthy and intelligent if he/she is well cared for (summary of priority care is listed)
V	**BREAST-FEEDING**	SESSION 1: Welcome and pre-test.	
		SESSION 2: Sharing histories of breast feeding	--All trainees share experiences with each of their children.
		SESSION 3: Identifying cultural knowledge and practices related to breastfeeding	--CHW and CS experiences are analyzed through a cultural lens.
		SESSION 4: Knowing the benefits and features of the first milk or colostrum	--In the first days, though you have little milk, this is sufficient for the baby´s needs. This is called colostrum.
		SESSION 5: Knowing the benefits of breastfeeding the baby frequently	--If your baby feeds frequently, day and night, you will produce the milk that he/she needs. --If you fill the baby´s stomach with infusions or other milks, the baby will not have space for the breast milk he/she needs.
		SESSION 6: Learning the reasons for not giving infusions or other liquids or food to the baby during the first six months	--If you think the baby is thirsty, give breast milk more frequently. This has all the liquid the baby needs. --Infusions do not solve colic. On the contrary, they can worsen it. Steps to calm colic.
		SESSION 7: Knowing the correct positions of the baby and the mother for effective breastfeeding	--The correct position of the baby ensures he/she can suckle well and your nipples are not injured.
		SESSION 8: Learning to prevent swollen and painful breasts	--To avoid hardened and painful breasts, breastfeed more frequently.
		SESSION 9: Learning about the continuation of breastfeeding if the mother is sick	--Breastfeed even though you are sick.

		SESSION 10: Learning about the power of mothers to know and decide how to care for her child	--Mothers who breastfeed need to eat more than they normally consume. No special foods are required.
		SESSION 11: Learning about the importance of giving only mother´s milk for the first six months	--Until six months, the baby needs only breast milk. Afterward, in addition to breast milk, give other foods.
VI	**CHILD DIARRHEA, HYGIENE AND SANITATION PRACTICES**	SESSION 1: Welcome and pre-test.	
		SESSION 2: Sharing histories of diarrhea	--All trainees share experiences with each of their children.
		SESSION 3: Identifying cultural knowledge and practices on child diarrhea and hygiene.	--CHW and CS experiences are analyzed through a cultural lens.
		SESSION 4: What is diarrhea and what consequences it may have	--If your baby has stool that is looser than normal, he/she has diarrhea. --If your baby has diarrhea, his/her health and life are in danger. Dehydration can kill your baby. --When your baby has stool that is loose and more frequent than normal, give him/her more liquids than normal. --If your baby is less than 6 months old and has diarrhea, continue giving breast milk. If older than six months, continue giving him/her thick food in addition to breast milk.
		SESSION 5: Recognizing the danger signs of dehydration	--All family members should know what is dehydration. Signs of dehydration. --If your baby has diarrhea with danger signs, take him/her immediately to a health facility. Danger signs.
		SESSION 6: Knowing how to prepare oral rehydration salts and homemade solutions	--All family members should know how to prepare Oral Rehydration Salt packages.
		SESSION 7: Knowing ways to prevent diarrhea	--All family members should wash their hands to avoid that the baby gets diarrhea. --We should all drink treated water, store water properly, wash fruits and vegetables, bury garbage, eliminate feces in a latrine, not have animals in the home, do not let the baby play where animals leave feces.

VII	**CHILD GROWTH AND FEEDING**	SESSION 1: Welcome and pre-test.	
		SESSION 2: Sharing histories of the growing children and power	--All trainees share experiences with each of their children.
		SESSION 3: Identifying cultural knowledge and practices of infant growth and infant feeding	--CHW and CS experiences are analyzed through a cultural lens.
		SESSION 4: Getting to know the importance of good nutrition for the mother and child	--From six months on, the child should receive complementary foods in addition to breast milk. --Children who are fed well are healthy, intelligent, grow quickly, and are happy. --If pregnant women and those who breastfeed eat well, they will have healthier and more intelligent children.
		SESSION 5: Knowing the importance of monitoring child growth in the first two years of life	--My future in my first centimeters. How fast should a child grow. What happens if he/she grows less.
		SESSION 6: Feeding the child with patience and affection	--Feeding your child is a moment of love. What to do while you feed your child.
		SESSION 7: Recommendations to prepare food for the child	--When preparing food for your child, take these recommendations into account.
		SESSION 8: Feeding the child 6 months to 7-8 months	--Feeding your child at six months of age. Recommend-ations on consistency, amount, content, and frequency. --Feeding your child 7-8 months of age. Recommendations on consistency, amount, content, and frequency.
		SESSION 9: Feeding the child 9-11 months and 1-2 years	--Feeding your child 9-11 months of age. Recommendations on consistency, amount, content, and frequency. --Feeding your child 12-24 months of age. Recommendations on consistency, amount, content, and frequency.
		SESSION 10: Feeding the child during and after an illness episode	--Feed your sick child so he/she recuperates weight
		SESSION 11: Learning to organize a session to demonstrate preparation of food for the child from six months to two years	--What is and how to conduct a demonstration session on infant food preparation for groups of mothers.
VIII		SESSION 1: Welcome and pre-test.	

	INFANT PNEU-MONIA	SESSION 2: Sharing histories of pneumonia in children	--All trainees share experiences with each of their children.
		SESSION 3: Identifying cultural knowledge and practices for pneumonia	--CHW and CS experiences are analyzed through a cultural lens.
		SESSION 4: Knowing about pneumonia and what consequences it can have	--Pneumonia kills. If your baby has pneumonia, he/she is in danger. Take him/her immediately to a health facility. --Fathers, mothers, and everyone in the community should recognize the danger signs of pneumonia.
		SESSION 5: Recognizing danger signs of pneumonia	--If your baby has cough and rapid breathing, he/she could have pneumonia.--If your baby cannot wake up, he/she could have pneumonia. --If your baby has fever, he/she could have pneumonia. If the baby is under 2 months old and is shaking with cold, he/she could have pneumonia. --If your baby does not want to breastfeed or eat, he/she could have pneumonia. --If your baby has one of these danger signs, take him/her rapidly to a health facility. Tell a CHW to help you.
		SESSION 6: Knowing the importance of continuing treatment at home for pneumonia. Role of the father.	--After returning from the health facility, continue giving the medicine for the full number of days as the doctor recommends.
		SESSION 7: Learning ways to prevent pneumonia	--To avoid pneumonia in your baby, feed him/her with only breast milk then add complementary foods after six months, keep him/her warm, avoid smoke, and always wash your hands frequently.

The minimum duration of training for each module according to type of personnel trained is described in the following table:

Table 24: Minimum duration of each training module by type of trainee

MODULES		Minimum duration of training by module topic and type of personnel		
		Trainers for Promotion of MNCAH	Community Supervisors and Community Health Workers	
			# of days	# of times per month
1	**TRAINING OF TRAINERS IN ADULT EDUCATION METHODS**	3 days	--	---
2	**EMPOWERMENT, EQUITY, AND LEADERSHIP IN THE COMMUNITY**	1 day	1 day	1-2 times a month
3	**PREGNANCY**	1 day	2 days	1-2 times a month
4	**BIRTH & POST-PARTUM**	1 day	2 days	1-2 times a month
5	**THE NEWBORN**	1 day	2 days	1-2 times a month
6	**EXCLUSIVE BREASTFEEDING**	1 day	2 days	1-2 times a month
7	**DIARRHEA, HYGIENE AND SANITATION**	1 day	1 day	1-2 times a month
8	**GROWTH, NUTRITION AND MICRONUTRIENTS**	1 day	2 days	1-2 times a month
9	**PNEUMONIA**	1 day	1 day	1-2 times a month
	TOTAL	11 days	13 days for one training cycle	11-22 times per year on a continuous basis

STAGE 6 IMPLEMENTING AND MONITORING THE PROMOTION OF MNCAHN

Each CHW is responsible for accomplishing specific tasks oriented to achieving change of mothers´ behavior and for improvements in infant health. Each CHW is responsible for a group of about 30 households which are her closest neighbors, among which there are an average of five or six (5-6) pregnant women and children under two years of age. To each of these households with pregnant women and children under two years of age, the CHW should make at least one home visit each month.

Each CS is responsible for overseeing two to four groups of five to seven female CHWs, from a total of 15-20 CHW, for the fulfilment of her responsibility as supervisor and supporter of CHW with the goal to achieve behavior change in homes and communities. The CSs are trained in health facilities at least once a month by Trainers for Promotion of MNCAHN in workshops along with the CHWs.

At least once or twice per month, the CS meets in a decentralized location with each of her small groups of CHWs to reinforce the training on the topic that was discussed by the Trainer in the health facility workshop held that month. Likewise, in these monthly decentralized small-group meetings, the CS collects the information on the community follow-up of pregnant and lactating women and children under of two years. To do this, CS use observation guides as tools that allow the tracking and monitoring of the activities of CHWs in their communities.

At their monthly training sessions in the health facility, CSs hand in their reports to Trainers with information on their activities in the previous month such as their small group meetings with CHWs and the home visits they made to accompany CHWs. These monthly reports show compliance of the four main tasks that the CS should complete in the course of each month. See Table 9. That completed report should be put on file in the health facility, and also submitted to the district municipality to provide evidence of task completion, on the basis of which is calculated the amount of stipend paid to the CS by the district municipality.

Trainers for Promotion of MNCAHN monitor and evaluate the processes for training CHWs and CSs, and report this information to the head of the primary health care facility, to the regional health official responsible for training, and other appropriate persons, utilizing a supervision matrix format. Community leaders should also receive feedback from Trainers and participate in evaluation of the program.

Every year, there should be a random-sample monitoring of behavior and key practices of mothers in order to assess the effectiveness of the strategy and to make the necessary modifications.

TYPES OF POLICY STATEMENTS OR RESOLUTIONS NEEDED TO INSTITUTIONALIZE AND GUIDE IMPLEMENTATION OF COMMUNITY-BASED HEALTH

The Ministry of Health should ideally emit policy resolutions that:

1. Approve a document that establishes methodological guidelines for strengthening of primary health care services and for implementation of community-based health promotion in the framework of strengthening primary health care services to support that work.

2. Approve a document that establishes the skill profile of primary health care staff as Trainers of health promotion for maternal, neonatal, child, and adolescent health, with criteria and processes for selection and designation, certification, evaluation and supervision, job expectations and criteria for maintaining the designation and certification.

3. Approve the reproduction, dissemination and use of educational materials for mothers and families (Flipcharts) for used by CHW and in health services, at least on the topics: pregnancy, birth and postpartum, newborns, breastfeeding, infant growth and feeding, diarrhea, and pneumonia. These would be used as part of community-based health promotion for behavior change for the first 1000 days.

The Ministry of Economy and Finance should ideally develop budget programs that incentivize and/or directly finance activities for community/based health promotion through regional/provincial and district municipalities (or other decentralized or deconcentrated units) including partial stipends for Community Supervisors and/or non-monetary incentives for Community Supervisors and CHWs.

Regional/provincial and district municipalities (or other decentralized or deconcentrated units) should ideally authorize the incorporation into the Municipal District budgets, the financing needed for stipends for Community Supervisors on a monthly basis during the fiscal years. Include specification of the sources of financing: concept; and type of resource.

ANNEX 1

Background on development of this manual

The teaching/learning method "*Sharing Histories*" and system for community-based health care and community health worker training and support was developed, implemented, and evaluated by the international non-profit organization Future Generations in two parallel efforts. One of these was the effort to develop the Sharing Histories method for teaching CHW. The second parallel effort was development of a system framework that would sustainably support CHW in their community health work in collaboration with the public health and other government sectors.

The Sharing Histories method for teaching CHW was developed through a series of field projects in Afghanistan, India, and Peru over a period of 12 years. The idea for Sharing Histories was empirically discovered in Afghanistan in 2003 [4] when public health experts visited remote villages to assess child mortality rates in remote villages. They gathered together local women and asked them to share detailed accounts of each of their pregnancies, with probing to identify any deaths. Beliefs, practices, problems, and successful health actions, both traditional and modern, were brought out for discussion through the shared histories. The women were deeply fascinated to hear each other's stories and became highly enthused and empowered to ask probing questions and learn more about each situation. This observation led to development of a strategy and field tests in collaboration with the Afghan Ministry of Health (MOH). Older women trained as CHWs became empowered to replicate their learning with other women, convincing them to take charge of their family´s health and to use available health services. Two years after the initial pilot ended, the CHWs continued the work demonstrating a sustainability that had not been seen before. A retrospective evaluation showed a 46% reduction in child mortality [4]. Based on the evidence, the Afghan MOH scaled up the CHW training strategy to 13 provinces, achieving an increase in health coverage by 77% [5] [12]. Adaptation and application of the method was later conducted in 40 villages in Himalayan valleys of Arunachal Pradesh in east India, with qualitative reports on similar success of the method in empowering women to change [6].

Two tests of the method were conducted in rural Peru. First, a small cluster-randomized controlled trial was conducted in 28 rural indigenous villages of extreme poverty in the high Andes Mountains of Peru with half of 75 community health workers trained with Sharing Histories method, and the other half trained with standard CHW teaching methods by local

health professionals [7].[1] A second larger field test was conducted also in Peru with a cluster-randomized controlled trial in two study groups distinguished by type of CHW teaching method used. Outcome measured was child stunting [9].

The second parallel effort, for the purpose of developing a community-government system to sustain CHW work with mothers in the home to promote health and nutrition of women and children, had several stages in Peru. This began with a pilot project to develop a basic operational model of community-based primary health care in a periurban township of 22 "community" sectors in a poor peripheral settlement in urban Huanuco city in the region of Huanuco, Peru.[2] This model was then scaled up to a large field project in 17 municipalities in the region of Cusco, Peru with 230 communities that continued to build on the model on a larger scale with iterative innovative strategies for linking mothers in the home with communities and government services, through work with community health workers.[3]

The final project tested the Sharing Histories methodology in a randomized-controlled trial in the region of Huanuco, Peru within the larger context of implementing the locally adapted operational model for community-based primary health. [9] [4]

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[1] "Sharing Pregnancy Histories as Part of Community Education for Maternal and Neonatal Health" (2010-2011) supported by a subgrant from EngenderHealth - Agreement GMH-107-1 under a grant from the Bill & Melinda Gates Foundation (prime grant #51636) and through an agreement with the Regional Health Directorate of Cusco, Peru.

[2] "Pilot Teaching-Learning Center: CLAS Las Moras-Huánuco" (2002-2007) with support from the Mulago Foundation and the Duane Stranahan Charitable Trust and through an agreement with the Regional Health Directorate of Huanuco, Peru.

[3] "NEXOS Project: Promotion of Maternal-Child Health in the Context of Co-management of Primary Health Care Services" (2005-2009), supported by a grant from the United States Agency for International Development - Cooperative Agreement GHS-A-00-05-00011-00 and through agreements with the Regional Government and Regional Health Directorate of Cusco, Peru.

[4] "Health in the Hands of Women: A Test of Teaching Methods" (2010-2014) with support from the United States Agency for International Development - Cooperative Agreement AID-OAA-A-10-00048 and through agreements with the Regional Government, Regional Health Directorate, and district governments of Chinchao, Churubamba, Santa María del Valle, and Umari in Huanuco, Peru. Throughout, support was provided by Future Generations Inc. and Future Generations University of Franklin, WV, U.S.A.

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