Evaluating the Effect of Gender-Equity Maternal and Child Health Programs in Uganda

Final Report

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This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Innovations for Poverty Action. The principal investigators for the project are Martina Bjorkman Nyqvist and Seema Jayachandran. Pricilla Marimo and Jaye Stapleton assisted in writing the report.

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ACRONYMS

ASTE	Average Standardized Treatment Effect
BMI	Body Mass Index
CC	Community Connector
DHS	Demographic and Health Survey
HFA	Height-for-age
IPA	Innovations for Poverty Action
LC1	Local Council 1
MHN	Men's Health and Nutrition
MUAC	Mid Upper Arm Circumference
PCA	Principal Component Analysis
RCT	Randomized Controlled Trial
SD	Standard Deviation
USAID	U.S. Agency for International Development
VHT	Village Health Team
WHN	Women's Health and Nutrition
WFH	Weight-for-height
WEMP	Women's Empowerment

EXECUTIVE SUMMARY

BACKGROUND

Child malnutrition is widespread in most developing countries. In order to combat the high levels of under-nutrition, food insecurity, and related child health problems, USAID Uganda issued a grant to Innovations for Poverty Action in 2012 to design and implement a randomized controlled trial that evaluated interventions aimed at reducing child malnutrition in Uganda. The approach to reducing malnutrition and improving health was gender-focused, that is, it addressed the differing positions of mothers and fathers within the household. Specifically, the interventions were designed to close mother-father gaps in health and nutrition knowledge and in decision-making power within the household. This was done via village training sessions that provided parents of young children with communication skills and health and nutrition knowledge to improve their children's health.

EVALUATION PURPOSE AND QUESTIONS

This study evaluated an innovative set of interventions aimed at improving child nutrition and health in Uganda. The goals of the study were to provide insight into the reasons that mothers, according to many previous studies, spend more than fathers on children's health and also to evaluate scalable interventions that give skills and knowledge to parents that enable them to improve their children's health and nutrition. Evaluating the impact of these interventions, thus, provides two types of knowledge. First, our evaluation was designed to provide broadly applicable insights into the reasons that mothers typically spend more than fathers on children's health. Second, we assessed the effectiveness of scalable programs that could close mother-father gaps in knowledge and decision-making power and thereby reduce child malnutrition. The study answers the following questions: (1) Can addressing gender gaps between mothers and fathers improve maternal and child health and economic well-being? and (2) What approach to closing gender disparities is more effective at improving child health and other outcomes—increasing mothers' empowerment, increasing fathers' knowledge about the health needs of children, or increasing mothers' knowledge about the health needs of children? The findings from this evaluation can be used to inform other USAID programming and guide other international organizations, governments and stakeholders to design effective programs for improving child and maternal health and nutrition, especially in contexts where men have considerably more decision-making power within the household than women.

RESEARCH DESIGN

A randomized controlled trial (RCT) methodology was used to evaluate three different interventions designed to explore knowledge and female decision-making power as barriers to child health. The first intervention aims to increase fathers' knowledge about the health needs of children (Men's Health & Nutrition, or MHN). The second intervention increases mothers' knowledge about the health needs of children (Women's Health & Nutrition, or WHN). The third intervention builds on WHN and additionally aims to increase mothers' empowerment (and ultimately, their decision-making power in the household) by teaching communications skills (Women's Health & Nutrition plus Empowerment, or WEMP). The rationale behind WEMP is that, in addition to knowledge, women need increased say in the household in order for their views on health spending, family diet, and health-seeking behaviors to be reflected in the household's decisions.

An RCT allowed a rigorous evaluation of the effectiveness of each of the interventions compared to the status quo and to each other. The sample population was randomly divided into one of three treatment

groups (villages that received a particular intervention) and a comparison group (villages that did not receive any intervention). Each of the treatments consisted of 19 bi-weekly village-level training sessions that provided parents of young children with knowledge and communication skills to improve their children's health and nutrition. The trainings emphasized behavior changes that families could make even with limited financial resources.

The study was conducted in 412 rural villages in the four districts of Mitooma, Ntungamo, Rukungiri and Sheema in southwestern Uganda. The evaluation uses two waves of data collection (a pre-intervention baseline survey and a post-intervention endline survey) in which mothers and fathers were surveyed and anthropometric measurements of mothers and children were collected. The evaluation examines the effects of the interventions on child and maternal height, weight, anemia, and other health indicators, as well as intermediate outcomes such as health behaviors, knowledge, and women's empowerment.

FINDINGS AND CONCLUSIONS

The results show no statistically discernible effect of any of the three interventions on child health in general, but disaggregating by child gender, there is suggestive evidence of positive impacts on girls' health (weight and height) for the WEMP group. Specifically, girls in the WEMP group are more likely to have higher height for age (HFA) scores and higher weight for age (WFA) scores than boys. The WEMP group also had a reduction in mortality for infants less than 6 months old. However, we note that this result is based on a small sample of infant deaths. There are no statistically significant health impacts of the WHN or MHN programs on infant mortality and no impacts on maternal anthropometric measures for any of the three interventions.

The WEMP program did not lead to improvements in women's self-reported decision-making power within the family, but women who participated in this intervention are working slightly more and discussing child health and nutrition more with husbands. Moreover, the three programs increased conversations between husbands and wives about important topics that affect maternal and child health such as the woman's nutrition during pregnancy and whether to have antenatal checkups. All three interventions significantly increased participants' health and nutrition knowledge. Survey responses indicate that children and women in the WHN intervention had improved diets.

There is also evidence of better antenatal and postnatal practices and an improvement in health and nutrition practices such as improved feeding practices for babies in the WEMP and WHN groups. In terms of immunization, children are more likely to have received the required dose of Vitamin A in the WEMP group.

Overall, the WHN and WEMP programs were more effective than MHN. This is partly but not entirely due to mothers being more likely than fathers to attend the program meetings regularly. Although these programs did not improve child height and weight overall, the improvement in health behaviors, reduction in infant deaths, and improved weight and height of girls suggest that parent classes that convey both concrete health knowledge to mothers and communication skills so that they can affect change in household spending and health-seeking behaviors hold promise as a tool to improve child health.

BACKGROUND

Child malnutrition is widespread in developing countries. Globally, 175 million children under age 5 are stunted and 55 million are wasted (Bhutta et. al. 2009). In Uganda, despite significant strides over the last 10 years, the child mortality rate (defined as mortality before age five) remains high at 55 per 1,000 live births (World Bank, 2015)[1]. Malnutrition among adults and children is also high, with more than half of Uganda's population unable to access nutrient-dense food and a 33% rate of stunting among children under five (Uganda Demographic and Health Survey, 2011). Vitamin A deficiency and iron-deficient anemia in women and children are also prevalent. A myriad of factors contribute to these poor health outcomes such as child care and hygiene practices in the home, access to health-care and nutrition services, access to food and a diverse diet, agricultural productivity, and employment and access to monetary and non-monetary resources.

In order to combat the high levels of under-nutrition, food insecurity, and related child health problems, USAID Uganda together with the Government of Uganda developed a comprehensive and integrated approach—the Community Connector (CC) project under the USAID Feed the Future initiative. The CC program is an effort to provide a multi-sectoral approach to poverty, food insecurity, malnutrition and poor maternal and child health in Uganda targeting those communities that experience disproportionate levels of each. Going beyond traditional interventions, the CC project aims to increase participation of women in household production and decision-making, especially regarding the use and distribution of resources, and increase exposure to important nutrition and hygiene interventions. Innovations for Poverty Action (IPA), U.S.-based non-profit, was contracted by USAID to conduct a randomized controlled trial designed to investigate key Feed the Future and CC hypotheses about gender inequities as a barrier to maternal and child health and food security.

It is widely held among development practitioners and academics that mothers are more likely to spend money on goods and services that improve children's health and well-being than fathers are.[2] However, less is known about exactly *why* mothers spend differently than fathers. Two quite different possible reasons (that are not mutually exclusive or exhaustive) are that:

(A) Women put higher priority on the health and nutrition of children.
(B) Women know better than men what is needed to achieve better child outcomes.

If (A) is paramount, then to improve child health and nutrition, one promising policy approach might be to shift household decision-making power toward women. However, if (B) is a large factor behind the pattern, then it might be sufficient and simpler to educate men about child health needs without changing the balance of decision-making power in the household. Testing these two different approaches is one of this study's objectives, as described below.

[1] In 2005 the child mortality rate was 107 per 1,000 live births (http://data.worldbank.org/indicator/SH.DYN.MORT?page=1)
[2] Examples of studies in developing countries are (Thomas 1990, 1997) and Duflo (2003).

EVALUATION PURPOSE & QUESTIONS

EVALUATION PURPOSE

Given the pressing need to develop and evaluate interventions to combat under-nutrition and related child health problems, this study evaluates an innovative set of interventions aimed at improving child nutrition and health. In particular, the study uses a randomized controlled trial (RCT) methodology to explore how mother-father disparities in knowledge and decision-making power contribute to poor child health and evaluates different interventions aimed at closing these mother-father gaps in Uganda. This study evaluates three different interventions to explore these barriers to child health. The first intervention aims to increase fathers' knowledge about the health needs of children. The second intervention increases mothers' knowledge about the health needs of children. The third intervention aims to increase mothers' empowerment (and ultimately, their decision-making power in the household). The goal of the study is to provide insight into the reasons that mothers typically spend more than fathers on children's health and also to evaluate scalable interventions that give skills and knowledge to parents that enable them to improve their children's health and nutrition. Evaluating the impact of these interventions provides two types of knowledge. First, we assess the effectiveness of scalable programs that could close mother-father gaps in knowledge and decision-making power and thereby reduce child malnutrition. Second, our evaluation is designed to provide broadly applicable insights into the reasons that mothers typically spend more than fathers on children's health.

The findings from this evaluation can be used to inform other USAID programming and guide other international organizations, governments and stakeholders to design effective programs for improving child and maternal health and nutrition. Within Uganda, representatives of the Uganda government and USAID Uganda's implementing partners, many of which work in the area of child nutrition, will benefit from the evaluation. We believe the results are broadly applicable in developing countries since child malnutrition is a global problem. Moreover, the pattern that money in the hands of mothers has a bigger impact on children's health than money in the hands of fathers has been documented in Africa, Latin America, and Asia. Hence, mother-father disparities in knowledge or bargaining power are likely to affect child health outcomes in many regions of the world. The interventions are designed to shed light on why intra-household bargaining power affects child health. Since the importance of bargaining power between parents as a determinant of child health seems quite universal, it is also likely that our findings about the underlying reasons that bargaining power matters will be applicable in many settings. Thus, the findings from this study will be useful in designing other types of interventions aimed at improving child health outcomes, for example, transfer programs that provide money to mothers versus fathers.

EVALUATION QUESTIONS

The study aims to answer two main questions:

(1) Can addressing gender gaps between mothers and fathers improve maternal and child health and economic well-being?

(2) What approach to closing gender disparities is more effective at improving child health and other outcomes—increasing mothers' empowerment, increasing fathers' knowledge about the health needs of children, or increasing mothers' knowledge about the health needs of children?

RESEARCH DESIGN

The study was conducted in 412 rural villages from four Southwest districts in Uganda: Mitooma, Ntungamo, Rukungiri and Sheema. To compare the effectiveness of the innovative approaches mentioned above, an RCT methodology was used. An RCT allowed a rigorous evaluation of the effectiveness of each of the gender equity strategies relative to the status quo and relative to each other. Villages were randomly assigned to three treatment groups and one control group which did not receive any intervention (see Table 1). The randomization process ensured that participants in each of the groups were, on average, similar at the outset of the study and differed only with respect to the interventions they received; this allows one to measure the causal effect of the interventions by comparing outcomes (e.g., child health) in the treatment and control groups.

Table 1: Treatment groups and control group

Treatment 1	**Treatment 2**	**Treatment 3**	**Control**
Women's Empowerment +Women's Health & Nutrition Education (WEMP) (98 villages)	Men's Health and Nutrition Education (MHN) (105 villages)	Women's Health Nutrition Education (WHN) (105 villages)	Control Group (104 villages)

INTERVENTION

The intervention, called the Healthy Futures Initiative (HFI), consisted of village-level training sessions that provided parents of young children with skills and knowledge to improve their children's health. More specifically, the intervention was designed to close mother-father gaps in health and nutrition knowledge and improve communication and decision-making within the household. The different treatment arms are described below. The specific curricula content and how the modules were implemented will be discussed in more detail in the 'Intervention Implementation' section.

Treatment 1: Women´s Health and Nutrition plus Women's Empowerment - the Women's Empowerment curriculum was designed to increase women's decision-making power within the household and enhance skills related to dialogue and communication. The Nutrition Education curriculum was designed to teach women about safe antenatal and birthing practices, recommended breast-feeding behaviors, nutrition needs for women and children, and sanitary food and water preparation.

Treatment 2: Men's Health and Nutrition – used the same Nutrition Education curriculum and format utilized in Treatment 1, but with men as the participants.

Treatment 3: Women's Health and Nutrition – used the same Nutrition Education program as in Treatment 2 but instead targeted women.

Control: The control group did not receive any intervention.

TIMELINE OF ACTIVITIES

This section gives an overview of the timeline for the different study activities. Figure 1 is a graphical depiction of the timeline.

Figure 1: Project Timeline

Intervention Development & Baseline Preparation - January 2012 to August 2012

The first phase of the project focused on successfully laying the groundwork for efficient data collection and development of an effective and culturally appropriate educational intervention. Preparation for field operations included hiring of key staff, testing intervention curricula content, equipment procurement, survey development and testing and identifying the sample population to be included in the survey. In June and July 2012, the sample population for the baseline survey was determined by identifying, with the assistance of the Uganda Bureau of Statistics, the universe of villages in the four study districts. Parishes and individual villages that were deemed urban were excluded from the sample frame. Of the over 2,000 villages remaining, a geographic algorithm was applied to randomly select villages as geographically distant from each other as possible with the aim of reducing spillovers of knowledge from one village in the study to another. Once the 412 villages to be included in the study were randomly selected, a Household Listing exercise was undertaken to identify eligible households within each village (more detail below). Due to the nature of the intervention, which aimed to change decision-making power within the household, it was important that one of the household eligibility criteria be that both partners were living in the household (staying in the household more than 16 nights within the last month).

Household Listing Exercise

The Household Listing exercise was undertaken in August 2012. The exercise was done to create a list in each village of eligible households for the baseline survey. A household was considered eligible if both parents lived at home and either the woman was pregnant or the youngest child in the household was age 24 months or younger. The questionnaire collected information related to household demographics and other household characteristics (e.g. marital status of household head, whether or not household had any children under age five and the ages of the children, whether or not the spouse of the household head was pregnant, etc.). The exercise was conducted by working with members of the Village Health Teams (VHTs) and the Local Council 1(LC1). VHTs maintain record books which include household names, births, deaths and immunizations, and their responsibilities include regular visits to households within their catchment areas. They are consistently the most knowledgeable community members in terms of village demographics and health and collectively are able to discuss each household within their village. Representatives of the LC1 also have keen insight into the members of their community and served as a check to VHTs.

Enumerators were responsible for organizing a meeting of all VHTs and a representative of the LC1 to create a list of all households within the village with a cohabitating couple and either a young child or a pregnant woman. At the conclusion of the listing the enumerator asked a series of questions to reconfirm that each household was included in the list. After the initial listing was complete, enumerators visited all households with a child between 18 and 30 months (that is, near our age cutoff of 24 months) to confirm child ages, using the Child Health Card if available and the mother's account if not. This exercise resulted in a list of all eligible households in the study villages from which to randomly draw the baseline survey sample.

Baseline Survey - August 2012 to January 2013

The sample of households for the baseline survey was selected from data collected in the household listing exercise. Households were selected with a preference placed on those with children less than 6 months of age or pregnant women since the interventions were expected to be most beneficial for families with pregnant women or young infants. Seven replacement households per village were identified whenever possible; these households were interviewed if one of the originally chosen households was determined to be ineligible or could not be located. Mobilizers (that is, the "advance team" for the surveyors) also consulted the LC1 to identify additional eligible households that were not included in the census performed in the previous month due to a woman being newly pregnant or a household with a child under 24 months recently moving to the village. The main goal of recruiting a sufficient number of participant households in every village was to ensure the intervention group size was large enough for a lively discussion. The total baseline sample was 5,516 households (2,270 in Ntungamo; 1,361 in Rukungiri; 1,078 in Mitooma and 807 in Sheema), which represents about 13 households per village.

Field Logistics

Pretesting of the baseline survey instruments began in June 2012. The baseline data collection included three surveys in total: the women's survey, the men's survey, and an anthropometric survey. The man and woman in an eligible household were each interviewed separately - a full survey to the mother/pregnant woman and a shorter questionnaire to the male partner. Anthropometric measurements were recorded for the woman and all children under about three years of age (specifically, less than or equal to 28.5 months) who were living in the household at the time of the baseline survey. The surveys were finalized and programmed for electronic data collection in August and September. A two-week surveyor training for the IPA field team took place in September, and data collection took place in all 412 villages between October 2012 and January 2013. Survey data were collected using portable PDAs (Samsung Galaxy Players) and later imported, compiled, and analyzed. Anthropometric data were collected using Hemocue 301 Hb Analyzers, Seca 874 Mother Baby Scales, and ShorrBoard Infant/Child/Adult Portable Height-Length Measuring Boards. Anthropometric measurements included height, weight, middle upper arm circumference, and hemoglobin levels as determined by a finger prick blood draw. Survey-based measurements included variables for: health (e.g., self-reported illness, child survival); health-care utilization (e.g., health clinic visits, immunization coverage); household consumption; health and nutrition knowledge of mothers and fathers; and proxies for women's empowerment and decision-making. Prior to administering the baseline survey, informed consent was obtained and all communication was done in the local language. The key sources used to develop the baseline questionnaire were the 2006 Uganda DHS, the 2010 Tanzania DHS, the International Men and Gender Equality Survey of 2011, and a survey from a recent peer-reviewed health economics study in Uganda by Björkman and Svensson[3].

To ensure high-quality data were collected, auditors re-visited a randomly selected subset of households the day after a village was surveyed to administer a shortened version of the same survey. This shortened version focused on key outcomes and questions for which it was most important to verify data quality. Data from audits were analyzed on the spot by comparing them to the data collected by the surveyors the day before. The results were presented to surveyors on a weekly basis both to hold surveyors accountable for any errors and to minimize future errors in the field. During the survey we found that in a larger than expected percentage of households, fathers were working away from home for extended periods of time, making otherwise eligible households ineligible.

[3]Björkman, M. and Svensson, J. (2009). "Power to the People: Evidence from a Randomized Field Experiment of a Community-Based Monitoring Project in Uganda." *Quarterly Journal of Economics.* 124 (2): 735-769.

Intervention Implementation - February 2013 to November 2013

The intervention was implemented in 308 villages randomly chosen out of the 412 study villages: Women's Health & Nutrition (105 villages), Men's Health & Nutrition (105 villages), and Women's Health & Nutrition plus Women's Empowerment (98 villages). The remaining 104 villages received no program and served as the control group for the study. The randomization was stratified along two dimensions, first, the baseline level of women's decision-making power and, second, baseline child and maternal health. Specifically, several variables from the baseline survey were combined into an index measure of women's decision-making power, and villages were divided into those with above- and below-median women's decision-making power. Similarly, villages were categorized as above- and below-median on an index of child and maternal anthropometric measures. Randomization was conducted separately within each of the 4 categories (high decision-making index/high health index, high decision-making/low health, low decision-making/high health, low decision-making/low health). Stratification ensures better balance along these characteristics between the different treatment arms and the control group.

Activities related to the intervention began in January 2013 with the hiring and training of field supervisors and program facilitators. Facilitators were assigned specific villages for the duration of the intervention, and in February 2013 facilitators visited each of their villages in person to mobilize program participants (those who participated in the baseline survey in the treatment villages). Each village visit began by meeting with the Local Councilperson (LC1) to discuss the program. LC1s were provided with a small one-time incentive (4,000 UGX, $1.50) to assist the facilitator in locating the participants. Once all participants in a village were contacted, the facilitator established a convenient meeting time to ensure maximum attendance. Thereafter, training sessions for participants were held in each village once per fortnight. Each group also elected a group leader to act as a contact person for the facilitator and aid in the continued mobilization of participants throughout the program. Group leaders were required to own a mobile phone to enable communication. Group size varied from 5 to 16 invited participants. In some villages, residents who were not part of the IPA evaluation asked permission to also participate in the program. Other residents who fit the eligibility criteria[4] were allowed to sit in on the program but did not receive financial incentives for attendance. After 19 bi-weekly meetings in all treatment villages, the final sessions were completed at the end of November 2013. Throughout the implementation period, facilitators were closely monitored by the field supervisors and the IPA Project Coordinator.

Participants were given incentives for participation- male participants received an incentive of 1,000 UGX (approximately $0.40) at every session, and female participants receive an incentive of 1,000 UGX at every other session. The rationale for this difference is that, in the absence of financial incentives, men are less likely to participate than women; this difference may be due to men having less flexible employment or a lower interest level in the topics. In an ideal world, fathers would be intrinsically motivated enough to attend as much as mothers do, but in reality, it appears that giving them a larger financial incentive to attend is necessary to obtain attendance rates that are comparable to those for mothers. Note that even with the higher incentive level for men, the average participation rate was 59% for fathers compared to 78% and 76% for women in the WEMP and WHN groups respectively.

Curricula Development

Both the Health and Nutrition and the Women's Empowerment curricula (see Annex 1) were developed based on extensive literature reviews as well as meetings and consultations with local health professionals and advocacy organizations. Each Health and Nutrition session was designed to be approximately one hour in length, while each Women's Empowerment session was approximately 45

[4] To be eligible to participate in the program, residents had to live in same households as their spouse/partner (i.e., both the mother and the father live in the same house) and either have a child under two years of age or are pregnant.

minutes (1 hour and 45 minutes in total when combined with the Health and Nutrition curriculum). All lessons were field-tested in villages in Bushenyi in summer of 2012. Eight villages in the district of Bushenyi were selected to receive the program and act as pilot villages. (Four received the Women's Health & Nutrition plus Women's Empowerment curricula and the other four received the Men's Health & Nutrition curriculum.) To enable the facilitators to have a thorough understanding of Health and Nutrition topics, they participated in 1.5 weeks of training prior to implementation of the program. During facilitator training, project supervisors reviewed facilitator roles and responsibilities before going over the Health and Nutrition curriculum and handbook in detail. Training included an overview of each session, including main education points, information on general logistics, directions for learning activities, and discussion questions. Other topics covered during the training week included adult learning, staff expectations, and facilitation skills. The facilitators were also provided with the curriculum guide for the lessons (Annex 1, Parts A and B) and an accompanied facilitator's guide (see Annex 1, Part C) containing additional information on each topic. This guide includes more detailed technical information as well as common misconceptions and participant questions that were documented during field-testing.

Learning materials were developed by Mango Tree, a local NGO that specializes in developing and field-testing education materials for households in Uganda. Materials included a set of flip charts in Runyankole (the local language) with color illustrations covering a range of concepts and topics covered in the curricula as well as a set of flash cards with various local foods (e.g. see Image 1). Flip charts displayed images such as food groups, women attending antenatal checkups, and examples of assertive, passive, and aggressive body language. As an additional resource, facilitators and supervisors were also given materials published by UNICEF such as diagrams of breastfeeding positions, male and female reproductive systems, and various forms of contraception.

Image 1: Mango Tree illustrations depicting (1) steps for making an oral rehydration solution (2) and a woman receiving antenatal care at a health clinic.

Curricula Content

The Health and Nutrition curriculum covers 16 topics aimed at improving health outcomes for mothers and children less than two years of age. The curriculum also includes an introduction and overview session as well as two review sessions to help consolidate participants' knowledge adding up to 19 lessons in total. The Health and Nutrition curriculum is identical for both the Men's and the Women's sessions. The session topics are as follows:

1. Introduction and overview
2. Maternal health and child nutrition
3. Prenatal nutrition
4. Breastfeeding

5. Complementary feeding
6. Food groups
7. Micronutrients for mothers and children
8. Safe water and sanitation practices
9. Food preparation and recipes
10. Review
11. HIV / AIDS
12. Contraception and family planning
13. Preconception
14. Pre and postnatal practices in your community
15. Birthing
16. Infant illness and preventative health practices
17. Postnatal care and birth spacing
18. Infant growth monitoring and promotion
19. Review and graduation

The Women's Empowerment curriculum is similarly structured but has only one review session. The first half of the program covers general skills, and in the second half (i.e., Session 11 onwards) the topics specifically complements the Health and Nutrition curriculum. The session topics are as follows:

1. Overview and introduction
2. General communication strategies
3. Decision making process
4. Communicating infant needs
5. General negotiation strategies
6. Power and preventing conflict
7. Healthy relationships and healthy families
8. Gender relations
9. Financial negotiation
10. Self-esteem and goal setting
11. HIV/AIDS prevention
12. Negotiating family planning use
13. Communicating and negotiating antenatal needs
14. Resources in my community
15. Household budgeting
16. Healthy children
17. Fatherhood
18. Domestic violence
19. Review and graduation

Endline Survey - March 2014 to September 2014

The endline survey was built upon the baseline survey, allowing the research team to measure changes in key variables over time in both treatment and control groups. Similar to the baseline survey, the endline survey collected data on anthropometric measures (height, weight, middle upper arm circumference, and hemoglobin levels as determined by a finger prick blood draw), health (e.g., self-reported illness, child survival); health-care utilization (e.g., health clinic visits, immunization coverage); household consumption; health and nutrition knowledge; and proxies for women's empowerment and decision-making. Households in treatment villages were also surveyed about their participation in and opinions about the intervention. Preparations for the endline survey included field-testing the survey and a two-week staff training.

Endline data collection activities launched in in March 2014. The man and woman from the baseline couples were each interviewed separately - a full survey to the mother/pregnant woman and a shorter questionnaire to the male partner. The field team attempted to interview both spouses, even if the couple was no longer living in the same household. It should be notes that men were generally found to be home less often than women, and therefore the women's questionnaire and the anthropometric questionnaire were designed to capture the main outcomes of interest. Anthropometric measurements were recorded for the woman and all children who were sampled at baseline, as well as any other biological children from age 0 to 7 who were living in the household at the time of the endline survey. A child was considered to be living in the household if he or she spent at least 16 days of the last month in the family household. This could include sleeping in a close relative's house, such as an aunt or grandmother, so long as the mother was the primary caregiver. Prior to administering the survey, informed consent was obtained and all communication was done in the local language. Shortly after launching the initial data collection the team began tracking activities for respondents categorized as needing short-term tracking (e.g., respondents still living in the area but unavailable during the enumerator's initial visit). Respondents that required long-term tracking (e.g., respondents who may have moved or were working/traveling outside the village) were monitored and slated for follow-up at later dates. Some households were not found despite several follow-up attempts by the survey team, resulting in an attrition rate of 5.5% for the main data collection tools. The field team was also unable to complete the men's questionnaire for an additional 3.8% of the sample. Reasons for households being lost to follow-up included fleeing legal and financial issues, economic migration, and dissolution of families (divorce). Data collection was carefully monitored by Field Managers and survey team leaders via audits, high-frequency data reviews, and spontaneous spot checks. Similar to the baseline, data from audits were analyzed on the spot, with results presented to surveyors on a weekly basis both to hold surveyors accountable for any errors and to minimize future errors in the field.

Quantitative data was supplemented with qualitative data collection in a subset of 36 treatment villages. Both male and female participants were surveyed on what intervention modules they found most useful and on what modules could be expanded to include more information. Additionally, qualitative data provided anecdotal examples of ways in which participants made lifestyle changes to incorporate teachings from the HFI program. Participant feedback was collected from each village by facilitators via focus group discussions in the final session of the program during November 2013. Supplementary feedback from facilitators was collected by the Project Coordinator during the final staff meeting in December 2013.

Data Cleaning and Analysis - October 2014 to September 2015

After the data collection, data cleaning was done to prepare data for analysis. Data cleaning included renaming and recoding of variables, checking for duplicates and merging of endline and baseline data. Baseline and endline survey data were cleaned and analyzed using STATA, a statistical software package.

Data analysis was done using statistical tests of mean outcomes across groups, as well as regression analyses that allowed for adjustments of any differences between the groups in baseline characteristics. To assess the effect of the intervention, we estimate the following linear regression model

$$Y_{ijd} = \alpha + \beta T_{jd} + \theta_d + \gamma_j + \varepsilon_{ijd} \qquad (1)$$

where Y_{ijd} is the outcome of household i, in village j in district d, T_{jd} is an indicator variable for assignment to treatment, θ_d are district fixed effects, γ_j are the stratum fixed effects and ε_{ijd} is the error term. We cluster standard errors at the village level, accounting for the fact that the intervention varies at this level.

For some outcomes, we have a group of related outcome measures. To assess the impact of the intervention on a set of K related outcomes, we follow Kling et al. (2004)[5] and estimate a seemingly unrelated regression system, to derive average standardized treatment effects (ASTE),

$$\widetilde{\beta} = 1/K \sum_{k=1}^{K} \hat{\beta}_k / \hat{\sigma}_k \qquad (2)$$

where $\hat{\beta}_k$ is the point estimate on the treatment indicator in the kth outcome regression and $\hat{\sigma}_k$ is the standard deviation of the control group for outcome k (see Duflo et al. 2007)[6].

To perform between-group comparisons of the effect of the treatments on mortality rate, a Poisson regression was estimated.

[5] Kling, J. R., Liebman, J. B., Katz, L. F., & Sanbonmatsu, L. (2004). Moving to opportunity and tranquility: Neighborhood effects on adult economic self-sufficiency and health from a randomized housing voucher experiment.

[6] Duflo, E., Glennerster, R., & Kremer, M. (2007). Using randomization in development economics research: A toolkit. *Handbook of development economics*, *4*, 3895-3962.

FINDINGS, CONCLUSIONS & RECOMMENDATIONS

BASELINE RESULTS

This section highlights the results of the baseline survey. The baseline survey data was used to randomly select the villages that would receive the HFI program. The results from the baseline survey also provided the research team with a better understanding of health problems, gender norms, and health knowledge in the study area, which the team was able to use to refine the HFI lessons. Summary statistics from the baseline survey can be found in Table 2.

Table 2: Summary statistics at baseline

	Mean	Std. Dev.
Household size	5.409	2.140
Number of kids age 0-5	1.640	0.678
Husband is employed	0.968	0.176
Husband is employed in non-skilled labor	0.572	0.495
Mother is employed	0.952	0.214
Mother is employed in non-skilled labor	0.876	0.329
Mother's total wage last week (1,000UGX)	0.003	0.006
Household's income last month (1,000UGX)	128.300	274.360
Household owns some land	0.790	0.407
Size of land (acres)	1.861	2.343
Assets PCA	0.000	3.742
Consumption PCA	0.000	3.472
House materials PCA	0.000	1.995
Woman's health knowledge index	0.649	0.071
WFA z-score (<5 years)	-0.100	1.409
HFA z-score (<5 years)	-1.177	1.906
Observations	5,505	

Notes. 1. PCA is used when the dataset has a large number of variables such that the dispersion matrix may be too large to study and interpret properly because of too many pairwise correlations between the variables. PCA reduces the number of variables to a few, interpretable linear combinations of the data -each linear combination corresponding to a principal component. 2. Assets PCA includes owning: cattle, goats, chicken, a stove, a water tank, a bed, a paraffin/kerosene lantern, a television, a radio, a generator, a cell phone, a bicycle, a motorcycle and a motor vehicle. Consumption PCA includes consuming: sugar, paraffin, soap, tea, milk, meat/fish, salt, transport, air time or public phones; and spending on: rice, babies/children's clothing, funeral expenses, health expenditure, school fees, school supplies, parties/weddings and women's clothes. Housing materials PCA includes using raw materials for household's floor, roof, or wall, as well as main sources of lighting and cooking. 3. The woman's health knowledge index is an unweighted average of its components and includes knowledge variables related to e.g. breastfeeding, children's health and nutrition, sanitation, etc.

Baseline Household Characteristics

Households in the sample ranged in size from 2 to 20 members, with a median size of 5 members. Farming was the principal activity among the respondents, especially women: 83% of the women reported working on a farm as their main occupation, compared to 58% of the men. About 89% of the households in the sample had (at least) one child less than 2 years old and in 21% of the cases the woman was pregnant. In almost the totality (99%) of the surveyed households, the household head was a man. The median educational attainment of the household head was class P6. In addition, more than two thirds of the households in the sample owned agricultural land (79%) and at least one cattle, goat or chicken (76%). The average monthly income of the households was 128.300 UGX (approximately $50). Differentiated by district; household size tended to be quite similar, with Ntungamo and Rukungiri districts having a slightly larger average size; while male (self-reported) literacy was quite homogeneous across the districts, female (self-reported) literacy was significantly higher in Sheema district (80%) and lower in Mitooma district (68%); households in Sheema district were relatively less engaged in farming

and were richer, while Rukungiri had the highest average participation in farming activity and the lowest average monthly income.

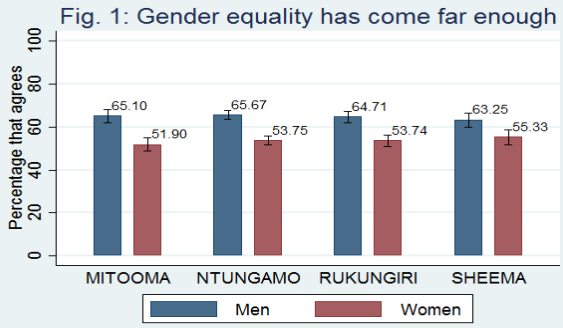
Baseline Gender Norms

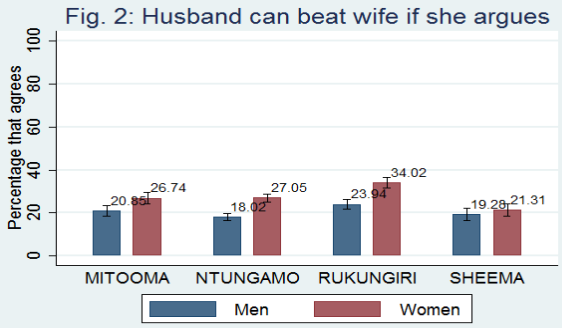
Both the women's and the men's questionnaire contained questions to measure prevailing gender norms. In the first set of questions, the respondent had to say how much she/he agreed (or disagreed) with a given statement. In most cases the statement was exactly the same in both the men's and the women's questionnaires, making it possible to identify discrepancies in the way gender norms are perceived. Results revealed significant discrepancies across genders in how women's empowerment was perceived. For instance, 40% of the men felt that women's rights took away their own rights, while only 30% of the women believed that to be the case. Similarly, 65% of men believed that gender equality had already come far enough compared to 54% of women. Based on these findings, men appear to be significantly less favorable toward women's empowerment than women are. However, it is also noteworthy that a large portion of women were not in favor of further advances in women's empowerment. Discrepancies also clearly emerge when looking at who should have the final say over birth control: 70% of the women believe they should be in charge, while only 52% of the men agree. The pattern appears to reverse when considering the obligations that a wife has towards her family and husband: Women revealed, on average, a predisposition to accept and tolerate any action or decision of their husbands, which is more than what husbands seemed to expect from them. Almost all women (94%) agreed that women should tolerate domestic violence in order to keep the family together, while 90% of the men agreed with that.

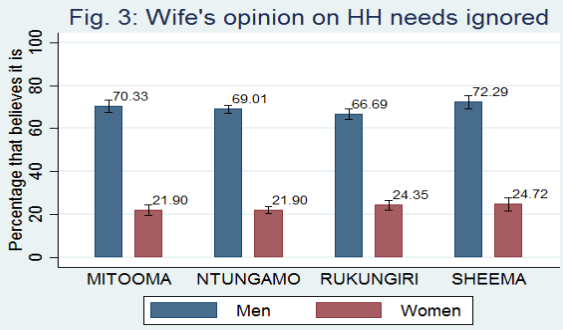
A second set of survey questions measured how much consideration women's opinions garner within the household. Whereas the first set of questions was designed to elicit respondents' views on women's empowerment in general, the second set focused on the dynamics of the specific household being surveyed. The respondent was asked to identify the primary decision maker in the household for certain topics and then asked whether he or she ever has opinions which differ from those of the decision-maker (if different). Follow-up questions investigated whether these different views are ever made explicit, whether they then lead to arguments, and who is the winner of the arguments. By relying on a decision tree that takes into account all the possible combinations of answers, it is possible to create an index that captures whether women's opinions in the household are valued or ignored.

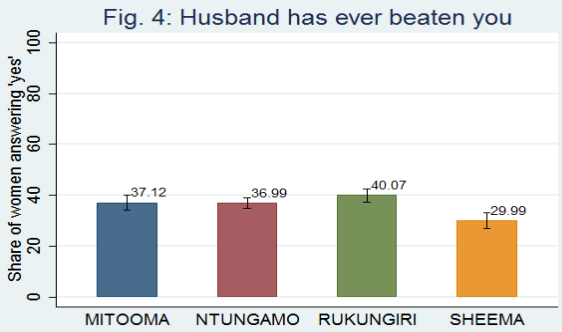
At baseline, the two sexes answered similarly when considering how to spend women's income or how much to feed the children: Both men and women reported that the woman's view was ignored in less than 14% of the cases, with some minor variation across the two questions. However, answers significantly differed when looking at decisions over daily household needs and children health costs. In these cases, respectively 69% and 75% of men believe that the woman's view is ignored, while only 23% and 9% of the women report that this is the case.

The women's questionnaire also contained questions concerning the husband-wife relationship in the household. The vast majority of women (92%) report that their husband gets angry whenever they disagree with him. Moreover, 37% report having been beaten, and 17% state they have been humiliated in front of others by their husband. Additionally, 21% of the women claim that their husbands do not trust them with money. Figures 1 to 4 below show the variation across the four districts for four representative questions discussed above. There is quite some heterogeneity in the spatial distribution of the answers, depending on the question considered. The most striking difference seems to concern Sheema district, where a significantly lower number of women agree that a husband can beat his wife if she argues with him. A significantly lower number of women in Sheema also report that their husband ever beat them.









Parental Health Practices

At baseline, parental health practices were captured through a set of questions contained in the women's questionnaire. The first set of questions recorded parents' health behavior. Overall, 84% of the women report treating water before using it. Concerning family planning, less than half (45%) of female respondents report ever using family planning and 28% report that they currently use it. 36% of the women who gave birth in the last two years gave birth at home.

A second set of questions looked at parental health practices for their children. For children under three years of age, 71% of mothers reported taking iron supplements either while pregnant with the child or within two months after giving birth. However, only 40% of these children had all the required vaccinations. There were also a series of health questions pertaining to children under five years of age. We find that 60% slept under a bed net the night before the interview, while one out of four children under the age of 5 suffered from diarrhea in the two weeks before the interview. On average, these children ate 4 meals per day and ate protein (at least once) 5 days out of the week in the week prior to the interview. Figures 5 - 8 illustrate the heterogeneity across districts for four representative questions analyzed in this section.

Child Health Status

At baseline, the median age of the children was 10 months, while average weight and height were 8.3 kg and 67.9 cm, respectively. Four main health indicators were examined for each child. Weight-for-height (WFH) and Mid-Upper Arm Circumference for age (MUAC-for-age), which are two measures traditionally used in health research to characterize wasting. Height-for-age (HFA) was used to capture

stunting, as it identifies inadequate height relative to the age of the child[7]. These outcomes were measured using z-scores, or where the child was in the distribution of the outcome in the World Health Organization worldwide reference population for their age and gender. Finally, hemoglobin levels were recorded to measure the prevalence of anemia.

The average MUAC was 14.1cm, and the average hemoglobin level was 11.3 g/dl. Looking at the two measures of wasting, the mean z-score for WFH in the sample was 0.75 for boys and 0.73 for girls, while the mean z-score for MUAC-for-age was 0 for both genders. Overall, wasting affected only a small percentage of the children in the sample. When considering WFH, 4% of the boys and 3% of the girls had a z-score below -2 (two standard deviations (SD) below the reference population median) and were therefore classified as wasted, with 1% of the boys and 1% of the girls being severely wasted (i.e. z-score below -3 SD). Using MUAC-for-age gives only a slightly higher prevalence: 6% (2%) of the boys and 4% (1%) of the girls were classified as (severely) wasted. Stunting appeared to be much more prevalent among the sampled children. The mean z-score for the HFA indicator was -1.6 for boys and -1.3 for girls hence 41% of the boys and 33% of the girls were stunted. 40% of the children in the sample were anemic (41% of the boys and 38% of the girls). Girls appeared to have, on average, better health status than boys.

Women's Health Status

Women in the baseline survey weighed 57 kg and had a height of 157 cm, on average, which gives an average Body Mass Index (BMI) of 23 kg/m^2. Six percent of the women in the sample were considered

[7] It should be noted that when child weight was measured in the field, children's clothing was not removed. Therefore, our weight measurements may be somewhat overestimated compared to other studies and WHO norms, since the standard protocol is to remove as much clothing as possible. This oversight will not affect the impact evaluation results in which we compare the treatment groups to the control group, as all of the groups were measured using the same method. However, it does mean that the true rate of wasting may be higher than what we report here.

underweight (have BMI below18.5 kg/m2)[8]. Conversely, 20% of the women in the sample had BMI above 25 kg/m^2 and were classified as overweight. Additionally, on average, women in our sample had a MUAC of 26 cm. According to international standards[9], moderate malnutrition in adult women is defined by a MUAC below 22.1 cm (below 23 cm if the woman is pregnant); according to these references and in line with the pattern seen for BMI measurements, 6% of women suffered from malnutrition. Average hemoglobin level of the mothers in the sample was 13.3 g/dl. Using international thresholds[10] for hemoglobin levels, 11% of the women in the sample were anemic, with 8% suffering from mild anemia, 3% from moderate anemia, and less than 1% from severe anemia. The four districts were quite homogeneous in terms of women's health conditions, similar to child health outcomes.

Balance Check

Table 3 shows a balance check across the treatment groups and control groups for some key variables. No significant differences were found between villages that were selected to receive the program and those that were not, indicating that the villages were successfully randomized into comparable groups. As such, the treatment and control villages can be compared to one another to assess intervention impact.

Table 3: Randomization check between treatment and control groups

	Treat	Control	p-value
Household size	5.418	5.384	0.66
	(2.437)	(2.433)	
Number of kids age 0-5	1.64	1.64	0.988
	(0.745)	(0.744)	
Husband is employed	0.968	0.967	0.912
	(0.198)	(0.198)	
Husband is employed in non-skilled labor	0.571	0.574	0.884
	(0.617)	(0.616)	
Mother is employed	0.951	0.955	0.612
	(0.279)	(0.278)	
Mother is employed in non-skilled labor	0.877	0.875	0.898
	(0.407)	(0.406)	
Mother's total wage last week (1,000 UGX)	0.003	0.003	0.787
	(0.007)	(0.007)	
Household's income last month(1,000 UGX)	125.795	135.805	0.267
	(289.506)	(289.313)	
Household owns some land	0.79	0.791	0.936
	(0.491)	(0.490)	
Size of land (acres)	1.869	1.836	0.73
	(3.062)	(3.051)	
Assets PCA	0.015	-0.046	0.663
	(4.500)	(4.490)	
Consumption PCA	0.028	-0.083	0.454
	(4.782)	(4.767)	
House materials PCA	0.021	-0.062	0.394
	(3.142)	(3.130)	
Woman's health knowledge index	0.649	0.646	0.326
	(0.098)	(0.097)	
WFA z-score (<5 years)	-0.1	-0.102	0.96
	(1.740)	(1.730)	
HFA z-score (<5 years)	-1.179	-1.173	0.948
	(2.765)	(2.742)	
Observations	4133	1379	

Notes: 1. Standard errors are clustered by village and are shown in parentheses. 2. See Table 2 for description of variables.

[8] Pregnant women are excluded from these figures.
[9] http://www.unhcr.org/4b7421fd20.pdf, page 16.
[10] http://www.who.int/vmnis/indicators/haemoglobin.pdf, page 3.

FINDINGS

In this section, we incorporate the endline data to evaluate the impact of the program. Results will be presented as follows: first, we show whether or not intervention had any impact on gender empowerment and health and nutrition knowledge. Next, we present results on the effect of the program on health behaviors and practices (namely parental health practices, sanitation, reproductive health, antenatal care, postnatal care and child immunizations. Finally we show whether the program had any impact on health outcomes as measured by children's weight, height and mortality rates.

Women's Empowerment and Employment

Impact on Women's Empowerment

We hypothesized that the WEMP program would increase women's decision-making power, but using standard measures of women empowerment we find no evidence that this positive change occurred. The endline data indicates that there is no significant difference between the treatment groups and the control group in several women's empowerment variables. For example, we find no significant difference in women's spending and women's say about the following: daily household needs, major household's purchases, household spending, money, women's clothing, children's health costs, children's clothes, or schooling expenses (see Tables 4a and 4b). The tables also include a summary measure (denoted ASTE for average standardized treatment effect) which helps avoid the problem of multiple hypothesis testing whereby, with enough outcome measures, one would likely observe some to be statistically significant by chance.

Table 4a: Wife's say on household purchases and own spending

	Wife's say on household purchases				Wife's say on own spending		
	Wife has a say about: daily HH needs	Wife has a say about: major HH purchases	Wife has a say about: spending HH money	Household purchases ASTE	Wife has a say about: women's clothing	Wife has a say about: spending wife's income	Women money ASTE
WEMP	-0.002	-0.027	0.000	-0.026	-0.018	-0.006	-0.041
	(0.019)	(0.018)	(0.018)	(0.034)	(0.015)	(0.013)	(0.036)
WHN	-0.015	-0.020	0.000	-0.029	-0.014	-0.009	-0.038
	(0.018)	(0.018)	(0.019)	(0.033)	(0.014)	(0.012)	(0.034)
MHN	0.019	-0.019	0.014	0.008	-0.002	0.001	-0.001
	(0.018)	(0.018)	(0.018)	(0.032)	(0.013)	(0.012)	(0.032)
p-value: WHN=WEMP	0.480	0.689	0.975	0.925	0.746	0.824	0.935
p-value: WHN=MHN	0.048	0.947	0.444	0.248	0.370	0.343	0.232
Observations	5,170	5,170	5,112	5,170	5,169	5,127	5,170

Notes: 1. Standard errors are clustered by village and are shown in parentheses. 2. All regressions include baseline values of the outcome, stratum fixed effects, district fixed effects, age dummies, a dummy for currently pregnant, and how many months pregnant. 3. *Significant at 10% level; **Significant at 5% level; ***Significant at 1% level. 4. The p-values are the test of the null hypothesis of equal treatment effects between the different intervention arms.

Table 4b: Wife's say on child related expences

	Wife has a say about: child's health cost	Wife has a say about: about: feeding children	Wife has a say about: about: child clothes	Wife has a say about: schooling expenses	Children expenses ASTE
WEMP	0.000	-0.015*	-0.004	0.011	-0.025
	(0.012)	(0.008)	(0.010)	(0.011)	(0.030)
WHN	0.002	0.001	0.001	0.011	0.009
	(0.010)	(0.006)	(0.010)	(0.011)	(0.026)
MHN	0.008	-0.001	0.005	0.014	0.017
	(0.010)	(0.007)	(0.010)	(0.011)	(0.026)
p-value: WHN=WEMP	0.857	0.047	0.622	0.938	0.263
p-value: WHN=MHN	0.544	0.795	0.665	0.731	0.790
Observations	5,155	5,153	5,154	4,382	5,158

Notes: 1. Standard errors are clustered by village and are shown in parentheses. 2. All regressions include baseline values of the outcome, stratum fixed effects, district fixed effects, age dummies, a dummy for currently pregnant, and how many months pregnant. 3. *Significant at 10% level; **Significant at 5% level; ***Significant at 1% level. 4. The p-values are the test of the null hypothesis of equal treatment effects between the different intervention arms.

Table 5a: Gender perceptions

	Disagree: Only women's resp. to avoid getting pregnant	Agree: Women should have a final say about birth control	Disagree: Wife has obligation to have sex w/ husband	Disagree: Women should tolerate violence for family	Disagree: Husband can beat wife if she goes out w/o approval	Disagree: Husband can beat wife if she argues	Disagree: Husband can beat wife if she doesn't cook on time	Husband respects wife's opinion	Husband gets angry when wife disagrees once in a while or less	Quarreled w/ husb. >1 year ago or never	Gender perceptions & violence ASTE
WEMP	0.012	-0.046***	0.017	-0.007	0.008	0.006	-0.004	0.029	0.055***	0.025	0.015
	-0.015	(0.016)	(0.020)	(0.008)	(0.019)	(0.018)	(0.020)	(0.019)	(0.019)	(0.021)	(0.017)
WHN	-0.001	-0.048***	-0.015	0.000	-0.010	-0.005	-0.012	0.035*	0.041**	0.013	-0.003
	(0.015)	(0.016)	(0.018)	(0.008)	(0.019)	(0.019)	(0.018)	(0.019)	(0.020)	(0.022)	(0.016)
MHN	0.005	-0.036**	-0.006	-0.005	-0.010	-0.023	-0.007	0.022	0.029	0.019	-0.008
	(0.014)	(0.016)	(0.020)	(0.008)	(0.021)	(0.019)	(0.019)	(0.019)	(0.020)	(0.023)	(0.015)
p-value: WHN=WEMP	0.365	0.881	0.091	0.364	0.385	0.564	0.709	0.758	0.469	0.58	0.283
p-value: WHN=MHN	0.652	0.450	0.635	0.486	0.985	0.341	0.794	0.505	0.522	0.778	0.772
Observations	5,287	5,287	5,284	5,284	5,284	5,285	5,282	5,187	5,191	5,170	5,288

Notes: 1. Standard errors are clustered by village and are shown in parentheses. 2. All regressions include baseline values of the outcome, stratum fixed effects, district fixed effects, age dummies, a dummy for currently pregnant, and how many months pregnant. 3. *Significant at 10% level; **Significant at 5% level; ***Significant at 1% level. 4. The p-values are the test of the null hypothesis of equal treatment effects between the different intervention arms.

Table 5b: Gender rights

	Disagree: Women's right takes away men's	Disagree: Gender equality has come far enough	Disagree: Wife should obey husb. even if she disagrees	Disagree: Men should show who is the boss	Disagree: Men should be leaders, not women	Agree: Women should choose her own friends	Agree: Women should decide alone how to spend free time	Disagree: Wife's power in HH takes away husband's	Agree: Husband and wife can share power	Agree: Women's opinion should be respected	Gender rights ASTE
WEMP	0.037**	-0.006	-0.014*	0.010	0.034*	-0.022	-0.032**	0.017	0.039**	0.002	0.010
	(0.018)	(0.022)	(0.008)	(0.021)	(0.019)	(0.016)	(0.013)	(0.019)	(0.016)	(0.005)	(0.016)
WHN	-0.008	0.037*	-0.012*	0.010	0.013	-0.026	-0.012	-0.003	0.026*	0.002	0.006
	(0.018)	(0.021)	(0.007)	(0.020)	(0.020)	(0.016)	(0.014)	(0.020)	(0.016)	(0.005)	(0.016)
MHN	-0.006	0.049**	-0.010	0.033	-0.020	-0.031**	-0.034***	-0.016	-0.003	0.004	-0.012
	(0.018)	(0.023)	(0.008)	(0.021)	(0.021)	(0.015)	(0.013)	(0.019)	(0.016)	(0.005)	(0.016)
p-value: WHN=WEMP	0.016	0.032	0.822	0.993	0.269	0.816	0.177	0.342	0.44	0.974	0.807
p-value: WHN=MHN	0.930	0.549	0.761	0.260	0.102	0.771	0.117	0.525	0.069	0.671	0.242
Observations	5,258	5,259	5,287	5,270	5,269	5,285	5,285	5,270	5,284	5,284	5,288

Notes: 1. Standard errors are clustered by village and are shown in parentheses. 2. All regressions include baseline values of the outcome, stratum fixed effects, district fixed effects, age dummies, a dummy for currently pregnant, and how many months pregnant. 3. *Significant at 10% level; **Significant at 5% level; ***Significant at 1% level. 4. The p-values are the test of the null hypothesis of equal treatment effects between the different intervention arms.

Women's Employment

While the results for intervention effectiveness on improving women's empowerment were weak, women in the treatment groups worked more days compared to those in the control group. WEMP and MHN groups also reported that women were less likely to disclose their income to their male partner, and WEMP women spent more on protein-rich food such as meat and fish (the importance of including proteins in the diet was highlighted in the nutrition curriculum).

Table 6: Women's employment

	Employed	Hours a day work	Days a week work	Disclose earning to husband	UGX spent on: Soap	UGX spent on: Milk	UGX spent on: Meat & Fish	UGX spent on: Health expenditures
WEMP	0.002	0.170	0.086**	-0.036*	10.137	79.064	726.806***	-2912.432
	(0.005)	(0.108)	(0.040)	(0.019)	(61.752)	(116.924)	(267.812)	(3258.675)
WHN	0.004	-0.011	0.071*	-0.028	-38.204	48.281	76.141	-3583.185
	(0.005)	(0.094)	(0.038)	(0.021)	(58.196)	(125.060)	(274.791)	(3131.524)
MHN	0.004	0.017	-0.009	-0.053***	-8.679	-132.550	44.763	-4343.705
	(0.005)	(0.091)	(0.041)	(0.020)	(62.880)	(114.172)	(252.004)	(3234.056)
p-value: WHN=WEMP	0.805	0.090	0.701	0.671	0.420	0.806	0.015	0.823
p-value: WHN=MHN	0.926	0.754	0.049	0.237	0.627	0.139	0.899	0.800
Observations	5,288	5,192	5,192	5,105	5,270	5,279	5,268	5,259

Notes: 1. Standard errors are clustered by village and are shown in parentheses. 2. All regressions include stratum fixed effects. 3. *Significant at 10% level; **Significant at 5% level; ***Significant at 1% level. 4. The p-values are the test of the null hypothesis of equal treatment effects between the different intervention arms.

Impact on Knowledge

Impact on Health Knowledge

The direct impact of the intervention was to increase parent's knowledge about young children's health and nutrition needs, and we find strong evidence that this positive change occurred. Participants in all three treatment groups were more likely to know that the lack of a balanced diet affects a child's growth and that protein is important for young children. Women in treatment groups were more likely to know about the following compared to the control group: that colostrum is important for child's immunity and growth, causes of malaria and diarrhea, what impacts child growth, when and what food/liquid to introduce during first year of child, what to feed children when sick with diarrhea, foods to eat if you have anemia, and foods to eat that have Vitamin A. The women in the treatment groups were also more likely to know that the following statements were false: cow's milk is as good as breast milk, HIV can be transmitted via breastfeeding and porridge during weaning should be thin and watery. However they were less likely to know that children should go to bathroom in a latrine.

Table 7a: Health and sanitation knowledge

	Health Knowledge							Sanitation Knowledge				
	False: Safe to go to primary health center if no pregnancy complications	Should feed colostrum to a newborn	Very much: Lack of balanced diet impacts child growth	Should breastfeed for 24 months	False: Cow's milk equally good as breastmilk	Give ORS if child is vomiting/has diarrhea	Health knowledge ASTE	Treat drinking water	Allows water to boil before removing	Washes hands after bathroom often	Washes hands before meal often	Sanitation knowledge ASTE
WEMP	0.067***	0.092***	0.065***	0.030*	0.070***	0.103***	0.161***	0.048***	0.054***	0.114***	0.077***	0.200***
	(0.022)	(0.025)	(0.011)	(0.018)	(0.014)	(0.022)	(0.019)	(0.010)	(0.014)	(0.021)	(0.022)	(0.030)
WHN	0.025	0.065***	0.054***	0.044***	0.065***	0.126***	0.144***	0.047***	0.043***	0.100***	0.078***	0.180***
	(0.022)	(0.024)	(0.012)	(0.017)	(0.015)	(0.022)	(0.017)	(0.010)	(0.014)	(0.022)	(0.022)	(0.030)
MHN	0.009	-0.012	0.036***	-0.019	0.015	0.038*	0.028	0.007	0.029*	0.033	0.023	0.064**
	(0.023)	(0.026)	(0.013)	(0.017)	(0.015)	(0.020)	(0.017)	(0.011)	(0.015)	(0.022)	(0.021)	(0.030)
p-value: WHN=WEMP	0.064	0.248	0.334	0.421	0.743	0.305	0.38	0.827	0.361	0.513	0.959	0.443
p-value: WHN=MHN	0.486	0.001	0.134	0.000	0.000	0.000	0.000	0.000	0.316	0.003	0.008	0.000
Observations	5,288	5,288	5,284	5,287	5,288	5,288	5,288	5,288	4,952	5,287	5,288	5,288

Notes: 1. Standard errors are clustered by village and are shown in parentheses. 2. All regressions include baseline values of the outcome, stratum fixed effects, district fixed effects, age dummies, a dummy for currently pregnant, and how many months pregnant. 3. *Significant at 10% level; **Significant at 5% level; ***Significant at 1% level. 4. The p-values are the test of the null hypothesis of equal treatment effects between the different intervention arms.

Table 7b: Child Health and breastfeeding knowledge

	Child health knowledge						Breastfeeding Knowledge			
	Safe to go to primary health center if no pregnancy complications	Should feed colostrum to a newborn	Somewhat/Very much: Lack of balanced diet impacts child growth	Little/Very little: Witchcraft impacts child growth	Lack of balanced diet: cause of kwashiorkor	Children health ASTE	Age to introduce other liquids: 6 months	Should introduce other food at age 6 months	How long a baby should be breastfed: 12 months	Breastfeeding ASTE
WEMP	-0.067***	0.092***	0.034***	0.000	-0.002	0.037*	0.106***	0.069***	0.003	0.138***
	(0.022)	(0.025)	(0.009)	(0.009)	(0.021)	(0.019)	(0.020)	(0.016)	(0.006)	(0.024)
WHN	-0.025	0.065***	0.030***	-0.005	-0.028	0.022	0.080***	0.067***	-0.008*	0.090***
	(0.022)	(0.024)	(0.009)	(0.008)	(0.020)	(0.019)	(0.020)	(0.017)	(0.005)	(0.022)
MHN	-0.009	-0.012	0.017*	-0.006	0.012	0.005	0.018	-0.003	0.000	0.005
	(0.023)	(0.026)	(0.010)	(0.008)	(0.020)	(0.019)	(0.020)	(0.018)	(0.006)	(0.025)
p-value: WHN=WEMP	0.064	0.248	0.52	0.541	0.201	0.433	0.149	0.908	0.019	0.023
p-value: WHN=MHN	0.486	0.001	0.091	0.978	0.037	0.351	0.000	0.000	0.113	0.000
Observations	5,288	5,288	5,284	5,210	5,288	5,288	5,288	5,288	5,287	5,288

Notes: 1. Standard errors are clustered by village and are shown in parentheses. 2. All regressions include baseline values of the outcome, stratum fixed effects, district fixed effects, age dummies, a dummy for currently pregnant, and how many months pregnant. 3. *Significant at 10% level; **Significant at 5% level; ***Significant at 1% level. 4. The p-values are the test of the null hypothesis of equal treatment effects between the different intervention arms.

Table 7c: Health and sanitation knowledge -True/False

	False: Boiling water for 1 min is enough to make it clean	True: Know ingredients of oral rehydration salts	False: Cow's milk equally good as breastmilk	False: Fruits more important for children than men	False: Animal protein less important for women	Knowledge true and false ASTE
WEMP	0.078***	0.040**	0.070***	0.017	0.012	0.105***
	(0.019)	(0.019)	(0.014)	(0.015)	(0.013)	(0.022)
WHN	0.070***	0.058***	0.065***	-0.007	0.021*	0.099***
	(0.020)	(0.018)	(0.015)	(0.014)	(0.012)	(0.021)
MHN	0.040**	0.017	0.015	0.004	0.022*	0.049**
	(0.020)	(0.017)	(0.015)	(0.014)	(0.013)	(0.022)
p-value: WHN=WEMP	0.676	0.303	0.743	0.118	0.426	0.755
p-value: WHN=MHN	0.133	0.013	0.000	0.435	0.931	0.012
Observations	5,288	5,288	5,288	5,288	5,288	5,288

Notes: 1. Standard errors are clustered by village and are shown in parentheses. 2. All regressions include baseline values of the outcome, stratum fixed effects, district fixed effects, age dummies, a dummy for currently pregnant, and how many months pregnant. 3. *Significant at 10% level; **Significant at 5% level; ***Significant at 1% level. 4. The p-values are the test of the null hypothesis of equal treatment effects between the different intervention arms.

Impact on Nutrition Knowledge

Women in the treatment groups were more likely to buy vegetables and meat if given money. However, there was no significant difference for men in the control and treatment group for this outcome. Women in the WEMP and WHN treatment arms ate better than women in the control group: they drank more liquids such as water and milk or yoghurt, ate more carbohydrate rich foods and ate more fruits and vegetables. Women in the WEMP treatment also ate more protein rich foods and fats and sugars (Table 9a).

Children under 7 years (84 months) in WEMP and WHN treatment households were more likely to eat well. They drank more liquids such as water and milk or yoghurt, ate more carbohydrate rich foods and ate more fruits and vegetables. Children in WEMP households were also likely to eat more protein-rich foods and oil, butter, fats and sugars. (Table 9b)

Table 8: Food spending preferences

	Vegetables	Beans	Meat
WEMP	0.027**	0.028*	0.028**
	(0.013)	(0.016)	(0.011)
WHN	0.039***	0.033**	0.014
	(0.013)	(0.015)	(0.010)
MHN	0.016	0.011	0.007
	(0.014)	(0.016)	(0.010)
p-value: WHN=WEMP	0.387	0.786	0.207
p-value: WHN=MHN	0.118	0.178	0.485
Observations	5,285	5,285	5,285

Notes: 1. Standard errors are clustered by village and are shown in parentheses. 2. All regressions include stratum fixed effects, a dummy for currently pregnant, and how many months pregnant. 3. Mothers were asked what they would buy if given 10,000 UGX. 4. *Significant at 10% level; **Significant at 5% level; ***Significant at 1% level. 5. The p-values are the test of the null hypothesis of equal treatment effects between the different intervention arms.

Table 9a: Women's nutrition

	Beverage ASTE	Fruits & vegetable ASTE	Protein rich food ASTE	Carbohydrates rich food ASTE	Fats & sugars ASTE
WEMP	0.077***	0.117***	0.086***	0.068***	0.058*
	(0.021)	(0.032)	(0.030)	(0.022)	(0.031)
WHN	0.052**	0.104***	-0.013	0.060 ***	0.035
	(0.021)	(0.030)	(0.028)	(0.022)	(0.032)
MHN	0.042**	-0.004	0.019	0.012	0.021
	(0.021)	(0.029)	(0.029)	(0.023)	(0.033)
p-value: WHN=WEMP	0.207	0.673	0.001	0.700	0.459
p-value: WHN=MHN	0.590	0.000	0.244	0.037	0.683
Observations	5,288	5,288	5,288	5,288	5,288

Notes: 1. Standard errors are clustered by village and are shown in brackets. 2. All regressions include stratum fixed effects. 3. Controls include: mother's health index (weighted continuous), health knowledge index, gender norms index, log HH income and mother's wage. 5. ASTEs were categorized as follows: Beverage (milk/yoghurt, water, tea/coffee, juice or other beverages), Fruits & vegetable (dark leafy greens, other fruits or vegetables), protein rich food (beef, pork, goat, chicken, egg, fish), Carbohydrates rich (matooke, rice, bread, grains, cassava, yams, potatoes,, roots, tubers), Fats & sugars (Oil, butter, fats & sweets). 6. *Significant at 10% level; **Significant at 5% level; ***Significant at 1% level. 6. The p-values are the test of the null hypothesis of equal treatment effects between the different intervention arms.

Table 9b: Child nutrition

	Beverage ASTE	Fruits & vegetable ASTE	Protein rich food ASTE	Carbohydrates rich food ASTE	Fats & sugars ASTE
WEMP	0.084***	0.108***	0.100***	0.050**	0.068**
	(0.021)	(0.033)	(0.033)	(0.021)	(0.032)
WHN	0.062***	0.109***	0.012	0.044**	0.019
	(0.019)	(0.030)	(0.028)	(0.022)	(0.032)
MHN	0.030	0.000	0.043	0.004	-0.020
	(0.020)	(0.031)	(0.030)	(0.024)	(0.033)
p-value: WHN=WEMP	0.226	0.962	0.004	0.794	0.146
p-value: WHN=MHN	0.076	0.000	0.274	0.069	0.255
Observations	8,874	8,719	8,719	8,719	8,719

Notes: 1. Standard errors are clustered by village and are shown in brackets. 2. All regressions include stratum fixed effects. 3. The sample is children 84 months old and younger at endline. 4. Controls include: mother's health index (weighted continuous), health knowledge index, gender norms index, log HH income and mother's wage. 5. ASTEs were categorized as follows: Beverage (milk/yoghurt, water, tea/coffee, juice or other beverages), Fruits & vegetable (dark leafy greens, other fruits or vegetables), protein rich food (beef, pork, goat, chicken, egg, fish), Carbohydrates rich (matooke, rice, bread, grains, cassava, yams, potatoes,, roots, tubers), Fats & sugars (Oil, butter, fats & sweets). 6. *Significant at 10% level; **Significant at 5% level; ***Significant at 1% level. 6. The p-values are the test of the null hypothesis of equal treatment effects between the different intervention arms.

Table 10: Sanitation practices

	Treat drinking water	Allows water to boil before removing	Washes hands after bathroom often	Washes hands before meal often	Improved latrine in last year	How often sweep latrine each week	Sanitation knowledge ASTE
WEMP	0.048***	0.054***	0.112***	0.076***	0.117***	0.393***	0.200***
	(0.010)	(0.014)	(0.021)	(0.022)	(0.023)	(0.090)	(0.030)
WHN	0.047***	0.042***	0.101***	0.079***	0.086***	0.217**	0.180***
	(0.010)	(0.014)	(0.021)	(0.022)	(0.023)	(0.088)	(0.030)
MHN	0.007	0.027*	0.031	0.022	0.018	0.132	0.064**
	(0.011)	(0.015)	(0.022)	(0.021)	(0.022)	(0.089)	(0.030)
p-value: WHN=WEMP	0.858	0.347	0.602	0.883	0.204	0.033	0.443
p-value: WHN=MHN	0.000	0.274	0.002	0.006	0.003	0.304	0.000
Observations	5,288	4,952	5,287	5,288	5,283	5,281	5,288

Notes: 1. Standard errors are clustered by village and are shown in parentheses. 2. All regressions include stratum fixed effects. 3. *Significant at 10% level; **Significant at 5% level; ***Significant at 1% level. 4. The p-values are the test of the null hypothesis of equal treatment effects between the different intervention arms.

Table 11: Reproductive health practices

	Currently use family planning	Husband knows: wife is using family planning	Ever used family planning	Will use family planning in the future	Years would wait to have next baby	Tested for HIV <1 year ago	HIV Positive	Both husb. & wife want to use contraception	Ideal fertility	Ideal fertility: % boys	Worse to have little time b/w preg.	Wanted to have sex all times
WEMP	0.007	0.021	0.019	0.002	0.007	0.037	0.004	0.007	-0.046	0.013*	-0.027*	-0.011
	(0.022)	(0.025)	(0.018)	(0.011)	(0.070)	(0.025)	(0.004)	(0.017)	(0.049)	(0.008)	(0.014)	(0.021)
WHN	0.000	0.015	0.018	0.018*	-0.070	0.033	0.000	-0.007	-0.004	0.014**	-0.002	-0.035*
	(0.022)	(0.025)	(0.018)	(0.011)	(0.062)	(0.023)	(0.004)	(0.018)	(0.050)	(0.007)	(0.013)	(0.020)
MHN	0.011	0.033	0.018	0.002	0.009	0.022	-0.002	0.044***	-0.068	0.015*	-0.008	-0.020
	(0.022)	(0.024)	(0.017)	(0.011)	(0.065)	(0.023)	(0.005)	(0.017)	(0.049)	(0.008)	(0.013)	(0.019)
p-value: WHN=WEMP	0.788	0.817	0.941	0.141	0.278	0.875	0.383	0.436	0.431	0.808	0.062	0.244
p-value: WHN=MHN	0.628	0.480	0.992	0.115	0.226	0.620	0.633	0.005	0.219	0.952	0.618	0.420
Observations	4,508	4,482	5,288	5,288	5,287	5,288	5,140	5,170	5,288	5,285	5,288	4,018

Notes: 1. Standard errors are clustered by village and are shown in parentheses. 2. All regressions include stratum fixed effects and currently pregnant and months pregnant. 3. *Significant at 10% level; **Significant at 5% level; ***Significant at 1% level. 4. The p-values are the test of the null hypothesis of equal treatment effects between the different intervention arms.

Health Behaviors and Practices

Sanitation

The program resulted in an improvement in self-reported hygiene and sanitation: Women in the WEMP and WHN treatments groups were more likely to treat drinking water, wash hands more often after bathroom use and before meals, sweep the latrine more often each week. All participants in the treatment groups were more likely to drink boiled water.

Reproductive Health

The results show no significant difference between treatment groups and control group on the following: current use of family planning, a man knowing that his partner is using family planning, years a couple would wait to have their next baby, and likelihood of having an HIV test less than a year ago.

WHN participants were more likely to plan to use family planning in the future and more likely to have not wanted to have sex on some of the occasions when they did; again, for self-reported measures, it is difficult to disentangle whether the incidence of this problem increased or the program made women more willing to report it in their survey responses. MHN participants were more likely to report that both the husband and wife wanted to use contraception.

Antenatal Care

Women in all treatment groups were significantly more likely than those in the control group to report they discussed with their husband the following: where/when to have an antenatal visit; nutrition during pregnancy and whether to have more children. All treatment groups were also more likely to report that women ate more of certain foods and fruits whilst pregnant. WEMP and MHN participants were more likely to have discussed where to deliver the baby.

Table 12a: Antenatal care practices

	Received antenatal care	Number times received antenatal care	Months preg. when first received care	Went w/ husb. on antenatal visit	*Discussed with husband about:*				
					Health advice	Where/when to have antenatal visit	Nutrition during pregnancy	Where to deliver baby	Whether to have more kids
WEMP	-0.002	0.055	-0.173**	0.048**	-0.003	0.033**	0.088***	0.031**	0.047**
	(0.008)	(0.061)	(0.068)	(0.021)	(0.015)	(0.015)	(0.020)	(0.015)	(0.020)
WHN	-0.008	0.013	-0.176**	0.013	-0.012	0.026*	0.054***	0.010	0.040**
	(0.008)	(0.062)	(0.069)	(0.019)	(0.014)	(0.014)	(0.021)	(0.016)	(0.019)
MHN	0.004	0.125*	-0.066	-0.001	0.005	0.036**	0.042**	0.032**	0.034*
	(0.008)	(0.066)	(0.071)	(0.020)	(0.014)	(0.014)	(0.021)	(0.015)	(0.019)
p-value: WHN=WEMP	0.491	0.443	0.964	0.085	0.526	0.634	0.074	0.152	0.682
p-value: WHN=MHN	0.107	0.067	0.094	0.472	0.176	0.510	0.547	0.132	0.773
Observations	4,401	4,400	4,401	4,401	4,393	4,401	4,401	4,401	4,401

Notes: 1. Standard errors are clustered by village and are shown in parentheses. 2. All regressions include strata fixed effects and controls include a dummy for current pregnancy, number of months until due date, and current pregnancy*months until due date. 3. The sample is current pregnancies & pregnancies in the past 2 years (at endline). 4. "Baseline value" controls for the value of the outcome from the mother's last pregnancy at baseline. 5. *Significant at 10% level; **Significant at 5% level; ***Significant at 1% level. 6. The p-values are the test of the null hypothesis of equal treatment effects between the different intervention arms.

Table 12b: Antenatal care practices

	Had malaria while preg.	Had complications while preg.	Husb. aware of complications	Husb. assisted w/ complications	Made plan for where to deliver	Discussed plan with husb.	Ate more of certain foods	Ate more: fruit	Ate more: meat	Ate more: vegetables
WEMP	-0.053**	-0.005	-0.001	0.013	0.020	0.028	0.063 ***	0.023	0.054***	0.067***
	(0.022)	(0.022)	(0.021)	(0.021)	(0.016)	(0.018)	(0.023)	(0.018)	(0.016)	(0.020)
WHN	-0.036	0.018	0.023	0.033	0.019	0.037**	0.081***	0.026	0.031*	0.089***
	(0.023)	(0.023)	(0.022)	(0.022)	(0.015)	(0.016)	(0.024)	(0.016)	(0.017)	(0.018)
MHN	-0.016	0.021	0.022	0.034	-0.001	0.020	0.051**	-0.001	0.046***	0.015
	(0.022)	(0.022)	(0.022)	(0.021)	(0.015)	(0.018)	(0.025)	(0.017)	(0.017)	(0.018)
p-value: WHN=WEMP	0.431	0.328	0.283	0.355	0.941	0.598	0.409	0.880	0.186	0.267
p-value: WHN=MHN	0.355	0.901	0.965	0.944	0.183	0.305	0.204	0.083	0.433	0.000
Observations	4,401	4,401	4,401	4,401	4,401	4,401	4,401	4,401	4,401	4,401

Notes: 1. Standard errors are clustered by village and are shown in parentheses. 2. All regressions include strata fixed effects and controls include a dummy for current pregnancy, number of months until due date, and current pregnancy*months until due date. 3. The sample is current pregnancies & pregnancies in the past 2 years (at endline). 4. "Baseline value" controls for the value of the outcome from the mother's last pregnancy at baseline. 5. *Significant at 10% level; **Significant at 5% level; ***Significant at 1% level. 6. The p-values are the test of the null hypothesis of equal treatment effects between the different intervention arms.

Postnatal Care

WEMP and WHN groups were significantly more likely than women in the control group to report: fewer days after birth before breastmilk came; that they ate more than normal during breastfeeding; and that they discussed infant care with their husband in the first month. WEMP women were also more likely to report that they were in good health in the first two months after birth and that they ate more meat while pregnant (Tables 12a and 12b).

Table 13a: Post-natal care practices

	Gave birth in hospital/health center	TBA assisted w/ birth	Husband present at birth	Baby's birth weight	Baby ever breastfed	Days after birth started breastfeeding	Baby fed colostrum	Days after birth breastmilk came	Ate more than normal during breastfeeding	Discussed baby care w/ husb. in 1st month
WEMP	0.017	-0.007	0.002	0.088	0.002	-0.037	-0.003	-0.324***	0.066***	0.064***
	(0.023)	(0.024)	(0.022)	(0.058)	(0.001)	(0.027)	(0.003)	(0.100)	(0.021)	(0.023)
WHN	-0.007	-0.002	0.033	-0.027	-0.002	-0.042	0.000	-0.266***	0.090***	0.069***
	(0.022)	(0.022)	(0.021)	(0.055)	(0.002)	(0.027)	(0.003)	(0.099)	(0.021)	(0.021)
MHN	0.037*	-0.054**	0.035	-0.052	-0.004	0.033	-0.002	-0.106	0.027	0.064***
	(0.022)	(0.021)	(0.021)	(0.059)	(0.003)	(0.048)	(0.004)	(0.111)	(0.023)	(0.023)
p-value: WHN=WEMP	0.305	0.836	0.132	0.031	0.045	0.811	0.336	0.512	0.246	0.842
p-value: WHN=MHN	0.048	0.016	0.946	0.650	0.674	0.091	0.433	0.116	0.006	0.837
Observations	3,288	3,474	3,474	1,793	3,474	3,458	3,474	3,466	3,465	3,474

Notes: 1. Standard errors are clustered by village and are shown in parentheses. 2. All regressions include strata fixed effects and controls include child's age. 3. The sample is living children born in the past 2 years (pregnancies in the past 2 years). 4. "Baseline value" controls for the value of the outcome from the mother's last pregnancy at baseline. 5. *Significant at 10% level; **Significant at 5% level; ***Significant at 1% level. 6. The p-values are the test of the null hypothesis of equal treatment effects between the different intervention arms.

Table 13b: Post-natal care practices

	Given other liquid in 1st week	Weight after 1st month	1st health check (days after birth)	Health check in first 2 months	Mother in good health in first 2 months	Weight after 3 months	Given other liquid in first 3 months	Number of meals given per day	Number days given milk	Number days given beans	Number days given meat
WEMP	-0.119***	0.004	0.881	0.008	0.055**	-0.058	-0.120 ***	0.106*	0.069	-0.193	0.122*
	(0.025)	(0.090)	(2.606)	(0.017)	(0.026)	(0.109)	(0.028)	(0.059)	(0.193)	(0.137)	(0.068)
WHN	-0.088***	-0.183*	-0.900	-0.007	0.029	-0.171	-0.089***	0.150***	0.043	-0.023	-0.005
	(0.026)	(0.098)	(2.410)	(0.017)	(0.026)	(0.117)	(0.028)	(0.057)	(0.183)	(0.131)	(0.060)
MHN	-0.023	-0.075	-2.898	0.007	0.022	-0.134	-0.030	0.035	-0.265	-0.012	-0.052
	(0.025)	(0.101)	(2.274)	(0.017)	(0.026)	(0.113)	(0.026)	(0.059)	(0.205)	(0.129)	(0.064)
p-value: WHN=WEMP	0.226	0.048	0.521	0.408	0.302	0.333	0.258	0.466	0.879	0.211	0.035
p-value: WHN=MHN	0.010	0.294	0.419	0.459	0.808	0.750	0.021	0.055	0.095	0.928	0.400
Sample	All	All	All	Age≥2 mths	Age≥2 mths	Age≥3 mths	Age≥3 mths	Age≥3 mths	Age≥3 mths	Age≥3 mths	Age≥3 mths
Observations	3,474	2,293	3,224	3,285	3,285	2,327	3,168	2,845	2,857	2,848	2,849

Notes: 1. Standard errors are clustered by village and are shown in parentheses. 2. All regressions include strata fixed effects and controls include child's age. 3. The sample is living children born in the past 2 years (pregnancies in the past 2 years). 4. "Baseline value" controls for the value of the outcome from the mother's last pregnancy at baseline. 5. *Significant at 10% level; **Significant at 5% level; ***Significant at 1% level. 6. The p-values are the test of the null hypothesis of equal treatment effects between the different intervention arms.

Immunizations

Children in WEMP group were more likely to have received the required doses of vitamin A at 0-3 months and less than a year old. Children in MHN group were more likely to have received the required immunizations & Vitamin A doses at 1-2years.

Table 14: Immunizations

	ASTE: Required immunizations				ASTE: Vitamin A			
	0-3 months	<1 year	1-2 years	2-3 years	0-3 months	<1 year	1-2 years	2-3 years
WEMP	-0.007	0.000	0.040	-0.088	0.532*	0.173*	0.001	0.022
	(0.122)	(0.069)	(0.043)	(0.054)	(0.306)	(0.099)	(0.065)	(0.060)
WHN	-0.069	-0.050	-0.008	-0.130**	-0.097	0.067	-0.001	-0.006
	(0.121)	(0.068)	(0.046)	(0.051)	(0.304)	(0.094)	(0.062)	(0.058)
MHN	0.058	0.035	0.092**	-0.043	0.469	0.089	0.071	-0.011
	(0.127)	(0.070)	(0.042)	(0.047)	(0.304)	(0.105)	(0.057)	(0.063)
p-value: WHN=WEMP	0.635	0.466	0.286	0.476	0.036	0.26	0.967	0.644
p-value: WHN=MHN	0.343	0.225	0.025	0.100	0.080	0.824	0.218	0.947
Observations	403	1,147	2,335	2,187	97	836	2,327	2,173

Notes: 1. Standard errors are clustered by village and are shown in parentheses. 2. All regressions include stratum fixed effects, district FEs, gender*age fixed effects, the village-level baseline average of the outcome and controls (mother's health index (weighted continuous), health knowledge index, gender norms index, log HH income and mother's wage). 3. For each age group, we take the number of required immunizations for BCG, polio, DPT, and measles at the child's age and calculate the ASTE. 4. The sample is limited to children age <36 months at endline. 5. *Significant at 10% level; **Significant at 5% level; ***Significant at 1% level. 6. The p-values are the test of the null hypothesis of equal treatment effects between the different intervention arms.

Anthropometric Measures

Children

Girls in the WEMP group had relatively higher height for age (HFA) score and higher Weight for age (WFA) score than boys. However, in absolute terms, the improvement in girls' HFA is not statistically significant, and the improvement in girls' WFA is only marginally statistically significant. The WHN intervention seemed to increase boys' but not girls' anemia levels; the increase in boys' anemia is puzzling, but the general pattern of the program leading to relative improvements in girls' health suggests that mothers' used the knowledge and skills disproportionately to help their daughters or that the behavioral changes they made were more likely to translate into health improvements for daughters. We do not find any effects for higher Hb levels.

Table 15a: Child anthropometrics (Height and Weight)

	WFA z-score	HFA z-score	MFA z-score
	(1)	(2)	(3)
WEMP × Girl	0.123*	0.184**	0.036
	(0.065)	(0.082)	(0.065)
WHN × Girl	0.038	0.123	-0.041
	(0.069)	(0.084)	(0.068)
MHN × Girl	-0.003	0.065	0.008
	(0.067)	(0.082)	(0.068)
WEMP	-0.046	-0.107*	-0.015
	(0.050)	(0.064)	(0.051)
WHN	-0.036	-0.064	0.072
	(0.051)	(0.064)	(0.057)
MHN	0.003	-0.070	0.013
	(0.051)	(0.067)	(0.054)
Girl	0.122	0.272	0.715***
	(0.243)	(0.337)	(0.108)
p-value: WHN=WEMP	0.833	0.532	0.091
p-value: WHN=MHN	0.459	0.933	0.280
p-value: WHN+WHN × Girl=0	0.960	0.361	0.561
p-value: WEMP+WEMP × Girl=0	0.103	0.229	0.687
p-value: MHN+MHN × Girl=0	0.995	0.934	0.682
p-value: WHN × Girl=WEMP × Girl	0.211	0.457	0.221
p-value: WHN × Girl=MHN × Girl	0.546	0.491	0.455
Observations	6,890	6,834	6,574

Notes: 1. Standard errors are clustered by village and are shown in parentheses. 2. All regressions include stratum fixed effects. 3. The sample is children 28 months old and under at baseline and children born between baseline and endline (50 months and under at endline). 4. Controls include: mother's health index (weighted continuous), health knowledge index, gender norms index, log HH income and mother's wage. 5. *Significant at 10% level; **Significant at 5% level; ***Significant at 1% level. 6. The p-values are the test of the null hypothesis of equal treatment effects between the different intervention arms.

Table 15b: Child anthropometrics (Hb levels)

	Hb level <10 g/dl	Hb level <10 g/dl
	(1)	(2)
WEMP	0.025**	0.005
	(0.013)	(0.021)
WHN	0.026**	-0.038*
	(0.012)	(0.020)
MHN	0.017	-0.015
	(0.012)	(0.019)
WEMP × Girl		0.021
		(0.015)
WHN × Girl		0.042***
		(0.016)
MHN × Girl		0.027*
		(0.014)
Girl		-0.093
		(0.058)
Observations	6,352	6,880

Notes: 1. Standard errors are clustered by village and are shown in parentheses. 2. All regressions include stratum fixed effects. 3. The sample is children 28 months old and under at baseline and children born between baseline and endline (50 months and under at endline). 4. Controls include: mother's health index (weighted continuous), health knowledge index, gender norms index, log HH income and mother's wage. 5. *Significant at 10% level; **Significant at 5% level; ***Significant at 1% level.

Women

The program had no significant effect on mothers' anthropometrics (weight, anemia levels, and mid-upper arm circumference), with the exception that WEMP women were more likely to have a BMI less than 18.5 (Table 16). The ASTE for mother's anthropometrics (not shown) is statistically indistinguishable from zero for all the treatment groups.

Table 16: Women anthropometrics (Hb levels, MUAC and BMI)

	Hb level	Mild anemia: Hb<12	Moderate anemia: Hb<11	MUAC	Moderate risk: MUAC<23	Mildly thin: BMI< 18:5
	(1)	(2)	(3)	(4)	(5)	(6)
WEMP	-0.005	0.019	0.008	-0.015	0.004	0.017**
	(0.076)	(0.017)	(0.009)	(0.110)	(0.008)	(0.008)
WHN	-0.015	0.012	0.008	0.070	-0.006	0.004
	(0.076)	(0.018)	(0.010)	(0.103)	(0.007)	(0.007)
MHN	-0.046	0.014	0.018*	0.071	-0.003	0.001
	(0.079)	(0.018)	(0.010)	(0.105)	(0.007)	(0.007)
Observations	5,193	5,143	5,193	5,195	5,146	5133

Notes: 1. Standard errors are clustered by village and are shown in parentheses. 2. All regressions include stratum fixed effects, a dummy for currently pregnant, and how many months pregnant. 3. Controls include: mother's health index (weighted continuous), health knowledge index, gender norms index, log HH income and mother's wage. Baseline value controls for the mother's baseline value of each outcome. 4. *Significant at 10% level; **Significant at 5% level; ***Significant at 1% level. 5. The p-values are the test of the null hypothesis of equal treatment effects between the different intervention arms

Mortality

Table 16 shows summary statistics for infant mortality during program implementation. We follow the conventional approach used in epidemiology and define the under-five (infant) mortality rate as the number of under-five (under-two, under-one, and under-six months) children that died during the period per 1,000 child-years (infant-years) of exposure over the same time period. The time period we are using is the intervention period between February and November 2013. The results, with the data aggregated to the village level, are reported in Table 17. The program did not have a significant impact on infant mortality rates except for a decrease in the WEMP group for infants less than six months. For the WEMP, the reduction in child mortality is decreasing by age (i.e. lower mortality rate the older the child is), but the results are only significant for the very young children (children below 6 months). For the WEMP, the estimated rate ratio; i.e., the ratio of the incidence of child deaths in the treatment relative the control group, implies a 50.1% reduced risk of under-five deaths in the treatment relative the control group (significant at the 10 percent level).

Table 17: Mortality rate by age

	Alive	Deceased	% Deceased
Age group			
0 - 5 months	501	17	0.033
6 - 11 months	478	17	0.034
12 - 23 months	2,113	56	0.026
24 - 59 months	5,510	53	0.010
Program month (Feb - Nov 2013)			
Month 1	7,228	9	0.0012
Month 2	7,364	13	0.0018
Month 3	7,474	9	0.0012
Month 4	7,556	10	0.0013
Month 5	7,639	12	0.0016
Month 6	7,736	3	0.0004
Month 7	7,811	9	0.0012
Month 8	7,876	7	0.0009
Month 9	7,966	11	0.0014
Month 10	8,042	8	0.0010
Gender			
Male	4,336	78	0.0180
Female	4,265	65	0.0152

Notes: The sample does not include stillbirths and is restricted to children age 59 and younger.

Table 18: Mortality

	IMR (<60 mths)	IMR (<24 mths)	IMR (<12 mths)	IMR (<6 mths)
WEMP	0.805	0.913	0.656	0.499*
	(0.193)	(0.240)	(0.221)	(0.204)
WHN	0.770	0.686	0.646	0.637
	(0.193)	(0.190)	(0.221)	(0.241)
MHN	0.991	0.927	1.014	1.089
	(0.208)	(0.237)	(0.314)	(0.356)
Observations	10,659	6,248	3,979	2,483

Notes: The sample does not include stillbirths. Exposure is not included in the regression. 1. Standard errors are clustered by village and are shown in brackets. 2. Results are estimated using a Poisson model and coefficients are reported as incidence-rate ratios; standard errors are also transformed. 3. All regressions include strata fixed effects. 4. Baseline village controls" include the baseline village-level average of mortality for the village-level average child health index. 5. Controls" include: mother's health knowledge index, gender index, health index (continuous weighted), log of HH wage, and mother's wage. 6. *Significant at 10% level; **Significant at 5% level; ***Significant at 1% level. 7. The p-values are the test of the null hypothesis of equal treatment effects between the different intervention arms.

Qualitative Analysis Results

Women's Health and Nutrition Curriculum

The sessions that women reported to be most useful were on the following topics: breastfeeding, food groups, safe water and sanitation, contraception and family planning, birthing and postpartum care. While information contained in the session on safe water and sanitation reinforced what many participants already knew, the other sessions contained information that was new to participants. For example, many women reported that they were not aware of the number of different methods of contraception, nor had they ever been given a comprehensive explanation of how each method should be used or information on efficacy.

Participants reported a range of behavior changes as a result of knowledge gained during the health and nutrition programs, some of which are supported by quantitative findings outlined above. The main areas of impact included improvements in: nutrition (e.g., increasing the amount of fruits and vegetables in household diets), breastfeeding practices (e.g., exclusively breastfeeding for six months), sanitation (e.g., increasing the frequency of hand washing with soap), and health care utilization (e.g., attending antenatal

appointments).

When participants were asked to identify sessions for which they would like to receive further information, the topics most frequently mentioned were: micronutrients for mothers and children, food preparation, HIV/AIDS, contraception and family planning, birthing, infant illness and preventative health practices and recipes, and postpartum care. The style of program delivery was well received by participants, who gave positive feedback regarding their facilitators, the scheduling flexibility, and the group dynamics.

Both participants and facilitators had similar feedback regarding improvements that could be made to the program if it were to be scaled up or extended into other areas. First, they suggested an increase in the amount of monetary incentives paid to participants as well as the provision of additional materials such as t-shirts, learning materials for home use, agricultural inputs, and contraceptives. Second, women agreed that the program would benefit from adding additional topics to the curriculum, such as sessions on agricultural and vocational information, which could be used to improve both nutrition and household earning capacity. Finally, participants suggested that future versions of the program be expanded to include particularly vulnerable women in the village (e.g., those who did not have a spouse and therefore were not eligible for this evaluation).

Women's Empowerment Curriculum

Women who received this treatment overwhelmingly reported that the session on general communication strategies was the most useful. Other sessions that women found to be helpful covered the decision making process, communicating infant needs, resources within their community, and domestic violence.

The most cited impacts of the WEMP sessions centered on women's improved communication with spouses and children, followed changes in budgeting practices. For example, some women stated they no longer argued in front of their children and instead chose to have such discussions privately with their husband. Improved communication and negotiation skills and a willingness to reach compromises also helped some women to provide better food and health care for their children by enabling them to reason and negotiate with their husbands for additional money and other household resources. Sessions on household budgeting allowed some women to start saving small amounts of money, which, paired with better negotiation skills, led to the women being able to pay their children's school fees on time, buy small plots of land to grow vegetables, or purchase chickens or goats.

Regarding modifications for future programs, both facilitators and participants expressed a strong desire for a men's program for husbands that would run in parallel with the women's empowerment program and similarly teach communications skills. If this were to occur, it would be most useful to begin the men's program at least half way through the women's program to give men an opportunity to see the positive changes that their wives had made. At the beginning of the program, women's husbands were more skeptical of the curriculum and would therefore be less likely to be willing to attend a parallel group. It should be noted that timing of sessions for a men's group would require additional piloting since the WEMP program is longer than the WHN/MHN programs and men generally have less flexible work schedules than women.

Men's Health and Nutrition Curriculum

Similar to the WHN groups, the men's health and nutrition (MHN) participants reported that the most useful sessions for them focused on HIV/AIDS and contraception and family planning. Men also stated that the sessions which were most useful for their families included: antenatal nutrition, food groups, safe water and sanitation practices, infant illness and preventative health, and post-partum care and birth

spacing. Men wanted to receive more information on the following topics: breastfeeding, food groups, food preparation and recipes, HIV/AIDS, and contraception and family planning.

Many of the sessions that men found most useful covered information that was new for them, because such information is traditionally only been taught to women (e.g., antenatal and post-partum care, nutrition, birth spacing, infant illness, and preventative health practices). By highlighting the impact that good health can have on a child's future and framing men as teachers for their families and communities, men were motivated to become more involved in their children's health and were more willing to help their wives during pregnancy and breastfeeding. Specifically, men cited behavioral changes in terms of improved: nutrition (e.g., increasing fruits and vegetables in their gardens), sanitation (e.g., building latrines), health care utilization (seeking care from health clinics earlier when children fell ill and being more proactive in getting their children vaccinated and dewormed).

Much of the feedback for future improvements mirrored that from the WHN and WEMP groups. Suggestions that were novel to the MHN groups included partnering with health providers to improve access to care and contraceptives as well as giving more practical examples on latrine improvements or cooking demonstrations. Men also expressed a desire for the program to send representatives to perform household inspections of latrines, hand washing facilities, food storage, and other sanitation practices, and provide feedback and further assistance based on these inspections.

CONCLUSIONS

The intervention achieved some of its goals but not others. A first success was that demand for the classes was strong. Participation rates were high, especially by mothers, and participants gave overwhelmingly positive feedback about the classes. In terms of program success at effecting change, the intervention successfully increased nutrition and health knowledge for all three types of parent classes – Women's Health & Nutrition (WHN), Men's Health & Nutrition (MHN), and Women's Health & Nutrition + Women's Empowerment (WEMP). The interventions also led to children and women eating healthier food such as milk or yoghurt, juice rice, bread and grains, eggs, and fruits and vegetables. For all treatment groups, women reported eating more of certain foods and fruits whilst pregnant.

There is evidence of better antenatal and postnatal practices and greater dialogue between husbands and wives about health and nutrition decisions, particularly related to pregnancy. For example, women were more likely to discuss infant care with their husband within the first month of birth, as well as where and when to have an antenatal visit; nutrition during pregnancy and whether to have more children. Interestingly, these positive impacts are not concentrated in the WEMP program that explicitly taught women how to discuss child and maternal health with their husbands.

Results also show an improvement in sanitation, health practices and nutrition practices such as better feeding practices for babies, boiling drinking water, and washing hands more often after bathroom use and before meals. There are also some improvements in immunization and Vitamin A rates.

The program was less successful in improving objective measures of health such as child height, weight, and anemia or maternal weight and anemia. There are, however, some indications that the interventions caused relative improvements for girls. The results show no significant impact on mortality rate on all analyzed age groups, with the exception of a reduction in the rate for very small children (< 6 months) in the WEMP group, concentrated among girls.

The WEMP did not lead to improvements in the survey-based measures of women's decision-making power. However, many of the program impacts on health and health behavior were stronger for the

WHN and especially the WEMP group. This is partly because attendance at the classes was higher for women than men, on average, but the attendance difference does not explain all of the differences. This suggests that the strategy of targeting fathers with health knowledge, under the view that they hold most of the power in the household, might not be the best strategy. Targeting mothers, even though they generally hold less power, seems to be more effective.

Overall, the study shows that discussion on issues related to health and nutrition can lead to important behavioral changes. While the health impacts were modest, it is possible that impacts on child health would materialize in the longer run. (Of course, conversely, the positive behavior changes might not persist.) The increased dialogue between husbands and wives about child health is also a major benefit of the program. While the women's empowerment component did not seem to increase women's empowerment as measured, the fact that program impacts were most promising for this intervention suggest that women's empowerment programs can have positive influence on children's health and nutrition. In summary, the approach of parent classes that convey both concrete health knowledge to mothers and communication skills so that they can affect change in household spending and health-seeking behaviors hold promise as a tool to improve child health.

LIMITATIONS

While this study utilized the well-reputed RCT research methodology to measure causal effects, the study has limitations. First of all, the study is only covering the southwest of Uganda and we cannot claim it to be representative for the whole of Uganda, or other countries. Additionally, this study focused exclusively on dual-partner households, as one of the study goals was to better understand the relationship between parental bargaining power and child health outcomes. As such, it is possible that this intervention would have a different effectiveness in single-parent households.

ANNEXES

ANNEX I: INTERVENTION CURRICULA

A – H&N Curriculum
B – WE Curriculum
C – H&N Facilitator's Guide

2013

HEALTHY FUTURES INITIATIVE

Program Curriculum

HEALTHY FUTURES INITIATIVE

CURRICULUM TABLE OF CONTENTS

SESSION 1 – INTRODUCTION, OVERVIEW & BASIC KNOWLEDGE

Session Length: ~60 minutes

Main Education Points:

- Overview of program and outline topics to be covered
- Instructions for discussion protocol for all future classes, importance of being on time and what to do if arriving late for future sessions, etc.
    - Explain what respondents should do if they disagree with the facilitator and/or other respondents (be respectful, promote dialogue, etc.).
    - Listen with the expectation of learning & assume that the speaker has something new and of value to contribute to your comprehension.
    - Questions are encouraged at all times.
    - Encourage respondents to communicate their reasoning process and assumptions.
    - Respect personal stories shared during the curriculum.
    - Stress importance of attendance and arriving on time. If participants arrive late they should try to join in when they arrive and the facilitator will greet them and bring them up to speed as soon as possible.

Activities/Assessments:

- Begin with welcome and program overview (**10 minutes**)
- Group discussion about the topics covered over 20 sessions and what participants will learn by participating in the program (**20 minutes**)
- Proceed with brief group icebreaker (**10 minutes**)
- Break into pairs to talk about the Discussion Questions below and reconvene in a group to discuss answers (**10 minutes**)
- Voting for a group leader: Explain the qualities of a good leader to the group (**10 minutes**)
    - A good leader should attend every meeting
    - Should be on time
    - Should be organized
    - Should be responsible
    - Should be respectful of others
    - Should be co-operative

Discussion Questions:

- What are important issues for your community related to nutrition and maternal/child health?
- How do these issues affect individual households and the community as a whole?
- Encourage participants to share examples about problems women face during pregnancy, delivery, and after the baby is born.

Instructor logistics:
Session should be one hour in length & held at a time and location selected by the group; if hangers-on enter during discussion greet them individually and incorporate them into the discussion of another group. It is important to get participants excited and interested about the program during the first session so that they keep coming back.

SESSION 2 – MATERNAL HEALTH AND CHILD NUTRITION

Session Length: ~60 minutes

Tools/Materials/Readings:

- Flip chart
- Markers
- Slides
- Mango Tree pictures of marasmus and kwashiorkor

Main Education Points:

- First 1,000 days
- Definition of malnutrition
- Symptoms of malnutrition
- Causes of Malnutrition
- Consequences of malnutrition
- Ways to prevent and manage malnutrition
- Highlight important nutrition related behaviors that can be promoted

Activities/Assessments:

- Recap: **(5 minutes)**
  Facilitator should start session by asking one person to provide a brief recap of what the group learned during the last session and then ask if anyone has questions.

- Introduction: (**10 minutes**)
  Introduce the topic by explaining the following points:
  - What is malnutrition
  - What are the causes of malnutrition in this community
  - What are the consequences of malnutrition
  - What is the first 1,000 days
  - Key Nutrition Actions

- Mango Tree Slides: (**10 minutes**)
  Facilitator presents the chart that identifies the symptoms of marasmus and kwashiorkor. Ask participants if they are surprised as to what it looks like? Are there other ways that they identify people with malnutrition? Participants should be informed to take their children to the hospital once they recognize these signs.

- Small group discussions: (**10 minutes**)
  Divide participants into 3 groups and assign each group one of the following categories:
  - Group 1: Baby
  - Group 2: Child,
  - Group 3: Pregnant Woman

  Instruct participants to brainstorm how to break the cycle of malnutrition in each stage of life. After 10 minutes of discussion, have one participant from each group present their findings to the larger group.

- Identify challenges: (**10 minutes**)
  Facilitator should lead a group discussion about the challenges of preventing malnutrition in their community. Is malnutrition a problem here? Why? What can we do to prevent malnutrition? Facilitator should emphasize the that malaria contributes to malnutrition.

- Identify Household Strategies: (**10 minutes**)

Participants should sit in a circle. Each participant should share one specific action they can take to prevent malnutrition in their own household. Examples include feeding my child more beans, feeding my child one extra snack everyday, etc. Challenges participants to each come up with something unique and different.

- De-Brief: (**5 minutes**)
  Facilitator identifies 2 participants to provide a **BRIEF re-cap** of what they have learned during this lesson. Each participant should also identify **how they can change their behavior** to incorporate the new knowledge they have learned. Facilitator should prompt participants to discuss **specific actions** they can take which will result in an improvement / incorporation of the topic in their lives.

Discussion Questions:

- Do people consider children or adults with signs of malnutrition to be sick? Why or why not? Should this be changed?
- What are the different types of malnutrition? Are some more prominent than others in this community?
- What are the consequences of malnutrition? Are they just physical? What about mental, social, and economic consequences in the future?
- Malnutrition through the life cycle and how it can be prevented? Are we more likely to be malnourished if we're part of certain groups or a certain age?
- How can I identify signs of malnutrition?
- Should I teach my partner about these signs? Why or why not? Will this be challenging?
- How can I manage/treat malnutrition? How can I prepare a multi mix food to prevent / treat moderate malnutrition with no complications?
- What are the key feeding practices during and after illnesses?

SESSION 3 – PRENATAL NUTRITION

Session Length: ~60 minutes

Tools/Materials/Readings: table below

- Flipchart
- Makers
- Food Flashcards
- MT Food Groups slide

Main Education Points:

- Diet during prenatal period
- What happens if nutritional recommendations are not met?

Activities/Assessments:

- Recap: **(5 minutes)**
  Facilitator should start session by asking one person to provide a brief recap of what the group learned during the last session and then ask if anyone has questions.

- Eating Habits During Pregnancy: (**15 minutes**)
  Facilitator should ask participants to think about the importance of optimum nutrition during pregnancy and the common food practices of pregnant women in their community. Participants should share experiences about how their (their wife's) eating habits changed during pregnancy.

- Facilitator Presentation: (**20 minutes**)
  Facilitator divides the flipchart into 3 sections, labeled "Folic Acid", "Calcium" and "Iron".

    - Facilitator explains the importance of each of the 3 nutrients during pregnancy
    - Facilitator identifies locally available foods that contain these nutrients. After identifying a food, have the participants use the flashcards and put them in piles on the ground or tape them to the flipchart in the appropriate section
    - Facilitator should fill in any missing foods

- De-Brief: (**5 minutes**)
  Facilitator identifies 2 participants to provide a **BRIEF re-cap** of what they have learned during this lesson. Each participant should also identify **how they can change their behavior** to incorporate the new knowledge they have learned. Facilitator should prompt participants to discuss **specific actions** they can take which will result in an improvement / incorporation of the topic in their lives.

Discussion Questions:

- Why is optimum nutrition important during pregnancy?
- What are common food beliefs practiced by women during pregnancy? Are they harmful to your health?
- How often should a pregnant woman eat?
- Which foods are good to eat when pregnant and why?
- Which foods should be avoided during pregnancy? And Why?
- What happens if the expected weight is not gained?
- Have you experienced these signs of (hypoglycemia)? If yes, you should eat more or more often
    - Tingling sensations around the mouth
    - Clumsy or jerky movements or shakiness
    - Sweating

- Headache
- Pale skin color
- Dizziness
- Seizure

SESSION 4 – BREASTFEEDING

Session Length: ~60 minutes

Tools/Materials/Readings:

- Flipchart
- Makers
- Breastfeeding cards
- UGANDA IYCF GUIDELINES

Main Education Points:

- When baby should be put to breast after birth
- Importance, definition, and duration of exclusive breastfeeding (WHO recommendations)
- Why breastfeeding is good for mother and baby
- Composition of breast milk
- How to breastfeed (sanitation, keeping breasts healthy, diet)
- HIV and breastfeeding

Activities/Assessments:

- Recap: **(5 minutes)**
  Facilitator should start session by asking one person to provide a brief recap of what the group learned during the last session and then ask if anyone has questions.

- Facilitator presentation: (**10 minutes**)
  Facilitator should lead a discussion on exclusive breastfeeding and its importance. Emphasize the following:
    - Breastfeed the baby soon after delivery to encourage milk production, and to give the baby the benefits of colostrum.
    - Immediate breastfeeding also helps with the delivery of the placenta and reduces bleeding.
    - Colostrum, the first yellowish milk, is a natural vaccine that protects the baby from illnesses. Do not throw it away; give it to your baby.
    - During the first 6 months after birth, do not give any other food or liquid (even water) besides breast milk to your baby.
    - HIV positive mothers should exclusively breastfeed for first 6 months

- Attachment and Positioning Demonstration: (**5 minutes**)
  Facilitator should explain and lead a demonstration on correct attachment and positioning of the baby on the breast

    - Discuss the five breastfeeding positions - the cradle position, under arm position, the cross cradle position, the under arm for twins, and the cross position for breastfeeding twins
    - Show positioning images and pass images around to the participants
    - Encourage participants to practice each position (women's groups only)

- Role-Play: (**15 minutes**)
  Present participants with the following scenario and explain that they should take a few minutes to think about what they would do. After preparation, have participants present to the class
    - Your sister gave birth this morning and when you came to visit her and the baby, she was feeding the baby tea. You know that babies should be exclusively breastfed immediately

after birth and want to convince your sister of this so she has a healthy baby. What do you tell her?

- Large group discussion: (**10 minutes**)
  Facilitator should lead a discussion about the challenges of exclusive breastfeeding and the possible solutions.

- Small group discussions: (**10 minutes**)
  Divide participants into 4 small groups. Assign each group one of the following questions. After discussion, have each group present their thoughts to the larger group.

    - Group 1: How long should a baby be exclusively breastfed and what is the importance of breastfeeding on demand?
    - Group 2: What happens if the baby is not correctly attached and positioned on the breasts, and what are common breastfeeding problems and how they can be solved?
    - Group 3: What are the reliable signs that a baby is not getting enough milk?
    - Group 4: What are some reasons why a baby may not be getting enough milk?

- De-Brief: (**5 minutes**)
  Facilitator identifies 2 participants to provide a **BRIEF re-cap** of what they have learned during this lesson. Each participant should identify **how they can change their behavior** to incorporate the new knowledge they have learned. Facilitator should prompt participants to discuss **specific actions** they can take which will result in an improvement / incorporation of the topic in their lives.

Discussion Questions:

- Define exclusive breastfeeding? And what is the composition of breast milk?
- What are the challenges of exclusive breastfeeding and how can they be solved?
- For how long should a baby breastfeed?
- What is the importance of breastfeeding on demand? And what are the advantages of breastfeeding?
- What happens if the baby is not correctly attached and positioned on the breast?
- What is the common breastfeeding complication and how can they be solved?
- What are the reliable signs that a baby is not getting enough milk?
- What are the reasons why a baby may not be getting enough breast milk?
- Do you think a baby needs fluids during exclusive breast-feeding?
- What are the nutritional needs of a breastfeeding mother?

SESSION 5 – COMPLEMENTARY FEEDING

Session Length: ~60 minutes

Tools/Materials/Readings:

- Food flashcards
- Flipcharts
- Markers
- MT Complementary Feeding slide

Main Education Points:

- Complementary foods
- Optimum complementary feeding practices for children 6-23 months
- The right time to introduce complimentary foods, how much, and how to prepare and serve
- How to make energy dense foods and drinks for babies
- Foods to avoid
- Importance of good hygiene

Activities/Assessments:

- Recap: **(5 minutes)**
  Facilitator should start session by asking one person to provide a brief recap of what the group learned during the last session and then ask if anyone has questions.

- Brainstorm: (**5 minutes**)
  Facilitator should lead a discussion about the complimentary foods that participants currently feed their children

- Introduction to complementary feeding: (**10 minutes**)
  Facilitator should use food flashcards to show appropriate weaning foods. Discuss possible combinations of foods and explain which combinations would not be appropriate.

- Facilitator presentation: (**10 minutes**)
  Facilitator will present the important points associated with weaning and complimentary feeding, including:

    - When to begin complimentary feeding
    - Energy required by age
    - Proper food preparation

- Baby Posters: (**20 minutes**)
  Working in pairs or small groups, participants will design an informational baby poster that depicts the ideal feeding patterns for that age group. Assign each group a different age:

    - Group 1: from Birth-6 months
    - Group 2: 6-9 months
    - Group 3: 9-12 months
    - Group 4: 1 year +.
    -

  Instruct participants to collect food flashcards, which display what the baby should be eating, when the baby should eat, and other important information to know about feeding a child of this age.

Explain that a mother who is curious about what to feed her baby should be able to understand the poster. The facilitator should stress that cold food is not good for babies and give disadvantages of giving cold food to babies.

- Facilitator Discussion: (**10 minutes**)
  Facilitator should lead a discussion on what happens if:
  - Food is introduced to a baby too soon
  - Food is introduced to a baby too late
  - Characteristics of complementary foods

- De-Brief: (**5 minutes**)
  Facilitator identifies 2 participants to provide a **BRIEF re-cap** of what they have learned during this lesson. Each participant should also identify **how they can change their behavior** to incorporate the new knowledge they have learned. Facilitator should prompt participants to discuss **specific actions** they can take which will result in an improvement / incorporation of the topic in their lives.

Discussion Questions:

- Why is there an optimal age for children to start complementary feeding?
- What might happen if complementary foods are started too soon (before six months)?
- What might happen to the child if complementary foods are started too late (older than six months)?
- What are the characteristics of complementary feeding?
- How can we use locally available foods to fill the energy gap?
- What are the suitable foods for a baby and which foods should be avoided?
- What is the importance of clean and safe feeding of young children?
- How to observe food hygiene during food preparation, serving and feeding infants.

SESSION 6 – FOOD GROUPS

Session Length: ~60 minutes

Tools/Materials/Readings:
- Flipchart
- Markers
- Food group handout
- Food flashcards

Main Education Points:
- Food groups and their importance in the diet and for the body
- The different types of cooking methods
- The problems that might occur if a well balanced is not eaten

Activities/Assessments:
- Recap: **(5 minutes)**
  Facilitator should start session by asking one person to provide a brief recap of what the group learned during the last session and then ask if anyone has questions.

- Introduction & Facilitator Presentation: (**20 minutes**)
  Facilitator begins by explaining that today we will be focusing on learning the different food groups and what kinds of foods are needed to ensure a healthy, balanced diet.

    - Introduce the 3 food groups (body-building foods, energy-giving foods, and protective foods) and explain their importance to the body and recommended daily intake
    - Ask participants to brainstorm foods that fit into each category
    - Explain foods that don't fit into any of these categories (fats, sugars, etc.)

- Food flashcards: (**10 minutes**)
  Divide the flipchart into 3 sections and label each section with one food group. Using food flashcards, ask participants to place the food cards in the correct places on the flipchart. Ensure that each participant places at least 1 flash card on the flipchart.

- Designing an Ideal Meal: (**10 minutes**)
  Facilitator should draw a plate on the flipchart. Facilitator should prompt all participants to pick food flashcards and create an ideal meal for a pregnant woman. Encourage participants to fill up the plate with as many foods as they see and indicate portion size of each food on a flip chart.

- Brainstorm: (**10 minutes**)
  Ask participants to think about which foods form the biggest parts of participants' current diets. Do these match the portion they should be according to the food pyramid? If not, why not? Is there anything participants can do to change this? How can participants' improve their families' diets?

- De-Brief: (**5 minutes**)
  Facilitator identifies 2 participants to provide a **BRIEF re-cap** of what they have learned during this lesson. Each participant should also identify **how they can change their behavior** to incorporate the new knowledge they have learned. Facilitator should prompt participants to discuss **specific actions** they can take which will result in an improvement / incorporation of the topic in their lives.

Discussion Questions:
- What is the importance of eating from each food group for our bodies?

- What is a balanced diet?
- How can a balanced diet be prepared?
- How can the nutrients be preserved?
- What problems might occur if a balanced meal is not eaten?

SESSION 7 – MICRONUTRIENTS FOR MOTHERS & CHILDREN

Session Length: ~60 minutes

Tools/Materials/Readings:
- Flipchart
- Markers

Main Education Points:
- Importance of Vitamin A, Iron, and Iodine (and other key micronutrients)
- Who is at the greatest risk of deficiency with these micronutrients
- Sources of Vitamin A, Iron, and Iodine
- How to incorporate micronutrients into the diet

Activities/Assessments:
- Recap: **(5 minutes)**
  Facilitator should start session by asking one person to provide a brief recap of what the group learned during the last session and then ask if anyone has questions.

- Facilitator Presentation: (**15 minutes**)
  Facilitator should lead a discussion on the importance of micronutrients, particularly Vitamin A, Iron, and Iodine. Explain the benefits of each nutrient and why it is important especially for mothers and children. Emphasize that mothers and children have the greatest risk of developing deficiency of these micronutrients

    - Vitamin A
    - Iron
    - Iodine
    - Zinc
    - Folate
    - Vitamin C
    - Calcium
    - Vitamin B

- "Cards Up": (**10 minutes**)
  Facilitator will prepare cards with images of foods that are good sources of Vitamin A, Iron, and Iodine. Pass out 3 cards to every participant and explain that you will call out the name of one nutrient and each participant must hold up one of her cards if that food is a good source of the nutrient. Continue until each participant has had the opportunity to hold up all cards.

- Small Group Discussions: (**10 minutes**)
  Divide participants into 3 groups. Assign each group one of the following micronutrients. Instruct participants to create a list of all the locally available foods that contain the assigned micronutrient. After 5 minutes of preparation, have each small group present to the larger group. Facilitator should correct any foods that are misidentified.

    - Group 1: Sources of Iron
    - Group 2: Sources of Vitamin A
    - Group 3: Sources of Iodine

- Group Discussion: (**15 minutes**)

Facilitator should lead a group discussion around how participants can incorporate the foods they have identified into their diets. Address the following questions:

- Are these foods easy to obtain?
- How can these foods be added the food I already eat?
- Are there new recipes that I can try that contain these foods?
- Control and prevention strategies (breastfeeding, deworming supplementation, eating fortified foods, dietary diversity)
- Types of preventive strategies for micronutrient deficiencies in Uganda
- Use of micronutrient powders for addressing childhood anemia

- De-Brief: (**5 minutes**)
  Facilitator identifies 2 participants to provide a **BRIEF re-cap** of what they have learned during this lesson. Each participant should also identify **how they can change their behavior** to incorporate the new knowledge they have learned. Facilitator should prompt participants to discuss **specific actions** they can take which will result in an improvement / incorporation of the topic in their lives.

Discussion Questions:

- What is the importance of Vitamin A to mothers and their children?
- Who is at the greatest risk of developing Vitamin A deficiency? And what is its outcome?
- Which interventions can be employed to improve Vitamin A uptake of women and their children?
- How Vitamin A is transferred from mother to the fetus what are the sources of Vitamin A?
- How can I get enough Vitamin A each day?
- What is the importance of Iron to mothers and their children?
- Who is at the greatest risk of iron deficiency?
- What are iron requirements by age and sex?
- What are the symptoms of iron deficiency in the body?
- What are the consequences of iron deficiency to the mothers and their children?
- What are the sources of Iron?
- What are the strategies to control iron deficiency? And what is its outcome?
- What is the importance of iodine?
- What are the sources of iodine?
- In which ways can these micronutrients be incorporated into our diets?

SESSION 8 – SAFE WATER & SANITATION PRACTICES

Session Length: ~60 minutes

Tools/Materials/Readings:
- Flip charts
- Markers
- MT Safe Drinking Water slides

Main Education Points:
- Link between health and hygiene
- Diseases caused by poor hygiene and contaminated water
- The five F's (feces, fingers, flies, fingers and fluids)
- Water purification methods
- When and how to wash hands
- Good sanitation practices

Activities/Assessments:
- Recap: **(5 minutes)**
  Facilitator should start session by asking one person to provide a brief recap of what the group learned during the last session and then ask if anyone has questions.

- Thinking about Hygiene and Health: (**5 minutes**)
  Divide participants into small groups. Instruct groups to think about the relationship/link between sanitation, hygiene, and disease. Use a selection of the Discussion Questions listed below as prompts for the small groups.

- Introduction: (**10 minutes**)
  Facilitator should lead a discussion around the impacts of drinking contaminated water. Some of the most common water-borne sicknesses are typhoid, dysentery, hepatitis, cholera, diarrhea, and amoebiasis. Discuss each illness and what it does to the body.

- Brainstorm: (**5 minutes**)
  Facilitator should ask participants to think about all the ways water and food can become contaminated. Record responses on the flipchart and add any that haven't been mentioned. Facilitator should stress that you cannot tell if water or food have been contaminated by looking at it!

- Facilitator presentation: (**10 minutes**)
  The facilitator should introduce the link between the 4 Fs and how this link can be broken to promote hygiene.

- Hand-Washing Demonstration: (**5 minutes**)
  The facilitator should talk about the critical points surrounding hand-washing and should demonstrate proper hand-washing with the use of soap. Remind participants when hand-washing should occur and how to ensure that your children are properly washing their hands

- Safe Water Map: (**5 minutes**)
  Divide participants into small groups and distribute a piece of flipchart paper to each group. Ask participants to identify safe water sources (protected springs, pumps, etc.) in their community. Draw a simple map of the community on the flipchart and mark safe water sources on the map.

- Safe Water Demonstration: (**10 minutes**)
  Facilitator will begin by presenting the Mango Tree Chart on Safe Water and explain how to make and store safe water based on the following method:
    - Collect the water in a clean container
    - Boil the water in a covered pan or pot for at least 3 minutes
    - Let the water cool and store it in a clean container with a cover
    - After treating the water, store it in a container with a small opening so that people do not dip dirty cups into it (show examples of safe water containers)
    - Always keep the water container clean!

- De-Brief: (**5 minutes**)
  Facilitator identifies 2 participants to provide a **BRIEF re-cap** of what they have learned during this lesson. Each participant should also identify **how they can change their behavior** to incorporate the new knowledge they have learned. Facilitator should prompt participants to discuss **specific actions** they can take which will result in an improvement / incorporation of the topic in their lives.

Discussion Questions:

- What diseases are due to poor hygiene and sanitation?
- When do you think hands should be washed and how?
- How do you use/maintain latrines?
- Do you use a safe water source to get water for my household? If no, why not? What would have to change for me to start using a safe water source? How can I start making those changes?
- How is water made safe in my community? Are they ways I can assist in this effort?
- Do you suspect that your children have ever become ill because of poor sanitation and hygiene? Diarrhea, vomiting, malaria, ringworms. What can you do to prevent this in the future? How can you treat them effectively if they fall ill again?
- How often do you clean a pot for drinking water? It should be at least every week
- What is the proper way of drawing drinking water from a pot? By using a selected clean cup. It should be done after washing hands with soap and left to dry
- Is it safe to share domestic use water with animals?

PREPARATION FOR NEXT SESSION

- Inform participants that the group will cook food during the next session based on recipes that include different food groups. Ask for volunteers to bring materials with them to the next session:

    - Different types of food
    - Water
    - Cooking materials
    - Fire Source

SESSION 9 – FOOD PREPARATION & RECIPES

Session Length: ~60 minutes

Tools/Materials/Readings:
- Different types of food
- Fire source
- Water
- Cooking materials

Main Education Points:
- Different ways of preparing food
- How to modify food recipes to increase nutrient content
- How to prepare complementary foods

Activities/Assessments:
- Recap: **(5 minutes)**
  Facilitator should start session by asking one person to provide a brief recap of what the group learned during the last session and then ask if anyone has questions.

- Review: (**5 minutes**)
  Facilitator should review the important points from the previous session including:
  - Foods Groups and RDA's
  - Foods that contain important nutrients
  - How to improve your diet to incorporate more nutritious foods

- Food Safety Discussion: (**5 minutes**)
  Facilitator should discuss how food can be prepared hygienically to ensure food safety, and how to dispose of refuse.

- Meal preparation: (**40 minutes**)
  Divide participants into small groups. Ask each group to plan at least one day worth of meals from this list (Mens groups should plan meals for one week):
  - Meals for a one year old baby
  - Meals for a 6 months old baby
  - Meals for a Pregnant mother

  Facilitator should lead a demonstration on how to prepare High Energy Porridge (see facilitators guide).

  At the end of the session ask the participants to suggest other useful ways the food could be prepared and how to increase nutrient content in the prepared meals.

- De-Brief: (**5 minutes**)
  Facilitator identifies 2 participants to provide a **BRIEF re-cap** of what they have learned during this lesson. Each participant should also identify **how they can change their behavior** to incorporate the new knowledge they have learned. Facilitator should prompt participants to discuss **specific actions** they can take which will result in an improvement / incorporation of the topic in their lives.

Discussion Questions:
- What are the different ways of food preparation? What are the pros and cons of each?

- What are the possible ways of increasing nutrient content using these food preparation methods? Have I even used any of these? What happened?
- Were the foods prepared during the demonstration something that I could make for my family/ children? Why or why not? (d) How could I modify them to make them more useful to my family?

SESSION 10 – REVIEW

Session Length: ~60 minutes

Tools/Materials/Readings:
Flipchart, makers, paper and pen
Jeopardy Board

Activities/Assessments:

- Recap: **(5 minutes)**
  Facilitator should start session by asking one person to provide a brief recap of what the group learned during the last session and then ask if anyone has questions.

- Jeopardy: (**45 minutes**)
  Divide the group into two teams and lead a trivia game that reviews the topics from weeks 1-7. Facilitator will use the prepared **Jeopardy Questions-Week 10** and should be prepared to address all topics from the previous weeks.

  Jeopardy Instructions:
  A team is randomly chosen to go first, and begins the game by selecting a category and point value (e.g. "Prenatal Nutrition for 100"). The Facilitator then reads the clue to the team and they have 2 minutes to answer the questions.

  Teams are encouraged to discuss responses prior to answering. The group should be in agreement about the answer before giving the answer to the facilitator.

  A correct response earns the point value of the clue, and gives the. If the team gives an incorrect response or fails to answer in time, that amount is deducted from the team's score and the other team is given the opportunity to respond. If neither team answers any questions correctly, take time to cover the topic again and reinforce key lessons from the previous sessions.

  The other team follows by selecting a category and a point value. The game continues until all categories and point values have been selected. The facilitator determines the winning team by adding up the points.

- Discussion Questions: (**15 minutes**)
  Facilitator should spend the remainder of the sessions leading a discussion around the questions listed below. Spend approximately 5 minutes on each question.

Discussion Questions:

- What are the key issues you have obtained from each of the previous module?
- How has it benefited you, your household, and the community?
- What are barriers for using knowledge outside the "classroom"?

SESSION 11 – HIV/AIDS

Session Length: ~60 minutes

Tools/Materials/Readings:
- Flipchart
- Markers

Main Education Points:
- HIV and infant feeding
- Nutritional requirement of HIV positive mothers
- How an HIV+ mother transitions from breastfeeding to complimentary feeding and weaning
- HIV and nutrition
- How to support HIV lactating and pregnant mothers meet their increased energy demands

Activities/Assessments:
- Introduction: (**5 minutes**)
  Facilitator should lead a discussion around HIV / AIDS by asking participants to think about the following questions:
  - What is HIV / AIDS?
  - Is HIV / AIDS a problem in my community?
  - Can HIV affect my unborn child? Can it affect my breastfeeding child?
  - Is HIV / AIDS a problem during pregnancy and lactation?

- HIV Transmission & Prevention: (**10 minutes**)
  Facilitator should ask participants to review all of the ways HIV is transmitted and record them on a flipchart. Next to each transmission answer, ask participants to brainstorm prevention methods. Facilitator should cover the following:

Transmission:	Prevention:
Sexual Activity	Male Condom / Female Condom / Abstinence
Blood Exchange	Avoid sharing Needles / Care with sharp objects
Mother-to-Child	Preventative measures during pregnancy, labor delivery & breastfeeding

- Living with HIV: (**5 minutes**)
  Facilitator should review how ARVs are used and how to prevent the spread of HIV in the body. Facilitator should stress that being diagnosed with HIV does NOT mean you will die soon. The importance of consistent medication should be stressed, especially for pregnant mothers.

- Preventing Mother-to-Child Transmission: (**15 minutes**)
  Facilitator should explain the ways that HIV is passed on from mother to child (during pregnancy, delivery, and breastfeeding) and explain that MTCT is preventable. Facilitator should stress that HIV positive women should consult a healthcare worker before, during, and after pregnancy. The facilitator should explain why it is important for an HIV+ mother to monitor her nutritional status.

- Group Discussion: (**10 minutes**)
  Facilitator should lead a discussion about the energy and nutritional needs of HIV positive women and lactating women.

- Transitioning to Complimentary Feeding: (**10 minutes**)

Facilitator explains the process for transitioning to complimentary feeding & weaning for HIV positive mothers

- De-Brief: (**5 minutes**)
  Facilitator identifies 2 participants to provide a **BRIEF re-cap** of what they have learned during this lesson. Each participant should also identify **how they can change their behavior** to incorporate the new knowledge they have learned. Facilitator should prompt participants to discuss **specific actions** they can take which will result in an improvement / incorporation of the topic in their lives.

Discussion Questions:

- What is HIV/AIDS?
- What are the causes of HIV/AIDS? What increases the risk of maternal to child transmission of HIV/AIDS?
- How can HIV/AIDS be prevented?
- How can an HIV positive mother feed her baby? What are the feeding options for HIV positive mothers?
- How can an HIV positive mother heat treat breast milk to make it safe for her baby?
- How can a breastfeeding mother transition from breast milk to solid feeds?
- How can HIV positive pregnant women and lactating women be supported to consume enough foods to meet their energy and nutrient needs?

SESSION 12 – CONTRACEPTION & FAMILY PLANNING

Session Length: ~60 minutes

Tools/Materials/Readings:
- Flipchart
- Markers
- Contraception supplies

Main Education Points:
- Family planning methods
- How to use family planning methods
- Advantages and disadvantages of family planning methods
- Possible side effects of family planning methods
- Frequently asked questions about family planning methods

Activities/Assessments:
- Recap: **(5 minutes)**
  Facilitator should start session by asking one person to provide a brief recap of what the group learned during the last session and then ask if anyone has questions.

- Introduction: (**5 minutes**)
  Facilitator should begin with an introduction to Family Planning. Ask participants the following questions:
  - Are you interested in learning more about family planning? Why?
  - Do many families in your community utilize family planning? Why or why not?
  - What would you like to know about family planning? (Facilitator should limit this question to a **few** responses! Try to answer these questions during the lesson)

- Facilitator Presentation: (**30 minutes**)
  Facilitator will present the different types of family planning methods. Show each method and pass around for participants to look at / touch. Stress the advantages, disadvantages, and possible side effects of each method.

- "Myth-Breakers": (**15 minutes**)
  Facilitator should address each family planning method, one by one. Ask participants about common beliefs surrounding each method and reasons why couples choose to use or not use specific methods. Explain why each belief is true/false and the reasons why. Write responses on the flipchart.

- De-Brief: (**5 minutes**)
  Facilitator identifies 2 participants to provide a **BRIEF re-cap** of what they have learned during this lesson. Each participant should also identify **how they can change their behavior** to incorporate the new knowledge they have learned. Facilitator should prompt participants to discuss **specific actions** they can take which will result in an improvement / incorporation of the topic in their lives.

Discussion Questions:
- What is family planning?
- What are the different family planning methods, their advantages and disadvantages?
- How can lactation menorrhea be used as a dual family planning method?
- Which beliefs influence family planning methods?

SESSION 13 – PRECONCEPTION

Session Length: ~60 minutes

Tools/Materials/Readings:
- Flipchart
- Markers

Main Education Points:
- Define Preconception Care
- Reproductive Plans
- Discuss Healthy Preconception Practices
- Prenatal Nutrition Focusing on Important Nutrients
- Signs of Pregnancy
- Importance of Prenatal Care

Activities/Assessments:
- Recap: **(5 minutes)**
  Facilitator should start session by asking one person to provide a brief recap of what the group learned during the last session and then ask if anyone has questions.

- Ice-Breaker: (**5 minutes**)
  "Know your neighbor better": One participant stands up and says everything she/he knows about the person next to them. Then the other person does the same. Everyone will have a chance to talk about someone else in the group.

- Introduction of Topic: (**10 minutes**)
  Ask participants to reflect about reproductive plans. Brainstorm as a whole group using the following questions and write the answers on the flip chart.

    - How old do I want to be when I stop having children?
    - How many children do I want to have?
    - How many children does my partner want to have?
    - How many children do your parents in law want you to have?

- Role-play: (**10 minutes**)
  Participants will act out a family with many children and another with few children sharing the same portion of food. Ask participants to share their observations and thoughts about the role-play. Conclude by stressing the disadvantages of having many children. Stress that it's not too late to have a reproductive plan.

- Facilitator Presentation: (**15 minutes**)
  Facilitator presents important information about preconception, addressing the following important points:

    - Unfavorable prenatal conditions
    - Knowing your HIV status before getting pregnant
    - Healthy nutrition leading up to pregnancy
    - Consequences of NOT having prenatal care

- Detecting Pregnancy: (**10 minutes**)
  Facilitator should lead a discussion around detecting pregnancy. The following questions should be addressed:
    - How do I know that I'm pregnant?
    - What should I do if I think I might be pregnant?
    - Should I be worried about weighing too little when I am trying to get pregnant?

- De-Brief: (**5 minutes**)
  Facilitator identifies 2 participants to provide a **BRIEF re-cap** of what they have learned during this lesson. Each participant should also identify **how they can change their behavior** to incorporate the new knowledge they have learned. Facilitator should prompt participants to discuss **specific actions** they can take which will result in an improvement / incorporation of the topic in their lives.

Discussion Questions:

- What is preconception care?
- What steps can I take to be as healthy as possible between births?
- How do I plan to stay healthy and eat right during pregnancy?
- Are there any nutrients that are especially important to eat when I'm trying to get pregnant or pregnant?
- Should I be concerned about weighing too little when I'm trying to get pregnant or pregnant?
- Why it is important to know my HIV status?
- What are unfavorable prenatal conditions?
- What is the importance of prenatal care?
- What are the signs of pregnancy?
- What are the consequences of not having prenatal care?

SESSION 14 – PRE & POSTNATAL PRACTICES IN YOUR COMMUNITY

Session Length: ~60 minutes

Tools/Materials/Readings:
- Flipchart
- Markers

Main Education Points:
- Review the Importance of Prenatal and Postnatal Care
- Common beliefs about Prenatal Care and Postnatal Care in your Community
- Barriers to getting information related to Prenatal Care

Activities/Assessments:
- Recap: **(5 minutes)**
  Facilitator should start session by asking one person to provide a brief recap of what the group learned during the last session and then ask if anyone has questions.

- Review of Prenatal and Postnatal Care: (**15 minutes**)
  Review what prenatal and postnatal care are, the places where women get prenatal and postnatal care, and the importance of prenatal and postnatal care. Record answers on flipchart
    - Ask each participant about a benefit of prenatal and/or postnatal care, one by one. Everybody should get a chance to mention a benefit.

- Identify Challenges: (**15 minutes**)
- Ask participants to identify the main reasons why some pregnant women in their community do not go for prenatal and postnatal care. When challenges are mentioned, write them on the flipchart. Then discuss how to overcome these obstacles?

- Myth Breakers: (**20 minutes**)
  Working in small groups, participants should discuss common belief in their community that prevent women from seeking prenatal and postnatal care. Groups should address the following questions:
    - What are common beliefs about prenatal care? Are any of them harmful to a pregnant woman's health?
    - Are these beliefs true?
    - What are barriers to getting information related to prenatal care?
    - Why do people believe these myths?

  After discussion, each group should share their thoughts. The facilitator should identify **harmful** practices and explain what should be done instead.
  **** When discussing herbal remedies, facilitator will have difficulty convincing participants not to use herbs. Instead, the facilitator should stress that if a woman is going to use herbs, she must <u>also</u> utilize medical care****

- De-Brief: (**5 minutes**)
  Facilitator identifies 2 participants to provide a **BRIEF re-cap** of what they have learned during this lesson. Each participant should also identify **how they can change their behavior** to incorporate the new knowledge they have learned. Facilitator should prompt participants to discuss **specific actions** they can take which will result in an improvement / incorporation of the topic in their lives.

Discussion Questions:

- Where do women go for prenatal knowledge?
- What are common beliefs about prenatal care? Are any of them harmful to your health?
- What are barriers to getting information related to prenatal care?
- Why don't some women go for prenatal care?
- What can be done to overcome these obstacles?

SESSION 15 – BIRTHING

Session Length: ~60 minutes

Tools/Materials/Readings:
- Flipchart
- Markers

Main Education Points:
- Where to give birth
- Pros and cons of giving birth in the hospital versus traditional birth attendants
- Care of premature and low birth weight babies
- Barriers that prevent pregnant women from giving birth in a hospital
- How to care for the newborn and complications that may result after pregnancy
- How to have a sterile birth

Activities/Assessments:
- Recap: **(5 minutes)**
  Facilitator should start session by asking one person to provide a brief recap of what the group learned during the last session and then ask if anyone has questions.

- Brainstorm**:** (**10 minutes**)
  Divide participants into 2 groups. Ask one group to think about all the "Pros" and "Cons" of giving birth in a hospital and the other to think of the "Pros" and "Cons" of giving birth with a traditional birth attendant. Have each group share their thoughts.
  *** After participants share their thoughts, the facilitator must stress that the Pros of giving birth in a hospital outweigh BOTH the Cons of giving birth in a hospital and the Pros of giving birth with a traditional birth attendant***

- Role-Play: (**15 minutes**)
  Participants will work in groups, with one person acting as the "husband" and the other acting as the "wife giving birth". Ask participants to sit in front of the room and facilitator will read them a common scenario (i.e. you have been in labor for 12 hours and there has been no progress, what do you do? your baby has been delivered, what happens next?). Participants should respond by explaining what each person should do in that situation.

- Demonstration of Keeping Low Birth Weight Babies Warm: (**10 minutes**)
  Facilitator demonstrates what should be done with premature babies and low birth weight babies. Show participants how to use a kangaroo method for providing warmth. Stress the importance of why low birth weight babies need to be warm. Facilitator should identify which additional methods participants use to keep babies warm and assess whether or not they are safe.

- Small Group Discussion: (**15 minutes**)
  Participants should work in groups of 3. Each group will be assigned one of the following topics and should discuss for 10 minutes before presenting to the large group:

  - Group 1: routine care for a new born
  - Group 2: care for the umbilical cord
  - Group 3: complications that may result after delivery

  Following presentations, Facilitator should stress that if any complications arise, the woman should be rushed to a doctor immediately.

- De-Brief: (**5 minutes**)
  Facilitator identifies 2 participants to provide a **BRIEF re-cap** of what they have learned during this lesson. Each participant should also identify **how they can change their behavior** to incorporate the new knowledge they have learned. Facilitator should prompt participants to discuss **specific actions** they can take which will result in an improvement / incorporation of the topic in their lives.

Discussion Questions:

- Where should I give birth?
- Are there any special considerations if this is your fifth or more childbirth?
- What should be done with low birth weight and premature babies?
- When should the baby be put on the breast?
- What is the importance of colostrum/ first milk?
- How should a baby be positioned on a breast?
- How is the new born cared for? And or what is the routine for the newborn baby?
- How should the umbilical cord be treated?
- Which complications may result after delivery?
- What alternatives exist for feeding babies born to HIV+ mothers?

SESSION 16 – INFANT ILLNESS & PREVENTATIVE HEALTH PRACTICES

Session Length: ~60 minutes

Tools/Materials/Readings:

- ORS
- Cups
- Water
- Flip charts
- Markers

Main Education Points:

- What Immunizations children should receive
- When and where to be immunized
- Understanding the immunization section of the child health card
- Importance of diet in preventing illness
- Warning signs of common illnesses
- Common childhood illnesses, and how they can be prevented

Activities/Assessments:

- Recap: **(5 minutes)**
  Facilitator should start session by asking one person to provide a brief recap of what the group learned during the last session and then ask if anyone has questions.

- Introduction: (**15 minutes**)
  Facilitator will introduce the topic by explaining to the participants what immunization is and promoting a discussion on diseases that can be prevented by immunization. Write the findings on a flip chart and add any that are missed. Stress that immunizations exist for 8 diseases (previously 6). The facilitator should explain when and which body part is immunized.

- Child health Card: (**5 minutes**)
  The facilitator should lead a discussion explaining the significance of a child health card and how it is used. Explain the immunization section, how to read this section, and answer questions that participants have.

- Brainstorm: (**10 minutes**)
  Ask participants to brainstorm common infant illnesses and write the answers on the flip chart. The facilitator will identify the most common childhood illnesses and talk about them. Ask participants to specify ways how they tell that the children are suffering from the mentioned diseases. Facilitator will fill in and explain any gaps in the responses.

- Small group discussion: (**10 minutes**)
  Divide participants into small groups. Instruct participants to think about the following questions. After 5 minutes of discussion, have each group present their thoughts to the larger group.
    - How can my household prevent common childhood illnesses?
    - How can my household manage a child with one of these illnesses?

  The facilitator should fill in gaps and stress hookworm prevention at this point.

- Demonstration: (**10 minutes**)
  Facilitator begins by explaining how to recognize and treat diarrhea. Then, show participants how to make ORS. Ask participants to mix ORS for the rest of the group as the facilitator reads to them the procedures, and let them measure how much is needed by the baby after every diarrhea motion.

- De-Brief: (**5 minutes**)
  Facilitator identifies 2 participants to provide a **BRIEF re-cap** of what they have learned during this lesson. Each participant should also identify **how they can change their behavior** to incorporate the new knowledge they have learned. Facilitator should prompt participants to discuss **specific actions** they can take which will result in an improvement / incorporation of the topic in their lives.

Discussion Questions:

- What is Immunization?
- What immunizations should children get and at what age?
- What are the common infant illnesses?
- How do these childhood illnesses spread?
- What are the signs and the symptoms of the common childhood illnesses? How can they be managed?
- How do you tell that the baby is sick? What should be done if the mothers notice that their babies are sick?
- How should a sick child be fed? What should a baby suffering from diarrhea eat?
- How can hookworms be prevented?
- How is ORS made?

SESSION 17 – POST-NATAL CARE & BIRTH SPACING

Session Length: ~60 minutes

Tools/Materials/Readings:
- Flipchart
- Markers
- MT Birth Spacing Slide

Main Education Points:
- How to care for your baby and yourself in the weeks immediately after birth
- How to prevent post-term pregnancies
- What the child and mother are provided with when they visit a post natal clinic
- Information on child spacing

Activities/Assessments:
- Recap: **(5 minutes)**
  Facilitator should start session by asking one person to provide a brief recap of what the group learned during the last session and then ask if anyone has questions.

- Introduction: (**5 minutes**)
  Facilitator begins by asking the group to think about what a typical mother's first week after giving birth is like. Ask participants to think about the day she gives birth to a new baby. What happens immediately after delivery? What happens the next day and the following days? What kind of experience is this for women in your community? How can this experience be improved?

- Facilitator Presentation: (**10 minutes**)
  The Facilitator will present the important points related to postnatal care including:

    - Where to go for postnatal care
    - When to go for postnatal care
    - Services offered at post-natal clinics
    - Importance of vitamin A supplementation
    - How to prevent postnatal pregnancy using LAM

- Brainstorm: (**10 minutes**)
  Have participants brainstorm all of the things that prevent women from accessing post-natal care. Then discuss how to get around these issues (Example: Women can't get to a clinic after giving birth because the transportation is too expensive. Solution: If a family begins saving a small amount every day that the woman is pregnant, the transportation cost won't seem so bad)

- Group discussions: (**20 minutes**)
  Divide participants into 3 groups and assign each group one of the following topics. After 5-10 minutes of discussion, have each group present to the larger group. The facilitator should answer any questions and fill in important points about the topics.

    - Group 1: How to take good care of yourself after giving birth
    - Group 2: How to take good care of your baby after birth
    - Group 3: Consequences of not receiving postnatal care

- Benefits of Birth Spacing: (**10 minutes**)
  Using flipchart paper, have participants draw pictures of every person in the family who benefits from birth spacing. Dedicate one page to each person and then draw all the ways that each person benefits.

    - Example: Pictures of Mother, Father, Baby, Sibling
    - Mother: Safe, Happy, Gets a lot of sleep, can work again
    - Father: Can pay school fees for other children, can spend time with his wife
    - Baby: Can breastfeed, is healthy, gets mother's attention
    - Sibling: Shares parent's attention, has plenty of food to eat, can play with younger sibling rather than taking care of them

- De-Brief: (**5 minutes**)
  Facilitator identifies 2 participants to provide a **BRIEF re-cap** of what they have learned during this lesson. Each participant should also identify **how they can change their behavior** to incorporate the new knowledge they have learned. Facilitator should prompt participants to discuss **specific actions** they can take which will result in an improvement / incorporation of the topic in their lives.

Discussion Questions:

- Where do women go for postnatal knowledge?
- Did you receive vitamin A after birth? And what is the role of Vitamin A supplementation in the child's health?
- How to take good care of yourself and the baby after birth?
- Which services are offered at postnatal clinics? And importance of Post natal clinics
- What are the barriers of receiving postnatal care? And how can they be solved?
- What are the consequences of not receiving postnatal care?
- What is child spacing?
- How much space is appropriate for spacing children?
- What are the benefits of child spacing?
- How can child spacing be promoted?

SESSION 18 – INFANT GROWTH MONITORING & PROMOTION

Session Length: ~60 minutes

Tools/Materials/Readings:
- Flipchart
- Markers

Main Education Points:
- Developmental milestones by age
- Signs of delayed developmental milestones and how they can be corrected
- The importance of growth monitoring and promotion
- The role of good nutrition in promoting growth and development
- Understanding the child health growth card

Activities/Assessments:
- Recap: **(5 minutes)**
  Facilitator should start session by asking one person to provide a brief recap of what the group learned during the last session and then ask if anyone has questions.

- Facilitator Presentation: (**5 minutes**)
  Facilitator introduces the concept of physical development milestones and how they can be used

- Small group discussions: (**20 minutes**)
  Make cards with ages 0-3months, 3-6months, 6-9months, 9- 12months, 1-2years,2-3years, 3-4years, and 4-5 years. Divide participants into pairs or small groups and assign each group one of the following age ranges:

    - Group 1: 0-3 months
    - Group 2: 3- 6 months
    - Group 3: 6-9 months
    - Group 4: 9- 12 months
    - Group 5: 12-24 months

  Give each group a card and ask them to discuss among themselves the physical milestones that children go through at those ages. One person in the group will discuss the findings to the whole group. The facilitator will fill in gaps and corrections where necessary.

- Child Health Card: (**10 minutes**)
  Facilitator should explain to the participants the growth indicators using the child health card and the importance of growth monitoring.

- Facilitator Presentation: (**10 minutes**)
  Facilitator will explain how to identify the signs of developmental delay using indicators including:

    - Behavioral signs
    - Gross motor signs
    - Vision signs
    - Hearing signs

- Identifying Strategies for Promoting Child Development: (**10 minutes**)
  Participants should sit in a circle. Each participant should share one specific action that they or their spouse can take in order to promote child development and create an environment that promotes their baby's development. Before sharing, the facilitator should stress the link between nutrition and child development and child's performance in school.

- De-Brief: (**5 minutes**)
  Facilitator identifies 2 participants to provide a **BRIEF re-cap** of what they have learned during this lesson. Each participant should also identify **how they can change their behavior** to incorporate the new knowledge they have learned. Facilitator should prompt participants to discuss **specific actions** they can take which will result in an improvement / incorporation of the topic in their lives.

Discussion Questions:

- Do you think these development milestones apply to children in this community? Why or why not?
- Are there other markers people use to measure their child's development? Do you think these are good measures?
- What is the link between my child's development and their diet? Are there things I can do to strengthen this link in a positive way?
- Are there any obstacles to promoting my child's growth in my community? How can we overcome these obstacles?
- How do I tell that my child's developmental milestones have delayed? What should I do if I suspect that my child's developmental milestone have delayed?
- What resources are available if a child is not growing properly?

SESSION 19 – REVIEW

Session Length: ~60 minutes

Tools/Materials/Readings:
Flipchart, makers, paper and pen
Jeopardy Board

Activities/Assessments:

- Recap: **(5 minutes)**
  Facilitator should start session by asking one person to provide a brief recap of what the group learned during the last session and then ask if anyone has questions.

- Jeopardy: (**45 minutes**)
  Divide the group into two teams and lead a trivia game that reviews the topics from weeks 1-7. Facilitator will use the prepared **Jeopardy Questions-Week 19** and should be prepared to address all topics from the previous weeks.

  Jeopardy Instructions:
  A team is randomly chosen to go first, and begins the game by selecting a category and point value (e.g. "Prenatal Care for 100"). The Facilitator then reads the clue to the team and they have 2 minutes to answer the questions.

  Teams are encouraged to discuss responses prior to answering. The group should be in agreement about the answer before giving the answer to the facilitator.

  A correct response earns the point value of the clue, and gives the. If the team gives an incorrect response or fails to answer in time, that amount is deducted from the team's score and the other team is given the opportunity to respond. If any questions are not answered correctly by either team take time to cover the topic again and reinforce key lessons from the previous sessions.

  The other team follows by selecting a category and a point value. The game continues until all categories and point values have been selected. The facilitator determines the winning team by adding up the points.

- Group Discussion: (**15 minutes**)
  Facilitator should spend the remainder of the sessions leading a discussion around the Discussion Questions listed below. Spend approximately 7 minutes on each question.

Discussion Questions:

- Have you applied any of the lessons from the last lesson to change practices in your household? Has it benefited you, your household, or the community?
- What have been the challenges to changing these practices? What are the solutions I've found so far?

SESSION 20 – GRADUATION

Session Length: ~60 minutes

Tools/Materials/Readings:
Certificates

Main Education Points:
- Review of program topics
- Reflection of what you have learned
- Recognition of participants
- Moving forward

Activities/Assessments:
- Recognition of participants with certificate presentation
- Special recognition of outstanding participants

Discussion Questions:
- What have you learned about in this course?
- Has the information you've learned caused you to make any changes in your life?
- Do you feel more comfortable regarding topics concerning health and nutrition?
- What are the next steps for the group? Can we continue after the program formally ends?
- What kinds of goals did I establish at the beginning of the program? Have I achieved these goals?
- What has been the most enjoyable part of this experience?
- What is the most useful information that I've learned?

END OF TRAINING

2013

HEALTHY FUTURES INITIATIVE

Women's Empowerment Curriculum

HEALTHY FUTURES INITIATIVE

TABLE OF CONTENTS

CURRICULUM GUIDE

- Facilitator should begin each lesson with an "Ice-Breaker" in order to energize participants and get them moving around / excited for the lesson. Each Lesson includes a *suggested* "Ice-Breaker". Facilitators will quickly learn which "Ice-Breakers" participants like best! These activities can be repeated, replacing the listed "Ice-Breaker" for a particular lesson.
- Facilitator should begin each lesson by providing a brief review of the previous week's lesson and ask participants to recall important points that were covered.
- Each new lesson begins with the *Introduction* section, followed by the *Activities and Assessments* Section. Each lesson contains time allotments for every activity. These are estimates of how long each activity should take. If a certain activity ends quickly, the facilitator can rely on the additional *Discussion Questions*. If an activity is taking longer than expected, the facilitator can either continue (if the exercise is going really well) and shorten the other exercises, or wrap up the session by eliminating some group presentations.
- Each lesson ends with a *De-Brief.* The facilitator should ask 2 participants to provide a brief overview of what they have learned that day and talk about how they can change their behavior to incorporate the new information / skills / knowledge. Ensure that different participants share each week and that all participants have an opportunity to provide the *De-Brief* at least once.
- If a lesson contains *Discussion Questions*, they should be addressed after all activities and assessments have been completed (time permitting).
- The Facilitator should review and be familiar with the following materials prior to each lesson:
    - Lesson plan by topic
    - Facilitator Notes by topic
    - Facilitator Preparation by topic
    - Handouts / Lesson Materials
    - Relevant Supplemental Materials by topic

SESSION 1 – OVERVIEW AND INTRODUCTION

Tools/Materials/Readings:

- Healthy Futures Initiative Empowerment Topics on Flipchart
- Group Roster from LC1
- Name Tags

Main Education Points:

- Overview of program and outline topics to be covered
- Instructions for discussion, protocol for all future classes, importance of being on time and what to do if arriving late for future sessions, etc.
    - Explain what respondents should do if they disagree with the facilitator and/or other respondents (be respectful, promote dialogue, etc.).
    - Listen with the expectation of learning & assume that the speaker has something new and of value to contribute to your comprehension.
    - Questions are encouraged at all times.
    - Encourage respondents to communicate their reasoning process and assumptions.
    - Respect personal stories shared during the curriculum.
    - Stress importance of attendance and arriving on time. If participants arrive late they should try to join in when they arrive and the facilitator will greet them and bring them up to speed as soon as possible.
    - Stress that the majority of the group meetings will consist of discussion and group activity. Encourage participants to be actively involved, as they will benefit from doing so.

- Ice-Breakers: (**15 minutes**)
  These activities are a way for participants to get to know one another and practice actively participating with other group members. The facilitator should explain that the group is going to begin with some fun, warm-up activities before discussing program content. The facilitator should decide which icebreakers are appropriate for the group. Continue with new icebreakers until the time has passed.

  " 2 Truths and a Lie": See Facilitator Notes for Instructions

  "Tall Stories": See Facilitator Notes for Instruction

  "The Silent Game": See Facilitator Notes for Instruction

  "Get to Know you Better": See Facilitator Notes for Instruction

- Discussion: (**15 minutes**)

"Healthy Futures Initiative": Facilitator will prepare a poster with the topics that will be covered in the program. Show the Flipchart to participants and ask them to work in pairs or small groups to discuss the following questions. After 10 minutes, the group should come back together and discuss their thoughts for the final 5 minutes.

- What do these topics means to you?
- Do you think these topics affect your household? How?
- Are you interested in learning more about these topics? Why or why not?
- What do you already know about each of these topics?
- Why are these topics important?

- Wrap-Up & Homework: (**5 minutes**)

Before ending the session, thank participants for coming and confirm the next meeting. Answer any questions about the program. Discuss the "Homework" for next lesson. Collect nametags.

Homework: Facilitator should explain that next session, we would discuss communication. Between now and the next session, participants should think about all the times that they communicate with their spouse. Think about what you communicate about regularly? How do you communicate with your spouse? Do you ever face any trouble communicating with your spouse? Participants should be prepared to share with the group at the beginning of the next session.

Instructor logistics: session should be 45 minutes in length & held in the afternoon; if hangers- on enter during discussion greet them individually and incorporate them into the discussion of another group. It is important to get women excited and interested about the program during the first session so that they keep coming back.

Facilitator Notes:

"2 Truths and a Lie": The purpose of this game is to reveal information about yourself that the rest of the group may not already know.

1.) Have participants sit in a circle.
2.) The facilitator will begin the game.
3.) One at a time, each participant will begin by stating their name and then state 3 facts about themselves. 2 of these facts should be true and 1 fact should be a lie.
4.) After a participant has stated the 3 facts, the rest of the group should guess which fact was a lie. The facilitator should call on 3 respondents to share what they believe was the lie and then the group member who shared the information will reveal the truth.
5.) Continue around the circle until all participants have had a chance to share.
Example: My name is Erica. I have 4 dogs. I once lived on a boat. I know how to drive a motorcycle.
The facilitator should encourage participants to think about true facts about themselves that make them unique or that most of the group may not already know. That way, it is difficult to determine which fact is the lie. This is the fun of the game!
* Participants will probably begin by saying things like "My name is Twina. I was born in this village. I have 4 children. I am 100 years old". In this case, it is very easy to pick out the lie. Encourage participants to make it difficult for other group members to determine the lie!

"Tall Stories": Participants should sit in a circle. The facilitator begins a story with a sentence that ends in SUDDENLY. Then, the person sitting next to the facilitator has to add to the story with her own sentence that ends in SUDDENLY. Continue the story until everyone has contributed. The story becomes crazier as each person adds her sentence.
Example: Yesterday I went to the zoo and was passing the elephant enclosure when SUDDENLY.....
An elephant called out to me. He said my name and I moved closer to listen when SUDDENLY……

"The Silent Game": The purpose of this activity is to have participants complete a task without talking to one another. The facilitator should explain that they would give instructions of what the group must do and give a time limit. The participants must complete the activity SILENTLY.
Example: Instruct participants to line up in order from youngest to oldest (2 minutes)
Instruct participants to separate themselves into groups according to the number of children they have (3 minutes)
Instruct participants to find and hold hands with the person who lives closest to them (4 minutes)

"Get to Know You Better": This activity is a way for participants to learn more about each other.

Participants will often say that they already know each other, which is why the game is titled "Get to know you BETTER".

1.) Have participants select a partner or the facilitator assigns partners
2.) Partners decide who will be the "sharer" and who will be the "listener"
3.) Facilitator instructs the "sharer" that they have 2 minutes to tell the "listener" everything they know about them (for example, I know your name is Erica. You are from the United States. You currently live in Kampala. You are 25 years old)
4.) After the 2 minutes are up, the facilitator calls time.
5.) Then, the "listener" has 2 minutes to correct any misinformation that they heard and tell the "sharer" additional information about themselves.
6.) After the 2 minutes are up the facilitator calls time.
7.) At this point, each "sharer" should tell the group everything NEW that they learned about their partner.
8.) Switch "sharer" and "listener" roles and complete the activity again.

NOTES:

SESSION 2 - GENERAL COMMUNICATION STRATEGIES

Time/Length: ~45 minutes

Tools/Materials/Readings:

- Modes of Communication Flipchart

Main Education Points:

- Overview of program and outline topics to be covered

Main Education Points:

- Definition of Communication
- Define Modes of Communication: passive response, assertive response, aggressive response
- Possible Barriers to Communication
- Ways of Improving Communication

Activities/Assessments:

- Ice-Breaker: (**5 minutes**)
  Begin with a game of "Telephone": See Facilitator Notes for Instruction.
  Discuss the initial message and compare to the final message. Why did it change? Why was it difficult to pass on the message? How could the message have been passed on more clearly?

- Introduction: (**10 minutes**)
  Facilitator should introduce the 3 types of communication responses (passive, assertive, aggressive) and provide specific definitions / examples of each (See Facilitator Notes). After introducing each response, ask a pair of volunteers to act out a situation where each type of response is usually used between spouses.

- Brainstorm: (**5 minutes)**
  Divide the flipchart into 3 sections, labeled "passive", "assertive" and "aggressive". Ask participants to identify examples of a time when they used each type of communication with their spouse. What was the outcome? Would another type of communication have been more appropriate to use? Facilitator should stress that responding assertively is desirable and that passive and aggressive communication often leads to conflict within the household.

- Role Play: (**15 minutes**)
  Participants will work in pairs to practice *assertively* communicating one of the following important points that they discussed in the **Preconception Lesson** to their spouse:
  - How old I want to be when I stop having children
  - The important foods I need to eat when I'm pregnant
  - Why I want to know my HIV status before I try to get pregnant

- De-Brief & Homework: (**5 minutes**)
  Facilitator identifies 2 participants to provide a **BRIEF re-cap** of what they have learned during this lesson. Each participant should also identify **how she can change their behavior** to incorporate the new knowledge they have learned. Facilitator should prompt participants to discuss **specific actions** they can take which will result in an improvement / incorporation of the topic in their lives.

  Homework: Before the next session, participants should practice assertive communication with their spouse. Encourage participants to think about a time that they can communicate

assertively and practice the new communication method they learned today. Inform participants that they will share their experience next session.

Discussion Questions:

- When are certain models of communication more appropriate than others?
- What are some examples of household miscommunication and what are the results?
- Why does miscommunication occur in my household?
- How can I improve communication with my spouse?

Facilitator Notes:

"Telephone"**:** Participants should stand in a line. The facilitator whispers a sentence to the first person in line (the sentence should be a bit complicated but nothing too confusing. For example, "Yesterday, I planted beans and potatoes"). Then, each participant must whisper the sentence to the next person in line until the message has reached the last participant, who says the sentence aloud to everyone. Each participant can only whisper the sentence to the next person once! If a person doesn't understand, he/ she must simply whisper whatever they did hear to the next person. By the last person, the initial sentence has usually changed dramatically!

Communication: To share or exchange information or news. Communication requires a sender, a message, and a recipient.

Modes of Communication:

- *Passive Response*: Behaving passively means not expressing your own needs and feelings, or expressing them so weakly that they will not be heard
    - *Example*: My husband went to the market today to buy food for the family. I asked him to buy carrots and pumpkin for my small children but when he returned home, he had only purchased matooke and some alcohol for himself. Instead of asking him why he didn't purchase the items, I simply take what was purchased and thank him

- *Assertive Response*: Behaving assertively means asking for what you want or saying how you feel in an honest and respectful way, so that it does not infringe on another person's rights or put the individual down
    - *Example*: My husband went to the market today to buy food for the family. I asked him to buy carrots and pumpkin for my small children but when he returned home, he had only purchased matooke and some alcohol for himself. I ask my husband why he didn't purchase the items and he said that they were too expensive and that he likes to eat motooke anyways. I calmly explain to him that carrots and pumpkins are very important for the children because they keep them healthy. Even though they are a bit more expensive, it is very important for our family to be healthy. I ask my husband to please return to the market and buy the items.

- *Aggressive Response*: Behaving aggressively is asking for what you want or saying how you feel in a threatening, sarcastic, or humiliating way that may offend the other person
    - *Example*: My husband went to the market today to buy food for the family. I asked him to buy carrots and pumpkin for my small children but when he returned home, he had only purchased matooke and some alcohol for himself. I immediately accuse my husband of caring more about himself and getting drunk than about our family. We begin arguing and yelling back and forth.

Ways of Improving Communication

- Clarify your ideas

- Design the message especially for the receiver
- Message should be relevant/important
- Use the right medium
- Choose the right time for your message
- Present your message clearly
- Make sure your message reaches the receiver
- Be aware of body language
- Ask questions when you do not understand
- Make eye contact
- Answer questions when asked
- Be friendly / open
- Encourage others with your words
- Be a good listener
- Speak slowly and clearly
- Speak with confidence
- The facilitator should stress that it is very important that we assess a situation and consider our personal safety before using assertive communication. For example, if my spouse is drunk, using drugs, or has a weapon it is not the time to use assertive communication. In relationships, however, it is very important to use assertive communication around important issues.

Common Questions:
1.) What can I do if I talk to my husband about getting an HIV test but he doesn't want to go?
2.) What can I do if I assertively communicate but my husband still won't respond?
3.) What if I try to communicate with my husband but he won't answer so I do what I want and then he stops talking to me?

Answer: The facilitator should be prepared to respond to questions like these. Women often ask these questions hoping for a response that they can use to solve their communication problems. Unfortunately, we cannot give them perfect solutions. It is important that the facilitator explains that the purpose of this group is to give the women some new skills and tools and the opportunity to practice communicating so that they are more comfortable doing so with their husband. Every scenario is different and it is important for women to try different methods if their husband is resistant to the first line of communication. It also very important to remember that improving communication with your spouse is an incremental process. You and your spouse will not become perfect communicators overnight. However, if you begin communicating effectively over small issues, eventually this will lead to larger issues and in time, overall communication can definitely change for the better!

Facilitator should prompt participants to answer their own questions. If a participant asks a question similar to the ones listed above, the facilitator can turn the question into a discussion point for the group by saying, "What a great question! What does everyone think about this?"

Facilitator Preparation:
Materials:
"Communication Responses Flipchart": The facilitator should prepare the flipchart by dividing it into 3 sections, labeled "passive communication", "assertive communication", and "aggressive communication".

SESSION 3 – DECISION-MAKING PROCESS

Time/Length: ~45 minutes

Tools/Materials/Readings:
Teaching Aide - "Decision Making Scenarios"

Main Education Points:
- Factors influencing a good decision
- Problems in decision-making
- Ways to improve the decision-making process
- Long-term effects of decision-making

Activities/Assessments:

- Ice-Breaker: "The Silent Game"- See Facilitator Notes for Instruction (**5 minutes**)

- Introduction: (**5 minutes**)
  Facilitator will introduce the topic of decision-making and ask if this issue is important to any of the participants. Ask participants to brainstorm a list of all the decisions they make on a daily basis. Are some decisions harder to make than others? Why?

- Presentation: (**10 minutes**)
  Using the prepared flipchart, facilitator should present the "Factors Influencing a Good Decision" and "Problems with Decision Making". The purpose of the presentation is to get participants to begin thinking about the decision-making process and the importance of gathering reliable information, consulting their spouse and others for advice, and taking the timing of decisions into consideration. Participants should use these strategies in the role-plays and group discussions.

- "Household Decision-Making": (**10 minutes**)
  Participants should work in small groups and will be assigned one scenario from "Decision-Making Scenarios" (**Teaching Aide**). Have one participant read the scenario aloud to the group and ask the following questions:
  - What information does the individual need to make this decision?
  - How can the individual communicate with their spouse about this decision?
  - Should the individual make this decision immediately? Or wait?

- Brainstorm & Presentation: (**10 minutes**)
  Have participants think about the most compelling way to present the important information about each postpartum care topic to their spouse. Challenge participants to identify all of the relevant information that should be considered before making a decision. List the pros and cons of each decision. Then discuss how you can communicate this information to your spouse and make the decision together.
  - Giving birth in a clinic vs. at home
  - Getting pregnant again vs. waiting
  - Going for postpartum care vs. relying on family to care for you

- Role Play: (**10 minutes**)
  Working in pairs, participants will practice decision-making with their spouse about what to do with a 100,000 UGX inheritance from a family member. Participants should practice utilizing the negotiating skills they learned (since both parties will have different ideas about what to do with the money). After practicing for 5 minutes, have a few pairs present in front of the group.

- De-Brief: (**5 minutes**)
  Facilitator identifies 2 participants to provide a **BRIEF re-cap** of what they have learned during this lesson. Each participant should also identify **how she can change their behavior** to incorporate the new knowledge they have learned. Facilitator should prompt participants to discuss **specific actions** they can take which will result in an improvement / incorporation of the topic in their lives.

Discussion Questions:

- What do you need to make a good decision? How do you make a good decision?
- What decisions do we make in my household? Who is the best person to make these decisions? Is that the personally actually making the decisions?
- Identify examples of when you made a good decision. What contributed to this decision? Identify a time when you experienced problems with decision-making. What was the result?

Facilitator Notes:

<u>"The Silent Game":</u>
The purpose of this activity is to have participants complete a task without talking to one another. The facilitator should explain that they would give instructions of what the group must do and give a time limit. The participants must complete the activity SILENTLY.
Example: Instruct participants to line up in order from youngest to oldest (2 minutes)
Instruct participants to separate themselves into groups according to the number of children they have (3 minutes)
Instruct participants to find and hold hands with the person who lives closest to them (4 minutes)

<u>Factors Influencing A Good Decision</u>:
- Source of Information (based on facts or rumor?)
- Having a clear goal
- Involvement of others
- Making consultations
- Timing
- Commitment

<u>Problems in Decision Making</u>:
- Fear of consequences
- Conflicting loyalties
- Lack of funds
- Hidden agenda
- Interpersonal conflicts

- ***Assertive Communication***: Behaving assertively means asking for what you want or saying how you feel in an honest and respectful way, so that it does not infringe on another person's rights or put the individual down
  - *Example*: My husband went to the market today to buy food for the family. I asked him to buy carrots and pumpkin for my small children but when he returned home, he had only purchased matooke and some alcohol for himself. I ask my husband why he didn't purchase the items and he said that they were too expensive and that he likes to eat motooke anyways. I calmly explain to him that carrots and pumpkins are very important for the children because they keep them healthy. Even though they are a

bit more expensive, it is very important for our family to be healthy. I ask my husband to please return to the market and buy the items.

Facilitator Preparation:
Prepare the flipchart with "Factors Influencing a Good Decision" and "Problems with Decision Making" from Facilitator Notes.

NOTES:

SESSION 4 – COMMUNICATING INFANT NEEDS

Time/Length: ~45 minutes

Tools/Materials/Readings:
Role Play Topics on slips of paper
Bowl / cup

Main Education Points:
- Review Important Points about Infant Needs from Women's Health Curriculum
- Communicating Infant Needs to my Husband
- Negotiating Preventative Healthcare for my Child

Activities/Assessments:
- Ice-Breaker: "My Story" See Facilitator Notes for Instruction (**5 minutes**)

- Introduction: (**5 minutes**)
  Ask participants to identify all of the different things that an infant needs to stay healthy. Participants should sit a circle and each member will share one thing until the group cannot come up with anything else.

- Role Play: (**20 minutes**)
  Participants should work in pairs to practice discussing the following topics with their spouse. Each pair will select a topic from the cup / bowl:

  - Exclusive Breastfeeding
  - Immunization
  - Nutritious Food / Balanced Diet
  - Treating Diarrhea with ORS
  - Hand Washing
  - Caring for a sick child
  - Preventing Malaria

  After 5-10 minutes of preparation, have each pair present to the group. Following each presentation, the facilitator should **de-brief the topic** by asking the following questions:
  1.) What are the challenges associated with this issue? How can we get around these challenges?
  2.) Does this issue affect my own household? If so, how can I address it?
  3.) Does anyone have personal experience with this that they'd like to share?

- Case Study: (**10 minutes**)
  Facilitator should present the following case study to the group and lead a discussion about what Barbara can do.

  Barbara is a mother of four and gave birth again 3 days ago, she is still exhausted but her husband has been drinking all day and she doesn't know what to do. What should she do, who can help her?

- De-Brief: (**5 minutes**)
  Facilitator identifies 2 participants to provide a **BRIEF re-cap** of what they have learned during this lesson. Participants should also identify how they **can change their behavior** to incorporate the new knowledge they have learned. Facilitator should prompt participants to discuss **specific actions** they can take which will result in an improvement / incorporation of the topic in their lives.

Discussion Questions:

- What are the unique needs of new mothers and their infants?
- How can new mothers ensure that their infants are healthy?
- What important steps must mothers take to keep their children healthy?
- How can mothers provide the best nutrition for infants?

Facilitator Notes:

"My Story":

1.) Send 3 people away from the group
2.) The 3 people must decide on a story of something that has ACTUALLY happened to one of them (i.e. I was bit by a dog, I fell down the stairs)
3.) The one it happened to must prepare the other people, explaining the story to them
4.) Then the 3 people come back in front of the whole group
5.) They each stand up, one at a time, and tell the story as if it happened to them
6.) The rest of the group can quiz each of them about the event
7.) Then the group takes a vote on who the story actually happened to

Common Questions:

My child is almost 2 years old and he doesn't like to eat any food except for bread. Is he sick? What can I do?

Answer: It is important that you try giving your child a variety of foods. If he doesn't respond to one food, try another food the next day. Make sure that you are introducing fruits and vegetables, along with carbohydrates. If he doesn't respond to a variety of foods, you should bring him to a health center for additional advice.

My child will only eat breast milk when I'm around but she resorts to other food when I'm not around. Is this OK?

My child has seizures. What is the problem? What can I do?

My child was dropped during delivery and now has trouble breathing. What happened? What can I do?

Answer: If participants continue to ask technical medical questions (a lot of "my child has…"), it is important to stress that we are NOT doctors and cannot diagnose your child. Stress that one of the important points we learned today is that if you have a sick child, it is important to bring your child to the health center or clinic. It is also important to communicate with your husband about your child to ensure your family makes the best decision about treatment together.

Facilitator Preparation:

1.) Prepare the "Role-Play Topics" by writing each topic on a small slip of paper and bring a cup or bowl to the meeting.

NOTES:

SESSION 5– GENERAL NEGOTIATION STRATEGIES

Time/Length: ~45 minutes

Tools/Materials/Readings:
- "Negotiation Role Play" (**Teaching Aide**)

Main Education Points:
- Definition of Negotiation
- Identify negotiation strategies
- Identify ways to improve negotiation skills

Activities/Assessments:
- Ice-Breaker: "Name and Adjective Game": See Facilitator Notes (**5 minutes**)

- Introduction & Review of Homework: **(5 minutes**)
  Begin by asking participants about their homework assignment. Then transition by asking participants what negotiation means and if they have ever negotiated with their spouse for anything. Facilitator should provide a definition of negotiation along with examples of issues where women can negotiate with their spouse to improve health outcomes for their families:
  - Purchasing healthy foods
  - Bringing my children to the clinic for vaccinations / de-worming
  - Using money for antenatal care visits
  - Birthing in a hospital / clinic

- Introduction to Negotiation Strategies: (**10 minutes**)
  Using the prepared flipchart, the facilitator should provide a brief overview of negotiation strategies to use and those behaviors that should be avoided during negotiation (**See Facilitator Notes**)

- Role-Play: (**15 minutes**)
  Divide participants into 3 groups and assign each group a role-play topic from "Negotiation Role Plays" (**Teaching Aide**). Groups should read their scenario and talk about the discussion questions. Then, groups should nominate 2 members to act out their role-play in front of the group. Role-plays should last no longer than 5 minutes and the group should closely observe and be ready to discuss.

- Wrap Up & Homework: (**5 minutes**)
  The facilitator should provide a brief re-cap of the negotiation strategies that were covered. Explain that negotiation is a process and that it will likely take some time before participants are able to negotiate major issues (like family planning or going for an HIV test) with their spouse. Stress that practicing negotiation around smaller issues with your spouse is a good way to begin developing a pattern of communication that is focused on compromise and collaboration.

  Homework: Participants should practice negotiating a small issue with their husband, utilizing the strategies they learned today. They should be ready to discuss this issue with the group next session, explaining how they were able to negotiate with their spouse.

- De-Brief: (**5 minutes)**
  Facilitator identifies 2 participants to provide a **BRIEF re-cap** of what they have learned during this lesson. Participants should also identify how they **can change their behavior** to incorporate the new knowledge they have learned. Facilitator should prompt participants to

discuss **specific actions** they can take which will result in an improvement / incorporation of the topic in their lives.

Discussion Questions:

- What is something that would be easy to negotiate with my spouse?
- What is something that would be difficult to negotiate with my spouse? Why would it be difficult to negotiate?
- How can I become a better negotiator with my spouse?
- Are there situations where I wish I could negotiate more? Why don't I? Can I change this?

Facilitator Notes:
Negotiation: To discuss with others in order to reach an agreement

"Name and Adjective Game": This introduction icebreaker helps review participants' names.
1.) Have participants sit in a circle
2.) The facilitator begins by stating their name, followed by an adjective that begins with the first letter of their name (example: I am Erica and I'm energetic)
3.) The person sitting to the left of the facilitator continue the game by first stating the facilitator's name and adjective and then saying their own name and accompanying adjective (Example: This is Erica and she is energetic. I am Mary and I am mellow)
4.) The game continues, going around the circle and each participant must first say the name and adjectives of everyone who has already spoken before saying their own name and adjective.
5.) By the end of the circle, it will be difficult for the final participant to recall all 13 names and adjectives. They can ask for help from other participants!
6.) This activity should last no longer than 5 minutes! The facilitator must encourage participants to respond quickly. If they cannot remember the people before them, stop them and move on the next participant. The game should be structured as a "challenge" and participants who can remember all names and adjectives should be applauded!

Facilitator Preparation:
Prepare the Flipchart with the following information and be prepared to briefly explain the information to participants:

Negotiation Strategies to Discuss:
- Collaboration: Working with someone to produce or create something
- Compromise: An agreement of settlement of an argument by giving something up
- Accommodate: Willing to help out or doing a favor or service to someone (** stress that this strategy should not be used all the time! If appropriate, spouses should be accommodating to one another equally)

Negotiation Strategies to Avoid:
- Competition: To gain something by defeating another who is trying to accomplish the same goal
- Avoidance: Keeping away from something or preventing it from happening

NOTES:

SESSION 6 – POWER AND PREVENTING CONFLICT

Time/Length: ~45 minutes

Tools/Materials/Readings:
Flipchart Paper
Markers
"The 4 Types of Power"
"Power Situations" (**Teaching Aide**)
Discussion Questions Written Out

Main Education Points:
- The 4 types of power
- Power affects control
- Power can be used positively and negatively
- Power is not in limited supply

Activities/Assessments:

- Welcome & Homework Review: (**5 minutes**)
  Begin by thanking participants for their participation in the group so far. Ask participants about their homework assignment and the issues that they practiced negotiating with their husband about.

- Introduction: (**3 minutes**)
  Facilitator explains to participants that this session will be focused on power. Explain that power is something that is always in our lives. It influences our decisions and choices, yet we rarely think about it.
    - Ask participants what comes to mind when they hear the word "power".

- "Power Images": (**5 minutes**)
  Pass around the 4 images of power to participants. After everyone has had an opportunity to see each image, hold the images up one by one and ask participants the following questions:
    - Did you imagine anything like this when you were thinking about power?
    - How would you describe this type of power?

- Overview of "Power Types": (**10 minutes)**
  Using the prepared flipchart, review the 4 types of power, providing an example of each type. After reviewing one power type, ask the participant who is holding the image of that power type to hold it up and describe it.

- "Power Situations": (**10 minutes**)
  To further explore the four types of power, participants will practice with scenarios. Explain to participants that you will read a statement and they should decide which type of power it describes. They should raise their hand and share which power type they believe describes the scenario. (Use "Power Situations" **Teaching Aide**)

- Discussion: (**15 minutes**)
  Facilitator should divide participants into 4 groups and distribute one of the following discussion questions to each group. Instruct the group to read the question and discuss together. After 10 minutes of discussion, each group should select a representative to discuss their question with the group as a whole.
  Questions:

- What are the 4 different types of power? Who has each type of power? Can a person have more than one type of power?
- Does one person having power mean that they are taking power away from someone else?
- What are the benefits of equal power within the household?
- Can I share power with my spouse?

- De-Brief: (**5 minutes**)
  Facilitator identifies 2 participants to provide a **BRIEF re-cap** of what they have learned during this lesson. Participants should also identify how they **can change their behavior** to incorporate the new knowledge they have learned. Facilitator should prompt participants to discuss **specific actions** they can take which will result in an improvement / incorporation of the topic in their lives.

Facilitator Notes:

Types of Power

Power Within: The strength that arises from inside ourselves when we recognize the equal ability within all of us to positively influence our own lives and community. By discovering the positive power within ourselves, we are compelled to address the negative uses of power that create injustice in our communities. **Definition for Flipchart: Power Inside ourselves that allows us to do good things for others and ourselves.**

Power Over: The power that one person or group uses to control another person or group. This control might come from direct violence, or from making someone else feel inferior

Power With: The power felt when two or more people come together to do something that they could not do alone.

Power To: When people or groups use power to create positive change in their community.

Facilitator Preparation:

1.) Prepare the flipchart with names and definitions of the 4 Types of Power

2.) Write Discussion Questions on handouts for each of the 4 groups

NOTES:

SESSION 7 – HEALTHY RELATIONSHIPS / HEALTHY FAMILIES

Time/Length: ~45 minutes

Tools/Materials/Readings:
Flipchart
Markers
1 Piece of paper for every participant for Icebreaker

Main Education Points:
- Identify the characteristics of a healthy relationship
- Identify the benefits of being in a healthy relationship
- Strategies for improving my relationship

Activities/Assessments:
- Ice-Breaker: The Paper Exercise – See Facilitator Notes for Instruction (**5 minutes**)

- Introduction: (**5 minutes**)
  Facilitator should explain that today we will be talking about healthy families and that a healthy family begins with a healthy relationship between partners. Ask participants to share ideas about what makes a healthy relationship.

- "Relationship Images": (**10 minutes**)
  Divide participants into groups of 2. Provide one piece of flipchart paper to each group. Ask groups to draw images on the flipchart that signify a happy, healthy relationship between a man and a woman. One person from each group should explain their image and why they believe it indicates a happy and healthy relationship. Facilitator should ask the following questions:
    - What do men value in a relationship? What do women value?
    - What are the similarities between what women and men value? What are the differences?
    -
- "Relationship Tree": (**10 minutes**)
  Participants will create a relationship tree that depicts the positive outcomes of having a healthy relationship. Begin with the basic elements of a healthy relationship as the roots (things like sharing, mutual respect, making decisions together) and then add on all the positive outcomes of each as branches (i.e. if sharing mutual respect is the root, the branches could be talking to one another about important decisions, which leads to both parties feeling happy, which leads to children observing happy parents, etc.)

- "Myth Breakers": (**10 minutes**)
  Ask participants to identify myths or taboos about relationships in their community. After a taboo has been identified, discuss why it came to be and how to work around it (i.e. the myth is that if a husband beats his wife, it means he loves her. This may have come to be as a way to justify violence. By asking questions like "when men and women first meet, does the man beat the women to show his love? the facilitator should begin to explore the rationale behind these taboos).

- Identifying Changes in my Relationship: (**10 minutes**)
  Facilitator will ask participants to identify one specific action that they can take to improve one of the roots (from previous exercise) of their relationship (i.e. trust, respect, love, etc.). After a participant identifies the root, they should present a specific action that they can take in their own relationship. Have each participant share one example.

Examples:
- In order to improve trust in my relationship, I am going to begin sharing my daily earnings with my spouse and tell him what I spend this money on.
- In order to improve the love in my relationship, I am going to cook the dinner that my husband likes tonight, rather than what I prefer to eat.
- In order to improve respect in my relationship, I am going to thank my husband for the work that he does to provide for my family and let him know I appreciate the fact that he provides for our family.

- De-Brief & Homework: (**5 minutes**)
  Facilitator identifies 2 participants to provide a **BRIEF re-cap** of what they have learned during this lesson. Participants should also identify how they **can change their behavior** to incorporate the new knowledge they have learned. Facilitator should prompt participants to discuss **specific actions** they can take which will result in an improvement / incorporation of the topic in their lives.

  Homework: Participants have already identified a specific action that they can take to improve their relationship. For homework, they should put this action into practice! Encourage participants to begin making a positive change in their relationship by doing the simple activity they identified.

Discussion Questions:
- What makes a relationship "healthy"? Which aspects of a relationship are most important?
- How do you know when someone is in a healthy relationship? Can you tell if someone is in an unhealthy relationship?
- What are the benefits of being happy in your relationship?

Facilitator Notes:

The Paper Exercise**:**
- Give each participant one sheet of paper (can use scrap) and facilitator one as well
- Ask all participants to close their eyes
- The facilitator will issue instructions and follows them as well. No questions are allowed.

Instructions:
1.) Rip off a corner
2.) Fold the paper in half
3.) Rip off a corner
4.) Fold the paper in half
5.) Rip off a corner
- The group can now open their eyes and find that there are many different shapes of paper

Relationship Tree Example

SESSION 8 - GENDER RELATIONS

Time/Length: ~45 minutes

Materials:
Teaching Aide - The Gender Game
Flipchart
Markers

Main Education Points:
- Define difference between sex and gender
- Identify gender roles in society
- Gender Equality
- Barriers to Gender Equality

Activities/Assessments:

- Introduction: (**5 minutes**)
  Facilitator begins by asking participants the difference between "sex" and "gender". After participants share their ideas, the facilitator should explain the difference between the two concepts and provide specific examples of activities that are sex-based and gender-based (i.e. difference between breastfeeding and cooking).

- The Gender Game: (**10 minutes**)
  The facilitator leads this exercise to ensure that participants understand the difference between sex roles and gender roles (using **Teaching Aide)**. Facilitator should read each statement aloud and participants should raise their hands to indicate if the statement is representative of a sex role or a gender role.

- Brainstorm: (**5 minutes**)
  Facilitator asks participants to identify activities that they enjoy doing. Are they gender-focused activities? Identify activities that they don't enjoy doing. Are they gender-focused activities?

- "A Day in the Life": (**15 minutes**)
  Divide participants into 2 groups for brainstorming and discussion. Have one group think about their husband's daily schedule (from the time he wakes up until he goes to bed at night). Have the second group think about their own daily schedule. After discussing in groups, ask one participant from each group to share. Discuss the differences between schedules for both parties. Which activities are women usually responsible for and which are men responsible for? Follow up with a discussion with the following questions:
  1.) Is the schedule your group came up with representative of your household?
  2.) Do you wish you could change the roles and responsibilities in your own household?
  3.) How can you use the negotiation strategies we learned last class to discuss sharing responsibilities with your spouse?
- De-Brief: (**5 minutes**)
  Facilitator identifies 2 participants to provide a **BRIEF re-cap** of what they have learned during this lesson. Participants should also identify how they **can change their behavior** to incorporate the new knowledge they have learned. Facilitator should prompt participants to discuss **specific actions** they can take which will result in an improvement / incorporation of the topic in their lives.

Discussion Questions:

- What are the traditional roles of men? Of women? Why are they different?
- How do gender roles affect my household? How can I change this?
- What are some of the cultural / religious beliefs that surround men and women's participation in certain activities?
- How do gender roles affect my children? Are sons and daughters treated differently? If so, how can I change this?

Facilitator Notes:

- Sex is the biological physical differences between men and women that cannot be changed.
- Gender concepts refer to the social relationships between men and women. Gender is socially constructed and assigns different roles to men and women in society.
- Gender stereotyping is what society thinks as representative for men and women.
- Differences in gender roles give different status to men and women. These differences often result in overwork and discrimination between the two sexes.
- For an issue to be termed as a gender issue it must possess the following characteristics:
    - It depicts inequality between men and women
    - It is discriminative
    - Favors one sex at the expense of another
    - Is oppressive
    - Creates a gap between both sexes

<u>Gender Equality</u>: Ensuring that men and women have equal rights

Facilitator Should:

- Emphasize that roles and activities have nothing to do with sex
- Try to break some cultural stereotypes

Help participants understand the importance of having equal control over the benefits of their resources between men and women.

NOTES:

SESSION 9 – FINANCIAL NEGOTIATION

Time/Length: ~45 minutes

Tools/Materials/Readings:
Flip chart or large paper
Markers

Main Education Points:
- Importance of Spending Money on Nutrition and Healthcare
- Negotiating with my Spouse about Spending Money
- Benefits of Saving Money
- Creating a Plan for Health Expenditures

Activities/Assessments:

- Ice-Breaker: "20 Questions" – See Facilitator Notes for Instruction (**5 minutes**)

  Facilitator should then transition by introducing the topic of financial negotiation. Explain that today we will be talking about how spouses can collaborate when deciding what to spend money on. Begin by asking participants the following questions:
  - Think about the last major purchase that your household made. What was it? Did you communicate with your spouse about making this purchase?
  - Do you think it is important for a husband and wife to talk about household purchases? Why?

- Identifying Healthcare Expenses: (**20 minutes**)
  Women should work together in groups of 2 or 3 for this activity.

  Instruct participants that they should come up with a list of the 5 most important things (can be an item or a service) that they can purchase for their children in order to keep them healthy. List the items in order of importance (1 is most important) and estimate the total cost of each item.
  Example: 1.) Vaccinations (10,000 UGX) 2.) De-worming (2,000 UGX) 3.) Hospital Visit (5,000 UGX for transport) 4.) Healthy Food (1,000UGX per week) 5.) Shoes (10,000 UGX)

  After creating the list of items, participants should identify a plan and timeline for how they would be able to purchase all of these items. Specifically, participants should:
  - Identify who will pay for the items. Will one person buy everything? Will both contribute to purchasing these items?
  - When is it possible to purchase the items? Can some be purchased immediately? Will you need to save up for any of the items?
  - How can you ensure that they items are purchased? Can you agree to purchase the next big item at a certain time, like after the next harvest?

  After 10-15 minutes of preparation, have each pair present to the group.

- Group Discussion: (**10 minutes**)
  The facilitator should lead a group discussion around the benefits of saving money. Explain that saving a small amount of money each week is a way to begin collaborating with your spouse financially. Ensure that you have a purpose for saving and that you and your spouse agree on what the money will be used for.

Example: A good way to begin financial negotiation is for spouses to agree to set aside a modest amount of money every week (say 200UGX) to be used for something they decide upon together. By getting into the habit of saving money, and establishing a clear purpose for the money, spouses may become more comfortable disclosing their earnings and discussing household purchases. Eventually, you can begin saving for larger purchases such as a pig or goat.

Ask participants to share their experience with saving money. Is anyone involved in a savings club? What do you hope to use the savings for? What do you think is the benefit of saving money?

- De-Brief & Homework: (**5 minutes**)
  Facilitator identifies 2 participants to provide a **BRIEF re-cap** of what they have learned during this lesson. Participants should also identify how they **can change their behavior** to incorporate the new knowledge they have learned. Facilitator should prompt participants to discuss **specific actions** they can take which will result in an improvement / incorporation of the topic in their lives.

  Homework: Explain to participants that they should begin talking about at least 1 of the important purchases that they discussed today. The conversation should not end with this session! Encourage participants to dedicate time during the next SESSION to talking about this purchase and creating a plan for how the household will make the purchase. We will discuss progress at the next session.

Discussion Questions:

- Do you avoid discussing money with your spouse? How can you talk about money in a way that won't upset your spouse?
- Why is it important to invest in healthy foods and proper healthcare?

Facilitator Notes:

"20 Questions": 20 questions is a game, which encourages deductive reasoning and creativity. One player is selected to think of an item. The rest of the group tries to guess the item by asking a question which can only be answered with a simple "Yes" or "No." The group has 20 questions ''yes or no'' questions before the final 3 guesses at what the item is.

Common Questions:

1.) My husband and I decided on some household items to buy. We agreed that I would contribute 10,000 and he would contribute 40,000. I gave him the money to buy the items but he never bought them. If I brought it up, it would turn into a fight. What should I do?
2.) Men never disclose their earnings and it isn't a woman's place to ask about it. If I don't have any idea how much money my husband makes, how can I negotiate about money?
3.) My husband and I decide on items for the business to buy. Sometimes I give him money and he doesn't buy the items. If I purchase the items myself, it means that I am supporting the business and he is not. What can I do?

NOTES:

SESSION 10 – SELF ESTEEM & GOAL SETTING

PART ONE - Self Esteem

Time/Length: ~30 minutes

Tools/Materials/Readings:
- Cup or Bowl for Paper
- 15-20 slips of small paper for "Identifying Great Traits" Activity

Main Education Points:
- Define self-esteem
- Awareness of the factors that affect self-esteem
- Recognizing that improving self-esteem has many benefits to women and their families
- Healthy perception of self

Activities/Assessments:

- Introduction & Homework Review: (**10 minutes**)
  Facilitator begins by asking participants to share their homework. Ask participants how the discussion with their spouse continued after the session. Has anyone purchased an item that they discussed? Has anyone established a plan for saving money?

  Facilitator introduces the topic of self-esteem and asks participants to define self-esteem. What causes a person to have high or low self-esteem? Why is self-esteem important?

- Identifying Personal Achievements: (**10 minutes**)
  Have participants think about all the achievements (big and small) that they have made throughout their life. Encourage participants to share examples of something that they accomplished that they are proud of and how they were able to do it. Stress that achievements are not just financial! Examples of achievements include finishing high school, being in a loving relationship with my husband, raising my children to be caring and polite, etc.

- Identifying Great Traits: (**10 minutes**)
  Have the women identify traits/ characteristics/qualities that describe great women they admire. Write these qualities (use adjectives like 'caring', 'strong', 'motivated', etc.) on slips of paper and place them in a bowl. Ensure that there is at least 1 paper for every participant. Next, have the participants sit in a circle. Pass around the bowl and have each woman select a quality. She must describe one of the following:
    - How she already has the quality and how it benefits her household
    - One area of her life that would benefit from having the quality
    - How she can achieve the quality

- Brainstorm: (**10 minutes**)
  Ask participants to think about how their health and the health of their children can improve if they have high self-esteem and believe in themselves. Think about how their relationship with their spouse will improve if they value themselves and are aware of the contributions they make to their families.
    - Ask participants to think of ways that women can improve their own self-esteem.

- De-Brief: (**5 minutes**)
  Facilitator identifies 2 participants to provide a **BRIEF re-cap** of what they have learned during this lesson. Participants should also identify how they **can change their behavior** to

incorporate the new knowledge they have learned. Facilitator should prompt participants to discuss **specific actions** they can take which will result in an improvement / incorporation of the topic in their lives.

Discussion Questions:

- Do women have a voice to be heard? Are women's opinions valued in the household?
- Do you feel smart? Why or why not?
- How do you measure self-worth?
- How can I become more comfortable expressing my opinions to my spouse?

Facilitator Notes:

Self-Esteem: Pride in oneself; respect and a favorable opinion of oneself

Facilitator Preparation:
- Facilitator should cut up paper so that each group has 15-20 small pieces.
- Facilitator should bring a cup or bowl to the meeting.

PART TWO – Setting a Household Goal

Time/Length: ~15 minutes

Main Education Points:

- Define Project, Goal, Timeline
- Identification of household goals related to child and maternal health
- Identification of a feasible project to improve hygiene / sanitation in the household

Activities/Assessments:

- Identifying Short-Term Household Goals: (**15 minutes**)
  Facilitator should begin by providing a brief overview of the difference between a project and a goal, as well as the definition of a timeline. Also explain that there are long-term goals (like having your child finish school) and short terms goals (like having your child begin eating more nutritious food) and that today's activity will focus on **short-term goals!**

  - Identifying Short-Term Household Goals: (**15 minutes**)

  Facilitator will ask participants to identify a *specific* short-term household goal that will improve the health of themselves or their children (**i.e. feed my child 3 Vitamin-A rich foods per day, Visit the doctor 4 times during my next pregnancy, etc. Participants will probably come up with general goals such as "feed my child nutritious food". It is important for the facilitator to prompt participants to identify specific goals such as "feed my child more pumpkin and dodo"**). Facilitator should prompt participants to utilize the knowledge they have learned in the Health & Nutrition course when thinking about goals. Each participant will share their goal, the facilitator should ask the following questions and have each participant respond according to her goal:
    - Why is this an important goal? How will your household benefit if you achieve this goal?
    - Do you have all the resources needed to achieve this goal?
    - How can you communicate this goal to your spouse?
    - What are the important steps you need to take to achieve this goal? What is the timeline for achieving this goal?

Discussion Questions:

- What is a goal? Do I have household goals? What are they?
- What is the process for achieving my goal? Does my goal have a timeline?
- How will I know when I've achieved my goal? What are the obstacles to achieving my goal?
- How do I share my goal with my husband?
- What happens if I don't accomplish my goals?

Facilitator Notes:

Project: An individual or group activity that is planned and designed to achieve something

Goal: The result or achievement towards which an effort is directed

Timeline: The set of actions that occur at different points in time that you must take in order to achieve a goal

NOTES:

SESSION 11 –HIV / AIDS PREVENTION

Time/Length: ~45 minutes

Tools/Materials/Readings:
Flipchart Paper
Markers

Main Education Points:

- HIV Testing and its importance
- Negotiating getting an HIV test with my spouse
- Negotiating Condom use with my spouse
- Communicating the importance of living a healthy life with HIV to my spouse

Activities/Assessments:

- Ice-Breaker – "Word Link": See Facilitator Notes for Instruction (**5 minutes**)

- Introduction & Homework Review: (**5 minutes**)
  Facilitator should begin by asking participants how their spouse reacted to the change in their behavior. Ask participants to sit in a circle and each person should share their experience.

  Facilitator will then begin with an informal discussion of HIV / AIDS and ask participants what they already know. Discuss how HIV / AIDS affects their community and the new information they learned in the Health & Nutrition lesson.

- "Condom Myth Breakers": (**15 minutes**)
  Facilitator should explain that there are many myths and much misunderstanding surrounding HIV / AIDS and condom use and that we will explore some today. Ask participants to share any common myths they have or questions where they would like clarification on. After identifying condom myths and reviewing the important information, have participants address the following questions:
  - When is a good time to talk to my spouse about using a condom?
  - What will my spouse think if I ask him to use a condom? How can I respond to his concerns?
  - What are the most important points about condom use that I should communicate to my spouse?

- Role-Play: (**15 minutes**)
  Participants will work in pairs to practice negotiating going for an HIV test with their spouse. Participants should address the following issues in their role-play:
  - Importance of testing
  - Benefits of testing
  - Common myths and why they are false
  - Living a healthy life with HIV through the use of ARVs

  After 10 minutes of preparation, have each pair present their role-play to the group.

- De-Brief: (**5 minutes**)

Facilitator identifies 2 participants to provide a **BRIEF re-cap** of what they have learned during this lesson. Participants should also identify how they **can change their behavior** to incorporate the new knowledge they have learned. Facilitator should prompt participants to discuss **specific actions** they can take which will result in an improvement / incorporation of the topic in their lives.

Facilitator Notes:

"Word Link":
This is a word association game.
1.) Ask the group to sit in a circle
2.) The first person starts with any word they wish i.e. red
3.) The next person repeats the first word and adds another word which links to the first i.e. tomato.
4.) The next person repeats the previous word and adds another word link i.e. soup, and so on. To keep this moving, only allow five seconds for each word link.

Common Questions:
1.) My husband finally agreed to get an HIV test and when we went, it was found that he was positive and I was negative. The doctor consulted us to use condoms and my husband agreed. But then when we got home, my husband refused to use a condom and I conceived. What can I do?

Answer: It is very important for you to get tested. If you find out that you are positive, you can begin medication that will treat you and protect your unborn baby. If you are found to be negative, you can talk with your husband about the importance of using a condom to protect yourself, but also your unborn child. Explaining to your husband that medication is free and available may encourage him to seek treatment himself.

2.) My husband went for an HIV test and found out he is positive. He said he would use a condom but I realized that he was taking it off during intercourse. I left and went to my parent's house but they said that I can't leave my children behind and I must go back to my husband. When I went back, I asked my husband again to use a condom but he refused. He told me that if I leave him, he will find me and kill me. What can I do?

Answer: The first step is for you to get tested so that you can begin treatment if necessary.

NOTES:

SESSION 12 – NEGOTIATING FAMILY PLANNING USE

Time/Length: ~45 minutes

Tools/Materials/Readings:
Teaching Aide -"Family Planning Methods"
Flipchart Paper
Markers

Main Education Points:

- Review Benefits of Family Planning Methods
- Communicating the Benefits of Family Planning to my spouse
- Negotiating use of Family Planning with my spouse

Activities/Assessments:

- Ice-Breaker: "Charades" – See Facilitator Notes for Instruction (**5 minutes**)

- Introduction: (**5 minutes**)
  The Facilitator will begin with a brief review of Communication and Negotiation (**Lessons 2 & 3**). Ask participants to recall important points and strategies that they have learned and utilized thus far. Encourage participants to share examples of how they have utilized these strategies in their household.

- Myth-Busters: (**15 minutes**)
  Participants should work in pairs and each pair will be assigned a different family planning method (See Facilitator Notes). In order to prepare for negotiation with their spouse regarding family planning, pairs will identify potential myths and beliefs that husbands may have. Each pair should do the following:

    - First brainstorm relevant myths/ cultural beliefs / reasons for opposition from a spouse or qualms a husband may have about the particular family planning method
    - Identify appropriate responses to each and explain why myths are myths and the important facts associated with each method
    - Identify if my husband would believe these myths and how I can convince him they are not true

  After 10-15 minutes of preparation time, have each group present to the larger group
  After a group presents, the facilitator should **de-brief** each method by asking if any group members have personal experience with any of these myths.

- Role Play: (**15 minutes**)
  Working in the same pairs, participants will create a role-play about their assigned family planning method. The role-play should depict a husband and wife discussing the family planning method and negotiating use of each desired method. Make sure to mention side effects and why the benefit of family planning outweighs the side effects. Identify negotiation strategies that will be effective for family planning discussions. Encourage participants to utilize the role-play as an opportunity to practice becoming familiar with family planning methods and formulating an effective argument for their use.

- De-Brief: (**5 minutes**)

Facilitator identifies 2 participants to provide a **BRIEF re-cap** of what they have learned during this lesson. Participants should also identify how they **can change their behavior** to incorporate the new knowledge they have learned. Facilitator should prompt participants to discuss **specific actions** they can take which will result in an improvement / incorporation of the topic in their lives.

Discussion Questions:

- What is Reproductive health? Why is it important?
- What are the benefits, drawbacks, and myths associated with family planning? How can I communicate these to my spouse?
- Am I currently utilizing family planning? Why or why not? How can I change this?

Facilitator Notes:

"Charades":

Charades is a silent acting game. The facilitator should come prepared with slips of paper that have the name of either a person, place, or thing written on them. These slips of paper should be placed in a cup.

1.) Facilitator selects one participant to be the actor.
2.) The actor picks a slip of paper from the cup / bowl and tells the group whether they have selected a person, place or thing (for example, if the participant selects "pineapple", they would tell the group it is a thing)
3.) The actor must act out their selection in front of the group without speaking.
4.) The group guesses what the actor is acting.
5.) The participant that correctly guesses the thing wins and becomes the next actor by selecting a paper.
6.) The game continues for 5-10 minutes depending on time available.

Family Planning Methods:

- Male Condom (Stressing as family planning and STI / HIV prevention)
- Female Condom
- Oral Contraceptives
- Injectable
- Implant
- IUD
- Sterilization

NOTES:

SESSION 13 – COMMUNICATING & NEGOTIATING ANTENATAL NEEDS

Time/Length: ~45 minutes

Main Education Points:

- Understand role that my spouse can play during the antenatal period
- Practice communicating the benefits of antenatal care to my spouse
- Practice negotiating access to antenatal care with my spouse

Activities / Assessments:

- Ice-Breaker: (**5 minutes**)
  "Follow the Leader": See Facilitator Notes for Instruction

- Introduction: (**5 minutes**)
  Facilitator will continue with a brief review of the important points that participants remember about Communication and Negotiation. Explain that communicating and negotiating with your spouse about antenatal care is important for your health and the health of your child.

- Brainstorm: (**10 minutes**)
  Ask participants to think about their own experiences with antenatal care.
  - When you were pregnant, did you utilize antenatal care? What was your experience like?
  - Would you like to utilize antenatal care more during your next pregnancy?
  - Are there barriers within your own household to accessing antenatal care?

- Case Study: (**10 minutes**)
  Ask a group member to read the following scenario and associated questions to the group. The participant should lead the discussion by calling on group members to share their thoughts.
  Case: Florence is a mom of 12, her in-laws and husband insist on a new child every year. She is too tired to dig yet her husband drinks and doesn't allow her to visit the health clinic.
  Questions: What is wrong with this situation? What can Florence do about it?

- Role Play: (**15 minutes**)
  Participants will work in groups to practice communicating 1 important part of antenatal care with their spouse (i.e. nutrition, antenatal visits, getting enough sleep, going for an HIV test, etc.). Participants must practice assertive communication and also explain the benefits of spousal involvement and stress what can go wrong if a woman doesn't take proper precautions during the antenatal period. After 10 minutes of preparation, have groups act out their role-plays in front of the larger group.

Discussion Questions:

- What is Antenatal Care? Why is it important?
- What are the barriers to accessing antenatal care? How can access be increased?
- How can I involve my partner or family in antenatal care?
- How can I communicate the importance of antenatal care to my spouse?
- What are the long-term problems that can be avoided by routine antenatal care?

Facilitator Notes:
Antenatal Care: The regular medical and nursing care recommended for women during pregnancy. Antenatal care is a type of preventative care with the goal of providing regular check-ups that allow

doctors or midwives to treat and prevent potential health problems throughout the course of the pregnancy while promoting healthy lifestyles that benefit both mother and child.

Facilitator Should:
Explain that many of the reasons women die or are injured during Pregnancy, Labor and Delivery are completely preventable. There are four main factors—or delays—contributing to maternal mortality and morbidity:

• Delay in recognizing there is a problem (person or persons assisting during the PLD are unaware of an issue requiring the help of a trained provider)

• Delay in seeking care after recognizing the problem (person or persons assisting during PLD recognize that there is an emergency, but delay in seeking care)

• Delay in arranging transportation to a medical facility when necessary (person or persons assisting during PLD recognize that there is an emergency, but cannot find and/or do not have the funds for appropriate transport)

• Delay in obtaining care after reaching the medical facility (upon arrival at the medical facility, there is a delay in being seen and treated by medical professionals)

"Follow The Leader":
1.) Ask the group to sit in a circle.
2.) One volunteer leaves the group for a few minutes
3.) After the volunteer is away from the group, a leader is selected
4.) The leader must perform a series of actions, such as clapping hands, tapping feet, snapping, etc. that must be copied by the whole group.
5.) The volunteer comes back to the group and stands in the middle of the circle, observing and tries to guess who the leader is.
6.) The group protects the leader by not looking at him/her. The leader must change actions at regular intervals without getting caught.

NOTES:

SESSION 14– RESOURCES IN MY COMMUNITY

Time/Length: ~45 minutes

Tools/Materials/Readings:
Flipchart Paper
Markers

Main Education Points:
- Identify resources that exist in my community
- Understand how to utilize existing resources
- Communicating the benefits of healthcare resources to my spouse

Activities/Assessments:
- Ice-Breaker "Two truths and a Lie" – See Facilitator Notes for Instruction (**5 minutes**)

- Introduction (**5 minutes**)
  Facilitator should begin the lesson topic with an explanation of what a resource is (can be a thing, person, organization, group, etc.) and should ask participants to share one example of a time when they had a problem and utilized a resource to help them through it.

- Community / Village Map: (**10 minutes**)
  Participants will work together in small groups to create a map of their village. They should indicate resources throughout their community that are important for good health. Each participant should individually identify a resource (keeping in mind that resources aren't just hospitals and schools, etc.), mark it on the map, and explain to the group why it is an important resource. After 5-10 minutes of preparation, have each group present their map to the larger group. **Facilitator will begin by presenting an Example Map – See Facilitator Notes.**

- Role Play: (**10 minutes**)
  Using the Community Maps from the previous exercise, have each participant identify one health resource that they are NOT currently utilizing but would like to utilize because it will improve their health or the health of their children. Each participant will explain the benefits of this resource, and how they can communicate / negotiate with their spouse about utilizing the resource.

- "I am a Resource": (**10 minutes**)
  Facilitator should begin by explaining to participants that each person is a valuable resource to someone else for one reason or another (providing specific examples such as "Charity has sold produce in the markets for 15 years so she knows the best time of the year to make a profit. She could help a young woman who is just beginning to sell her produce"). Encourage participants to think about their personal strengths and experiences and how sharing these could benefit somebody else. Participants should then be invited to give their pitch to the group, discussing why they are a good resource and whom they could help. Facilitator should prompt participants to think about things like expertise in agriculture, keeping your home clean, keeping your garden diverse, free time to watch over children, etc.

- De-Brief & Homework: (**5 minutes**)
  Facilitator identifies 2 participants to provide a **BRIEF re-cap** of what they have learned during this lesson. Participants should also identify how they **can change their behavior** to

incorporate the new knowledge they have learned. Facilitator should prompt participants to discuss **specific actions** they can take which will result in an improvement / incorporation of the topic in their lives.

Homework: Before the next session, participants should utilize/visit one resource in their community that they have never utilized/visited before. Encourage participants to think about all of the resources we identified today and stress that everyone should be aware of where these resources are and the benefits that they have to our health and the health of our children. Instruct participants to be prepared to share their experience with a new resource next session.

Discussion Questions:

- What is a resource? What kinds of resources are available to me?
- How can I use the resources in my community better?
- How can I communicate the benefits of various healthcare resources to my spouse?
- How will my household improve if I utilize more resources in my community?

Facilitator Notes:

2 Truths and a Lie

The purpose of this game is to reveal information about yourself that the rest of the group may not already know.
1.) Have participants sit in a circle.
2.) The facilitator will begin the game.
3.) One at a time, each participant will begin by stating their name and then state 3 facts about themselves. 2 of these facts should be true and 1 fact should be a lie.
4.) After a participant has stated the 3 facts, the rest of the group should guess which fact was a lie. The facilitator should call on 3 respondents to share what they believe was the lie and then the group member who shared the information will reveal the truth.
5.) Continue around the circle until all participants have had a chance to share.
Example: My name is Erica. I have 4 dogs. I once lived on a boat. I know how to drive a motorcycle.
The facilitator should encourage participants to think about true facts about themselves that make them unique or that most of the group may not already know. That way, it is difficult to determine which fact is the lie. This is the fun of the game!
* Participants will probably begin by saying things like "My name is Twina. I was born in this village. I have 4 children. I am 100 years old". In this case, it is very easy to pick out the lie. Encourage participants to make it difficult for other group members to determine the lie!

NOTES:

SESSION 15 – HOUSEHOLD BUDGETING

Time/Length: ~45 minutes

Tools/Materials/Readings:
Flipchart Paper
Markers

Main Education Points:
- Define Budget
- Outline Budget Process
- How to create a Budget
- Benefits of using a Budget

Activities/Assessments:
- Ice-Breaker: The Silent Game- See Facilitator Notes for Instruction (**5 minutes**)

- Introduction to Budgeting: (**5 minutes**)
  Facilitator will begin by asking the group what they know about budgeting. Ask basic questions including what is a budget? Why is a budget important? Does your household use a budget? Explain what a budget is and the importance of using a budget (See Facilitator Notes)

- Budget Creation: (**15 minutes**)
  Divide participants into 2 groups. Distribute one piece of Flipchart paper to each group and instruct a group leader to divide the paper into 2 sections, labeled "expenses" and "income". Each group will create a weekly budget for a typical family in their community (*Facilitator identifies the number of children appropriate for the group*) using a 4-step process:
  1.) Ask participants to think about all of the purchases that a household makes in an average week. Determine the 5 most important major purchases that are needed on a weekly basis. Write these in the "expenses" category and indicate the amount of each in shillings.
  2.) Ask participants to think about all income that the household generates in the average week. Write this in the "income" category and indicate the amount in shillings.
  3.) Now sum all of the "expenses" and all of the "income" and compare the two numbers. Is there a difference between the two? Is the difference positive or negative?
  4.) Participants should brainstorm ways to remedy differences between expenditures and income. If the difference is positive, they should discuss what is done with excess income. If the difference is negative, participants should think about ways to reduce spending. Is this possible? Why or why not?

- Budgeting for the Harvest: (**15 minutes**)
  Divide participants into groups of 3. Working in small groups, participants should discuss the following points and prepare a presentation for the large group. Encourage participants to think about their own households and to utilize the Communication and Negotiation strategies that they have learned.
    - Create a budget for using the profits from selling our crops (using abbreviated process from previous exercise)
    - How to communicate the importance of this budget to my spouse
    - How to ensure that my spouse and I stick to the budget / What to do if one of us spends money that we agreed would be used for another purpose
    - If there is excess income from the harvest, explain to my spouse why it is important to save money

- De-Brief & Homework: (**5 minutes**)
  Facilitator identifies 2 participants to provide a **BRIEF re-cap** of what they have learned during this lesson. Participants should also identify how they **can change their behavior** to incorporate the new knowledge they have learned. Facilitator should prompt participants to discuss **specific actions** they can take which will result in an improvement / incorporation of the topic in their lives.

  Homework: As a homework assignment, participants should track all of their household expenditures for the following week. Instruct participants to begin tracking on Sunday and to track expenses for exactly one week. Instruct participants to write down (in their notebook) every item that was purchased and the cost of the item.

  Participants should also track household income for one week. They should pay close attention to the difference between the amount of money that is spent versus the amount of money that is earned. If there is a difference between income and expenses, participants should identify what happened in their household.

Discussion Questions:

- What is a budget?
- What are the benefits of creating a household budget?
- How can I ensure that I stick to a budget?
- What are the benefits of saving money? How can I save money?

Facilitator Notes:

The Silent Game: The purpose of this activity is to have participants complete a task without talking to one another. The facilitator should explain that they would give instructions of what the group must do and give a time limit. The participants must complete the activity SILENTLY.

Example: Instruct participants to line up in order from youngest to oldest (2 minutes)
Instruct participants to separate themselves into groups according to the number of children they have (3 minutes)
Instruct participants to find and hold hands with the person who lives closest to them (4 minutes)

Budget: An estimate of income and expenditures for a certain period of time

Importance of Using a Budget: A budget allows you to plan for how money will be spent. It allows you to prioritize importance purchases and allocate money towards the things your family needs most. It also allows you to identify where spending can be cut if necessary or if there is excess money that can be saved.

NOTES:

SESSION 16 – HEALTHY CHILDREN

Time/Length: ~45 minutes

Tools/Materials/Readings:
Flip chart or large paper
Markers

Main Education Points:

- Ensuring my Children are Healthy
- Gender Equality Between Sons and Daughters
- Communicating the Importance of Nutrition and Healthcare for my Children
- Negotiating with my Spouse on Child Expenses

Activities/Assessments:

- Introduction & Homework Review: (**10 minutes**)
  Facilitator should begin by asking participants about their budgeting homework assignment. Encourage participants to share the weekly budget that they tracked. Were expenses more or less than you thought? How did household income compare to expenses?

- Brainstorm & Role-Play: (**15 minutes**)
  Participants should identify areas of their child's life that are currently impacted by poor nutrition, inadequate healthcare, poor sanitation & hygiene, etc. Explain what the outcome is and think about how this can be changed. After identifying an issue(s) that affects their household, participants should work in pairs to role-play, discussing the importance of this issue(s) with their spouse and how to improve behavior in order to improve health outcomes (Facilitator should stress the use of Communication skills from).

- Negotiation for De-Worming: (**10 minutes**)
  The facilitator should present the following scenario to participants and should act as the spouse for this negotiating role-play. Several participants will have the opportunity to negotiate with their husband (The Facilitator) in front of the group and should utilize the negotiation strategies they learned in **Lesson 2**.
    - Your children have been sick recently and the community health worker recommends that you take them to be de-wormed. Your husband thinks that this can wait another 6 months until the children can be de-wormed for free at school but you think it is important to have them de-wormed now. How do you negotiate with your husband to get your children de-wormed?

- Wrap –Up & Group Discussion (**5 minutes**):
  The facilitator should lead a discussion about the rights of all children to live healthy and happy lives. Stress the following points to participants and ask them to respond by sharing their own personal experience or experiences of people in their communities:
    - As mothers and caregiver, we have a responsibility to care for all children, regardless if they are our own children or our step-children
    - Husbands have a responsibility to provide healthcare, education, food and shelter for their children. If a man is not providing these things, it is a mother's legal responsibility to ensure that the child is cared for. The LC1 can refer to probation officers who will ensure that fathers provide for all of their children
    - If a man takes a second wife, he still must provide for all of his children

- De-Brief & Homework: (**5 minutes**)

Facilitator identifies 2 participants to provide a **BRIEF re-cap** of what they have learned during this lesson. Participants should also identify how they **can change their behavior** to incorporate the new knowledge they have learned. Facilitator should prompt participants to discuss **specific actions** they can take which will result in an improvement / incorporation of the topic in their lives.

Homework: The participants should communicate with their spouse about the issue that they identified during today's role-play. Participants should explain to their spouse that they have identified an area of their child's health that can be improved and that they would like to take action. Prompt participants to utilize the Communication strategies and tips and Negotiation strategies that they have been practicing throughout the course of the program. Remember to stress the health benefits for the child and the consequences of what could happen if this issue is left unaddressed.

Discussion Questions:

- What are the important lessons that I've learned about my child's health? How can I communicate these to my spouse?
- What can I do to improve the health of my children?
- Are my sons and daughters treated equally? Is one healthier than the other? Why? Can I change this?
- How are resources distributed between children? Are all children's health and nutritional needs met? Which are not?

NOTES:

SESSION 17 – FATHERHOOD

Time/Length: ~45 minutes

Tools/Materials/Readings:
Flipchart Paper
Markers

Main Education Points:
- Positive values and identities surrounding fatherhood
- Identify the role that fathers play in their wives' and children's health
- Contribution of fathers during Pregnancy, Labor, and Delivery

Activities/Assessments:

- Ice-Breaker "What Are We Talking About" See Facilitator Notes for Instruction (Use the word "Father" for this activity!): (**5 minutes**)

- Introduction: (**5 minutes**)
  Facilitator should begin by asking participants how their husbands or other men in their lives feel about being a father. Ask participants to address the following questions:
  - Are men proud to be fathers?
  - What kinds of responsibilities do men have to their families?
  - What are the challenges associated with being a good father?

- Role-Play: (**15 minutes**)
  Working in pairs, participants will practice communicating the important role that fathers play in each of the following areas of a child's life. Have each group select one topic from below and prepare a role-play of a wife communicating with her husband. Encourage participants to incorporate thanking their husbands for the contributions they make to their family and stress that a father should be involved in keeping their children safe and healthy. Wives should Identify and communicate **specific** actions that a father can take in each of the following areas: **(See Facilitator Notes for Examples of specific actions that a father can take)**
    - Immunization
    - Good Nutrition and a Balanced Diet
    - Child Development
    - Emergency Health Care
    - De-Worming
    - Hygiene and Sanitation
    - Support to Mothers

- Brainstorm: (**15 minutes**)

Participants will brainstorm the important role that fathers play during pregnancy, labor & delivery, and post delivery. The facilitator should divide the flipchart into 3 sections, labeled "Pregnancy", "Labor & Delivery", and "Post Delivery". Begin by asking what fathers can contribute during each time period and record the responses. Next, identify the activities that men actually do. Ask participants the following questions:
- What is the difference between the role that fathers play and what they can contribute?
- What are the challenges associated with husbands playing an active role at these times?
- How can I communicate with my husband about the importance of playing an active role during pregnancy, labor & delivery, and post-delivery?

- De-Brief & Homework: (**5 minutes**)

Facilitator identifies 2 participants to provide a **BRIEF re-cap** of what they have learned during this lesson. Participants should also identify how they **can change their behavior** to incorporate the new knowledge they have learned. Facilitator should prompt participants to discuss **specific actions** they can take which will result in an improvement / incorporation of the topic in their lives.

Homework: Participants should identify one important area of their child's health that they believe their husband can be more involved with. Ask each participant to share their idea and facilitator should record responses. After everyone has shared something, instruct participants to initiate a conversation with their spouse before the next session, explaining the importance of being involved in their child's health and the valuable contribution that they can make to the identified issue.

Discussion Questions:

- What are the challenges of being a father? How can these challenges be addressed?
- What is the positive side of being a father? What are the benefits of being a father?
- What are the benefits for a child who has a father active in his or her life?
- What are the benefits of a man having a good relationship with the mother of his child?
- What do men need to become better fathers?
- Are there positive role models of fathers in your community? What can be learned from them?

Facilitator Notes:

What Are We Talking About?:

* This Icebreaker requires a ball*

This activity introduces the idea that a word can mean many different things to different people.

1.) Participants should throw the ball around the group and when you catch the ball you have to explain what you think about when you hear the word. For example, if the word chosen is 'religion', definitions might include 'how I decide right from wrong', 'people praying' or even 'a cause of arguments'. Other words could include: 'paradise', 'conflict', 'the name of your village' etc.

Examples of Specific Actions that a Father Can Take:

- Immunization: Accompany mothers to have children immunized after birth, provide transport for mother to take child to health center (if it isn't feasible for both parents to go), keep up with child health card to ensure child has received all immunizations
- Good Nutrition and a Balanced Diet: Purchase nutritious foods like fruits, vegetables and proteins for children, During meals stress the importance of a health diet to your children
- Child Development: Spend time with your child, play with toddlers, talk to your baby,
- Emergency Health Care: If child is sick, bring them to the health center, If both parents cannot afford to bring child, fathers can provide transport to mothers as well as hospital fees, ensure that children are brought to the hospital /clinic when they are sick
- De-Worming: Ensure that children are de-wormed at Child Plus Days, obtain de-worming medication from the health center every 3 months for your whole family and take the medication with your children, setting an example
- Hygiene and Sanitation: Ensure that children are practicing good hygiene by encouraging them to wash their hands regularly, ensure that children are using the latrine properly, establish rules about clean drinking water
- Support to Mothers: Ensure that mothers stay healthy and able to look after children by offering to watch children so that mother can rest, providing healthy food for mothers

SESSION 18 – DOMESTIC VIOLENCE

Time/Length: ~45 minutes

Tools/Materials/Readings:
Flipchart Paper
Markers
Talking Stick

Main Education Points:

- Domestic Violence is a public, not private issue
- The root cause of Domestic Violence is an imbalance of power in relationships
- Domestic Violence hurts everyone, not just women
- Women experience Domestic Violence more than men
- Everyone has a right to live free of violence

Activities/Assessments:

- Ice-Breaker: (**5 minutes**)
  "The Name Game": See Facilitator Notes for Instruction

- Introduction: (**5 minutes**)
  Facilitator should begin with a brief discussion about what violence is and what it means to the participants. In an informal group discussion, or using a "talking stick", have each participant share the meaning of violence.

- Review the 4 types of power: (**3 minutes**)
  Discuss how imbalances in power leads to domestic violence.

- Case Study: (**15 minutes**)
  Select a group member to lead this discussion. Before starting the session, give the participant the handout, "Gender Violence Case Study" (**See Facilitator Notes**) and instruct them that they will read the case study aloud to the group and ask the associated questions. Encourage the group member to probe participants to provide different answers to each question.

- Role Play: (**10 minutes**)
  Participants will practice communicating the important points that they have learned about domestic violence to their spouse. Facilitator should explain that preventing domestic violence begins with dialogue about why it is so harmful. Participants should work in pairs and brainstorm an appropriate time to have this conversation with their spouse. Practice discussing why domestic violence is a problem, how it affects women, and the impact it has on children. Participants should think about how they can explain the issue to their husbands in a way that will facilitate understanding rather than blaming men for the issue. Have participants practice independently for 10 minutes and then ask 3 groups to demonstrate their role-play to the group as a whole.

- Group Discussion: (**10 minutes**)
  Facilitator should lead a group discussion about what victims of domestic violence usually do and what they can do. Ask the group the following questions:
    - What do women who suffer from domestic violence do?
    - Do women fear reporting domestic violence? Why?
    - Is there stigma attached to families affected by domestic violence?

- Do women feel that they are betraying their family if they report domestic violence?
- How can we change the way women feel about reporting domestic violence?

- De-Brief: (**5 minutes**)
  Facilitator identifies 2 participants to provide a **BRIEF re-cap** of what they have learned during this lesson. Participants should also identify how they **can change their behavior** to incorporate the new knowledge they have learned. Facilitator should prompt participants to discuss **specific actions** they can take which will result in an improvement / incorporation of the topic in their lives.

Discussion Questions:

- What to do if you've been a victim of Domestic Violence
- How can I communicate with my spouse about Domestic Violence?
- What can I do to prevent Domestic Violence in my household?

Facilitator Notes:

"The Name Game":
1.) Ask all participants to stand in a line, shoulder to shoulder.
2.) Ask participants who thinks they remember everyone's names.
3.) Once a participant volunteers, they must start at the beginning of the line and work their way through the line, stating everyone's first names.
4.) Instruct participants that they will be timed and the person who can get through everyone's names correctly in the fastest time wins!

The Facilitator Should:

- Explain that this is not a support group but that you can talk to anyone afterwards to tell them about support services you know about
- Be aware of people's reactions and body language and remind the group of the importance of people taking care of themselves
- Explain that keeping full confidentiality is very difficult and that participants who want to talk about their own experience, but who do not want others to know about it, can choose to talk about violence that "people like them" experience
- Challenge participants who deny or try to reduce the significance of violence

Gender Violence Case Study:
Mtitu and Latifa are married. Mtitu's family is coming to their home for dinner. He is very anxious that they should have a good time, and he wants to show them that his wife is a great cook. But when he gets home that night, nothing is prepared. Latifa attended a group meeting with some other women from the village that afternoon and is just preparing the dinner now. Mtitu is very upset. He does not want his family to think that he cannot control his wife. They begin to yell at each other. The fight quickly escalates and Mtitu hits Latifa.

Questions:

- Do you think Mtitu was right to hit Latifa?
- How should Latifa react?
- Could Mtitu have reacted differently in this situation? How?

Common Questions:

1.) I have asked my husband to buy us more food but he just spends the money on alcohol. I've started using my own money to buy food and will prepare a meal for my children and myself before my husband gets home. Then, when he comes back, I cook the little food he brings and we have a second meal. I tell my children not to tell my husband that we have already eaten. I am scared that he will find out and punish me for this. What should I do?

Answer: Your health and the health of your children are important so it is good that you are keeping your family healthy in this way. It is probably not a good idea to do this behind your husband's back if you fear he will be violent when he finds out. You can talk to your husband about how your family needs more food and explain that you would like to begin work in order to get the money to buy this food. If your husband sees that you are contributing in this way, he may begin to appreciate you as a contributor to the household. Explain that you are willing to raise the money, buy the food and prepare it and the health benefits associated with a healthy, balanced diet for your children. When preparing to have this conversation with your husband, consider the timing, your financial situation and your husband's behavior.

NOTES:

SESSION 19 – REVIEW

Time/Length: ~45 minutes

Tools/Materials/Readings:
Flipchart Paper
Markers
Program Topics Written Out
Bowl / Cup for Review Activity

Main Education Points:
- Review of program topics
- Reflection of what you have learned
- Identify changes you have already made
- Identify changes that you can continue to make
- Identify ways to share this information with others

Activities/Assessments:
- Ice-Breaker "Name and Adjective Game-With a Spin!" – See Facilitator Notes for Instruction (**5 minutes**)

- Introduction & Homework Review: (**5 minutes**)
  Facilitator begins by asking each participant to share their experience of utilizing a new resource in their community (homework review). Ask each person to share which resource they utilized/visited, what the experience was like, and what the impact on their health has been or will be.

  Facilitator should then explain that today would be dedicated to reviewing all of the topics that have been covered in the program. Thank participants for attending the sessions and being active participants. Today is about sharing what you have learned, discussing how you have made changes in your life, and thinking about how you can continue to make changes based on what you have learned.

- Review of Topics: (**25 minutes**)
  Facilitator will come prepared with a list of all program topics written out and a bowl / cup that will be passed around to participants. The Review will consist of 3 different rounds of selecting topics and sharing information. Each participant should select at least 1 topic for every round.

  Round 1: Pass around the cup / bowl and have each participant select a topic. After everyone has a topic, participants should share **something important that they have learned about the topic in this program** (Example: If "Communication" was selected, the participant can share that it is important to assertively communicate)

  Round 2: Pass around the cup / bowl and have each participant select a topic. After everyone has a topic, participants should share **a change they have made in their life related to the topic** (Example: If "Communication" was selected, the participant can share that they have begun communicating with their husband about sensitive topics over dinner, when both people are calm and have time to discuss the issue in depth.)

  Round 3: Pass around the cup / bowl and have each participant select a topic. After everyone has a topic, participants should share **a change they can still make in their life related to the topic** (Example: If "Communication" was selected, the participant can share that they are planning to communicate a major purchase with their spouse next month after the harvest)

- Sharing Information with Others: (**10 minutes**)
  Facilitator should lead a discussion about how participants can share what they have learned with others in their community. Address the following questions:
    - Who else in my community could benefit from learning about the information in this program?
    - How can I share the information I've learned in this program with others?
    - How can I learn more about the topics that I'm interested in?

Discussion Questions:

- What have you learned about in this course?
- Has the information you've learned caused you to make any changes in your life?
- How can you share the information you've learned with others in your community?

Facilitator Notes:

"Name and Adjective Game With a Spin":
This Icebreaker requires a ball
1.) Have participants sit in a circle
2.) The facilitator begins by stating their name and then tosses the ball to another participant. The participant who catches the ball must say an adjective that describes the facilitator, which begins with the first letter of the facilitator's name (for example, the Facilitator Erica tosses the ball to a participant who catches it and says "Erica is Excellent")
3.) Then, the participant says their own name and tosses the ball to another participant who continues by doing the same (the participant Miria tosses the ball to another participant who says "Miria is Marvelous").
4.) The game continues, until everyone has caught the ball and all names have been linked with an adjective.

NOTES:

SESSION 20 – WRAP UP & RECOGNITION CEREMONY

Time/Length: ~45 minutes

Tools/Materials/Readings:
Participant Certificates
Group Photos

Main Education Points:
- Reflection of what you have learned
- Recognition of participants
- Moving forward

Activities/Assessments:
- Facilitator Survey
- Recognition of participants with Certificate presentation
- Special recognition of Team Leader

Discussion Questions:
- What are the next steps for the group? Can we continue after the program formally ends?
- What kinds of goals did I establish at the beginning of the program? Have I achieved these goals?
- What has been the most enjoyable part of this experience?
- What is the most useful information that I've learned?

2013

HEALTHY FUTURES INITIATIVE

Facilitator's Guide

USAID
FROM THE AMERICAN PEOPLE

HEALTHY
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FACILITATOR GUIDE TABLE OF CONTENTS

SESSION 1 – INTRODUCTION, OVERVIEW & BASIC KNOWLEDGE

This facilitator's guide is designed to help the Healthy Futures Initiative Facilitators effectively communicate and encourage behavior changes to improve maternal and newborn health in local communities. The guide covers the key messages to be delivered by facilitators in each session and provides technical information on the health concepts covered in the curriculum. With this guide, facilitators should be able to give participants current information and practical advice as well as answer questions that participants may have. Each facilitator is likely to have their own expertise in this area, but it is important that the information in this guide is covered in each session to make sure the program is standardized across all villages.

Facilitator Preparation

The first session should be used to welcome participants and get them excited about the program and let them know how it will be run. The ground rules and expectations for participants should be outlined (e.g. arrive on time, respect other people in the group, do not interrupt people speaking) and some ice breaking activities should get participant feeling comfortable with the group and get them to start thinking about health in their community.

Logistics

1.) Confirm meeting time and location with LC1
2.) Ask LC1 to make a brief introduction at the beginning of the meeting, introducing the program and stressing that participants were selected to be involved
3.) Prepare class roster and attendance sheet
4.) Prepare nametags for all participants
5.) Prepare the flipchart by writing out all of the topics that will be covered in the curriculum

Potential Questions from Participants:
1.) Do I have to pay to participate in this program?
Answer: No

2.) Should I bring my child to this program?
Answer: It is ideal if someone can care for your child during the time of the program as you will be able to fully participate and will benefit from the role-plays. However, you are more than welcome to bring your child with you if there is no one to care for them.

3.) The LC1 did not mobilize me for the group but I'd like to participate, can I?
Answer: No. Unfortunately, there is a limit to the number of participants we can work with and we have randomly selected these participants.

4.) What if I get sick and have to miss a session?
Answer: If you are unable to make a session, please notify the group leader who will tell the facilitator. We do not expect you to come if you are very ill, however, we expect participants to attend all sessions unless the illness is serious

NOTES:

SESSION 2 – MATERNAL HEALTH AND CHILD NUTRITION

KEY MESSAGES:

1. The first 1,000 days (24 months, or two years) of a child's life is the most important time for growth and development
2. Interventions to prevent malnutrition have the greatest benefit during these 1,000 days
3. It is important for mothers to look after themselves as well as their children to allow for children to grow up strong and healthy
4. Children suffering from malnutrition face physical stunting, mental impairment, higher susceptibility to disease, increased risk of mortality, poorer performance in school, and lower future incomes.

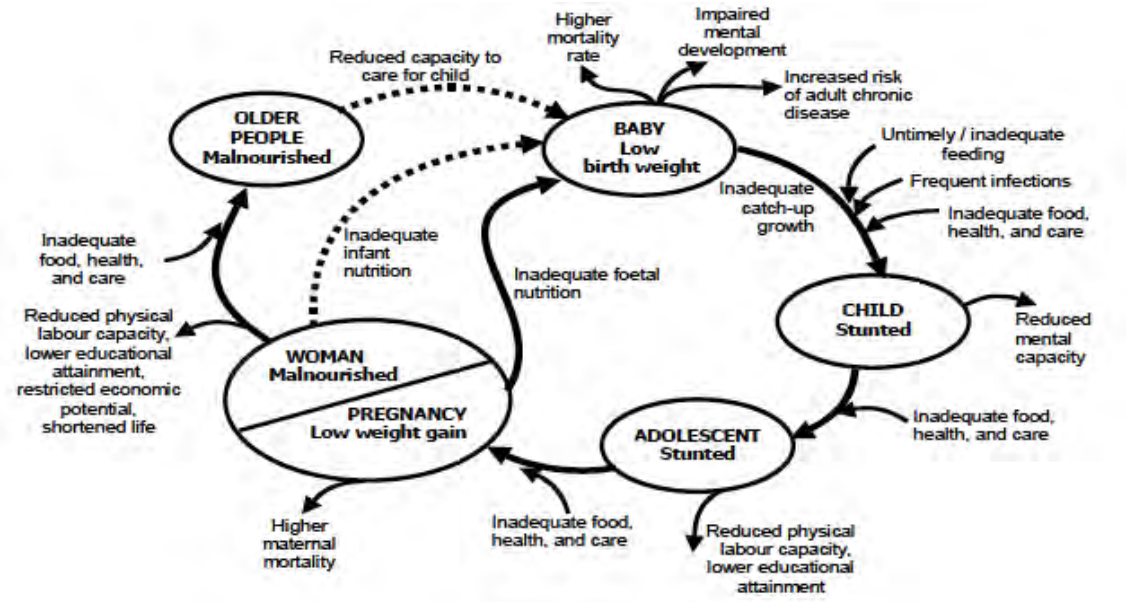
Malnutrition is a medical condition experienced due to insufficient intake of nutrients. Children, pregnant and breastfeeding mothers and people with HIV and AIDS are the people most vulnerable to malnutrition.

Optimal infant and child nutrition is fundamental for the survival, health, growth and development of children. However, many children are not fed in the recommended way. Not eating enough or not eating the right kinds of foods can cause people to have a higher risk of illness and death. Children are especially affected when they do not eat properly. When children are not fed properly, they become malnourished and their bodies are less able to fight off disease and infection. Not eating properly, falling ill often, not being well-cared after, and poor hygiene and sanitation can lead to young children being malnourished. If a woman is malnourished during pregnancy, or if her child is malnourished during the first two years of life, the child's physical and mental growth and development may be slowed. This cannot be made up when the child is older—it will affect the child for the rest of his or her life. For this reason, how women eat during pregnancy and how children are fed during the first two years of life are especially important.

Malnutrition is one of the main health problems facing many women and children in Southwest Uganda. Malnutrition can lead to sickness, poor growth, lifelong disability and even death. There are some simple steps that will help mothers and fathers to care for themselves and their children and help to avoid malnutrition and give their children the best start in life.

Malnutrition's Impact on Productivity during the Life Cycle and across Generations

Malnutrition among young children and mothers in Southwest Uganda has significant economic costs for the malnourished individuals, their households and communities, and the nation as a whole. These costs stem from the need to deal with an increased disease burden and other physical and mental problems related to malnutrition and the enormous reductions in human potential and economic productivity throughout life caused by hunger and malnutrition. Malnourished children suffer from irreparable stunted physical growth. Hungry children make poor students and are prone to drop out of the educational system. Hungry and malnourished adults are unable to be fully productive workers and are more likely to be ill, increasing the strain on oft en overburdened health systems. Malnourished, stunted women give birth to low birth weight babies, transferring the broad economic disadvantages of malnutrition in their own lives to the next generation.



First 1000 Days

For young children, the period from conception to their second birthday is characterised as the 1,000 days of opportunity to effectively and sustainably address malnutrition. Interventions to prevent malnutrition have the greatest benefit during these 1,000 days. Interventions after the second birthday can make a difference but oft en cannot undo the damage done by malnutrition during the

Healthy, well-nourished mothers are considerably more likely to give birth to and be able to nurture and raise healthy children. Ensuring the proper nutrition of these future mothers will result in their experiencing pregnancies and deliveries that are less prone to problems and giving birth to healthier babies who have a good birth weight.

Good nutrition means having the best possible intake of nutrients that allow our bodies to be as healthy as they can.

Information about how to feed young children and babies can come from a number of difference places such as family beliefs, community practices and information from health workers, however often this information is not correct. It is essential for mothers, caregivers, family members, and communities to have accurate information on how women should eat during pregnancy and breastfeeding and how best to feed infants and young children. The best source of information about maternal and child health comes from trained health workers at health centers.

Lifelong good nutrition:

- Promotes cognitive (mental) performance (e.g. intelligence, concentration, reading and writing skills)
- Promotes physical performance (e.g. strength, endurance)
- Maintains healthy immune system and helps to fight diseases
- Helps you to live a longer, healthier life

Poor nutrition:

- Increases your chance of getting sick
- Decreases your cognitive performance
- For example: it becomes more difficult to concentrate, intelligence is lower and you may become tired more easily
- Decreases your physical strength and growth

- Decreases your ability to work and earn a living
- May make you more irritable and more often in a bad mood
- May make it more difficult for you to help care for your family
- Increases your risk of getting sick in later life

Causes of Malnutrition

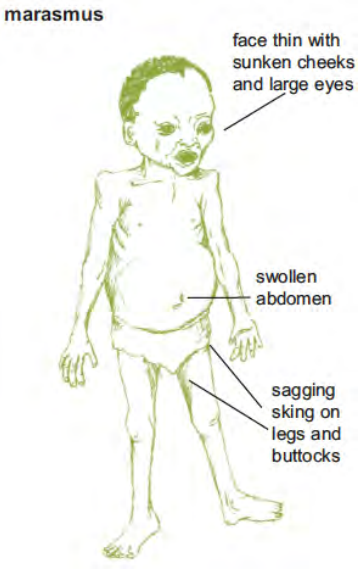
Malnutrition can be caused by many factors, including environmental conditions such as a lack of clean water and poor sanitation, social factors such as a lack of education about nutrition and hygiene, fitness and poor access to health care and economic factors such as a lack of income and ability to buy food. Cultural beliefs may also play a part. For example, some communities believe that children should not eat eggs. It is important to discuss the causes of malnutrition in the community that you are working with so that they can identify and address these issues.

Some causes of malnutrition in infants:

- Inadequate nutrition as a fetus
- Because of low weight gain of the mother during pregnancy
- Because of malnourished mother during pregnancy

Illness and Malnutrition

Many illnesses, including diarrhea, measles, TB and HIV/AIDS, can make the effects of malnutrition worse and vice versa. They stop the body from absorbing important nutrients and they also increase the body's need for more nutrients in the diet. People who are malnourished are more susceptible to diseases and infections. This is called the malnutrition–infection cycle. People who are ill need special diets.



Signs and Symptoms of Malnutrition

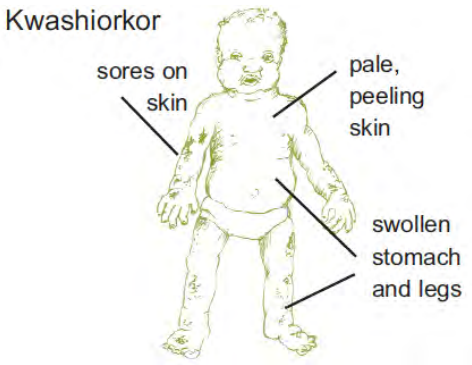
Malnutrition can be classified as either Marasmus or Kwashioror

Marasmus:

When children do not get enough energy giving food their bodies become thin and they feel weak. Children with marasmus look old and wrinkled. Their skin is dry and their faces are thin, with sunken cheeks and large eyes. Their abdomen looks swollen. Children with marasmus often cry a lot and are liable to infections.

Kwashiorkor:

When children do not get enough of the right kind of food, for example when they eat only mealie meal porridge, their bodies (especially their stomachs and legs) swell so that they look fat. Sores develop on their skin and it starts to peel off. Their skin becomes pale and they get sores at the corner of their mouths. Their hair is sparse and de-pigmented to brown. Sometimes this weakness and other symptoms can affect their behavior. Kwashiorkor children are very irritable. They cry a lot and do not want to eat. They often get diarrhea.



Marasmus and kwashiorkor symptoms can be combined. These conditions need to be treated medically and with a well-balanced, high-energy diet. A child suffering from these conditions need to be referred immediately to a health clinic.

Iron deficiency

When people do not get enough iron in their diet, their blood becomes weak and cannot carry enough oxygen around the body. Iron deficiency is also called anemia. Anemia affects women and children in particular, as well as adolescents and the elderly. It makes people feel weak and slows down learning in children. Anemia increases the risk of problems for mother and baby during and after delivery. Signs of anemia include a pale tongue and inside of the lips, tiredness and breathlessness. Everyone should eat plenty of dark green leafy vegetables, offal (liver, kidney, heart), red meat, chicken and fish, legumes and cereals to treat and avoid anemia.

SESSION 3 – PRENATAL NUTRITION

KEY MESSAGES:

1. A mother's nutrition during pregnancy plays an important role in her child's health
2. During pregnancy women should eat one extra small meal or snack each day and drink water whenever they feel thirsty, to provide nutrition for her and her growing baby
3. It is important to attend at least 4 prenatal care visits at a health center starting from when a woman finds out she is pregnant
4. Pregnant women should eat the best foods available including milk, fresh fruit and vegetables, meat, fish, eggs, grains, peas and beans
5. Young mothers need extra care as they are still growing too. They should eat more food and get more rest than older mothers.

Pregnant and breastfeeding women are at risk from malnutrition because their body needs increase during pregnancy and lactation. An unhealthy diet will not only threaten the health of these women but also puts their babies at risk. Pregnant women need more body-building food and more protective food, especially vitamin A and iron, than men. Teenage girls who become pregnant need special rich, balanced diets, because they themselves are still growing and can become malnourished.

It is important to eat the right mix of foods during pregnancy to ensure the baby gains weight and gets the right nutrients. Pregnant women must eat a variety of foods to be strong enough to deliver without problems. Good nutrition can help to prevent adverse birth outcomes such as premature birth, low birth weight and inter-uterine growth retardation. Each of these conditions can have long term effects on your child's health and harm development, growth and quality of life, as well as increase sickness and health care costs for the family.
Women who are pregnant and breastfeeding should eat more meals each day to ensure they have enough energy to stay healthy. During pregnancy women should eat one extra small meal or snack each day and drink water whenever they feel thirsty, to provide nutrition for her and her growing baby. When breastfeeding, women should eat 2 – 3 extra small meals or snacks each day to ensure she can produce enough milk for her baby. Not eating enough food can lead to the following signs which may be due to hypoglycemia: shakiness, dizziness, sweating, hunger, headache, pale skin color, sudden mood changes, clumsy movements, seizures, difficulty concentrating, confusions, tingling sensations in the mouth. If women experience these symptoms they should eat more.

By eating special nutrients during pregnancy, women can help their baby to grow and be healthy. These nutrients are found in foods but it can be helpful to take vitamin tablets if they are available from your health center. Women can find out more about these tablets by attending prenatal care visits at a health center. It is important to attend at least 4 of these check ups, starting as soon as a woman finds out she is pregnant. These are important to check that the mother and baby are healthy, for the mother to receive any vaccinations and give mothers the chance to ask health workers any important questions about pregnancy, birth and motherhood.

These tablets are:

- Iron and folic acid tablets to prevent anemia during pregnancy and after the baby is born
- Vitamin A tablets as soon as your baby is born so that it can be passed on in the breast milk to help prevent illness and promote healthy eyes
- De-worming tablets to help prevent anemia
- Anti-malarial tablets if the are prescribed

- Antiretroviral medication is prescribed to HIV positive mothers
- Using iodized salt instead of regular salt to help your baby's brain and body develop well (note, you do not need to use extra salt, just the same amount you should normally use)

Foods that are important during pregnancy:

Folic Acid rich foods

These foods are very important during pregnancy so that the fetus can grow and produce healthy cells. It is also important for producing blood cells and helping the placenta to grow.

Examples: asparagus, broccoli, okra, peas, spinach, onions, leeks, avocados, beans, chickpeas, peanuts, soya flour, corn flakes, wheat germ, meat (including cooked liver, beef, pork, chicken) and egg yolks.

Calcium rich foods

These foods are important for you and your baby to have strong and healthy bones and teeth.

Examples: milk, bananas, low sugar breakfast cereals, whole-wheat flour, almonds, spinach, green vegetables, peanut butter, sesame seeds, table salt

Iron rich foods

These foods are important for avoiding anemia and maintaining healthy blood. It is also important for the immune system and helps you to fight off illness. During pregnancy your baby will consume a large amount of your iron, therefore you must eat more than usual to stay healthy.

Examples: spinach, parsley, corn flakes, beans, soya flour, lentils, wheat germ, fortified breakfast cereals, all meat, particularly red meat (beef, lamb, goat), egg yolks.

Vitamin A rich foods

These foods are important for healthy brain and eye development. Vitamin A deficiency can lead to blindness.

Examples: carrots, sweet potatoes, pumpkin, spinach and other dark green leafy vegetables and beef.

Vitamin C rich foods

These foods are important to stop diseases and illness and can help the immune system to fight off colds. Vitamin C is also important to help the body absorb iron effectively.

Examples: citrus fruits (oranges, limes, lemons, grapefruit, mandarins), kiwi fruit, green or red peppers

Protein rich foods

These foods are important because protein is essential for muscle growth and maintaining healthy blood and energy levels. Protein rich foods also have nutrients like iron, which is vital for energy levels and healthy development.

Examples: Groundnuts, cashew nuts, peas, beans and soybeans. All kinds of meat (chicken, goat, beef, lamb, pork, fish) and eggs, milk, and cow ghee.

Carbohydrate rich foods

These foods are important because they provide energy for the body. They are essential in growth and development and boosting the immune system.

Examples: potatoes, rice, pulses, cereals, bread, pasta, beans

Fat rich foods

These foods are important because they provide another source of energy for the body and help vitamins to be absorbed. They are very important for the development of your baby's nervous system.

Examples: margarine, plant oil, walnuts, peanuts, hazelnuts, egg yolk, milk, cheese, butter

Foods to avoid during pregnancy

Some types of food that you normally eat are dangerous to eat during pregnancy and may harm you or your baby. During pregnancy you should not have any of the following foods:

- Raw meat: meat that is not properly cooked can have bacteria which may cause fetal death and maternal illness
- Raw eggs: uncooked eggs can also contain bacteria that is very dangerous to pregnant women and their unborn babies
- Uncooked milk: uncooked milk can contain bacteria called listeria, which can cause a miscarriage. It may also infect the baby and can lead to blood poisoning.
- Caffeine: caffeine, found in coffee, tea and soft drinks /sodas is not good during pregnancy. It is a diuretic, which makes you need to urinate more often, which may lead to water loss. It also stops calcium from being absorbed by the body. It can also lead to restlessness in your baby once he or she has been born. It is much healthier to drink water, juice and milk during pregnancy.
- Alcohol: drinking alcohol during pregnancy, even in small amounts, is never safe. By drinking alcohol during pregnancy, you may damage your child's development and cause them to have life long disabilities. Drinking large amounts of alcohol during pregnancy can also lead to miscarriage.

NOTES:

SESSION 4 – BREASTFEEDING

KEY MESSAGES:

1. Breast milk is the best food a mother can give to her baby, it is all that they need for the first 6 months of their lives
2. Breastfeeding should start within an hour of the baby being born
3. There is no need to give any other fluids such as water or cow's milk to the baby during the first 6 months of their life. Doing so may make them sick
4. Colostrum, the first yellowish milk, is a natural vaccine that protects the baby from illnesses. Do not throw it away; it is very important to feed your baby colostrum.
5. For most HIV-positive women in our communities, exclusive breastfeeding is the best way to feed their babies for the first six months, with continued breastfeeding through at least 12 months.

Breastfeeding is very important for mothers and their baby's health, it protects the baby from many illnesses such as diarrhea and respiratory infections. Breast milk is very nutritious and hydrating and provides the best possible start in life for a baby. It provides all the liquid and nutrients that a baby needs for the first 6 months of their life. Exclusive breastfeeding means feeding the baby ONLY breast milk for the first 6 months of their life. Complementary feeding means feeing a baby anything other than breast milk while continuing to breast feed, this includes water, formula milk, animal milk and solid foods including porridges and soups. Complementary feeding is not recommended until a baby is 6 months old, as young babies' stomachs cannot properly digest food other than breast milk.

Advantages:

- Exclusive breastfeeding gives a baby the healthiest start to life
- Exclusive breastfeeding does not cost any money, unlike formula milk and other foods
- Exclusive breastfeeding protects babies from illnesses by passing on immunity from the mother
- Women who are exclusive breastfeeding normally do not experience menstrual periods and are therefore protected against another pregnancy during this time

Early and exclusive breastfeeding

Breast milk is the best food for the baby. Skin to skin contact and early initiation of breastfeeding within the first hour after delivery is beneficial for both the mother and her baby. There is no need to give any other fluids before initiation of breastfeeding. These may actually result in problems in the baby such as infections.

Key messages:

- Breastfeed the baby soon after delivery to encourage milk production, and to give the baby the benefits of colostrum
- Immediate breastfeeding also helps with the delivery of the placenta and reduces bleeding.
- Colostrum, the first yellowish milk, is a natural vaccine that protects the baby from illnesses. Do not throw it away; it is very important to feed your baby colostrum.
- During the first 6 months after birth, do not give any other food or liquid (even water) besides breast milk to your baby.
- Breast milk is a complete food and contains the amount of water the baby needs during this period, even in dry and warm weather. Giving other fluids or foods may cause serious infections in the baby.

Additional information:

While breastfeeding, wait until the baby spontaneously lets go of the nipple before switching to the other breast. In this way, the baby is more likely to receive the fat-rich breast milk that comes out near the end as the breast gets emptied. Breastfeed on demand.

How and when to breastfeed

When to breastfeed:

- Breastfeeding should begin in the first hour after the baby is born
- Breastfeed on demand, that is, when the baby shows signs on hunger, during the day and night

The baby should be breastfed if:

- The baby is restless
- The baby starts opening its mouth and turning its head from side-to-side
- The baby starts to put its tongue in and out
- The baby is suckling on its fingers and fists
- The baby is crying (this is a late sign of hunger and means that the baby is already very hungry)
- Women should let their baby finish one breast before offering the other. Switching back and forth between breasts prevents the baby from getting the complete nutrition that a longer feed on each breast would offer.
- If the baby is ill or sleepy, women should wake the baby to offer them the breast often
- Sick babies should be fed more frequently, the milk provides important nutrients and the skin to skin contact is very comforting to the baby
- If the mother is sick, she should continue to breast-feed but she may need extra food to support herself during that time.

Breastfeeding positions:

- Good breastfeeding position helps the baby to suckle well, reduces any pain that the mother feels while breastfeeding and ensures a good supply of milk
- Women should breastfeed in a position that is comfortable for them and their baby. There are a number of different positions to choose from and each one works well. However, there are four main points to remember:
- The baby's body should be straight, not bent or twisted, and with the head held slightly back
- The baby's body should be facing the breast, not held flat to the chest or stomach and the baby should be able to look up into the mother's face
- The baby should be held close
- The baby's whole body should be held and supported with the mother's hand and arm

These are some of the best breastfeeding positions

- Cradle position
- Cross cradle position (good for small babies)
- Side-lying position (use to rest while breastfeeding at night)
- Under arm position (this can use good after a caesarean section, if your nipples are painful or if you are breastfeeding twins or a small baby)

Good attachment while breastfeeding:

- Good attachment helps to ensure that the baby suckles well and helps the mother to produce a good supply of breast milk

- Good attachment helps to prevent sore and cracked nipples and reduce any pain associated with breastfeeding
- Effective suckling helps the mother to produce milk

There are five signs of good attachment:

- The baby takes slow, deep suckles, sometimes pausing
- The baby can be seen or heard to swallow after every couple of suckles
- Suckling is comfortable and pain free for you
- The baby finishes the feed, releases the breast and looks content and relaxed
- The breast is softer after the feed

How to know when your baby is getting enough milk:

- If the baby is not visibly thin and is putting on weight
- If the baby is responsive and active for their age
- If the baby is gaining adequate weight. This can be checked at a health facility
- When they baby passes light colored urine 6 times or more during the day while being exclusively breast fed
- It is particularly important to make sure low birth weight babies are getting enough milk. These babies should be fed more often.

How to hand express breast milk and cup feed:

Sometimes it is not possible to breastfeed the baby. This can happen if the mother and baby are separated or if the baby is very small. It is still important that the baby gets breast milk and by learning to express their breast milk women can still use it to feed their babies. Use the following steps:

1. Wash your hands thoroughly with soap and water
2. Make sure all the utensils and containers that you will use are very clean
3. Clean and boil the container that you will collect and store the breast milk in
4. Sit or stand in a comfortable position. It is also sometimes useful to gently stroke your breasts or use a warm cloth to stimulate the flow of milk.
5. Put your thumb on the breast above the dark area around the nipple (areola) and the other fingers on the underside of the breast behind the areola
6. With your thumb and first two fingers, press a little bit in towards the chest wall and then press gently towards the dark area (areola)
7. The milk may start to flow in drops or sometimes in fine streams. Collect the milk in the clean container

8. Avoid rubbing the skin which can cause bruising, or squeezing the nipple which stops the flow of milk
9. Rotate the thumb and finger positions and press/compress and release all around the areola
10. Express one breast for at least 3 – 5 minutes until the flow stops, the express the other breast, then repeat both sides again (20 – 30minutes total)
11. Store the breast milk in a clean, covered container. Milk can be stored for 6 – 8 hours in a cool place, and 72 hours (3 days) in the back of the refrigerator
12. Give the baby the expressed milk from a cup (NOT a bottle). Bring the cup to the baby's lower lip and allow the baby to take small amounts of milk with their tongue. Do not pour the milk into the baby's mouth.

When the mother is separated from the baby:

- Sometimes women may be separated from their baby (e.g. to go to work). In this instance women should express and store breast milk before they leave home so that the baby's caregiver can feed them while the mother is away.
- The mother should teach the caregiver how to feed the baby from a clean open cup
- The mother should have longer feeds with the baby when she and the baby are together again
- The mother should express milk while they are away to prevent breast swelling and ensure the milk supply is adequate
- For women in formal employment: get the employers consent for breastfeeding breaks at work (to feed or express) and safe storage for expressed breast milk at the work place

Breastfeeding difficulties

Sometimes directly breastfeeding a very small baby may not be possible. In this case mothers should express milk and feed the expressed milk to the infant using a cup (NOT a bottle as these are difficult to clean)

Important note about fertility and breastfeeding:

Women may not experience menstrual periods while they are exclusively breastfeeding. This means that it is very unlikely that they will become pregnant. However, if the child is not exclusively breast fed, if the child is older than 6 months or if the woman's menstrual periods return, she is not protected against pregnancy and should consider another form on contraception if she wants to prevent further pregnancies.

Mother-to-child transmission of HIV

- Approximately 8 out of 20 babies born to HIV-positive mothers would be infected with HIV, even if the mothers do not use PMTCT services or practice safer infant feeding. So most children will not become infected
- Approximately 3 out of 20 babies born to HIV-positive mothers would be infected with HIV if their mothers use PMTCT services and practice exclusive breastfeeding. So by taking these preventive actions, mothers can reduce the risk of transmission to their baby by more than half

Research has shown that there are many factors that can increase the risk that mothers will pass HIV to their babies. These factors include:

- Recently infected or re-infected with HIV while pregnant or breastfeeding
- Being in labor for a long time
- The mother is very sick with HIV (the stage of her illness)
- Mother has breast problems while breastfeeding, including cracked nipples, swollen breasts, or mastitis
- The baby has oral thrush or sores in his or her mouth
- The baby breastfeeds and receives other foods or liquids at the same time

What can be done to help prevent or reduce the risk of an HIV-infected woman passing HIV to her baby?

- All pregnant women and their partners should go for HIV testing and seek health care
- Services if they are positive.
- Women who are positive should give birth in a health facility.
- Women who are positive should attend PMTCT services.
- Women who are positive should take antiretroviral drugs during labor and give the drugs to their baby when it is born.
- Women should talk with a health worker about how best to feed the baby safely.
- Women should sleep under an insecticide-treated net during pregnancy.

A woman who is infected or re-infected with HIV during pregnancy or breastfeeding is more likely to pass the virus to her child. Unprotected sexual intercourse while pregnant or breastfeeding places a woman at risk of HIV infection, and increases the risk of HIV infection to her child. When someone is newly infected or re-infected with HIV, the amount of HIV in her blood is very high, increasing the risk of mother-to-child transmission.

- For most HIV-positive women in our communities, exclusive breastfeeding is the best way to feed their babies for the first six months, with continued breastfeeding through at least 12 months.
- However, if women breastfeed and give other foods or liquids (including water) at the same time before 6 months of age, it makes the risk of HIV transmission and death from other illnesses much higher. This is called mixed feeding.
- Although giving only formula (and never breastfeeding) can reduce the risk of HIV transmission, it can double the number of children who become sick and die from other illnesses, like pneumonia and diarrhea. For this reason, exclusive breastfeeding for the first six months and continued breastfeeding through at least 12 months is the safest option for most women in our communities.
- At 6 months, HIV-positive mothers should introduce complementary foods and continue breastfeeding through 12 months. At 12 months, mothers should talk with a health worker again about how best to feed their babies and about whether stopping breastfeeding would be appropriate.
- If mothers choose to feed their children using infant formula and not to breastfeed, they should talk with a health worker to learn if this would be an appropriate option for them and how to do this safely.

NOTES:

SESSION 5 – COMPLEMENTARY FEEDING

KEY MESSAGES:

1. From the time a baby is 6 months old, it is safe to start introducing solid foods and liquids other than breast milk into their diet
2. It is important to continue to breastfeed during this time as well, this is called complementary feeding
3. Introduce foods gradually as the child grows
4. Sick children need extra food and nutrients to recover

As a baby grows, he or she will begin to need more food to give them the energy and nutrition to continue to grow. From 6 months old, it is safe to begin feeding babies certain foods and liquids. It is important to continue to breastfeed until the baby is two years old.

These additional foods are called complementary foods, as they complement the nutrition gained from breast milk. The term complementary feeding emphasizes the fact that the foods will be eaten in addition to breastfeeding, rather than replacing it. During this time the child will gradually become accustomed to eating family foods. How the child is fed can be just as important as what the child is fed.

It is important to start complementary feeding at the right time, that is, when the child is 6 months old. Starting complementary foods too soon may:

- Reduce the amount of milk produced by the mother
- Reduce the number of nutrients that the child received
- Increase the risk of illness and diarrhea
- Increase the risk of digestive problems because babies cannot digest and absorb solid foods
- Increase the mother's risk of pregnancy if she is not using another family planning method

Starting complementary foods too late can also be harmful to the child because:

- From 6 months old breast milk does not have enough nutrients to supply all of the child's nutritional needs
- The child may therefore grow and develop slowly and be short and thin for their age
- May develop deficiencies (such as iron, vitamin C, vitamin A, iodine deficiencies) which can cause illness and disability
- The child may become a fussy eater and refuse to eat solid foods

There are some foods that are best to start introducing the baby to. These include:

- Baby rice
- Mashed vegetables
- Mashed fruits such as bananas
- Well cooked and finely chopped meat

It is important not to add sugar or salt to the baby's food as this encourages unhealthy eating habits and may put a strain on their kidneys. For the same reason it is best to avoid sweets, canned vegetables (because they have too much salt added) and raw eggs.

Important characteristics of complementary feeding

Baby's Age:	6 months	6 to 9 months	9 to 12 months	12 to 24 months
Frequency	2 times per day	3 times per day	4 times per day	5 times per day
Amount	2 – 3 tablespoons of food per feed	Gradually increase to half a 250ml cup per feed	Half a 250ml cup per feed	Three quarters to one full 250ml cup per feed
Texture	Food should be thick enough to be fed by hand	Give finely mashed up or pureed family foods	Finely chopped foods, finger foods and thinly sliced foods	Finger foods and foods cut into small pieces
Variety	Begin with staple foods (e.g. corn, wheat, rice, potatoes and mashed banana)	Try to feed a variety of foods at each meal. Include food from each food group: carbohydrates, protein, fruit and vegetables. Include as many vitamin rich foods as possible, particularly vitamin A. Avoid sugary drinks and biscuits. Remember all animal source foods must be thoroughly cooked. Use iodized salt in place of regular salt.		
Responsive	Be patient and encourage the baby to eat. Gradually introduce foods. Do not force the baby to eat.			
Hygiene	Use a clean plate/bowl/cup and clean spoon to feed the baby. Wash your hands and your baby's with soap and water before preparing food and feeding. Store the foods to be given to the baby in a safe and hygienic place.			

Young children's immune systems are still developing so it is very important that the correct hygiene procedures are followed to avoid illness.

- Make sure all eggs and meat are cooked all the way through
- Use safe water
- Wash your hands and all utensils and bowls before starting to prepare a meal
- Do not cough or sneeze into the food
- If possible, store meat, milk, cheese and eggs in the refrigerator or somewhere cool so that bacteria do not grow and so that they last longer

NOTES:

SESSION 6 – FOOD GROUPS

KEY MESSAGES:

1. Foods can be placed into categories according to their nutritional value
2. It is important to get a good mix of these food groups to stay healthy and grow
3. Use the healthy food plate to see how much of each food group you should eat

Food Groups

1. Carbohydrates
   - Bread, rice, cereal (not sugary cereals), wheat, millet, maize, flour, cassava, matooke, sweet potato, yams
   -

2. Fruit and Vegetables
   - All fruits and vegetables are good for you and the most important thing is to get a good variety. One way to tell is to make sure that you eat a lot of different colored fruits and vegetables
   - Vitamin A rich foods are important for babies and young children. These include: mango, papaya, passion fruit, oranges, dark green leafy vegetables, carrots, yellow sweet potato

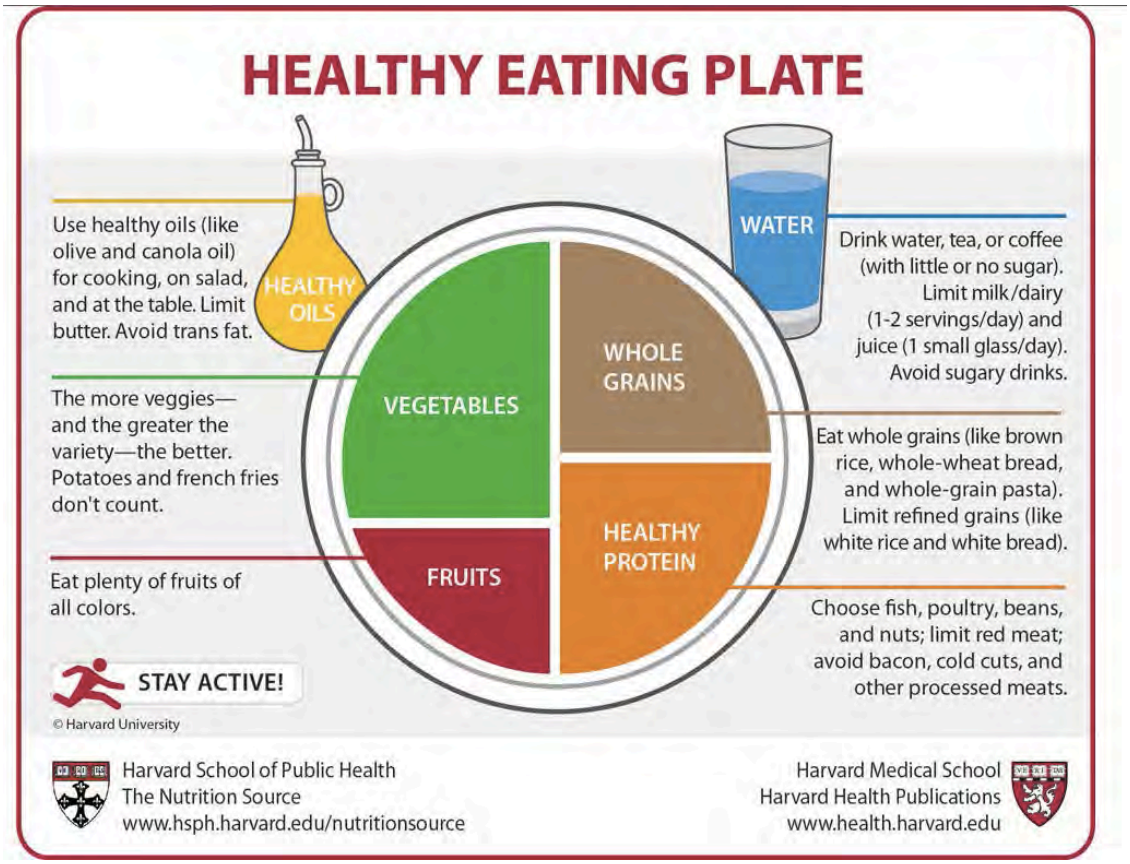
and pumpkin

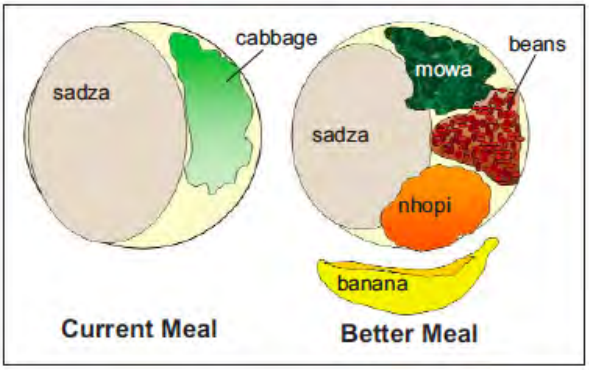
3. Proteins
   - All kinds of meat
   - Milk and foods made from milk such as cheese and yoghurt
   - Eggs
   - Beans, peas and nuts

4. Sugars and Fats
   - Sweets and candies, soda and sugary drinks, oils, margarine and butter (blue band), iodized salt, sugar, ghee

Healthy eating plate

Follow the healthy eating plate to see how much of each food group you should eat. Foods including fruits, vegetables and carbohydrates are very healthy and should be eaten at every meal. Protein from meat and eggs should be eaten often, at least two times per week. Moderate portions of dairy products such as milk and yoghurt should be eaten at least once a week. Sweet food like sugary biscuits and sodas should only be eaten occasionally, as they are not very healthy for the body and do not contain useful nutrients. **Water should be drunk very frequently and is the best thing to drink for adults and children who are no longer breastfeeding.**





SESSION 7 – MICRONUTRIENTS FOR MOTHERS & CHILDREN

KEY MESSAGES:

1. Micronutrients are nutrients that are essential for being healthy
2. Different micronutrients are found in different foods so it is important to eat a balanced diet
3. Some foods (e.g. spinach) are very healthy for you as they contain a number of different micronutrients. Eating lots of these foods will ensure the correct balance of nutrients.
4. When your body does not have enough of a micronutrient it is called a deficiency
5. Deficiencies in babies, children and adults can lead to serious illness and sometimes lifelong disabilities and can harm the healthy development of your body and brain
6. Sometimes it can be difficult to eat enough of these foods, if this is the case, women should visit their health center to find out about vitamin supplement tablets

Micronutrient	Function in the body	Food sources
Iron	Required for healthy blood and for the body to use energy stored in cells. An iron deficiency is called anemia and can result in very low energy levels. Blood loss may result in low iron levels so women should try to have extra iron during menstrual periods, pregnancy, birth and following any other blood loss.	Red meats (beef, lamb, goat) are best but other types of meat are also good sources, liver, breast milk, spinach and other leafy greens, sunflower seeds. Iron tablets available from health centers can also be very helpful.
Zinc	Zinc is important for immune functioning and wound healing. Zinc deficiency can lead to illness, diarrhea, poor eyesight, taste and smell, and cognitive (mental) impairments.	Meat, breast milk, whole grain cereals, legumes, peanuts, milk, cheese, yoghurt, avocado and pumpkin
Vitamin A	Vitamin A is essential for immune system function (particularly against measles) and the development of good eyesight. Vitamin A deficiency can lead to blindness.	Breast milk, liver, egg yolk, milk, fish, carrots, oranges, mangoes, spinach and other dark green vegetables.
Folate	Folate is particularly important for pregnant women to ensure their baby develops well and does not develop birth defects like spina bifida. It is also important to help prevent diseases later in life like cancer and heart disease.	Green leafy vegetables such as spinach, beans and peas, egg yolks, sunflower seeds and liver. Women who are planning on getting pregnant can also take folate tablets.
Vitamin C	Vitamin C helps the body to resist infections such as the common cold, it is also very important to help the body to absorb iron properly.	Citrus fruits (oranges, lemons, limes, grapefruit, mandarins), peppers, breast milk, animal milks.
Calcium	Calcium is required for building strong bones and teeth.	Breast milk, animal milk, yoghurt, cheese, beans and peas, leafy green vegetables, broccoli. Caffeine, found in tea, coffee and some sodas, can stop the absorption of calcium so children should avoid caffeine and women should limit their consumption.
Iodine	Iodine is important for brain and nervous system development as well as for growth. Iodine deficiency can lead to illness and conditions such as goiter.	Using iodized salt is the best way to make sure you are getting enough iodine. You do not need to use extra salt, just replace regular salt with the iodized kind.
Vitamin B	Vitamin B is important for healthy metabolism, healthy skin and enhanced memory.	Dark green leafy vegetables, milk, eggs, whole grain cereals, beans and peas.

Importance of Vitamin A:

Vitamin A is a particularly important nutrient for pregnant women and children. Vitamin A deficiency in women can cause miscarriage and birth defects in their children. Babies and children who do not eat enough vitamin A can become irreversibly (permanently) blind which can impact on their ability to learn at school and earn a living later in life. Vitamin A is also important for immunity and can protect infants from illness. Breast milk from mothers with adequate vitamin A levels is an excellent source of vitamin A; therefore children who are not exclusively breastfed may be at risk of low vitamin A levels. Vitamin A also helps to prevent children from getting the measles, which can be fatal. Mothers who think that their children may not be getting enough vitamin A should ask their local health care center about supplementation tablets.

NOTES:

SESSION 8 – SAFE WATER & SANITATION PRACTICES

KEY MESSAGES:

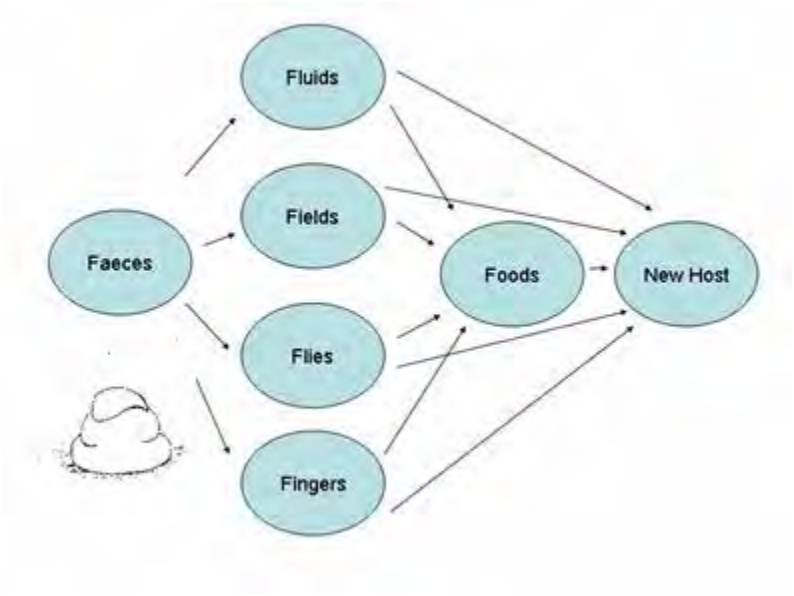
1. Following the correct safe water, sanitation and hygiene practices is one of the best ways to keep your family healthy and reduce the risk of you and your family getting diarrhea and other dangerous illnesses
2. Hand washing is the easiest and most effective way of protecting you and your family against sickness
3. By reducing illness you can save money by having smaller medical bills

One of the major causes of malnutrition in an individual is the presence of disease. Poor sanitation and the use or consumption of unsafe or contaminated water is usually the primary source of diseases related to environmental hygiene. Food and water should be handled in a hygienic manner in order to avoid food and water-borne illnesses. Pregnant women's immune systems are weaker, and thus they are susceptible to infection.

Transmission Routes

The Six Fs - Feces, Flies, Fields, Fluids, Fingers and Foods

Diarrheal diseases develop from the spread of human feces via fluids such as water. Fields, another mode of transmission, can spread diarrheal disease via open defecation and subsequent human contact with feces. Fingers can spread disease if they are not washed and then touch the mouth or prepare food. Flies land on human excrement and can in turn make a home on your foods providing an additional transmission route. Finally, foods themselves can be contaminated if they are not prepared with clean hands or proper utensils.



Hand washing is the easiest and most effective way of protecting you and your family against sickness. Hands should be washed thoroughly using water and soap. To make sure that you have

washed your hands thoroughly, sing the song "Happy Birthday" (for about 20 seconds) in your head while you wash with soap and water. Once you have sung the song, your hands should be clean. Make sure you rinse all the soap off your hands.

Critical Hand-washing Times

You should wash your hands:

- Before touching and preparing food
- Before eating food
- Before feeding someone else food
- After going to the toilet or helping a child to go to the toilet
- Before and after changing diapers
- After blowing your nose or wiping a child's nose
- After touching pets or other animals
- After cleaning or handling garbage

Children should wash their hands:

- Before touching food
- After going to the toilet
- After sneezing, coughing or using a tissue
- After playing with other children and toys touched by other children
- After playing outside or in the sand
- After touching animals

How to use and maintain a pit latrine:

- Clean the roof, walls and floor regularly
- Smoke the latrine at least twice a week to prevent bad smells
- Disinfect the latrine with oil to kill insects
- Have a latrine cover and cover the latrine whenever it is not in use
- Have a place with water and soap outside the latrine for washing hands every time anyone uses the latrine

Recommended actions

- Always wash hands with soap before and after touching food
- Wash fruits and vegetables thoroughly before eating
- Make sure that food preparation and eating areas are perfectly clean
- Cover food that is not eaten to avoid contamination
- Serve cooked foods when hot
- Serve foods using clean utensils
- Water meant for drinking should be brought to a rolling (bubbling) boil and boiled for 3 minutes to kill germs

Important questions to ask about the location and use of pit latrines

For villages:

- Do people defecate so that their waste is kept away from places where people may walk, and where flies cannot reach it?
- If children leave feces near their homes are they immediately removed?
- Is the latrine in an area far away from the source of drinking water and any other water sources (e.g. lakes, rivers)?

- Is the latrine in an area far away from where food is prepared and stored?
- Is the drinking water source different from the place where people and animals bathe and women wash clothes?
- Does the village have a protected water source, such as a protected spring, a well with a pump, or a piped water supply?
- Do people use water from protected sources?
- Are there enough water collection points (e.g. wells, pumps, taps) for everybody who needs to collect water?
- Is the area around the wells or public taps dry?
- Do people make sure that all stagnant water is drained away so that the rain does not leave big puddles in the village?
- Are there any waste burial pits or rubbish bins in the village?
- Are these far away from all water sources?

For households:

- If the household has a latrine is it clean?
- Does the household latrine have a cover or other means of keeping flies out?
- Does the family have access to clean drinking water?
- Are their clean, covered containers for storing water?
- Is there a bowl of water and soap for hand washing near the latrine?
- Do people always wash their hands after using the latrine and before eating?
- Is there water or toilet paper available at the latrine for use after defecation?
- Is there a way for young children to defecate hygienically in or near the house (e.g. in a pot)?
- If the household has pigs, goats or other animals, are they confined to a pen? Is the pen kept clean?
- Is there a waste pit or bin where animal droppings and children's feces can be discarded?
- Do family members throw rubbish into a pit or bin?
- Is there a clean place to prepare food in the house?
- Is this place convenient for the wife and other members who cook?
- If cooking occurs inside, is the area well ventilated (e.g. open windows or doors) to stop indoor air pollution from the smoke?

NOTES:

SESSION 9 – FOOD PREPARATION & RECIPES

KEY MESSAGES:

1. Safe food preparation and storage can help to keep your family healthy
2. The temperature that foods are stored at and how well they are cooked is important to kill bacteria which can be in any food and can cause disease

Food Hygiene

When preparing food for the family and particularly for children and sick people remember the following important rules:

- Wash you hands, preferably with soap and warm water, before handling food;
- Make sure all surfaces, cloths and utensils (knives, boards, cloths, plates, bowls, pots and spoons) are clean,
- Make sure your ingredients are clean and the fruit and vegetables have been washed in clean water,
- Use only clean water to cook with,
- Protect the food you are preparing from flies and dust.

Food storage:

- Store foods in sealed, clean containers in a cool, dry spot. Use a refrigerator if possible
- Meat and milk products can not be kept for long periods of time if unrefrigerated, they should be eaten soon after they are bought
- Foods that require cooking (e.g. meat, fish, eggs) should be kept separate from ready to eat food (e.g. fruit and vegetables) to prevent bacterial contamination

Utensils:

- All utensils (knives, forks, spoons, cutting boards, bowls, plates, containers) that will come into contact with food should be thoroughly cleaned, sanitized and dried before and after use
- You should not prepare raw and ready to eat foods using the same utensils, either use different ones or clean the utensils
- If raw meat, milk or eggs touches other kinds of food it can become contaminated and make you sick

Food:

- Thoroughly rinse all fruit and vegetables in clean water to remove soil, bacteria and chemicals
- Make sure all food (especially meat and animal products) are cooked through to the center so that there meat is not red in the center
- The cooked food should have reached at least 750C to ensure all bacteria have been killed
- High-risk foods such as meat and dairy (milk, cheese, yoghurt, butter, ghee) should be kept below 50C and cooked above 750C. Bacteria can grow between these temperatures.
- Do not leave cooked food out to cool down, eat it straight away or put it in a refrigerator
- Making sure food is properly cooked is particularly important for pregnant women and children as bacteria in uncooked food can cause illness and even death

Outcomes of eating food that has not been prepared properly:

- Nausea and vomiting
- Stomach pain and abdominal cramps
- Diarrhea
- Fever

- Dehydration

It is important to remember that symptoms of food poisoning may not appear straight away. People often get sick within a few hours of eating contaminated food, but sometimes it can take up to a month to notice symptoms.

Recipes

Kitobero (multi mix):

Ingredients:
- 1 palm of dry beans or ground nuts
- 2 palms of ground nut flour
- 4 teaspoons of ground silver fish
- 2 palms of maize flour
- 1 pinch of iodized salt
- Half a mug (125ml) of water

Method:
1. Measure the dry beans and let them soak in a clean container overnight or for about 6 hours
2. Remove the husks and wash the beans and put them into a clean saucepan with a cover
3. Measure 2 palms of ground nut flour
4. Add 4 teaspoons of silver fish mukeene and a pinch of iodized salt
5. Put 2 palms of maize flour into a different saucepan with half a mug of water
6. Cover in a large saucepan and steam for 3 hours
7. When the foods are ready, mash and divide a half for lunch and half for supper

High Energy Porridge:

Ingredients:
- Cereal
- Legume
- Oil 90g of maize
- 90g of ground nuts paste
- 25g of 10ml of vegetable oil
- 20g of sugar
- 1.5L of water

Method:
1. Cook cereal porridge until ready
2. Add ground nut paste
3. Add vegetable oil and mix well
4. Add sugar and serve

NOTES:

SESSION 10 – REVIEW

JEOPARDY GAME

Breastfeeding
For how long should a baby breastfeed?
What is the importance of breastfeeding on demand?
Name two reliable signs that a baby is not getting enough breast milk.
What are the nutritional needs of a breastfeeding mother?
Cow's milk is better than breast milk. TRUE or FALSE

Complementary feeding
When do you start complementary foods?
Name two dangers of starting complementary foods too early.
Name two dangers of starting complementary foods too late.
List one appropriate food combination for complementary feeding
Name one danger that may result from poor/ bad complementary feeds.

Prenatal nutrition
Doctors supplement which nutrients during pregnancy?
Matooke is a good source of protein: TRUE or FALSE?
Why is it important for women to eat a balanced diet while pregnant?
Name 3 Vitamin rich foods
Which is better - A large portion of matooke with a small portion of beans or a small portion of matooke with large portion of beans?
Name something you shouldn't do when you are pregnant.
How many prenatal visits are recommended?

Micronutrients
Name three sources of Vitamin A
Name 3 sources of iron
Name 1 source of iodine
Vitamin A boosts immunity TRUE or FALSE
What is the importance of iron?

Malnutrition
Name two diseases associated with poor feeding?
Name two signs of Kwashiorkor
Name two consequences of malnutrition
Pregnant women can get sick of malnutrition TRUE or FALSE
Name 2 ways of preventing malnutrition

Safe Water, Sanitation and Hygiene Practices
Name the 6 F's
What is one of the best ways to prevent diarrhea?
Name 3 critical hand washing times
Water that is boiled is unsafe to drink TRUE or FALSE
What is the main source of water contamination?

SESSION 11 – HIV/AIDS

KEY MESSAGES:

1. HIV is a virus that can lead to AIDS, and it is spread when blood, semen or vaginal fluids from an infected person enter another person's body
2. HIV can be passed from a mother to her baby through pregnancy, delivery or breastfeeding
3. With the proper medicines, the risk of mother to child transmission can be reduced to less than 2%
4. Mothers should all know their HIV status so that they can take measures (e.g. medicines) to protect their children from infection
5. All infants who have been exposed to HIV (through HIV positive mothers) should be exclusively breast fed for the first 6 months, regardless of their own HIV status

What is HIV?

Human immunodeficiency virus (HIV) is a virus that causes an acquired immunodeficiency syndrome (AIDS). In humans this condition leads to a progressive failure of the immune system that allows life-threatening infections and cancers to thrive. HIV is spread when blood, semen or vaginal fluids from an infected person enter another person's body, usually through sexual contact, sharing needles for injecting drugs and from a mother to their baby during birth.

Even though mothers can transmit the virus to their babies, an HIV positive mother does not guarantee an HIV positive baby. The risk of transmission from an infected mother to her baby before or during birth is 15 to 25%. This risk increases if an HIV positive mother also breastfeeds her baby. However, if antiretroviral medicines are used for the mother during pregnancy and birth and for the baby after they are born, and if breastfeeding is avoided, the risk of passing the disease to the baby is less than 2%.

Prevention of mother-to-child transmission

It is important for mothers to know their HIV status so that they can decide on the best feeding method for their children. Even though HIV can be transmitted through breastfeeding, with proper treatment HIV positive mothers can lower the risk of mother to child transmission to only 2%, making breastfeeding the best option. Replacement feeding (eliminating breastfeeding entirely), eliminates mother to child transmission of HIV, however it carries the risk of diarrhea, pneumonia and malnutrition if breast milk substitutes are not prepared properly, following instructions, given to the baby in a hygienic way and given in correct quantities.

Because replacement feeding is unfeasible in many cases, the Ugandan Ministry of Health recommends exclusive breastfeeding for infants of HIV infected women for the first 6 months of the infant's life, regardless of the infants HIV status, unless replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS) for them and their infants before that time. It is important to note that it is not recommended to breastfeed and replacement feed infants. Mothers and families should decide on one option, either exclusive breastfeeding or replacement feeding and continue with that one method only. Combining the two increases the risk of mother to child transmission of HIV as well as increasing the infant's risk of other diseases.

The definition of AFASS

Replacement feeding of babies of HIV positive mothers should **only** be considered if the following conditions (AFASS) are met, if they are not it is best to proceed with exclusive breastfeeding.

Acceptable: the mother perceives no barrier to replacement feeding and is happy and willing to do so. Barriers can be for social and cultural reasons, or be due to fear of stigmatization or discrimination.

Feasible: The family has adequate time, knowledge, skills and other resources to prepare the replacement food and feed the infant up to 12 times in 24 hours (1 day).

Affordable: the mother and family, with community or health-system support if necessary, can pay for the cost of purchasing/producing, preparing and using replacement feeding, including all ingredients, fuel, clean water, soap and equipment without compromising the health and nutrition of the rest of the family.

Sustainable: There is availability of a continuous and uninterrupted supply and dependable system of distribution for all ingredients and products needed for safe replacement feeding, for as long as the infant needs it, up to one year of age or longer.

Safe: replacement foods can be safely and hygienically prepared and stored, and fed in nutritionally adequate quantities with clean hands, clean utensils and preferably using a cup.

HIV positive mothers should be encouraged to:

- Get their infant tested for HIV
- Increase their food intake by eating one additional snack per day if they have no symptoms, or by 2 to 3 snacks per day if they have symptoms
- Have their weight monitored frequently and to seek medical care immediately if their weight decreases significantly

Stopping breastfeeding

HIV can be transmitted at any time during breastfeeding, therefore some HIV positive mothers may choose to stop exclusive breastfeeding at 6 months to stop the risk of mother to child transmission of HIV. This should only be done if replacement feeding is AFASS. The period of time during which a mother stops breastfeeding and changes to replacement milk is known as the **transition period**. The amount of time it takes for mothers to stop breastfeeding can vary between women from 3 days to 3 weeks. In order for infants to stay healthy, it is important for mothers to start to think about the transition period and make a transition plan ahead of time.

- While a mother is breastfeeding, she should teach her baby to drink expressed, unheated, breast milk from a cup for about 10 days before beginning the transition period.
- Once the baby is drinking comfortably, replace one breastfeed with one cup-feed using expressed breast milk.
- Increase the frequency of cup feeding while reducing the frequency of breastfeeding. Ask a family member to help cup feed the baby so that the baby gets used to different people and so that there is some one to help if required.
- Once breastfeeding has stopped, it is best to heat-treat breast milk to destroy the HIV virus and make it safe for the infant to drink
- Gradually replace the expressed breast milk with formula or fresh animal milk

- To avoid sore swollen breasts, mothers should express a little milk and discard it whenever the breasts feel too full. Using a cold compress on the breasts and wearing a firm but comfortable bra can also help to reduce pain and swelling.

What to feed infants when mothers stop breastfeeding

Infants less than 6 months old:

- Commercial infant formula **only** if it is prepared in a hygienic way, exactly according to instructions. If the family cannot access clean water, or adequate amounts of formula it is **not** advised as it could harm the infant the mother's own expressed, heat treated breast milk

Infants over 6 months old:

- Commercial infant formula **only** if it is prepared in a hygienic way, exactly according to instructions. If the family cannot access clean water, or adequate amounts of formula it is **not** advised as it could harm the infant
- Animal milk (heat treated for infants under 12 months) in addition to other foods
- A combination of age appropriate meals (discussed in earlier sessions) and animal milk

Conditions to safely formula feed

Formula feeding can be an alternative to breast milk however, if it is not prepared hygienically and carefully following instructions it can be harmful to infants and increase their risk of sickness.

- There must be an adequate supply of clean water for making up the formula
- There must be an adequate supply of water and soap for cleaning all utensils
- The family must be able to access / afford enough formula for the baby, watering down the formula or not feeding the infant frequently can be very harmful
- Formula should not be fed at the same time as breast milk, mothers and families should decide on whether the infant will be exclusively breast fed or formula fed and not mix the two methods
- There should be a clean, dry, safe place to store the formula so that it does not become contaminated

How to heat-treat and store breast milk

Heat-treating breast milk can help to make breast milk safer for infants to drink during the transition period from exclusive breastfeeding to replacement feeding. As always, it is important to maintain good hygiene practices when heat treating milk.

1. Gather the following equipment:
    a. Clean containers with covers to store the milk in
    b. A small cup to feed the infant with
    c. A large saucepan
    d. A large container of cool, clean water
    e. Fuel for the fire that will be used to heat the milk
    f. A glass jar or metal container that is large enough to put the breast milk in, but small enough to fit inside the saucepan. It is important to make sure this container will not break or melt in high temperatures.
    g. Soap and clean water for washing all equipment

2. Carefully wash all equipment from step 1 with soap and water
3. Hand express enough breast milk for one feed
4. Put this milk into the jar or metal container and then place this container in a small saucepan
5. Fill the saucepan with water. Make sure the water in the saucepan is above the level of the milk so that all of the milk will be heated well
6. Heat the water until it reaches boiling (when the water starts to make large bubbles)
7. Remove the jar of milk and place it in the container of cool water so that it will cool down enough for the infant to drink. Be careful not to get burnt on the hot jar of milk, if it is too hot to touch it is best to let it cool down a little first.
8. This milk should be fed to the infant once it is cool enough to drink. It can be stored for 8 hours at room temperature and up to 24hours in a refrigerator

SESSION 12 – CONTRACEPTION & FAMILY PLANNING

KEY MESSAGES:

1. Contraception and family planning is important to protect you from infections and to help you to plan how many children to have and when to have them
2. There are a number of different methods of family planning and it is important to understand the advantages and disadvantages of each before deciding on a method which is best for you and your family
3. Not all methods of family planning protect against sexually transmitted diseases and HIV
4. Not all methods of family planning are equally effective

What is family planning?

Family planning is a conscious decision by individuals or couples to choose for themselves when to start having children, how many children to have, how to space them or when to stop having children. There are different methods of contraception and it is important to understand the advantages and disadvantages of each when deciding which method is best for you.

Short Term Family Planning Methods:

Male condom

The male condom is a thin sheath worn over the erect penis. It provides protection against pregnancy as well as sexually transmitted infections and HIV. It is important not to re-use condoms, use a new one every time you have sex. New condoms do not have any holes or pores in them and nothing is able to pass through them.

How to use:

- Make sure the condom wrapper has not been opened and does not have any holes in it
- Open the foil carefully to prevent the condom inside from tearing
- Squeeze out the air from the tip
- Put the condom on the top of the erect penis, ensure that the part to be unrolled is on the outside
- Carefully roll it on the erect penis while holding the space at the end of the condom
- After ejaculating but before the penis becomes soft, the man should remove the penis from the woman being careful that the condom does not come off
- Carefully roll the condom off the penis being careful not to spill the semen
- Throw the used condom in a pit latrine or burn it

Female condom

How to use:

- Carefully remove the condom from its package, being sure not to tear it
- The female condom can be inserted any time between 8 hours before sexual intercourse to immediately before sexual intercourse
- Check the inner ring is at the closed end of the pouch. Do not use if discolored or has a bad odor.
- Hold the pouch with the open end hanging down. Use the thumb and middle finger of one and to squeeze the inner ring into an oval insertion. Insert the inner ring and pouch into the vaginal opening.
- Use the finger next to the thumb to push the pouch the rest of the way into the vagina. The outside ring lies against the outer lips of the vagina outside the body.

- Remove the female condom immediately after intercourse before standing up
- Squeeze and twist the outer ring to keep sperm inside the pouch
- Use an new female condom for each act of sexual intercourse
- Dispose of the used female condom in a pit latrine or burn it

Advantages:

- Safe, effective and easy to use
- Protects against STI/HIV
- Excellent option for someone who does not need ongoing contraception
- Does not require a prescription or medical examination
- Can be used in combination with another method

Disadvantages:

- May cause decreased sexual sensitivity
- Requires skills to use properly and negotiate use with a partner
- A new condom must be used each time the couple has sex
- Occasionally a condom may break or slip off during intercourse
- Interrupts the sex act

Possible side effects:

- Itching or Burning

Frequently asked questions

Qn. Can it disappear in the woman's uterus when having sex?
A. No, this cannot happen because the entrance to the uterus (the cervix) is very small

Qn. Can it burst inside the vagina during intercourse?
A. New condoms are very strong and rarely burst. Breaking is not expected if they are not expired, they did not have contact with sharp objects or have not been kept in a hot place.

Qn. is it true that the HIV- virus can pass through the pores of a condom?
A. Condoms don't have pores; neither the virus nor the sperm can pass through unless there are holes.

Qn. Can the female condom disappear in the woman's uterus?
A. No, this cannot happen because of the ring that holds the condom outside the body.

Oral Contraceptive Pills

Pills are tablets containing hormones. A woman takes one tablet daily to prevent pregnancy. Pills work by preventing the release of the egg from the ovary and by making cervical mucus thick so the sperms cannot pass through. There are two kinds of pills: the mini pill (progestin only pill POP) for breast-feeding women and the combined Oral Contraceptive (COC). As soon as the woman stops breast-feeding, it is advisable to change her to COC' s because she can get pregnant just by forgetting to take a mini pill once.

Advantages:

- Safe, effective and easy to use
- Lighter, regular periods with less cramping
- Can become pregnant again after stopping the pill
- May be beneficial for women who have irregular or heavy periods, dysmenorrheal or acne
- Mini pill for breastfeeding mothers

Disadvantages:

- Have some side effects
- Must be taken at the same time every day
- To be used with caution in women with high blood pressure

Possible side effects:
Nausea, weight gain, Breast tenderness, headaches or dizziness, unexpected bleeding or spotting and depression

Frequently asked questions

Qn. does the pill cause cancer?
A. No, the pill can actually help protect women against some forms of cancer of the female reproductive organs

Qn. Do they burn all of the woman's eggs?
A. No, they prevent the monthly release of an egg from the ovary, so the eggs stay in the ovaries.

Qn. is it true that pills cause infertility?
A. No, when a woman stops taking the pill, her normal fertility will return within several months. Remember pills do not protect against STIs including HIV/AIDS

Qn. Can the pill can cause an abortion?
A. No, Pills cannot cause abortion. Pills prevent pregnancy by preventing ovulation and making the cervical mucus thick. If a woman is pregnant, she should not take pills.

Injectable (Depo-Provera)

Depo-Provera is an injection containing the hormone progestin. The injection is given every three months into the arm or buttocks. Depo-Provera works by preventing the release of the egg from the ovary and making cervical mucus thick. Without an egg, a woman cannot become pregnant.

Advantages:
- Safe and effective
- Protection lasts for three months
- Periods may become very light and often disappear after a year of use
- Completely reversible, you can become pregnant again after stopping Depo-Provera

Disadvantages:
- Menstrual pattern will probably change
- May increase appetite which may cause weight gain
- Often a delay in getting pregnant after stopping Depo-Provera
- Does not protect against STI/HIV
- May be difficult to remember to return for next injection after the 3 months

Possible side effects:
- Menstruation that is likely to become lighter, less frequent, or stops altogether
- Spotting
- Weight gain or headaches
- Prolonged bleeding in some cases

Frequently asked questions

Qn. Can it make the woman sterile?

A. No, however a few women may have delayed return of fertility. Therefore if at risk of STIs, a condom should be used in addition to the injectables as a dual method.

Qn. Do injectables cause cancer?
A. No, in fact, Depo-Provera (DMPA) is sometimes used to treat uterine cancer.

Qn. Can injectables make you fat?
A. That depends on the person. Some women do gain a little weight while using injectables while others may experience loss of weight.

Qn. Does it make you fail to menstruate?
A. Some women may experience this but not always. If it persists please seek medical advice. Yes, you may not menstruate after the injection. But menstruation will return after this.

Breastfeeding (LAM)

The lactation Amenorrhea Method (LAM) is the use of exclusive breastfeeding as a temporary family planning method. LAM prevents eggs from being made (ovulated) because breastfeeding changes the rate of release of natural hormones responsible for ovulation.

How lactation amenorrhea works

- Lactation amenorrhea is a temporary family planning method based on the natural effect of breastfeeding on fertility. (“Lactation” means related to breastfeeding. “Amenorrhea” means not having monthly bleeding.)
- The lactation amenorrhea method (LAM) requires 3 conditions and all 3 must be met:
    - The mother’s monthly bleeding has not returned
    - The baby is fully or nearly fully breastfed and is fed often, day and night
    - The baby is less than 6 months old
- This can be best used as a dual method of family planning

Advantages:

- Effective in preventing pregnancy for at least 6 months if periods have not returned, and mother is exclusively breastfeeding on demand.
- Encourages the exclusive breastfeeding pattern that have health benefits for the mother and baby
- Can be used immediately after childbirth
- No need to do anything at the time of sexual intercourse
- No supplies or procedures needed to prevent pregnancy

Disadvantages:

- Effectiveness after 6 months is not assured
- Exclusive breastfeeding may be difficult for working mothers
- Does not provide protection against STI/ HIV
- If the mother has HIV there is some chance that breast milk will pass HIV to the baby
- If period returns earlier, then its not effective

Side effects: None

Frequently asked questions

Qn. Can I give my baby other drinks/ foods besides breast milk when using LAM as a Family Planning Method?
A. No, Lam is only effective when breastfeeding is done exclusively and on demand.

Qn. What if I don't have enough milk?
A. LAM may not be the most appropriate method. If you feed on demand, more milk is produced.

Other natural methods

Natural Family Planning methods make use of periodic abstinence and fertility awareness to avoid pregnancy. They involve partner co-operation and awareness of fertile and non-fertile days for regular menstrual cycles. Moon beads are a string of colored beads which the woman moves each day to know when to abstain from sex.

There are a variety of ways to know the fertility of the body based on:

- Taking a daily temperature
- Recoding a regular menstrual cycle (either with a calendar or beads)
- Feeling cervical secretions

These only work for a regular menstrual cycle of 21 to 35 days.

Standard Days Method (Moon-beads)
Moon – beads are a string of differently colored beads. The beads help a woman to be aware of her fertile days, so she can avoid sexual intercourse on the days she is likely to get pregnant. Each bead represents a day of a woman's menstrual cycle. A ring is moved forward each day to keep track of her safe days. They are available and simple to use if the instructions in the packet are followed correctly.

Advantages:
Easy to use, effective, and inexpensive

- Causes no side – effects
- Can be stopped at any time, either to switch methods or to get pregnant.
- Can be used as a temporary method during fever or Vaginal infections
- Helps women become more a ware of their cycle and fertility
- Helps to involve the partner in family planning.

Disadvantages:

- Only suitable for women with a regular cycle between 26 and 32 days long.
- Not very effective
- Women who are breastfeeding or have recently used some hormonal contraceptives may need to wait for regular cycles to begin using the standard Days Method.
- Successful use of the Standard Days Method requires the woman's awareness of her fertile days.

Frequently asked questions

Qn. is my cycle the right length to use moon beads?
A. Yes, if your cycle is between 26 to 32 days long. No, if is shorter or longer

Qn. What should I do if I forget to move the ring?
A. You move the ring twice the next day. If you have forgotten to move the ring several days you can refer back to the calendar where you wrote down the first day of your period. You count how many days have passed since then and you move the ring forward.

Long Acting Family Planning Methods:

Implants

An implant is a set of 6 very small plastic silicon capsules (usually 1-6) containing the hormone progestin. The capsules are placed under the skin of a woman's upper arm and can prevent pregnancy for at least 3 years. Implants work by thickening cervical mucus, making it difficult for an egg to pass through, and by preventing the release of the egg from the ovary sometimes.

Advantages:
- Safe and effective
- Lasts for 3- 7 years, depending on type
- Completely reversible, can become pregnant shortly after removing implant
- May improve anemia

Disadvantages:
- Menstrual cycle will probably change to an unfamiliar one
- Does not protect against STI/ HIV

Possible Side Effects:
- Weight gain
- Irregular periods (prolonged light to moderate bleeding initially)
- Headaches, dizziness, or nervousness
- Nausea

Frequently asked questions

Qn. Can the implant prolong or delay conception after you have stopped?
A. No, Return of fertility is reported to be immediate after use of implants. However remember that the implants do not protect against STIs, which is the leading cause of infertility in Uganda.

Qn. Does it make you fail to menstruate?
A. Absence of periods is reported as one of the side effects of the implants. Therefore a few women using the implants may experience absence of their periods for sometimes.

Qn. Can the implant move around inside the woman's body, or even fall out?
A. No, the implant remains under the skin in the woman's upper arm. The implant stays there until a health provider removes it.

Qn. Will the implant break when it gets bumped?
A. No, the implant is very flexible and soft and cannot break under the skin of the woman's arm. The woman need not worry about putting pressure on her arm, such as carrying her child.

Coil (IUD)

A coil is a small plastic and copper device that is inserted into the uterus to prevent pregnancy. The coil works by preventing sperms from joining with the egg.

Advantages:
- Safe, highly effective and has long- lasting action (12 years)
- Easy to remove if the user wants to become pregnant
- No hormonal related side effects
- Does not interact with medications
- Can be used by women of any age
- Do not need to come back for new supplies

Disadvantages:

- Menstrual changes especially during the first few months. These may be longer and heavier menstrual periods
- Slight pain during the first few hours after IUD insertion
- Does not protect against STI/HIV
- Must be inserted and removed by a trained provider

Possible side effects:

- Cramping
- Heavier and / or longer periods
- Some pain during and immediately after insertion
- Increased vaginal discharge

Frequently asked questions

Qn. Is it true that the copper can rust or react and cause infection in the womb?
A. No, the copper has been tested and cannot rust inside.

Qn. Can it move through the womb and pierce other organs?
A. No, it cannot move anywhere else than through the cervix. It must be inserted and removed by a trained provider.

Qn. Can the string of a coil tie around the man's penis during intercourse?
A. No, the string is cut short after insertion. It is soft and cannot prick.

Permanent Methods:

Tubal Ligation (women only)

This method requires a simple operation to cut and tie the tubes so that the sperm cannot meet the egg in the woman's tubes. A woman cannot become pregnant. It is a simple operation. The doctor gives an injection to make the abdomen numb, then makes a small cut to open and identifies the tubes, ties each of them and makes a cut between the ties. They are then returned inside the abdomen, which is stitched, closed. She can no longer get pregnant but will continue to menstruate.

Advantages:

- Safe
- Simple surgery
- Usually done without putting the woman to sleep
- Drugs are used to block the pain during the operation
- Very effective
- No negative effects on sexual ability or feelings
- Done on out- patient basis

Disadvantages:

- No protection against STI/HIV
- Cannot be reversed

Possible side effects:

- Some minor lower abdominal pains
- Discomfort after surgery

Frequently asked questions

Qn. Does tubal ligation stop women from menstruating?
A. No, the operation is done on the tubes only and uterus remains intact hence, menstruation continues because it is as a result of breakdown of the lining of the womb.

QN. Is it true that the womb is turned upside down during operation?
A. No, the tubes from your ovaries to your womb are cut. Your womb is not affected at all.

Qn. Will the woman loose her sexual desire after tubal ligation?
A. No, a woman's interest and ability in sex will not change. It could even be better because there is no worry of getting pregnant.

Vasectomy

This is a permanent method of contraction from men who are sure that they and their partners do not want more children? It requires a simple operation. A doctor makes a small cut in the skin of the scrotum and ties and cuts the tubes that carry sperm to the penis. A painkiller is given. Now the sperm will not mix with the semen and not be part of the fluid a man ejaculates during orgasm. Without sperm, a man cannot get a woman pregnant but will continue to ejaculate. After the operation, the couple should use another method for 3 months to ensure there are no sperms coming in the ejaculating fluid.

Advantages:

- Safe
- Simple
- Convenient surgery – done in a few minutes in a clinic or health facility
- Drugs are given to block the pain
- Very effective after 3 months following surgery, or semen- analysis

Disadvantages:

- You need to use another method until 3 months are over
- No protection against STIs/HIV
- Cannot be reversed

Frequently asked questions

Qn. Is vasectomy the same thing as castration?

A. No, castration is done to animals, and involves permanently damaging the testicles. Vasectomy does not affect the testicles so the man functions like a man in the same way as he has been.

Qn. Does it make men impotent?
A. No, men remain with the same sexual desire and ability to have sexual intercourse

Qn. Does it make men become mentally disturbed?
A. No, if men start having any mental (psychological) problems they could arise from the fact that the method is irreversible. These range from fear, anxiety to worry, which is why they should.

NOTES:

Contraception Methods

Method	Description	How it works	Effectiveness	Comments
Combined oral contraceptives (COCs) or ''the pill''	Contains two hormones (estrogen and progestogen)	Prevents the release of eggs from the ovaries (ovulation)	>99% with correct and consistent use 92% as commonly used	Reduces risk of endometrial and ovarian cancer; should not be taken while breastfeeding
Progestogen-only pills (POPs) or "the minipill"	Contains only progestogen hormone, not estrogen	Thickens cervical mucous to block sperm and egg from meeting and prevents ovulation	99% with correct and consistent use 90–97% as commonly used	Can be used while breastfeeding; must be taken at the same time each day
Implants	Small, flexible rods or capsules placed under the skin of the upper arm; contains progestogen hormone only	Same mechanism as POPs	>99%	Health-care provider must insert and remove; can be used for 3–5 years depending on implant; irregular vaginal bleeding common but not harmful
Progestogen only injectables	Injected into the muscle every 2 or 3 months, depending on product	Same mechanism as POPs	>99% with correct and consistent use 97% as commonly used	Delayed return to fertility (1–4 months) after use; irregular vaginal bleeding common, but not harmful
Monthly injectables	Injected monthly into the muscle, contains estrogen and progestogen	Same mechanism as COCs	>99% with correct and consistent use 97% as commonly used	Irregular vaginal bleeding common, but not harmful
Intrauterine device (IUD): copper containing	Small flexible plastic device containing copper sleeves or wire that is inserted into the uterus	Copper component damages sperm and prevents it from meeting the egg	>99%	Longer and heavier periods during first months of use are common but not harmful; can also be used as emergency contraception
Intrauterine device (IUD) levonorgestrel	A T-shaped plastic device inserted into the uterus that steadily releases small amounts of levonorgestrel each day	Suppresses the growth of the lining of uterus (endometrium)	>99%	Reduces menstrual cramps and symptoms of endometriosis; amenorrhea (no menstrual bleeding) in a group of users
Female condoms	Sheaths, or linings, that fit loosely inside a woman's vagina, made of thin, transparent, soft plastic film	Forms a barrier to prevent sperm and egg from meeting	90% with correct and consistent use 79% as commonly used	Also protects against sexually transmitted infections, including HIV
Male sterilization (vasectomy)	Permanent contraception to block or cut the vas deferens tubes that carry sperm from the testicles	Keeps sperm out of ejaculated semen	>99% after 3 months semen evaluation 97–98% with no semen evaluation	3 months delay in taking effect while stored sperm is still present; does not affect male sexual performance; voluntary and informed choice is essential
Lactational amenorrhea method (LAM)	Temporary contraception for new mothers whose monthly bleeding has not returned; requires exclusive breastfeeding day and night of an infant less than 6 months old	Prevents the release of eggs from the ovaries (ovulation)	99% with correct and consistent use 98% as commonly used	A temporary family planning method based on the natural effect of breastfeeding on fertility
Emergency contraception (levonorgestrel 1.5 mg)	Progestogen-only pills taken to prevent pregnancy up to 5 days after unprotected sex	Prevents ovulation	Reduces risk of pregnancy by 60–90%	Does not disrupt an already existing pregnancy
Female sterilization (tubal ligation)	Permanent contraception to block or cut the fallopian tubes	Eggs are blocked from meeting sperm	>99%	Voluntary and informed choice is essential
Withdrawal (coitus interruptus)	Man withdraws his penis from his partner's vagina, and ejaculates outside the vagina, keeping semen away from her external genitalia	Tries to keep sperm out of the woman's body, preventing fertilization	96% with correct and consistent use 73% as commonly used	One of the least effective methods, because proper timing of withdrawal is often difficult to determine
Fertility awareness methods (natural family planning or periodic abstinence)	Calendar-based methods: monitoring fertile days in menstrual cycle; symptom-based methods: monitoring cervical mucus and body temperature	The couple prevents pregnancy by avoiding unprotected vaginal sex during most fertile days, usually by abstaining or by using condoms	95-97% with correct and consistent use	Can be used to identify fertile days by both women who want to become pregnant and women who want to avoid pregnancy. Correct, consistent use requires partner cooperation.

SESSION 13 – PRECONCEPTION

KEY MESSAGES:

1. A woman's health is an important factor in the health of her baby, therefore women who are planning on getting pregnant should try to be as healthy as possible
2. There are certain things that are very dangerous during pregnancy including: drinking **any** alcohol, smoking, using drugs, drinking too much caffeine (found in coffee, tea, some sodas) and using some medications
3. It is also important for women who are planning on becoming pregnant or are already pregnant to have good nutrition to help her baby to develop well
4. Women should find out their HIV status before becoming pregnant

Importance of preconception care

Preconception is the time before a woman becomes pregnant, during this time women who are planning on becoming pregnant should think about ways to make sure they are as healthy as they can be so that their baby is able to grow and develop well. The health of a woman has a strong impact on the health of her baby. It is also important for women to consider the type of prenatal care (that is, care during pregnancy) available. Ideally, prenatal care should begin before a woman gets pregnant. If a woman is planning a pregnancy she should see her local health care provider for a check up, this can help to have a healthy pregnancy for both the mother and her baby and give them the best start in life.

Mothers who already have health conditions (e.g. diabetes, asthma, high blood pressure, heart problems, allergies, HIV, sexually transmitted infections and other illnesses) should talk to a health care professional about them as they may affect the pregnancy. In many cases, it is possible for mothers with health conditions to have very healthy pregnancies if they are able to get the right prenatal care. Women who are HIV positive can take medicines called ARVs to reduce the risk of transmitting the disease to their baby; this is why women should find out their HIV status before becoming pregnant. Prenatal care is associated with healthy mothers and babies and reduced infant and maternal mortality

Common signs of pregnancy

Women who experience the following signs should think about having a pregnancy test to confirm whether they are pregnant.

- Missed menstrual period
- Spotting and cramping: some women experience light blood spotting and stomach cramps around the time they become pregnant. This happens as the fertilized egg implants itself into the wall of the uterus.
- Nausea and vomiting, also known as 'morning sickness'
- Feeling much more tired than usual
- Sore breasts
- Headaches
- Stomach bloating
- Vaginal discharge without itching or burning

Unfavorable prenatal conditions

Women who are planning on becoming pregnant or are already pregnant should not do any of the following things are they can be very harmful to unborn babies.

Improper use of medication:

- Some medicines that are prescribed by doctors may be unsafe during pregnancy. Women should always tell their doctor if they are planning on becoming pregnant or have found out that they are pregnant

Drug use:

- Drugs contain substances that can harm the unborn baby and cause miscarriage and birth defects. It is best not to take any drugs, even in small amounts when you are planning on having a baby, are pregnant or breastfeeding

Smoking:

- Smoking while pregnant is very harmful to the baby; it can result in a range of problems including stunted growth, birth defects and low birth weight

Drinking alcohol:

- Drinking **any** amount of alcohol while pregnant is dangerous for the baby's health and may even result in miscarriage or stillborn babies.
- There are a number of conditions that may affect the baby including mental retardation, cleft palate, poor concentration and reduced cognitive abilities.

Presence of viruses:

- Viruses that infect the mother may be transmitted to the baby.
- Because babies are small and do not have well functioning immune systems, viruses canned be extremely harmful and even cause death in babies.
- If you are infected with a virus, it is best to seek treatment at a health care facility so that it can be treated

Infectious diseases:

- Some sexually transmitted diseases can be passed on to babies during pregnancy and birth. Some may even cause severe conditions such as blindness.
- With help from a health care worker you may be able to treat the infection and prevent it from harming the baby
- Other diseases can also be very harmful to babies as well and should be treated

Accidents:

- Women should take care and not take unnecessary risks, which may result in accidents while pregnant.
- Accidents such as falling can also harm unborn babies and even result in hemorrhage and miscarriage
- Some strenuous activities like heavy lifting may be more difficult for women when they are pregnant, in these cases women should find someone else to help them with the task so that they do not risk harming the baby

Nutritional deficiency

- During pregnancy and breastfeeding, women use a lot of energy and therefore need to have extra nutrients for her and her baby
- Pregnant women should try to get the best nutrition available (discussed in earlier sessions) and also increase the number of meals per day

- Undernourished mothers are more likely to have low birth weight babies, babies with lower IQ and poorer cognitive performance and babies who suffer from nutritional deficiencies themselves

SESSION 14 – PRE & POSTNATAL PRACTICES IN YOUR COMMUNITY

KEY MESSAGES:

1. Prenatal care, also known as antenatal care means care before birth, it can include health check ups, education, ensuring good nutrition, screening for diseases and treatment of conditions
2. Postnatal care means care after birth, it can include health check ups for mothers and babies, ensuring good nutrition
3. Babies are at highest risk of death in the first 2 days after birth, therefore postnatal care is very important
4. Low birth weight and premature babies are at the highest risk and should be looked after very carefully during the first **** of their life

What is prenatal care?

Prenatal care means care before birth, it can include health check ups, education, ensuring good nutrition, screening for diseases and treatment of conditions. The World Health Organization recommends that all women have at least 4 prenatal care check ups at health centers for each pregnancy. These visits should begin as soon as a woman finds out she is pregnant. These checkups can help to make sure the mother and baby are healthy, give the mother any necessary immunizations or medication, help the mother with any questions she has, manage any preexisting illnesses that the mother has so that the baby is healthy and help the mother to make a safe birth plan.

Prenatal care visits are also a good time for a woman to find out her HIV status if she does not already know. HIV positive women can be treated with antiretroviral (ARV) medications so that the chance of her passing the disease on to her baby is very low.

What is postnatal care?

Postnatal care is the name for the type of care a mother and her baby receive after giving birth. This type of care is important, particularly in the first two days after birth, as this is the most dangerous time for babies where complications can result of death. Ongoing postnatal care includes check ups to see if the baby is growing well and if the mother is recovering from the pregnancy and birth, to help the mother with any breastfeeding difficulties, to give the baby their scheduled immunizations, to make sure the mother and baby are getting the right amount of nutrients and to help mothers and families with any additional questions or health concerns.

Challenges to getting prenatal and postnatal care

- Cultural beliefs
- Financial constraints
- Lack of support from family members and the local community
- Distance to facilities
- Lack of knowledge about the type of care available and how to access it
- Untrained TBAs
- Finding someone to look after your other children while at appointments
- The news of a birth is sometimes kept confidential until all relatives have been informed, this can take some time and therefore may delay important postnatal checkups

NOTES:

SESSION 15 – BIRTHING

KEY MESSAGES:

- When you find out your are pregnant, it is important to start to think about giving birth and create a birthing plan for you and your family
- Women should attend at least 4 prenatal care check ups at a local health care center starting from when she finds out she is pregnant
- 85% of delivery complications cannot be predicted before birth, women who have normal pregnancies can still have difficult births
- 85% of delivery complications can be easily treated if they receive immediate attention from a trained doctor or midwife, it is therefore very important to try to give birth in a health facility or have the birth attended by trained health professionals

Making a birth plan

It is important for pregnant women to make a plan for the birth of their child. This plan should be discussed with other family members and health workers if possible so that they know what to do in the event of an emergency. It is important for women to decide on a place to give birth that is safe, secure and clean. A good supply of clean water and clean towels and sterile equipment to cut and tie the umbilical cord is also very important.

Pregnant women should also think about what they will do if an emergency happens and how they will get help. Birth complications can be hard to predict and can happen to women who have had healthy pregnancies. For this reason it is best if a woman can give birth in or near a health facility which has staff who are trained in how to help during an emergency. Health facilities with an operating theatre are the best type as they are able to perform a cesarean (C-section) operation if required. They are also more likely than smaller clinics to have blood supplies in case a transfusion is required.

Care of the newborn baby

There are some simple steps to follow to care for a baby once it has been born. By doing these in addition to breastfeeding, women can give their baby the best start in life.

- The baby's mouth and nose should be cleaned so that the air passage is clear. Check to make sure the baby is breathing easily
- The eyes should carefully be cleaned using a clean towel that has been dampened with safe water
- The umbilical cord should be cut using a sterile instrument and tied with sterile dressing
- This dressing should be changed each day until the cord dries up and falls off
- The baby should be weighed and examined carefully and then wrapped up to keep warm
- During examination the baby should be checked to make sure there are no abnormalities on the face, head, arms, legs, hands, feet, torso or back
- The genitals should also be examined; males should have both testicles present in the scrotum and the urethra opening should be unobstructed; for female babies, the urethra and vagina should be checked for obstructions
- Any abnormalities or complications following birth (for both the mother and the baby) should be immediately followed up in a local health center with trained health workers

Breastfeeding

It is recommended that the baby be put on the breast within 30 minutes of delivery so that breastfeeding can begin within the first hour after delivery. The first milk that a mother produces is called **Colostrum**. It is thick and often yellowish in color. This is a special kind of milk, which is essential for babies. It contains high levels of protein, special nutrients and antibodies. These antibodies protect newborn babies from sickness and diseases. Colostrum is also important to help the baby's digestive system to start working properly.

It is therefore **very** important that colostrum is fed to all newborn babies for them to be as healthy as possible. It also helps mothers to avoid conditions such as mastitis and sore breasts and makes sure that the mother is able to produce enough milk to feed the baby.

Babies should be fed on demand, that means that they should be fed whenever they are hungry, day or night. Mothers can tell that their baby is getting enough milk if he or she passes urine at least 6 times each day and if the urine is a light color.

NOTES:

SESSION 16 – INFANT ILLNESS & PREVENTATIVE HEALTH PRACTICES

KEY MESSAGES:

- Immunizations are an important way to protect babies, children and adults against certain diseases
- Certain immunizations are recommended for children and these are outlined on child health cards
- It is essential that children get each of the recommended immunizations, even if there are multiple immunizations for the same disease. Without doing this the child will not be protected from that disease
- Most illnesses can be treated if the child is taken to a health facility in time, it is important to know signs of a serious illness and when it is time to take the child to get medical attention

How illnesses spread

An infected person may have the virus or bacteria on their hands after wiping their eyes or nose, coughing or sneezing. These bacteria are then transferred to objects and surfaces, which they touch and may remain there for several hours. Germs and bacteria can be spread when infected people cough or sneeze without covering their mouth. Tiny droplets containing the virus or bacteria can travel through the air and infect people who are close by, or sit on surfaces and infect people who touch them. Illnesses, particularly diarrheal diseases, can also be spread through contaminated food, water and feces.

Prevention of illnesses

There are some simple steps that can help to prevent sickness and disease. By following these and helping your family and members of your community to also follow them you can help to stop the spread of illness.

1. **Hand washing**. Always wash hands thoroughly with soap and water before eating, before feeding anyone, before breastfeeding, before cooking or touching food and after using the toilet, after helping someone else to use the toilet, after touching animals, after touching rubbish, after changing diapers, after being around sick people and any other time that you feel your hands might have become dirty.
2. **Safe food storage and preparation**: Use the information that you learnt in previous sessions to prepare food in a safe and hygienic way.
3. **Sanitation:** always dispose of rubbish and feces and wash hands thoroughly with soap and water afterwards. Keep latrines clean and wash hands after use. Be particularly careful if you are looking after sick children or adults as diseases can be spread through feces.
4. **Immunizations**: make sure you and your children have received all recommended immunizations at a health center.

Here is the recommended immunization schedule for Ugandan babies:

Age of Child	Vaccine Name	Protects Against	How it is given
At birth	BCG	Tuberculosis	Arm injection
	Polio 0	Polio	Mouth drops
6 weeks	Polio 1	Polio	Mouth drops
	DPT-HebB-Hib1	Diphtheria, Tetanus, Whooping Cough (Pertussis), Hepatitis B, Haemophilus Influenza Type B	Thigh injection
10 weeks	Polio 2	Polio	Mouth drops

	DPT-HebB-Hib2	Diphtheria, Tetanus, Whooping Cough (Pertussis), Hepatitis B, Haemophilus Influenza Type B	Thigh injection
14 weeks	Polio 3	Polio	Mouth drops
	DPT-HebB-Hib3	Diphtheria, Tetanus, Whooping Cough (Pertussis), Hepatitis B, Haemophilus Influenza Type B	Thigh injection
9 months	Measles	Measles	Arm injection

5. **Medication**: if a doctor or health worker has given you medication to take it is very important that you follow the instructions carefully. Some medications like antibiotics need to be taken for several weeks, even if you no longer have symptoms of the disease.

6. **HIV Status**: get tested for HIV and take any prescribed antiretroviral medications to stay healthy and prevent transmission to children and other family members

7. **Indoor air pollution**: the smoke generated from cooking can be harmful, particularly for babies and children who do not have fully developed respiratory systems. Try to cook somewhere near a window or door, where the smoke can flow outside rather that stay inside the house.
8. **Healthy diet**: by having a healthy diet and good nutrition, the body is able to be stronger and can fight off illnesses. People who have poor nutrition are much more likely to get sick more often, take a longer time to recover and are more likely to die from illnesses.

9. **Early intervention**: if conditions are treated early, recovery is much more likely. It is important to know the signs on common illnesses and know when to take a child to a health clinic.

When to see a doctor

When a child becomes sick it is best to go to a health care center to see a doctor to make sure the sickness does not become serious. There are several signs of a serious disease; if a child displays any of these they should seek medical care at a health facility as soon as possible:

- Very high fever
- Dehydration after diarrhea or vomiting
- Bloody diarrhea
- White colored diarrhea that looks like the water that is cooked with rice (this can be a sign of cholera, a serious disease)
- Weight loss, failure to gain weight and malnutrition
- Discoloration of the mouth or lips
- Difficulty breathing or a rattling, rasping sound when the infant breathes
- Seizures or convulsions
- Refusal to feed and physical weakness

Oral rehydration Salts (ORS)

Diarrheal diseases are a common cause of death in young children. This occurs because excessive diarrhea and/or vomiting dehydrate a child quickly. This can often be exacerbated when safe water is not available. ORS can be added to water to rehydrate children and adults after periods of vomiting or diarrhea. ORS contain ingredients which help the child to become hydrated more effectively than if they were given water alone. If a family member becomes dehydrated following illness, it is important that they are given safe water to drink, with ORS added if possible.

NOTES:

SESSION 17 – POSTNATAL CARE & BIRTH SPACING

KEY MESSAGES:

1. Postnatal means the period of time from when a baby is born until it is 6 weeks old
2. During the postnatal period it is important that mothers and new babies are looked after properly as this is the time where they are most at risk from diseases and infections
3. Giving birth takes a lot of energy and new mothers need some time to recover and regain their energy
4. Families can help the mother to recover and care for the baby, if the mother is well looked after then she will be able to breastfeed well and take the best care of her baby
5. Child spacing means using family planning methods to prevent pregnancies that are close together, usually leaving a gap of 24months (2 years) or more between the birth of each child
6. Child spacing means that mothers have more time to devote to caring for each child and it also gives the mother's themselves a chance to recover from pregnancy, birth and breastfeeding

The postnatal period is the time from birth until the infant is 6 weeks old. This is the period where the mother and baby are at the highest risk of health complications. It is recommended that mothers be checked after birth as soon as possible, this is another reason why giving birth in a health facility is important. Three to four postnatal visits are recommended, 6 hours after delivery, 6 days after delivery, 6 weeks after delivery and 6 months after delivery. Visits during the first week are particularly important, as this is when infection typically occurs, both in the mother and the new baby. Doctors and health professionals can help to make sure the umbilical cord has been cared for correctly and has not become infected.

Postnatal care visits can help women and their families by checking that the mother is recovering, treating any complications, checking the health and development of the baby, helping the mother with breastfeeding, giving the mother advice on how to care for the baby and herself, helping the family to understand how to help the mother to care for the baby, helping the family to decide on family planning methods, providing immunizations for the baby and helping with any other health related questions the family may have.

In addition to postnatal care at heath clinics, there are some steps that mothers and their families should take to care for the mother and baby following delivery.

Looking after yourself and your baby after birth

Observation

- After delivery, the woman should be properly observed for signs of excessive bleeding which may indicate the retention of part of the placenta. Vital signs should be observed and any abnormality should be appropriately treated. The woman should also be observed for signs of early infection, which could be detected through raised body temperature.

Rest

- The new mother should be advised on the importance of adequate rest. This will help to enhance the fast recovery of the uterus and the rest of the woman's body. Rest is also important because of the vast amount of energy expended during pregnancy and birth and that will continue to be required during breastfeeding. Being well rested means that the mother will be able to give the best level of care to her new baby.

Early ambulation

- It is absolutely critical that if any complications occur before, during or after birth, the woman should be rushed to the nearest hospital or health facility. Many complications can be easily treated in a health center but may lead to death without proper treatment. The key is to take the woman to a health facility as quickly and safely as possible.

Physical care

- As always, good personal hygiene is important after birth. If possible women should have a daily bath, take good care of any cuts or lesions after the birth and make sure to change any used pads or wound dressings regularly. Women should not clean their breasts with harsh soaps or put any irritants (e.g. perfume) on their skin as this may be harmful to the baby. Frequent hand washing for all people who will come into contact with the baby, including the mother, is important to prevent the transmission of any illnesses.

Care of the cord

- The care of the baby's umbilical cord is important. It should be cut and tied with sterile (clean) equipment and cleaned after the baby is bathed and after each feed. Care must be taken not to infect the cord; it should not be touched unless the person has washed their hands with soap and water. Clean cotton wool and methylated spirits can be used to clean the cord and it should then be left uncovered to dry. The cord should not be tucked into diapers or clothes and powder should not be poured on it.

Drugs

- Women should not take un-prescribed drugs after delivery. If women experience pain they should check with their health facility about the best method of pain relief that will not interfere with breastfeeding or recovery.

Diet

- Good nutrition is important for women following delivery to help them recover and to enable them to breast feed well. Protein and iron rich food is particularly important to help replace any blood that was lost during delivery.

Feeding of the baby

- Exclusive breast-feeding is important for the baby's health as well as the mothers. Breastfeeding enables the uterus and the rest of her body to recover, as well as encouraging a strong bond between the mother and baby.

Immunizations and supplements

- As part of postnatal check ups at health centers mothers should consider whether they would benefit from any additional supplements (e.g. vitamin A, iron tablets) or immunizations (e.g. tetanus). During these visits women should obtain their child's health card, which will be useful during growth monitoring and immunizations.

Barriers to seeking postnatal care

- Women may not think that they need it, especially if they do not feel unwell
- The cost of appointments
- The location of health centers
- Long waiting times at health centers
- Women may not be aware of how to access a health center and organize postnatal care appointments
- Negative attitudes towards health care providers

- Women's tendency to give priority to the needs of their children and families rather than look after themselves

Benefits of child spacing

- Child spacing allows women to devote more time to looking after each child, giving each one the best start to a healthy life
- Pregnancy and breastfeeding place high demands on a woman's body, child spacing allows for time between births so that the mother can recover between pregnancies, maintain good health and have more energy
- Child spacing also allows mothers to give more attention to her older children and husband and help to ensure good health for her family
- Child spacing allows the new baby a longer time to breastfeed and grow strong and healthy and fight off illnesses
- If mothers have children very close together, they will become very tired and often malnourished and find it very difficult to care for so many small children. Her babies may also be born very small and be much more likely to get sick
- Birth spacing also allows families to invest more time and money in each child, making the child much more likely to be healthy and successful later in life

NOTES:

SESSION 18 – INFANT GROWTH MONITORING & PROMOTION

KEY MESSAGES:

1. Milestones are activities or skills that children achieve, for example, rolling over, walking, talking
2. Most children achieve milestones at certain ages, this gives a good indication that children are developing well
3. If a child is not reaching milestones or does so much later than other children it is a sign that they should be taken to a health clinic for a checkup to make sure they are healthy

Importance of growth monitoring

Healthy children grow and develop well, any signs of reduced growth may mean that something is wrong and the child may need to see a health care professional. Babies and small children should gain a certain amount of weight each month to be healthy; therefore, children should be weighed each month from birth until they are 2 years old to monitor their growth. If problems with health and development are noticed early, they are much easier to correct. Child health cards have a section for growth monitoring, it is important to make sure these cards are kept up to date.

In addition to growth milestones (e.g. children should be a certain height and weight for their age), there are physical milestones, which are helpful as indicators that children are developing well.

Physical milestones

Here is a guide to the developmental milestones that babies and young children should be reaching. All babies are different and some babies may achieve these milestones earlier than others, however if a baby has not achieved these milestones by the end of the age range (i.e. by 3 months for the 0 – 3 months category), it is a good idea to take them to a health clinic for a check up.

0 – 3 months

- The baby is able to life his or her head when they are lying on their tummy
- The baby can hold their hand in a fist
- The baby uses the sucking and grasping reflex

3 – 6 months

- The baby has become stronger and can roll over
- The baby can push themselves forwards
- The baby can reach out for objects
- The baby begins to explore their environment and enjoys noises like rattles
- The baby is attracted to bright colors
- The baby can sit up on their own or with a little support

6 – 9 months

- The child is becoming more mobile and can crawl
- The child can push and pull objects
- The child can pass objects from one hand to the other

9 – 12 months

- Some children can begin to stand with support
- The child may take their first steps

1 – 2 years

- The child can walk comfortably
- The child continues to push and pull objects
- The child can move to musical rhythm and moves around when music is played
- The child's hand eye coordination (e.g. picking up and moving objects, catching objects, kicking objects) continues to improve
- The child becomes more and more mobile

2 – 3 years

- The speed of the child's movement increases
- The child can jump with both feet
- The child can manipulate small objects with increased control (e.g. drawing)
- The child can draw a circle
- The child can run

Warning signs of developmental delay

There are some signs that children may have some sort of developmental delay. When considering these signs it is important to remember that they should be compared with the behavior of other children their age. For example it is normal for a 6-month-old baby not to be able to speak, however it is not normal for a 4-year-old child to not be able to speak. However it is important to note that if a child displays one or more of these signs, it does **not** mean that there is anything wrong with the child, it simply means that it should be discussed with a doctor or health worker to find out ways to manage the behavior or symptom. Some signs may be symptoms of problems that are very easy to manage, for example, if a child is not paying attention to what a parent is saying, it may not be that they are being disobedient, but they may have some difficulty hearing. It is important to remember not to get angry with children who may have developmental delays. The most important thing is to identify any signs and seek treatment as soon as possible. Early intervention is the best intervention.

Behavioral warning signs

- Child does not pay attention or stay focused on an activity for as long as other children of the same age
- The child focuses on unusual objects for long periods of time and enjoys this more than interacting with other people
- The child avoids eye contact with other people
- Gets unusually frustrated when trying to do simple tasks that most children of the same age can do
- Shows very aggressive behaviors towards adults, other children and animals on a regular basis
- Stares into space, rocks body back and forth or talks to themselves more than children of the same age
- Does not seek love and approval from caregivers or parents

Motor warning signs

- The child has stiff arms or legs
- The child has a floppy or limp body posture compared with other children of the same age
- The child uses one side of their body much more than the other side
- The child is very clumsy and has difficulty making smooth movements compared to children of the same age

Vision warning signs

- The child seems to have difficulty following moving objects with their eyes
- The child rubs their eyes frequently
- The child turns or tilts their head in a strained or unusual position when trying to look at an object
- The child seems to have difficulty finding or picking up small objects dropped on the floor (after the age of 12 months)
- The child has difficulty focusing or making eye contact
- The child closes one eye when looking at distant objects
- The child's eyes appear to be crossed, turned or looking in different directions
- The child has to bring objects very close to their eyes to look at them
- One or both eyes appears to be abnormal in size or coloring
- The child squints their eyes a lot when looking at objects

Auditory (hearing) warning signs

- The child talks in an abnormally loud or soft voice
- The child does not talk at all while other children their age do
- The child has difficulty responding when called from across the room
- The child turns their body so that the same ear is always pointing towards the sound
- The child has difficulty understanding what has been said or following directions (after 3 yrs. old)
- The child doesn't get startled to loud noises
- The child's ears seem abnormally small or deformed
- The child fails to develop sounds or words appropriate for their age

NOTES:

SESSION 19 – REVIEW

Pre-conception
What are the essential nutrients?
Name two the signs of pregnancy?
Name 3 reasons why it's important to know your HIV status before you conceive?
The care you receive when pregnant has no impact on your unborn child: TRUE or FALSE?
Name 1 food that is a good source of iron
Spinal bifida is caused by a lack of what nutrient during pregnancy?

HIV/ AIDS
Name the 3 causes of HIV
Name two preventive measures of HIV
How can an HIV+ mother transition from breast milk to solid feeds?
HIV can affect an unborn child TRUE or FALSE
How can mother to child transmission of HIV be prevented?

Family Planning
What is the importance of family planning?
Name two short-term methods of family planning
Name two long-term methods of family planning
A breastfeeding mother can use family planning TRUE or FALSE
Lactation amenorrhea can be used a dual method of family planning TRUE or FALSE

Birthing
Name 2 benefits of feeding your child colostrum?
When should your child be put on the breasts?
Name 2 major pregnancy complications
Name 1 unhealthy practice associated with the umbilical cord
Name 2 reasons it's important to go to the hospital after giving birth
Name 3 things you can do to prepare for giving birth

Postnatal and child spacing
How can child spacing be promoted?
How do you take good care of yourself and the baby after birth?
Name two consequences of not receiving postnatal care.
Importance of child spacing to family members
Name 2 services offered at the postnatal clinics.

SESSION 20 – GRADUATION