

THINKING HEALTHY

A TRAINING GUIDE FOR PSYCHOSOCIAL
MANAGEMENT OF PERINATAL DEPRESSION



Thinking Healthy. A training manual.

January 2023

IFRC Reference Centre for Psychosocial Support

c/o Danish Red Cross

Blegdamsvej 27

2100 Copenhagen Ø

www.pscentre.org

psychosocial.centre@ifrc.org

Twitter: @IFRC_PS_Centre

Facebook: www.facebook.com/Psychosocial.Center

© Copyright sign International Federation of Red Cross and Red Crescent Societies

Reference Centre for Psychosocial Support, 2023.

Contents of this training guide are used with permission and includes materials based on published WHO copyrighted Thinking Healthy Generic field-trial version 1.0.

Authors: Ahlem Cheffi and Sarah Harrison

Lay-out and illustrations: Laetitia Ducrot

Suggested citation: *Thinking Healthy. A Training Guide for Psychosocial management of Perinatal Depression*. IFRC Reference Centre for Psychosocial Support, Copenhagen, 2022.

Translations and adaptations

Please contact the IFRC Reference Centre for Psychosocial Support for translations and formats of *Thinking Healthy. A Training Guide for Psychosocial management of Perinatal Depression*. All endorsed translations and versions will be posted on the PS Centre website. Please obtain approval from the IFRC Reference Centre for Psychosocial Support if you wish to add your logo to a translated or adapted product. There should be no suggestion that the IFRC Reference Centre for Psychosocial Support endorses any specific organisation, products or services. If you wish to translate the document kindly add the following disclaimer "*This translation/ adaptation was not created by the IFRC Reference Centre for Psychosocial Support. The PS Centre is not responsible for the content or accuracy of this translation*".

ACKNOWLEDGMENT

The guide has been adapted following peer review sessions, face-to-face workshop and offline review. Special thanks to the following National Red Cross Red Crescent Societies, organizations and individuals for their expertise and contributions to the development of the Thinking Healthy training guide:

Ganna Goloktionov, Jesper Guhle, and Shona Whitton, IFRC Psychosocial Reference Centre.

Greisy Massiel Trejo Rodriguez, IFRC American regional office.

Louise Steen Kryger, Anouk Boschma and Asger Toft Johannsen, Danish Red Cross.

Arz Stephen and Anne Filorizzo Pla, Save the Children Denmark.

Esubalew Haile Wondimu, International Rescue Committee New York.

Developed through contributions from Nokia funding through IFRC Health and Care Department, Geneva

TABLE OF CONTENT

ACKNOWLEDGMENT	3
TABLE OF CONTENT	4
HOW TO USE THIS MANUAL.....	7
HOW TO PREPARE FOR THINKING HEALTHY TRAINING?	12

DAY 1

SECTION 1: STARTING THE TRAINING	22
SECTION 2: THINKING HEALTHY BACKGROUND	26
SECTION 3: PERINATAL DEPRESSION	29
SECTION 4: NEWBORNS DEVELOPMENTAL MILESTONES (BIRTH TO 1 YEAR)	36
SECTION 5: CLOSING OF THE DAY	37

DAY 2

SECTION 6: WHAT IS THINKING HEALTHY AND WHO IS IT FOR?	40
SECTION 7: THINKING HEALTHY TOOLS	42
SECTION 8: KEY ELEMENTS FOR THINKING HEALTHY	43
SECTION 8.1 Cognitive Behavior Therapy (CBT) used in Thinking Healthy	43
SECTION 8.2 Adapting the Cognitive Behavior Therapy (CBT) approach to mother and infant health in the perinatal period	46
SECTION 8.3 Thinking Healthy structure	46
SECTION 8.4 The three steps of Thinking Healthy.....	52
SECTION 9: PREREQUISITES TO BE PART OF THE PROGRAMME	56
SECTION 9.1 BASIC HELPING SKILLS	59
SECTION 10: CLOSING OF THE DAY	60

DAY 3

SESSION 11: SESSION 0: ENGAGING THE FAMILY AND INTRODUCING THINKING HEALTHY	63
SECTION 12: TASK 1: THE FIRST INTRODUCTION.....	64
SECTION 13: TASK 2: INTRODUCING THE 3 AREAS OF THINKING HEALTHY	66
SECTION 14: TASK 3: SHIFTING THE AGENDA OF THE FAMILY FROM PROBLEMS TO FINDING SOLUTIONS	67

SECTION 15: TASK 4: INTRODUCING THE BASIC PRINCIPLES OF COGNITIVE BEHAVIOR THERAPY (CBT)..... 68

SECTION 16: TASK 5: GROUND RULES FOR TAKING PART IN THE PROGRAMME..... 70

SECTION 17: TASK 6: THE HEALTH CALENDAR AND PRACTICE WORK..... 70

SECTION 18: TASK 7: IDENTIFYING A FAMILY MEMBER OR FRIEND TO ASSIST THE MOTHER 71

SECTION 19: TASK 8: EXPLAIN PRACTICE WORK BETWEEN SESSIONS 0 AND 1 71

SECTION 20: CLOSING OF THE DAY 73

DAY 4

SECTION 21: MODULE 1: PREPARING FOR THE BABY – PREGNANCY 76

 Session 1.1: Mother’s personal health 76

SECTION 22: BARRIERS THE MOTHER EXPERIENCE IN ACCOMPLISHING THE TASKS..... 82

SECTION 23: CLOSING OF THE DAY 82

DAY 5

SECTION 24: CARE PRACTICES IN MATERNAL, NEWBORN AND CHILD HEALTH..... 85

SECTION 25: THINKING HEALTHY IMPLEMENTATION PLAN 93

DAY 6

SECTION 27: SELF-CARE, PEER SUPPORT AND SUPERVISION 98

 27.1 Self-care and peer support 98

 27.2: Supervision 101

SECTION 28 ENDING THE TRAINING..... 103

ANNEX

ANNEX 1 - THINKING HEALTHY PROGRAMME COMPETENCIES 104

ANNEX 2 - REPLACING UNHEALTHY THOUGHTS 110

ANNEX 3 - PATIENT HEALTH QUESTIONNAIRE - PQ9 111

ANNEX 4 - EDINBURGH POST NATAL DEPRESSION SCALE (EPDS)..... 112

ANNEX 5 - DIET CUTOUTS SECTION 21 ACTIVITY 4 114

ANNEX 6 - AWARENESS RAISING/PSYCHOEDUCATION SESSIONS 115

ANNEX 7 - INTER-AGENCY REFERRAL FORM AND GUIDANCE NOTE 120

INTRODUCTION TO THE THINKING HEALTHY TRAINING GUIDE

From 2021, the IFRC Psychosocial Centre has been increasing its focus on mental health care and especially on community-based mental health care approaches including psychological interventions as part of a wider piece of work on Care in Communities - *IFRC Guidelines for National Red Cross Red Crescent Societies; A community health systems approach 2020*. [IFRC_CIC_Guidelines_EN_20200212_Web.pdf](#)

The Thinking Healthy training guide for community health workers and community level volunteers guides national societies and organizations in delivering community-based mental health and psychosocial support for mothers living with pre-existing and/or perinatal depression. Thinking Healthy is an evidence-based intervention for perinatal depression incorporating cognitive and behavioral techniques into community health workers' routine work. It is one of the largest randomized controlled trials for psychological interventions to be conducted in the developing world.

In 2015, Professor Atif Rahman and WHO developed the Thinking Healthy manual to support mothers with depression through evidence based cognitive behavioral techniques that are recommended by the mhGAP programme. The manual was developed in rural Pakistan and about 4000 pregnant women were screened to identify 903 with perinatal depression. Later, Thinking Healthy was applied in many other countries (Bolivia, Yemen, Nepal, Afghanistan). WHO, in collaboration with Prof Rahman and with the advice from an international group of experts, have produced a generic version of the manual for global use: [Thinking Healthy \(who.int\)](#)

This manual is the first volume of WHO's new series on low-intensity psychological interventions and to the best of our knowledge (and WHO's), there is no official training guide for Thinking Healthy.

With the agreement of WHO, the IFRC PS Centre have developed this official training guide and to share it within the Red Cross Red Crescent Movement and among other international actors, as an open resource.

“ Thinking Healthy Programme has been tried successfully in various settings across South Asia and has been adopted by the World Health Organization for global dissemination. The stage is set for all stakeholders to assist with the scale-up of this intervention to *reduce the suffering* of millions of women across the world. “ - Prof Atif Rahman, Thinking Healthy Programme. ”

HOW TO USE THIS MANUAL

This training manual is written as a guide for delivering 6 days of training on Thinking Healthy to community health workers. It aims to provide knowledge and skills on how to psychosocially manage perinatal depression and its negative impact on child development and mothers' Well-being in resource-poor settings through task shifting. In order to provide Thinking Healthy interventions, trainees will need to understand the different Thinking Healthy techniques to improve access to mental health care for women with perinatal depression by incorporating cognitive and behavioral strategies into community health workers' and volunteers' routine work.

The role of a trainer is to ensure that, after this training, participants:

- Are familiar with perinatal depression and its impact on mothers and newborns
- Master the Thinking Healthy sessions that combine cognitive behavioral therapy with activities to improve maternal well-being, mother-infant interaction and maternal social support

The participants may have different backgrounds as volunteers, staff, or managers. For this reason, trainers should use their judgement to adapt the training in a way that suits the educational and professional backgrounds of the participants. Trainers can, for instance, change the proposed schedule (the 'when'), and the suggested training methods for different activities (the 'how'). However, it is important that the content (the 'what') remains the same. The length of the training may vary depending on the needs and level of understanding of the participants. It is recommended that 16 is the maximum number of participants per training course.

This manual includes varied training approaches, including lectures, presentations, plenaries and active discussions, role plays, individual and group activities and information revision sessions. Thinking Healthy trainers may choose which approaches is preferred. However, it is recommended to regularly change the teaching approach to cater for all types of learners and keep the training active and interesting. Using more active forms of training, such as role plays, as this best facilitates learning.

To ease the delivery of training, the Thinking Healthy training manual includes pictorial reminders. For each section, you will find a table that includes **TOPICS**, which refers to topic covered and the section number; **TIME** which refers to how much time is needed; **WHAT**, which refers to the material needed for each module; and lastly, the **PURPOSE**, which refers to the objective of each training module.

SECTION COVERED	PURPOSE	TIME	WHAT
			

This training contains 28 sections:

- Section 1: Starting the training
- Section 2: Thinking Healthy background
- Section 3: Perinatal depression
- Section 4: Newborns developmental milestones from birth to 1 year old
- Section 5: Closing of the day
- Section 6: What is Thinking Healthy and who is Thinking Healthy for?
- Section 7: Thinking Healthy tools
- Section 8: Key elements for Thinking Healthy
- Section 9: Prerequisites to be part of the programme
- Section 10: Closing the day
- Section 11: The opening session (session 0): Engaging the family and introducing Thinking Healthy

INTRODUCTION

- Section 12: The first introduction (Task 1)
- Section 13: Introducing the 3 areas of Thinking Healthy (Task 2)
- Section 14: Shifting the agenda of the family from problems to finding solutions (Task 3)
- Section 15: Introducing the basic principles of Cognitive Behavioral Therapy (Task 4)
- Section 16: Ground rules for taking part in programme (Task 5)
- Section 17: Introducing the Health Calendar and practice work (Task 6)
- Section 18: Identifying a family member or friend to assist the mother (Task 7)
- Section 19: Explain practice work between sessions 0 and 1 (Task 8)
- Section 20: Closing the day
- Section 21: Preparing for the baby – pregnancy (Module 1; session 1.1)
- Section 22: Barriers the mother can experience in accomplishing the tasks
- Section 23: Closing the day
- Section 24: Care practices in maternal, newborn and child health
- Section 25: Thinking Healthy implementation plan
- Section 26: Closing the day
- Section 27: Self-care, peer support and supervision
- Section 28: Ending the training

The length of this training can vary depending on the needs of the participants and the requests for training. The preferred maximum number of participants per training course is 16. The person conducting Thinking Healthy training should have completed ToT training on Thinking Healthy. The training can be run in 6-days straight or in shorter blocks of 2-3 days.

DAY 1

TIME	SECTION COVERED
1h30	1. Starting the training
1h00	2. Thinking Healthy background
30min	Break
1h30	3. Perinatal depression
1h00	Lunch break
1h30	4. Newborns developmental milestones from birth to 1 year old
30min	5. Closing the day

DAY 2

TIME	SECTION COVERED
1h30	6. What is Thinking Healthy and who is Thinking Healthy for?
1h00	7. Thinking Healthy tools
30min	Break
1h30	8. Key elements for Thinking Healthy
1h00	Lunch break
1h30	9. Prerequisites to be part of the programme
30min	10. Closing the day

DAY 3

TIME	SECTION COVERED
30min	11. The opening session (session 0): Engaging the family and introducing Thinking Healthy
30min	12. The first introduction (Task 1)
30min	Break
30min	13. Introducing the 3 areas of Thinking Healthy (Task 2)
30min	14. Shifting the agenda of the family from problems to finding solutions (Task 3)
30min	Break
1h00	15. Introducing the basic principles of Cognitive Behavioral Therapy (Task 4)
1h30	Lunch break
30min	16. Ground rules for taking part in programme (Task 5)
30min	17. Introducing the Health Calendar and practice work (Task 6)
30min	18. Identifying a family member or friend to assist the mother (Task 7)
30min	Break
30min	19. Explain practice work between sessions 0 and 1 (Task 8)
30min	20. Closing the day

DAY 4

TIME	SECTION COVERED
1h30	21. Preparing for the baby – pregnancy (Module 1; session 1.1)
30min	Break
1h30	Continuation of section 21
1h00	Lunch break
1h30	22. Barriers the mother can experience in accomplishing the tasks
1h00	23. Closing the day

DAY 5

TIME	SECTION COVERED
1h30	24. Care practices in maternal, newborn and child health
30min	Break
1h00	Continuation of section 24
1h00	Lunch break
1h30	25. Thinking Healthy implementation plan
30min	Break
1h00	Continuation of section 25
30min	26. Closing the day

DAY 6

TIME	SECTION COVERED
2h00	27. Self-care, peer support and supervision
30min	Break
1h30	Continuation of section 27
1h00	Lunch break
1h30	Continuation of section 27
1h00	28. Ending the training

HOW TO PREPARE FOR THINKING HEALTHY TRAINING?

To help the training run smoothly, it is important to be well prepared. The following is a checklist of things to consider when preparing for the training.

VENUE

- Ensure access to the venue, including washroom facilities.
- Suitable temperature and lighting in training room with opportunity to darken room if using projector or screen.

SETTING UP THE ROOM

- Consider how to set up the room to encourage participation and comfort.
- Make sure there is enough space to conduct multiple role plays simultaneously (e.g. with small groups of participants), or additional rooms for people to use.
- Position a clock visible to all.

KEY POINTS FOR A THINKING HEALTHY TRAINING

- The trainer will need to obtain consent from the participants with regard to taking photographs, filming or posting on social media at the beginning of the training. The date and place where consent was given by a participant needs to be documented, and if oral consent is given there needs to be a witness and the trainer needs to document the name and contact information of the witness. The consent form should also state the purpose of using the content, who will use it and for how long.
- At least two trainers are recommended to lead a training course. The person who is not facilitating should pay attention to participants who may need support.
- Do not spend more than 20 minutes talking or teaching at any one time. After 20 minutes, introduce a role play, activity or discussion.
- In the agenda 30 minutes are set aside to “close the day”. This is where the trainer has time to address questions that were left unanswered, ensure that all trainees are clear about their tasks for the next day and to get feedback on the day. A simple way to get feedback is to ask each participant to say one word, that expresses how they feel about the day or to briefly state what they are taking with them from the training today. The trainer may suggest ending each day with a ritual that is meaningful to the group. Use the same ritual throughout the training.

- The time spent on each activity will largely depend on the group (e.g. size, how talkative they are, how quickly they learn the material and concepts)
- Avoid using complicated psychological terms as many participants may not understand these
- Use icebreakers and energizers as needed
- Preparation of snacks, water, tea and coffee or meals if these will be provided. Consider if you require an additional person to support you with this

In addition to the materials needed for delivering each section of Thinking Healthy, the trainer also include the following items:

- List of participants
- Consent forms on taking photos and videos
- Printed copies of the training manuals for trainers
- Printed and laminated flip cards or photos, illustrations, work sheets needed for each Thinking Healthy section
- Copies of the IFRC Minimum Standards for Protection, Gender and Inclusion in emergencies
- Pre/Post self-competencies assessment form
- Training evaluation forms

CONDUCTING ROLE PLAYS WHEN TRAINING ON THINKING HEALTHY

There are two types of role plays when training on Thinking Healthy. Use both types of role plays:

- **Demonstration role plays:** Trainers act as helper to demonstrate how to deliver Thinking Healthy
- **Active role plays:** Between training's participants

Case Examples are included for active role plays. Case examples must be adapted to suit the culture and social context. If training health workers supporting mothers in camps (refugees, IDPs, etc. develop a case story about the living condition in camps and/or for someone living in a displacement situation.

Demonstration role plays: It can be helpful to demonstrate a role play twice using the same case example, to demonstrate the differences between poor use of communication skills and good use of communication skills.

Active role plays: Encourage participants to take role plays seriously, as this will help other participants to learn more when they are, for example, playing the role of a health worker giving psychological first aid during Thinking Healthy intervention.

ROLE PLAY GUIDELINES

- No filming or photography unless participants give their oral/written consent to be filmed or photographed.
- Assign one person to take photos or film so that everyone stays focused on the role play
- Participants should not use their real names during role plays.
- Always ask participants who are involved in role plays if they are comfortable with the case example, story and role they have been assigned. No one should feel obliged to participate in a role play that makes them feel uncomfortable.
- Tell the participants that if, at any time, they feel uncomfortable in a role play they must raise their hands as a sign to stop the role play.
- End role plays as soon as you feel there are enough learning points to discuss.
- Participants who are not in a role play can be given the task of observing the role play and providing feedback after the role play ends, together with the trainers. If it relates to active listening for example, the observers can focus on listening, communication, and body language aspects.
- After each role play, the trainer must bring the participants back into a circle (standing or sitting) and “de-role”. De-role is a way to get people out of the roles they were playing. Ask each participant (one by one) to say: “My name is not (the name used in the role play), my true name is (real name of participant).” Then ask the participant to tap his/her shoulders with their hands and turn around once.
- The trainer begins the feedback session by reminding everyone how to give feedback (see below), stressing that this is a learning space, and we are not here to criticize, judge or evaluate people. Participants should accept feedback without defending themselves. Then, the trainer asks participants who were Thinking Healthy helpers in the role play to describe how they felt during it. After that, the trainer asks participants who were playing the role of “mothers” how it felt, and then the observers can give their feedback. Last, but not least, the trainers give their feedback.

FEEDBACK AND LEARNING

When providing feedback, as both trainers and participants, always follow these three steps, in this order:

- Give feedback on what went well
- Give ideas for the future on what could be done differently or improved upon
- Always end with overall positive feedback

WHAT MAKES A GOOD TRAINER FOR THINKING HEALTHY?

To help Thinking Healthy training run efficiently, it is important to be well prepared. Here are some important elements of the training to consider and address in preparation for Thinking Healthy training:

A good trainer will:

- Prepare well for every workshop
- Trust and believe in the abilities and capabilities of the participants
- Listen to understand, not to evaluate, judge or challenge what is being said
- Use active listening skills
- Include group members in discussions in a participatory approach
- Manage group processes
- Take responsibility for good, positive communication with the participants
- Be sensitive to unexpressed feelings
- Protect minority points of view
- Keep the discussion moving
- Use questions to explore deeper learning
- Limit their own contribution to make more time for others' participation
- Use appropriate language, posture, gestures and facial expressions
- Be flexible and responsive, adapting activities when needed
- Give emotional support within the group dynamic to reassure participants especially when dealing with sensitive issues, as is often the case when the training is about psychosocial support.
- Function less as a teacher (giving lectures) and more as a trainer
- A good trainer knows the geographical and cultural context:
 - The training should always be adapted to the specific geographical and cultural context
 - The trainer should know something about the psychosocial needs and programmes in the context where the training is taking place.
 - Relating the topics to participants' real life and work situations is essential when giving training in Thinking Healthy. It shifts the learning process from pure knowledge acquisition to the application of knowledge and the integration of skills.
 - Trainers should draw on their own professional experience and that of colleagues and local networks to make the training even more specific to the target group.

THE ROLE OF THE TRAINER

As a Thinking Healthy trainer:

- Improve the skills and knowledge of helpers so they can competently deliver Thinking Healthy
- Make helpers confident to deliver Thinking Healthy

By the end of the whole training, trainees might not feel completely confident in delivering Thinking Healthy intervention.

That's why it is important to emphasize on the importance of practicing the new Thinking Healthy skills in pairs (every day participants can sit together after the training) and completing all the home practice. The role is also to:

- Assess the trainees' competencies. You are highly recommended to use the Thinking Healthy competencies assessment tool from the WHO EQUIP programme. See annex 1
- Ensure that trainees have the right skills and understanding to be able to deliver Thinking Healthy effectively and in alignment with the protocol

As trainer, you are expected to develop a self- assessment form (with two columns: Initial and final) that you can distribute the first day of the training. During the "opening the training" session 20 minutes are given to fill the self-assessment form. They need to keep the form with them and the last day of the training (during "ending the training session) they are given 20 minutes to complete the final assessment part.

- Once you end the training, distribute the Thinking Healthy competencies assessment tool from the WHO EQUIP programme that you have completed throughout the training days. Sit with each participant 15 minutes for a feedback final session (focusing on issues trainees may need support to improve their skills or knowledge)

IMPORTANT NOTE

This feedback process will only work if there is a manageable number of trainees. That's why it is important to be two trainers. If, for any reasons there cannot be this level of support and feedback to trainees, seek alternative approaches. Supervision is highly recommended for Thinking Healthy helpers and as trainer encourage the trainees (future helpers) to advocate with their organization to get supervision. Supervision ensures that helpers are following the protocol for Thinking Healthy, they are using the newly learnt basic helping skills effectively and crucially supervision is a crucial component of well-being for future helpers.

BUDDY SYSTEMS

The trainer introduces the buddy system as a support system when training or working alone. The trainer can print this section on Buddy Systems and distributes the hand-out.

AIM OF THE SESSION

To introduce the buddy system set up and the three-phased model before, during and after or 'Are you ready, checking in and cool down' for buddy conversations.

The buddy system is an effective method where peers share in the responsibility for each other's safety and well-being. This type of active support is important in any workplace. Buddy systems can build resilience. There is safety in numbers. The term "buddy system" originated in the safety industry and has been used for the mutual safety of the partners in hazardous situations. This underlines the protective aspect of the buddy system.

Buddy systems build relationships between co-workers (on equal power level in the organization so not a manager or team leader and a team member), creates trust and understanding and makes it easier to speak your mind. Buddy systems develop confidence, as people are more likely to be innovative and creative if they have a support system behind them. If they have someone validating that what they are doing is right, and encouraging them to do their best, then they build more confidence in themselves.

In emergencies it can be useful to buddy an experienced staff member or volunteer with a newer member. It is important the more experienced one is supportive of the newer member and does not dominate. The buddy system can be adapted and used in volunteer organizations for more general and trust building peer support.

A recent scoping study underlined "To reduce the impact of traumatic exposures it is important to provide immediate practical support to those engaged in dealing with a trauma or disaster, and to ensure that emergency response staff are demobilized (such as standing down from 'combat-ready' status) at the end of each shift in order

to allow for emotional and mental processing of the event and time to promote self-care and recovery. Although debriefing is not designed to prevent or treat PTSD (Regal and Dyregrov, 2012; Ruck et al., 2013), the provision of an organizational early intervention following a traumatic incident meets several needs for leaders and their teams including: a) mutual support that is highly valued by workers, b) an opportunity to identify workers requiring clinical support, c) an increase in level of social cohesion, d) a reduction in harmful responses (e.g. alcohol abuse), e) a reduced level of sick-leave, and f) increased performance (Creamer et al., 2012).”

The scoping study also stressed how the buddy system can prevent stress in front line workers, as buddies know each other and can monitor the workload and stress reactions. The buddy system should be supported and endorsed by management, what is said should be confidential and buddy systems should never be mixed with appraisals. For training with a co-trainer its easier for them as buddies to show consideration for one another. When training with a peer, it’s easier to step in if already knowing where the other needs your support.

Trainer explains that throughout the Thinking Healthy training they will be using the buddy systems model. Trainer highly encourages the future Thinking Healthy helpers to implement the buddy systems in their work.

The buddy support or systems when implementing Thinking Healthy can be between for example pairs of community health workers or pairs of health volunteer. In this type of peer support, the relation is mutual as buddies as equals give and receive support. Buddy support can be a formal as well as an informal arrangement.

PHASES IN BUDDY SYSTEMS IN THINKING HEALTHY WORK TEAMS

The formalized approach helps buddies mentally prepare, check in, and defuse through the following three phases:

- **BEFORE:** Are you ready?
- **DURING:** Checking in
- **AFTER:** Cool down

BEFORE - ARE YOU READY?

Through explicit preparation buddies get ready for the Thinking Healthy assignment carried out in pairs or alone if a buddy is absent.

1. First buddies go over their mentally preparedness to handle what will happen and agree what they are to do.
2. Next, they clarify if they need to park worries or if there are practical issues, they need to finalize that would otherwise occupy their minds.
3. They need support from each other during the assignment.

If responding in a crisis, they talk over, what they can expect to meet during the task. They discuss a plan A and plan B.

ARE YOU READY FOR THE DAY?

Example of questions

- How are you today?
- Is there anything that prevents you from being fully mentally present today?
- What do you expect to get out of today?
- What can you do to get the most out of the work today?
- Do you need any support from me today?

DURING: CHECKING IN

During intense or emergency work it is important to include a check in phase. When the level of arousal is high in times of intense and distressing workload, the practice of checking in is important to ensure volunteers take time out to breathe, take care of themselves, economise with their mental resources, as all of this can ensure they keep the focused and have an overview of their work.

CHECKING IN

Example of questions

- How are you doing?
- Did you eat, drink, and have breaks?
- Did anything happen, we should talk about?

AFTER: COOL DOWN

During the cool down phase, buddies finish the assignment by talking it over. They share how they are doing, and the first impressions of how it went. Next, the cool down is part of information and learning sharing. Finally, it marks the end of the assignment, a transition to the rest of the day and is used to share plans for restitution.

ARE YOU READY TO END THE DAY?

Example of questions:

- How was the day for you?
- What was the most important learning of the day?
- Anything you need to put aside before moving on with the day?
- Any selfcare plans for the rest of the day?

DAY 1

SECTION 1: STARTING THE TRAINING

1.1 OPENING THE TRAINING

Trainer begins the training by warmly welcoming the participants and introduces the ice breaker game

- Pick a brick from a memory game. LOOK for your partner who has the same brick
- Ask buddy pairs to LISTEN to each other. What is your name?
- What is your position within your organization?
- Tell us something about yourself

Then, in the big circle each participant introduces his/her buddy by saying: *His/her name is...*, etc.

1.2. EXPECTATIONS

- The trainer asks the participants what their expectations of this training are. Ask each participant to write one expectation on a post-it note and then ask the participants to stick their expectations onto the flipchart paper that the trainer has prepared with the title "Expectations". Ask the participants to be specific (avoid statements such as: "*I am here to learn.*")
- Ask the participants to stick their expectations next to those showing similar expectations from other participants
- The trainer explains what the training will cover and what it will not

1.3 CREATING A SAFE SPACE (GROUND RULES)

- The trainer says: This is psychosocial training and we want to create an environment that is safe, inclusive and participatory
- In the plenary ask the participants to discuss and agree on ground rules that will ensure a safe, inclusive and participatory training course. Formulate the rules in a positive way, e.g. instead of writing *"Don't interrupt"*, you can write *"Listen to each other."*
- Write down the suggested ground rules mentioned by each participant (avoid duplication) and then ask everyone if they agree with them
- Write down additional rules that you as a trainer think should to be included and ask the group if they too agree, e.g. photos and videos cannot be shared on social media without the consent of the person(s) in the photos/video. Confidentiality is also an important ground rule
- A flipchart paper for "parking lot" will be hanged in the wall. Encourage the group to ask questions when they don't understand or place questions on the 'parking lot'.
- Inform the participants that if, at any point, they feel uncomfortable during discussions of potentially sensitive topics or role plays, they are welcome to leave the room or signal (agree on a signal with the participants) that they either wish to step out or remain present but refrain from participating
- Inform the participants that only those who attend each full day of training will be eligible to receive a training certificate
- Sign the photo consent

1.4 OBJECTIVES AND OVERVIEW OF THE TRAINING

Trainer explains that the Thinking Healthy training is about:

- Learning how to support mothers with perinatal depression with using cognitive and behavioural techniques
- Helps learning new skills for the psychosocial management of perinatal depression
- Importance of maternal and neonatal care

Trainer writes the agenda on a flipchart (the day before) and hangs it on the wall instead of printing out copies.

Trainer goes through the agenda and ends by saying to participants that question they may fall outside the range of this training or the topics being discussed can be put in the "parking lot" and the trainer will then address them at the end of each day or at the end of the training.

Trainer goes through the training agenda for day 1 and ensures that all participants are clear with it.

DAY 1

SECTION COVERED 	PURPOSE 	TIME 	WHAT 
<p>Section 1 Starting the training</p>	<p>To welcome the participants and familiarise them with how to create a safe space, to understand their expectations of the training</p> <p>To understand the overall objectives of the training, its content, and schedule</p>	<p>9.00 – 10.30 90 min</p>	<p>Agenda, overview of training and training materials</p> <p>Flipchart papers, flipchart stand, markers, tennis ball, building bricks/blocks, post-it notes in different colours, pre- and post-test, consent forms, name tags</p>
<p>Section 2 Thinking Healthy background</p>	<p>To introduce the participants to the Thinking Healthy intervention</p>	<p>10.30 – 11.30 60 min</p>	
<p>Break 11.30 – 12.00</p>		<p>30 min</p>	
<p>Section 3 Perinatal depression</p>	<p>To enable the participants to understand perinatal depression</p>	<p>12.00 – 13.30 90 min</p>	<p>Diagram to show the mother and child interaction p35</p>
<p>Lunch break 13.30 – 14.30 Buddy check In</p>		<p>60 min</p>	
<p>Section 4 Newborn developmental milestones from birth to 1 year old</p>	<p>To enable the participants to understand the newborn developmental milestones from birth to 1 year old</p>	<p>14.30 – 16.00 90 min</p>	<p>Child developmental milestones chart or a poster p37</p>
<p>Section 5 Closing of the day and the Buddy talk: <i>Are you ready to end the day?</i></p>	<p>To ensure that all the covered topics to end the day are completed and well understood in a timely and organized manner</p>	<p>16.00 – 16.30 30 min</p>	<p>Wrap up Key messages and learning points of the day</p>

1.5 SELF-ASSESSMENT FOR THE PARTICIPANTS (SEE ANNEX 1)

Note: Pre and post self-assessment tools are recommended to be included as part of each implementation plan

Explains that a self-assessment form will be distributed, and the purpose is for each trainee to assess their own competencies. Each competency has observable behavioral indicators. Participants have to carefully read the indicators of each of the competencies and objectively value their level against each. The self-assessment form will support the participants' learning during the Thinking Healthy days. It will establish a baseline from which each can grow in knowledge, skills, and attitudes. By the end of the Thinking Healthy face-to-face training, they will have the opportunity to re-evaluate themselves against the same indicators.

Note to the trainer¹ : Assess competencies for delivering Thinking Healthy by measuring:

1. The helpers' attitude towards the skill(s)
2. The helpers' confidence in his/her skill(s)
3. The helpers' knowledge of the skill(s)
4. The helpers' knowledge on how to apply the skill(s)
5. The helpers' ability to perform the skill(s) in controlled settings
eg. pretend session with a person using the services
6. The helpers' ability to perform the skill(s) in real-world settings
eg. during regular job duties with real persons

Give participants 20 minutes to complete the self-assessment form. The final evaluation includes the initial self-assessment done by each individual and the final feedback informed by the team of trainers. The trainer's feedback to each participant will reflect the consensus opinion from all trainers involved in the training. Participants must self-assess their knowledge, skills and attitudes with the following:

- 1) I consider myself skilled
- 2) I need help to develop
- 3) Don't know - never needed to perform this skill, never been in a certain situation

The participants should fill up the form with their self-assessment in each of the competencies at the early stages and the end of the training. The rest will be filled in by the trainers team.

1. To know more, go to Ensuring Quality in Psychological Support (EQUIP) platform: Home | EQUIP (equipcompetency.org)

Here is an example of a self-assessment form. The trainer is in charge to develop a specific self-assessment form that fits with the training objectives.

Competency 1	Behavioural Indicator	First self-assessment	Final self-assessment
Competency 2	Behavioural Indicator	First self-assessment	Final self-assessment
Competency 3	Behavioural Indicator	First self-assessment	Final self-assessment

SECTION 2: THINKING HEALTHY BACKGROUND

ACTIVITY 1:

Before this lesson begins, the trainer prepares three flip charts, each one with the following question:

- **Flipchart paper 1:** What is Thinking Healthy?
- **Flipchart paper 2:** Why Thinking Healthy was developed?
- **Flipchart paper 3:** What are cognitive and behavioural techniques?

Ask the participants to move around the room and write answers on every flipchart paper. The trainer says that there are no wrong or right answers.

The trainer reads the answers and then, in plenary, gives some background on Dr Rahman's study that was developed and tested in rural Pakistan: Context of the intervention, little of history of the testing of 'Thinking Healthy' that has been completed. Trainer distributes the following text to the participants. They are given 10 minutes to read it and then, 10 minutes for questions and answers.

Atif Rahman, University of Liverpool & Alder Hey Children's Hospital, UK; Human Development Research Foundation, Pakistan, is the author of the original Thinking Healthy Manual. He prepared the first draft of the current WHO generic field-trial version for global use, which was adapted by WHO.

Thinking Healthy was developed based on research that was conducted in rural Rawalpindi for 5 years. This consisted of 3 phases. In the first phase, an epidemiological study was carried out to understand the stresses that mothers living in poor areas face and the impact of such stresses on the mother and infant. Over 300 mother-infant pairs were studied from the third trimester of pregnancy to one year after birth, using various interviews and questionnaires. An important finding was that about a quarter of the mothers suffered from depression shortly during pregnancy or in the first year after giving birth. The infants of these mothers had poorer growth and higher rates of diarrhoea compared to non-depressed mothers. In the second phase, smaller groups of mothers with depression and without depression were studied through focus-group discussions and in-depth interviews. The thinking styles of both groups of mothers were studied and the way they dealt with health problems was explored. The Thinking Healthy manual incorporates information obtained from these 2 phases of research. In the third phase, the manual was piloted to see if it was easily understood and found practicable by community health workers and mothers in rural Rawalpindi in Pakistan. Many improvements in language and presentation were carried out, before reaching its present form.

ACTIVITY 2:

Participants are divided in 3 groups and each group discuss one of the questions. In the plenary, groups will present the outcomes of their discussion:

Group 1: *How are mothers supported (during pregnancy or after giving birth) in your communities or countries?*

- Participants are encouraged to share the ways of helping a mother, during pregnancy or after giving birth, who seem to have lower energy and mood, sleeping and eating problems, etc.
- In plenary, trainers and participants share the local practices for supporting mothers, formal and informal supports. The answers can be used later during the session on referral mechanisms.

Group 2: *How people with mental health condition are perceived in your communities or countries? Especially women during pregnancy and after giving birth*

Participants are encouraged to talk about stigma. In plenary trainer says that according to the WHO definition "A stigma is a mark of shame, disgrace or disapproval, which results in an individual being shunned or rejected by others". Trainer explains that:

- Stigma towards people living with mental health conditions can cause isolation and protection issues.
- There are lots of myths and misconceptions about mothers' mental and physical health (especially during pregnancy and after delivering) that can lead to stigma and exclusion of women with mental health conditions.
- Stigma around mental health is a major cause of discrimination and exclusion of women in many contexts and prevents them from seeking help, hence their condition worsens.
- Stigma causes isolation and exclusion of mothers from their communities or families.
- To avoid stigma, women can be reluctant to seek support and treatment during their pregnancy or after delivering and tend to isolate themselves.

Group 3: *Why do we need an early mother and child health and care practices intervention?*

Ensure that the following key points are covered by the group:

- Prevention from development of mental health condition
- Reduction of symptoms of pre- and post-natal depression
- Less delayed growth and less risk of infant mortality
- Better overall social functioning for the mothers
- Increased rate of breastfeeding
- Mother's Well-being is important as poor mental health is associated with higher risks of obstetric complications on women
- Increased play-related activities with the infant

- Infant's less likely to be malnourished
- The first 2 years of life are critical. Nutritional and psychosocial deficits during this time can result in lifelong impairment and disability.

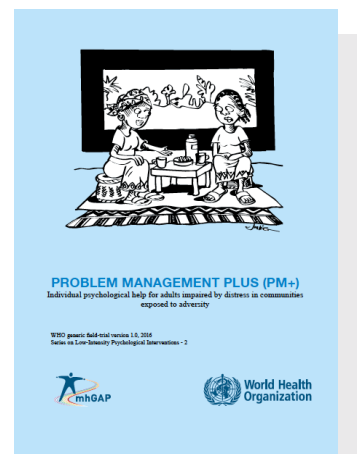
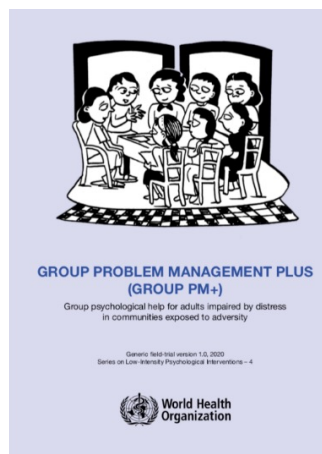
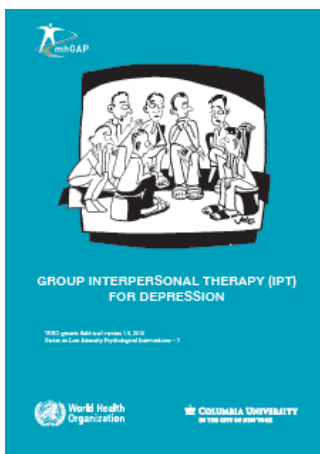
SECTION 3: PERINATAL DEPRESSION

Trainer explains that the WHO has developed a Guide for integration of perinatal mental health in maternal and child health services ² in 2022.

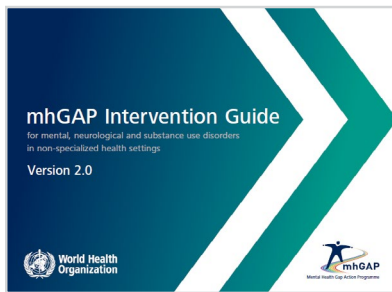
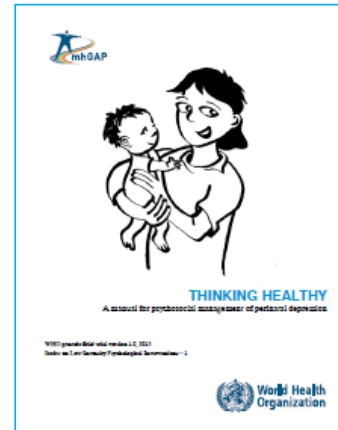
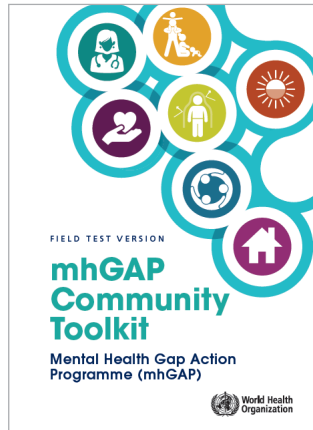
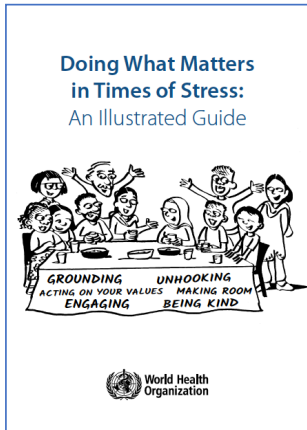
The aim of the guide is the integration of perinatal mental health in maternal and child health services. The guide outlines an evidence-informed approach describing how program managers, health service administrators and policy-makers responsible of planning and managing maternal and child health services can develop and sustain high-quality, integrated mental health services for women during the perinatal period. It brings together the best available evidence to support maternal and child health providers in promoting good mental health, identifying symptoms of mental health problems, and responding in a way that is adapted to their local and cultural context.

NOTE: Remind the participants that WHO has published manuals for the delivery of effective brief low-intensity and scalable psychological interventions. These interventions can be delivered by community health workers, volunteers, midwives, nurses and doctors. Some of the WHO interventions are:

- mhGAP Intervention Guide (about mental health conditions)
- mhGAP community Toolkit
- Thinking Healthy (for perinatal depression)
- Problem Management Plus (for depression, anxiety and stress for individuals)
- Group Problem Management Plus
- Group interpersonal therapy (for adults' depression)
- Self-Help Plus (on stress)



² WHO guide for integration of perinatal mental health in maternal and child health services.



Add that the recent WHO guide for integration of perinatal mental health in maternal and child health services needs to be read and understood to efficiently deliver Thinking Healthy intervention, especially the first session of the intervention.

ACTIVITY 1

Write: *“Thinking healthy: Psychosocial management of perinatal depression”* on a flipchart paper and highlight in a different colour the words PERINATAL DEPRESSION

Ask in plenary: What is perinatal depression? Write their answers on the same flipchart paper. read the list of answers, corrects them, if needed, and add:

- Mental health is often understood as a spectrum, ranging from good mental health to day-to-day struggles and more severe mental health and psychosocial conditions
- Depression is a health condition that negatively affects how we feel, the way we think and how we act
- A depression which begins during pregnancy and extends into the postnatal period is called perinatal depression
- Studies have showed that 1 in 5 women will experience a mental health condition during pregnancy or in the year after the birth

Trainer says the prevalence (how often this condition occurs in a general population) of depression is:

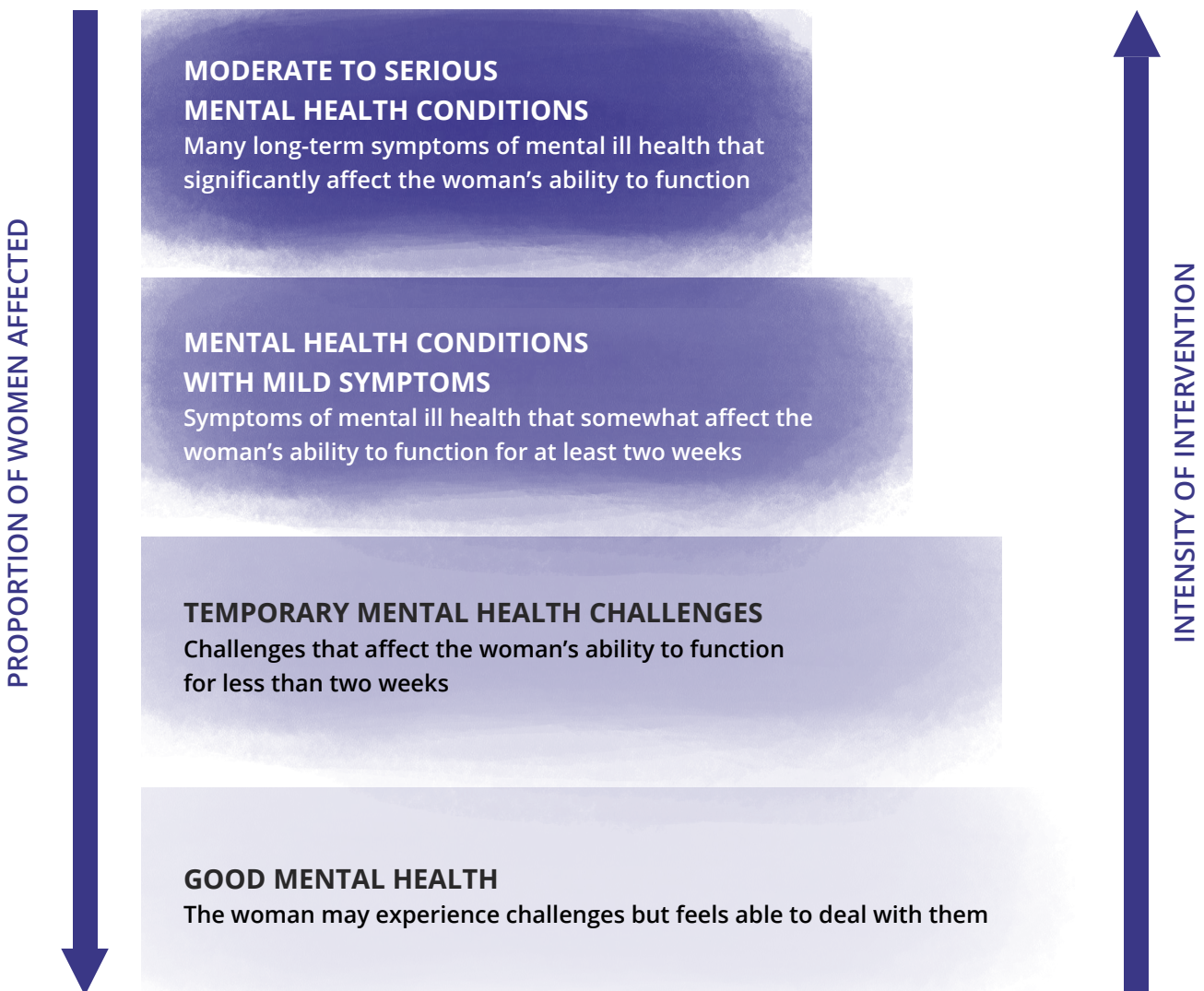
- **Globally:** 11.9% (Woody et al 2017)
- **High income countries:** 4% - 13% (Gavin et al., 2005)
- **Low-income countries:** 15% - 20% (Fisher et al., 2012)

Add different forms of maternal depression (OPTIONAL):

- Maternity blues: relatively mild and temporary that occurs a short period after giving birth
- Perinatal depression in relation to its severity, it lies somewhere between maternity blues and postpartum psychosis
- Post-partum depression with “psychotic features” - as post-partum psychosis can exist on its own with or without depression

ACTIVITY 2

Show the spectrum of mental health and related requirements for care from the *WHO guide for integration of perinatal mental health in maternal and child health service*.



Adapted from WHO guide for integration of perinatal mental health in maternal and child health service

Add:

- There can also be mothers living with chronic depression, who are pregnant and need to manage their depression through psychosocial interventions, instead of medication due to the potential harm to the baby whilst breastfeeding.
- Thinking Healthy helps also with chronic and pre-existing depression in mothers too that existed before pregnancy.
- Mention that the training will be focusing on perinatal depression and add that perinatal depression is a complex mix of physical, emotional, and behavioural changes that happen in a woman after giving birth. It is a form of major depression that has its onset within four weeks after delivery.

NOTE: Reference to other maternal health conditions, especially anxiety and trauma that are common in many contexts and key to understanding the difficulties some mothers face with attachment and bonding

ACTIVITY 3:

Divide the big group of trainees in 4 small groups, and each is given with a flipchart paper with one topic to reflect on:

Flipchart paper 1: **Determinants of perinatal depression**

Flipchart paper 2: **Symptoms of perinatal depression**

Flipchart paper 3: **Protective factors for perinatal depression**

Flipchart paper 4: **Impact of perinatal depression**

Each group will present its work and in plenary share the outcomes of their discussions.

NOTE: Show the icons on the next page after each group presentation.

- **Determinants of perinatal depression**

- | | |
|---------------------------------------------|---------------------------------------------|
| • Early pregnancy | • Poor nutrition |
| • Low income and social precarity | • Unwanted pregnancy |
| • Low educational opportunities | • Natural disasters |
| • Physical and mental health conditions | • Gender based violence and other conflicts |
| • Little or no social support | • Substance use |
| • Difficult birth and pregnancy experiences | |

• **Symptoms of perinatal depression:**

- Changes in appetite and sleeping pattern
- Fatigue, lack of energy and feeling tired most of the time
- Frequent mood changes, persistent sadness or low mood
- Loss of pleasure or interest, not showing interest and/or not interacting with the newborn child, etc.
- Feelings of worthlessness and/or hopelessness, helplessness and thoughts of death or suicide, thoughts or hurting self or someone else

• **Likely protective factors of perinatal depression:**

- Socio-economic factors (education, income-generation/ livelihoods)
- Interpersonal relationships, social support (family, community)
- Health condition and access to health facilities and access to information about pregnancy and childbirth experience



STRONG SOCIAL SUPPORT

Presence of caring family, friends and community



EDUCATIONAL OPPORTUNITIES

Possibility of attending and completing schooling



OPPORTUNITIES FOR GENERATING INCOME

Ability to pay for essentials



HIGH QUALITY MCH SERVICES

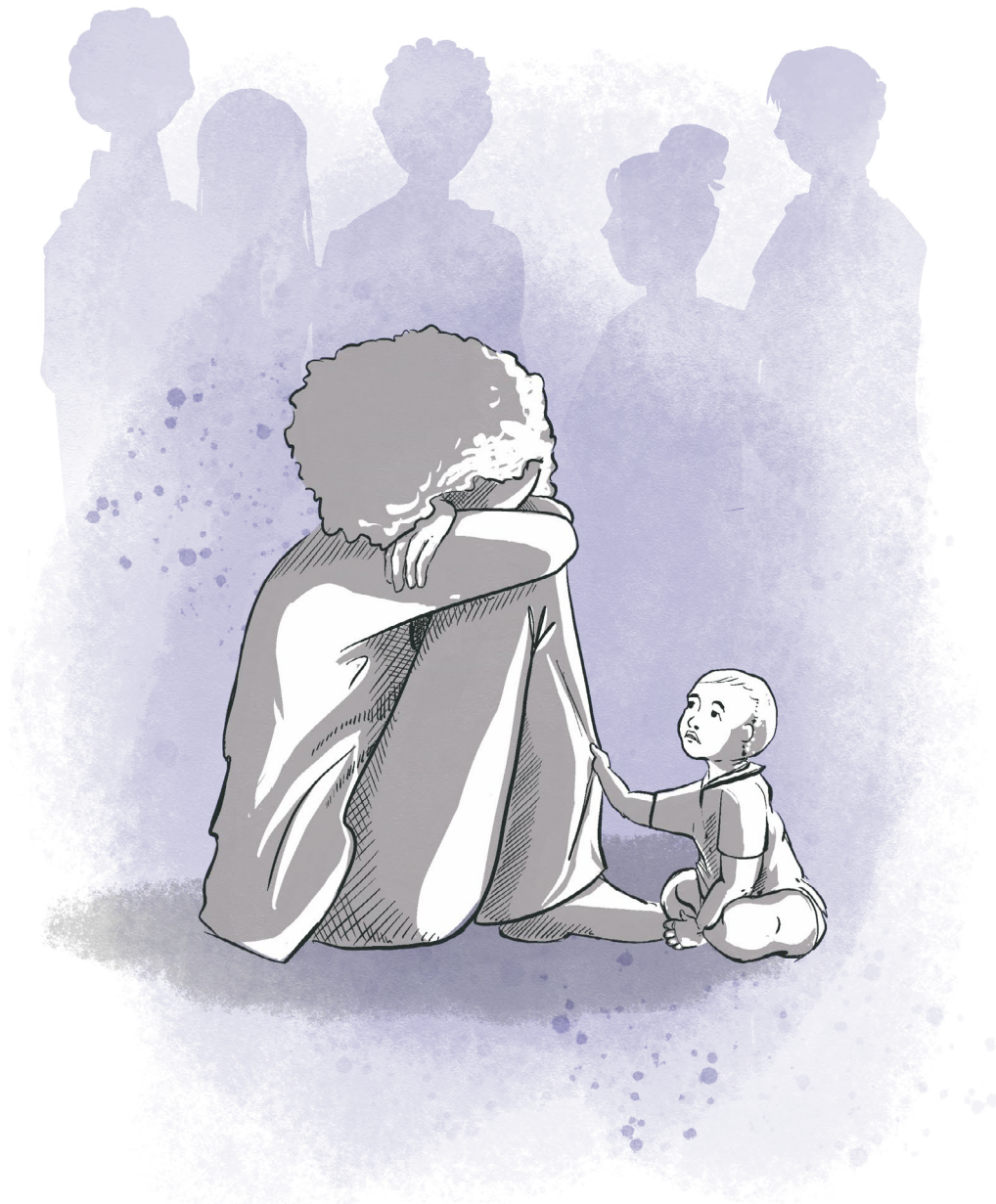
Empathetic, competent health care providers who treat women with respect and dignity



POSITIVE CHILDBIRTH EXPERIENCE

Feeling informed and able to make decisions

- **Impact of depression on the mother's well-being, mother-baby bonding and relationship with people around the mother**



ACTIVITY 4:

Role play where one participant plays the role of a health worker/community health volunteer and another plays the role of health manager. The health worker/ community health volunteer needs to convince the health manager that it is important to:

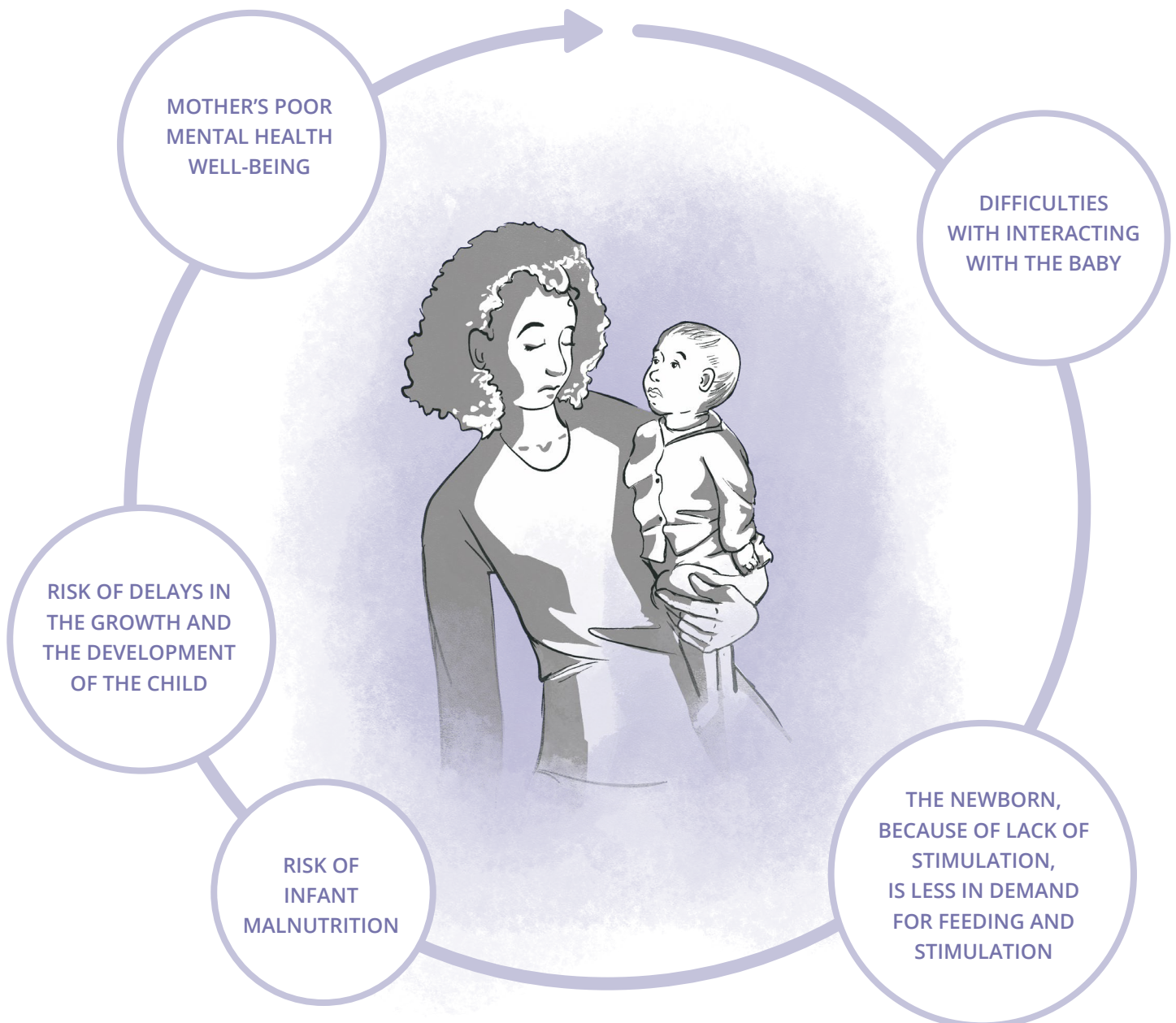
- Integrate perinatal mental health in maternal and child health service
- Manage perinatal depression

Ensures that all these elements are covered by the role players:

- Pregnancy, birth and early parenthood may be stressful because they may change women's identity, physical health and economic situation
- Perinatal anxiety and depression in the perinatal period are common, affecting an estimated

1 in 10 women in high-income countries and one in five in low- and middle-income countries (LMICs), indicating the importance of support for perinatal mental health globally

- Women who already have mental health problems may find that their symptoms worsen during the perinatal period. Others may experience poor mental health for the first time during this period
- Poor or lack of access to mental health care for women may lead to complications during pregnancy time (health issues like infection diseases, compromising the nutritional status of the mothers)
- Reducing mortality and morbidity of mothers is one of the key reasons we need to treat perinatal depression
- Mothers with mental health condition have difficulties with interacting with the newborn. The newborn, because of lack of stimulation, is less in demand for feeding and stimulation. This can lead to a risk of infant malnutrition and delays in the growth and the development of the child



SECTION 4: NEWBORNS DEVELOPMENTAL MILESTONES FROM BIRTH TO 1 YEAR OLD

ACTIVITY 1

Explain that the objective of this session is to understand the child's growth and development from birth to 1 year old.

Ask: Why is the first year of life important for a newborn's development?

Write all the answers in a flipchart paper and explain that early experiences make a difference in how young children's brains develop and can influence lifelong learning and health. Children reach milestones in how they play, learn, speak, act and move. All children develop at their own pace, but these milestones give a general idea of the changes to expect as the child grows.

ACTIVITY 2

Explain that developmental milestones fall into categories of development called domains. Divide the group into 4 small groups and ask each group to create a poster with a drawing of a newborn and the developmental competencies for each domain. Each group is given one domain or category of development.

Domain 1: Communication and language

Domain 2: Social and emotional

Domain 3: Cognitive development

Domain 4: Psycho-motricity, fine motricity and movement

In the plenary, each group presents its poster. Correct the answers and explain what developmental milestones are. Begin by saying that developmental milestones are things most children can do by a certain age. Skills such as taking a first step, smiling for the first time, and waving "bye-bye" are called developmental milestones. Children reach milestones in how they play, learn, speak, act, and move. You see children reach milestones every day. Though all children develop at their own pace, most children reach developmental milestones at or about the same age.

- **Communication and language:** This domain is about how children express their needs verbal and non-verbal, and share what they are thinking, as well as understand what is said to them.
- **Social and emotional:** This domain is about how children interact with others, form attachments, build relationships and show emotions.
- **Cognitive development:** This domain includes learning, thinking and problem solving. It includes how children explore their environment to figure things out – whether by looking at the world around them, putting objects in their mouths, dropping something to watch it fall, beginning to pass things from one hand to the other.
- **Psycho-motricity, fine motricity and movement:** This domain is about how children use their bodies and it includes crawling, beginning to sit without support.



0-2 MONTHS

- COPIES SOUNDS
- BEGINS TO SIT WITHOUT SUPPORT

3-4 MONTHS

- LIKES TO PLAY WITH OTHERS ESPECIALLY PARENTS
- RESPONDS TO OWN NAME

11-12 MONTHS

- SAY "MAMA" AND "DADA"
- PULLS UP TO STAND

5-6 MONTHS

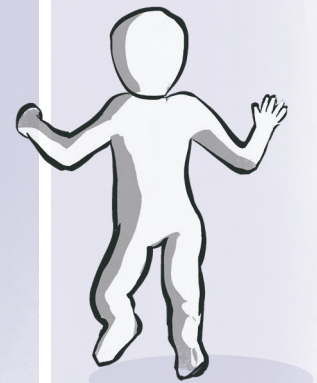
- STRINGS VOWELS TOGETHER WHEN BABBLING "AH", "EH", "OH"

9-10 MONTHS

- RESPONDS TO SIMPLE SPOKEN REQUESTS

7-8 MONTHS

- USES SIMPLE GESTURES SUCH AS SHAKING HEAD FOR "NO" OR WAVING "BYE BYE"
- COPIES GESTURES



Child developmental milestones

ACTIVITY 3:

Explain the hospitalism syndrome or maternal deprivation (Spitz, Bowlby) and emphasizes that hospitalism syndrome was recognized by WHO as adjustment disorder in the ICD-10, classification of diseases (AT f43.2)

Show one of these videos:

- <https://m.youtube.com/watch?v=aymvX-OrlS0>
- [\(16\) Still Face Experiment Dr Edward Tronick - YouTube](#)
- [16\) 1965. Effect of emotional deprivation and neglect on babies. Subtitled in English-YouTube](#)

SECTION 5: CLOSING OF THE DAY

- Passing a ball: Participants and trainers stand in a circle and everyone says one word about the day
- Trainer asks the group if there are any pending questions on the day's content and respond accordingly
- Trainer responds to any issues posted on the "parking lot"
- Trainer set out some home practice tasks for the evening. This home practice will be essential for trainers to reinforce learnings from each day

DAY 2

“ *Cognitive* aspect of Cognitive Behavioural Therapy in this intervention: Changing ways of thinking (mother’s thoughts, beliefs, ideas, and ways of directing her attention) — for the better

Behavioural aspect of Cognitive Behavioural Therapy in this intervention: Helping the mother make the link between unhealthy thoughts and emotions that can lead to unhelpful behaviors and guiding her towards healthy actions

Breaking the cycle of unhelpful cognitions or thoughts that is most likely leading to undesirable behavior

”

SECTION COVERED 	PURPOSE 	TIME 	WHAT 
------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------

8.30: Start the day with a recap

Ask participants to say one word that describes how they are doing this morning. Or say how they are doing today in the form of a weather report.

Could be participants say what they did the day before in a plenary brainstorm, one participant writes the statements on a card and then the cards are distributed, and the participants have to put the cards in order by standing in a line showing the order of yesterday's events.

Buddy talk: ARE YOU READY FOR THE DAY?

<p>Section 6: What is Thinking Healthy and who is it for?</p>	To enable the participants to understand the whole Thinking Healthy intervention and to whom it is addressed	9.00 – 10.30 90 min	<ul style="list-style-type: none"> Simple health calendar Mood chart; Diet chart; Rest and relaxation chart; Exercise chart; Relation with child chart; Sleep monitoring chart Poster with overview of Thinking Healthy Poster/diagram to show who would be involved in a Thinking Healthy programme (helper, supervisor, pregnant/ young mother, family etc.) Flip cards with illustrations on the vicious circle of perinatal depression
<p>Section 7: TH tools</p>	To be familiar with Thinking Healthy tools: reference manual, health calendar, activity workbooks	10.30 – 11.30 60 min	
<p>Break 11.30 – 12.00</p>			
<p>Section 8: Key elements for TH</p>	To understand the Cognitive Behavioural Therapy approach used in Thinking Healthy and learn how the intervention is structured	12.00 – 13.30 90 min	
<p>Lunch break 13.30 – 14.30 BUDDY CHECKING IN</p>		60 min	
<p>Section 9: Prerequisites to be part of the programme</p>	To enable participants to understand the admission process for Thinking Healthy intervention	14.30 – 16.00 90 min	
<p>Section 10: Closing of the day and the Buddy talk: ARE YOU READY TO END THE DAY?</p>	To ensure that all the covered topics are completed and well understood in a timely and organised manner	16.00 – 16.30 30 min	<p>Wrap up Key messages and learning points of the day</p>

SECTION 6: WHAT IS THINKING HEALTHY AND WHO IS THE INTERVENTION FOR?

ACTIVITY 1:

Write each statement on a piece paper and post them on the wall. Participants move around the training room and each is asked to pick 3 statements and explain in plenary what these statements mean:

- **Statement 1:** The Thinking Healthy manual is a supplement to the WHO mhGAP Intervention Guide. It was adopted by WHO as the first line of depression management during pregnancy
- **Statement 2:** Thinking Healthy should not be a stand-alone intervention but needs to be integrated into a holistic health and social services approaches that first and foremost addresses basic needs and care practices for the child and mother
- **Statement 3:** Thinking Healthy includes guidance on evidence-based interventions for mothers experiencing pre- and post-natal depression
- **Statement 4:** The Thinking Healthy strategies are tailored to individual needs of mothers and families
- **Statement 5:** It is delivered in health and social care settings by traditional birth attendants, Community Health Workers, Social Workers, Health Visitors, Nurses and Community Volunteers
- **Statement 6:** The approach used is simple and pictorial but retains the essential characteristics of Cognitive Behavioral Therapy. It has five modules covering the period from third pregnancy trimester to the first year of infant 's life
- **Statement 7:** Psychosocial interventions are the first line of management of perinatal depression during pregnancy and after delivery. Medication should be avoided as much as possible
- **Statement 8:** It involves delegating tasks to either already existing workforce as midwives, nurses, community volunteers, traditional health workers, social workers, health visitors, birth attendants, or creating a new cadre of workers (peer volunteers) through providing specific training for a particular task
- **Statement 9:** It incorporates general principles of care: empathy, clear and sensitive communication with the mothers and their families, mobilizing and providing social support
- **Statement 10:** It provides psychoeducation on stress, burden, childcare practices. Commonly understood terms are used instead of medicalized terms to avoid stigma
- **Statement 11:** It is delivered through a simplified form of therapy based on principles of Cognitive Behavioral Therapy (using pictures and structured activities)

- **Statement 12:** Reactivate social networks by involving family members
- **Statement 13:** It emphasizes the importance of the physical and psychological health of the mother
- **Statement 14:** It focuses on the health and psychological well-being of both mother and baby and encourages participation of the whole family.

ACTIVITY 2:

The trainer asks: Based on the previous discussions, what should be the ingredients of this intervention? Participants are divided into 6 small groups and each group to reflect on the following areas. Each group is given flipchart paper with the following titles:

- **Flipchart paper 1:** Psychosocial model
- **Flipchart paper 2:** Community-based
- **Flipchart paper 3:** Integrated
- **Flipchart paper 4:** Active and empowering
- **Flipchart paper 5:** Participatory
- **Flipchart paper 6:** Simple and practical

Ensure that the following elements are covered:

Psychosocial model:

- It moves away from the purely medical care model
- Depression is treated through a talking intervention with conversations with the mothers, and using a skills-building/ strengths-based approach rather than giving her pills or any kind of medicine
- It focuses on mother and infant well-being rather than maternal depression

Community-based:

- “Treat” or support the mother in the community or at home rather than at the health centre. This decentralised and community-based approach makes services and support more proximal to the mother and the infant and can help destigmatise any mental health and psychosocial support.
- It involves the whole household by using the infant’s health and well-being as common objectives: To engage families; to overcome stigma; to ensure support for the primary caregiver/the mother

Integrated: It is designed to be integrated into Maternal and Child Health Care Programmes in primary healthcare and nutrition programmes, and in social work outreach activities; routine care and *Thinking Healthy* can be delivered at the same time.

Active and empowering: It empowers and activates the mother to improve three key areas of her well-being (Personal health, Relationship with her baby, Relationship with people around her). It is active because mothers are not passive recipients of advice but actively participate in seeking and practicing health-promoting activities and in learning new skills (strengths focused).

Participatory: This intervention not only focuses on the mother but also includes all family members. It involves the whole household and cannot be practiced in isolation.

Simple and practical: It should be well structured and easy to follow, even by non-literate mothers. It should produce tangible results, which she can monitor easily.

SECTION 7: THINKING HEALTHY TOOLS

ACTIVITY 1:

Show the three tools. Trainees are with given 15 minutes to get familiar with the tools:

Reference Manual: gives clear step-by-step instructions to the health worker on how to conduct each session. It helps to explain the theoretical rationale of the intervention and serves as reference manual for the helpers.

Health Calendar: Serves as a visual for the mother and key supporting family members to follow the programme between sessions. It is used as monitoring tools that help the mother chart her own progress, also a tool for the helper to conduct the session in a structured way. A copy of the Health Calendar must be given to the mother in Session 0. The progress between sessions is discussed in the next sessions.

Activity workbooks: It is important for the intervention to be structured and standardized. Each of the 5 modules have a specially designed pictorial activity workbook that is used by the helper to conduct a session with the mother. Each mother will have her own activity workbook where activities carried out in each session will be noted.

NOTE TO THE TRAINER

Find the tools mentioned above in the WHO Thinking Healthy guide from p.134

SECTION 8: KEY ELEMENTS FOR THINKING HEALTHY

SECTION 8.1

COGNITIVE BEHAVIORAL THERAPY USED IN THINKING HEALTHY

ACTIVITY 1:

The trainer says: *Remember a situation or a difficult time you went through in the past and discuss how it made you feel, think what was going through your mind at that time? and act how it impacted your behavior?* Participants are encouraged to share only if they feel comfortable to do so.

NOTE TO THE TRAINER

This exercise can trigger emotional distress in some participants. You should consider the dynamics of the group and also warn participants that this activity is quite personal, and it is natural to feel a range of emotions.

ACTIVITY 2:

Ask if anyone is familiar with Cognitive Behavioral Therapy and in groups of 4, participants will discuss the following subject: *Cognitive Behaviour Therapy (CBT) as basis for Thinking Healthy intervention*. In plenary, trainer says that:

- Cognitions refer to our thoughts and behaviors refer to our actions
- Cognitive Behavioral Therapy is an evidence-based (coming from scientific research) and structured (step by step) form of talking therapy that aims to alter the cycle of unhealthy thinking (cognitions), leading to unhelpful emotions and the resulting undesirable actions (behavior)
- TH uses strategies (plans and activities) of cognitive behavioral therapy to contribute for a change in mothers' symptoms and functioning
- TH training does not make helpers CBT therapists. It only allows them to apply these strategies in their day-to-day work with women in the perinatal period
- Only a very basic understanding of Cognitive Behavioral Therapy is required by community health workers, social workers and community volunteers
- Shows the flip card (on the next page) and explains that:



Vicious cycle of perinatal depression

- Cognitive Behavioral Therapy is very effective in breaking this cycle in people with a number of problems such as depression, poor confidence, lack of assertiveness, inadequate coping skills, passivity and difficulty with relationships.
- The cycle is broken in two ways:
 - **Altering ways of thinking** — a mother’s thoughts, beliefs, ideas, attitudes, assumptions, mental imagery, and ways of directing her attention — for the better. This is the cognitive aspect of Cognitive Behavioral Therapy.
 - **Helping the mother meet the challenges and opportunities** of raising her baby with a clear and calm mind — and then taking actions that are likely to have desirable results. This is the behavioural aspect of Cognitive Behavioral Therapy.

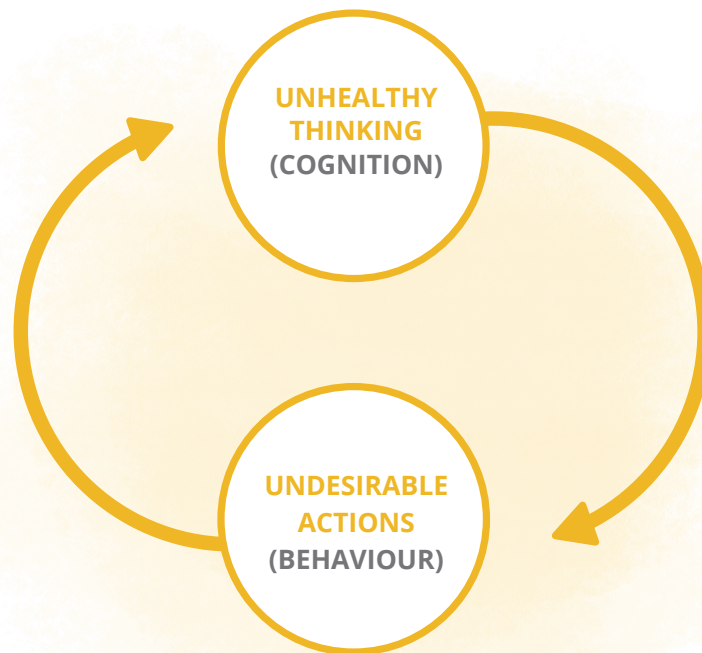
- Cognitive Behavioral Therapy provides clear structure and focus to dealing with health and psychosocial problems. Mothers take on valuable home practice / projects to speed up their progress. These assignments are developed as much as possible with the mothers' active participation) extend and multiply the results of the work done during a session
- One of the most powerful techniques in Cognitive Behavioral Therapy to change unhealthy thinking styles is imagery. The mother is asked to think of a picture in her memory that she thinks now was not helping her leading a healthy life by acting healthy. She is now asked to try to change the image: what would be a more helping thought to lead a healthier life?

ACTIVITY 3:

Show the cycle of unhelpful cognitions/undesirable behavior or actions and explain the cycle of unhealthy cognitions leading to undesirable behavior.

Explain that:

- Changing ways of thinking (mother's thoughts, beliefs, ideas, attitudes, assumptions, and ways of directing her attention) — for the better : the cognitive aspect of cognitive behavioral therapy
- Helping the mother make the link between unhealthy thoughts and emotions that are quite strong and can lead to unhelpful behaviors and then taking actions that are likely to be effective : the behavioral aspect of Cognitive Behavioral Therapy.
- Breaking the cycle of unhelpful cognitions or thoughts that is most likely leading to undesirable behavior.



The cycle of unhelpful cognitions (thoughts)
leading to undesirable behaviour

SECTION 8.2 ADAPTING THE COGNITIVE BEHAVIORAL THERAPY APPROACH TO MOTHER AND INFANT HEALTH IN THE PERINATAL PERIOD

ACTIVITY 4:

Trainees are divided in 3 groups and each group is given with 2 statements and reflect together on:

- Statement 1:** Thinking Healthy focuses on mother and infant health rather than maternal depression
- Statement 2:** Modified use of imagery in Thinking Healthy
- Statement 3:** Thinking Healthy is a training (focus on skill-building for the mother) rather than therapy
- Statement 4:** Thinking Healthy is family oriented
- Statement 5:** Thinking Healthy is developmentally appropriate
- Statement 6:** Thinking Healthy is culturally adapted

Trainees and trainer discuss them together (in plenary or in small groups)

SECTION 8.3 THINKING HEALTHY STRUCTURE

ACTIVITY 5:

The trainer goes through the timetable with the participants and recommends them to adapt it to their context of Thinking Healthy intervention

MODULES	SESSIONS	IDEAL FREQUENCY	APPROXIMATE PERIOD
Introductory session or session 0	Opening Session	Delivered in 1 or 2 visits	14 - 40 Weeks prenatal
Module 1 Preparing for the baby	Sessions 1.1 - 1.3	Weekly	14 - 40 Weeks prenatal
Module 2 The baby's arrival	Sessions 2.1 - 2.2 - 7	Fortnightly	3 rd to 5 th Weeks postnatal
Module 3 Early infancy	Sessions 3.1 - 3.3	Monthly	2 nd to 4 th Month postnatal
Module 4 Middle infancy	Sessions 4.1 - 4.3	Monthly	5 th to 7 th Months postnatal
Module 5 Late infancy	Sessions 5.1 - 5.3	Monthly	8 th to 10 th Months postnatal

Timetable of the thinking healthy sessions from the WHO Thinking Healthy Manual

NOTE TO THE TRAINER

If the mother has already given birth, then skip Module 1, or if the first interaction with the mother is later than just after birth, then adjust the intervention and start at the appropriate time (module 2, 3.).

“

Thinking Healthy:

- Focuses on mother and infant health rather than maternal depression
- Is a training that focuses on skill-building for the mother rather than therapy
- Is family oriented
- Is culturally adapted

”

THINKING HEALTHY STRUCTURE

The trainer presents how the Thinking Healthy intervention is structured and shows the chart below as well as the visual graphic on the next page.

THERE ARE 5 MODULES (=15 SESSIONS)

MODULE 1: PREPARING FOR THE BABY - PREGNANCY

Session 1.1: Mother's personal health

Session 1.2: Mother's relationship with the baby

Session 1.3: Mother's relationship with people around her

MODULE 2: BABY'S ARRIVAL - THE FIRST MONTHS

Session 2.1: Mother's personal health

Session 2.2: Mother's relationship with the baby

Session 2.3: Mother's relationship with people around her

MODULE 3: EARLY INFANCY - 2 TO 4 MONTHS

Session 3.1: Mother's personal health

Session 3.2: Mother's relationship with the baby

Session 3.3: Mother's relationship with people around her

MODULE 4: MIDDLE INFANCY - 5 TO 7 MONTHS

Session 4.1: Mother's personal health

Session 4.2: Mother's relationship with the baby

Session 4.3: Mother's relationship with people around her

MODULE 5: LATE INFANCY - 8 TO 10 MONTHS

Session 5.1: Mother's personal health

Session 5.2: Mother's relationship with the baby

Session 5.3: Mother's relationship with people around her

THERE ARE 3 AREAS

Each session covers one of these areas:

AREA 1: Mother's well-being

AREA 2: Mother-infant relationship

AREA 3: Relationship with people around the mother and infant

THE OPENING SESSION HAS 8 TASKS

TASK 1: The first introduction

TASK 2: Introducing the first area of TH

TASK 3: Shifting the agenda of the family from problems to finding solutions

TASK 4: Introducing the basic principles of Cognitive Behavioral Therapy that will be used in each session (done in 3 steps)

TASK 5: Ground rules for taking part in programme with 5 rules

TASK 6: Introducing the health calendar and practice work

TASK 7: Identifying a family member or friend to assist mother

TASK 8: Explain practice work between session 0 and 1

EACH SESSION IS DIVIDED UNTO FOUR TASKS

Sessions 1 to 15 are divided into four (4) tasks:

TASK 1: Review key messages from previous session

TASK 2: Review the mood chart

TASK 3: Conduct 3 steps to Thinking Healthy focusing on the area designated for the session

TASK 4: Explain practice work between sessions

3 STEPS

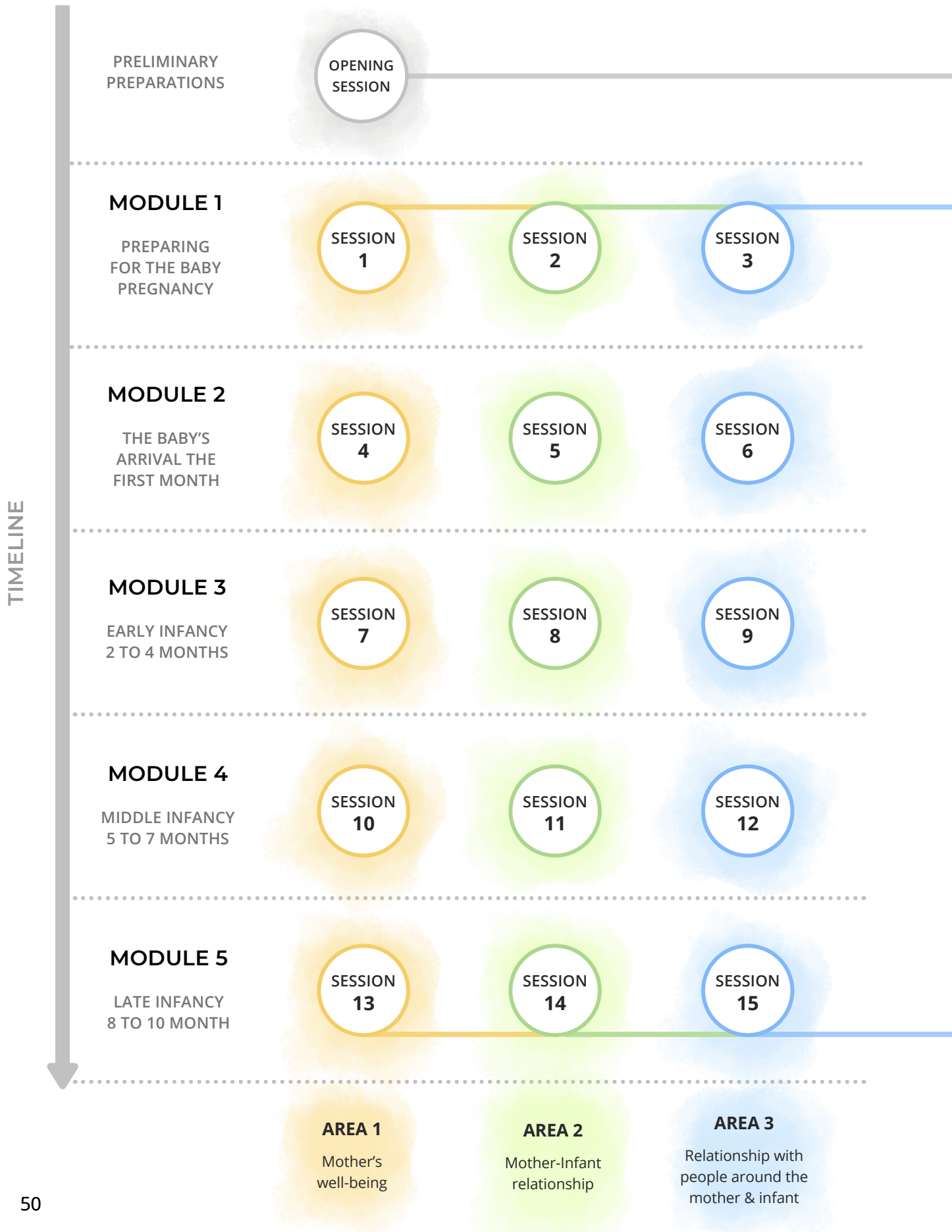
Each session incorporates the three (3) steps:

STEP 1: To identify negative thoughts

STEP 2: To replace the negative thoughts with constructive ones

STEP 3: To practice transferring positive/constructive thoughts into positive actions

SKELETON OF THE INTERVENTION



OPENING SESSION

- **TASK 1:** The first introduction
- **TASK 2:** Introducing the first area of TH
- **TASK 3:** Shifting the agenda of the family from problems to finding solutions
- **TASK 4:** Introducing the basic principles of Cognitive Behavioral Therapy that will be used in each session – done in 3 steps
- **TASK 5:** Ground rules for taking part in programme with 5 rules
- **TASK 6:** Introducing the health calendar and practice work
- **TASK 7:** Identifying a family member or friend to assist mother
- **TASK 8:** Explain practice work between session 0 and 1

STRUCTURE TO REPEAT FOR EACH SESSION

- **TASK 1:** Review key messages from previous session
- **TASK 2:** Review the mood chart
- **TASK 3:** Conduct 3 steps to Thinking Healthy focusing on the area designated for the session
 - **STEP 1:** To identify negative thoughts
 - **STEP 2:** To replace the negative thoughts with constructive ones
 - **STEP 3:** To practice transferring positive/constructive thoughts into positive actions
- **TASK 4:** Explain practice work between sessions

SECTION 8.4 THE THREE STEPS OF THINKING HEALTHY

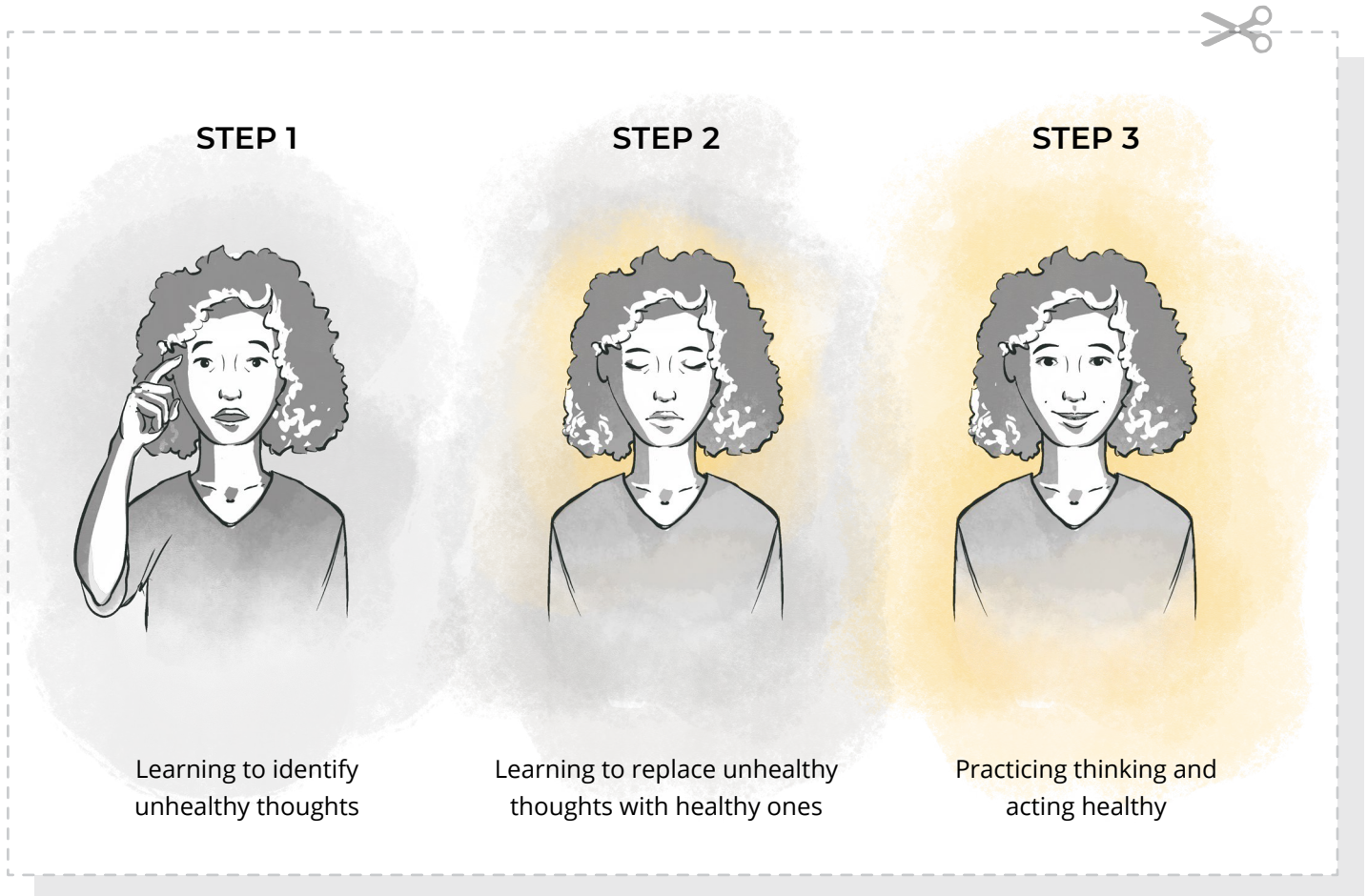
ACTIVITY 6

Ask the trainees to stand in an open space in the room. Say: Now we are going to speak about some common actions we use to cope with daily problems. Point to one side of the room and say if you think this is a helpful coping strategy, go to that side of the room. If you think this is an unhelpful coping strategy, point to the other side of the room and ask trainees to move to that side.

Explain that each Thinking Healthy session employs the three-step approach that is repeated throughout the whole intervention. The objective of these 3 steps: To promote positive psychological well-being, encourage healthy thinking and behaviours by the mothers

ACTIVITY 7

Trainer shows a flip card and explains the 3 Thinking Healthy steps.



How Cognitive and Behavioral Therapy approach is used in Thinking Healthy (see Annex 2)

ACTIVITY 8

Trainer shows the flip card on learning to identify unhealthy thinking and in plenary discusses the following steps:

STEP 1: Identification of negative thoughts

Objective of this step:

- Mothers are aware of their types of unhealthy thinking and unhelpful thinking styles – Psychoeducation on how to learn to identify them.

Unhealthy thinking styles	Typical thoughts
Blaming oneself if things go wrong, it's always your fault	If the child falls ill, it's always my fault, i'm not a good mother
Gloomy views of the future Believing or predicting that bad things are going to happen	Nothing can stop my children from getting diarrhea this summer
Mind reading Negative views of how others see you	Others think badly of me
Not giving oneself credit If things go well, it's luck or someone else's doing	It's only luck that my children are healthy
Thinking in extremes If things can't be perfect there's no point trying	As i am undereducated, i will never be a capable mother
Giving up before trying	I am no good at this

Table based on WHO thinking Healthy manual

ACTIVITY 9

Distribute one red coloured piece of paper and one green coloured piece of paper to each participant (or two different coloured pieces of paper). Read out the following statements one by one. If the participant thinks the statement is an unhealthy thought, they should hold up the red piece of paper. If the participant thinks the statement is a positive thought, they should hold up a green piece of paper. Follow this action for the full list and then discuss the results in plenary.

Note: If there is no access to paper, then one side of the room can be identified as negative/ unhealthy thoughts and the other side of the room as positive/ healthy thoughts. Instead of holding up pieces of paper, the participants can move to one side of the room after each statement is read out etc.:

<ul style="list-style-type: none"> • Nobody likes me or cares about me • I will not be a good mother • Yes, I can do it despite the challenges • I can't do anything to change my life • Yes, I can reply to my mother • I don't have time to care about my health 	<ul style="list-style-type: none"> • I am not feeling any bond or connection with my child • If I try, I can enjoy interacting with my child • I am a failure, I am a bad mother • It's my fault if my child is unwell
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Trainer shows the table in yellow above and explains the different unhealthy thinking styles:

- Blaming oneself
- Gloomy view of future
- Mind reading
- Not giving oneself credit
- Thinking in extremes
- Giving up before trying

Ask the participants to refer to the identified unhealthy thoughts from the previous exercise (here highlighted in bold) and to link them with these unhealthy thinking styles.

STEP 2: To replace the negative thoughts with constructive ones

Objective of this step:

- Mothers learn how to replace unhealthy thinking with healthy thinking.
- By identifying their proper unhealthy thinking styles this will enable mothers to examine how they feel and what actions they usually take when they think in this way.
- This step helps mothers to reflect on the accuracy of such thoughts and suggest alternative thoughts that are healthier.

ACTIVITY 10

Use the same unhealthy thoughts from step 1 (sentences above in bold) and ask the participants to pair. Each pair pick one sentence from the unhealthy thoughts. One participant act as a helper and the other one as a mother. Role plays should be conducted where the helper supports the mother to identify the unhealthy thoughts and replace them with healthy thoughts. Then switch roles.

STEP 3: To practice transferring positive/constructive thoughts into positive actions

Objective of this step:

- Mothers practice positive thinking and acting healthy
- Mothers turn constructive and healthy thoughts into positive and healthy actions
- Mothers receive health education and other materials tailored to their individual needs

The health chart is used here with activities and practice work to help mothers to practice thinking and acting in a healthy manner. The health chart assists the mothers in monitoring their progress and activities in between sessions

ACTIVITY 11

Read the following case story:

Mariam is a mother from the XXX district and is 7 months pregnant. She lives with her child and her mother. Mariam has had negative feelings for more than fifteen days, she has no desire to get ready, bathe and have breakfast with her child. Mariam has mentioned to her family several times *"Let me sleep, I don't want to think about my problems ..."*

A fortnight ago, her mother realized Mariam's emotional state and she suggested that she tell her midwife. Mariam thinks *"My mother is upset because I don't eat the food she prepares for me and, therefore, she wants me to talk to the midwife as punishment and that irritates me."* But her mother thinks that Mariam is not okay because when she gets upset she fights with her, does not eat, and wants to be in her room.

A demonstration role plays first done by the trainer with a participant to play Mariam: One participant acts as a helper and the other one as Mariam. Helper is helping Mariam to engage with healthy activities using the health calendar: Set tasks in collaboration with the Mariam and her family; Offer encouragement for even small steps that the mother takes. Mariam receives in step 3 health education and other materials tailored to her individual needs to help her progress between sessions.

Throughout the role play, trainer will observe how trainees (with the role of "helpers") use the three steps of Thinking Healthy.

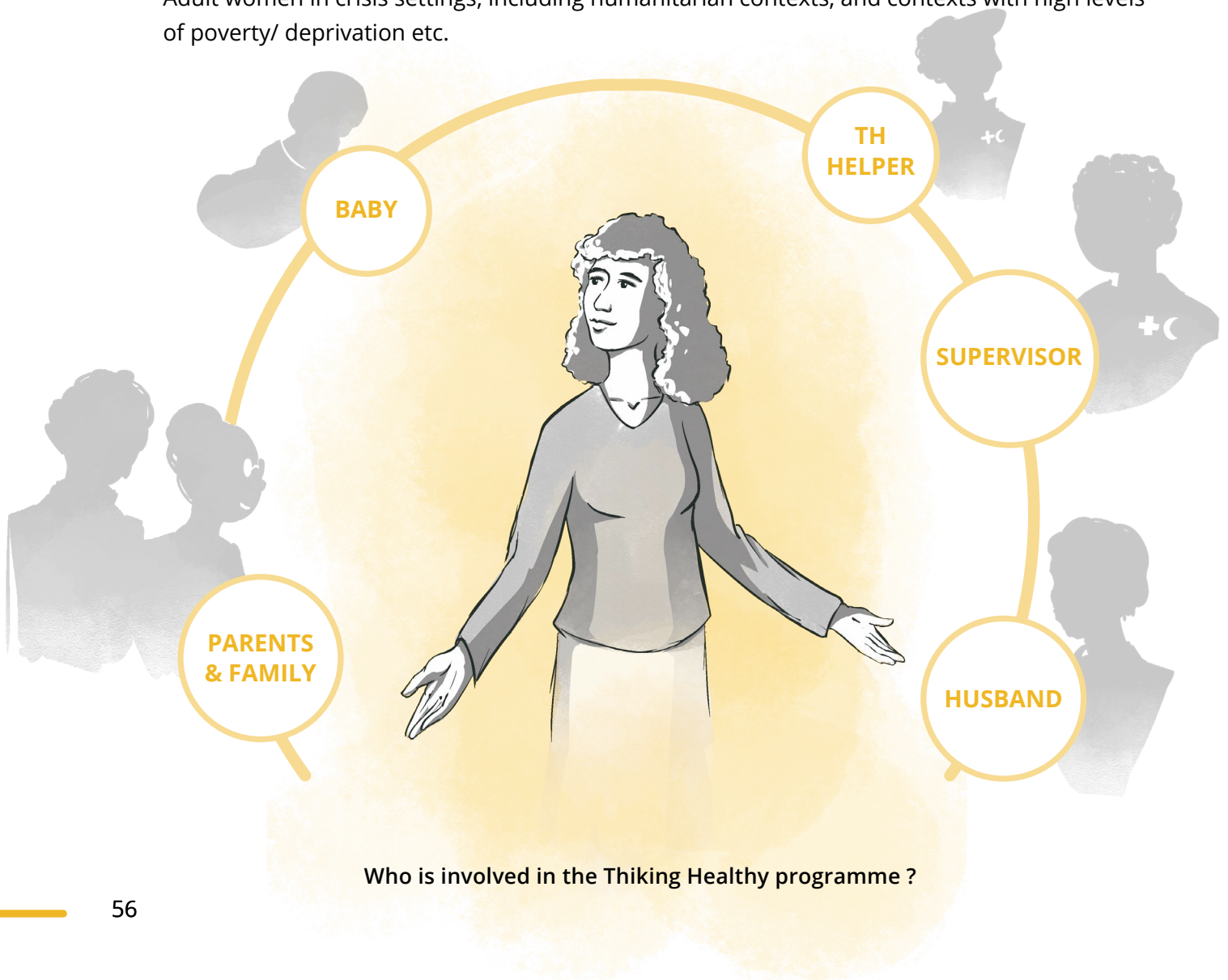
- The helper links the relationship between thoughts, feelings and behaviors of Mariam. The helper should remember to ask Mariam if she has had negative thoughts. Then, works with her to analyse the thoughts and the consequences that they can generate in emotion, behaviors and physically.
- The helper explains and practices the slow breathing technique and teaches Mariam simple steps to learn this technique. To do this, a comfortable place must be prepared, and a position found in which the mother feels relaxed. Tell the mother to close her eyes and begin to breathe slowly. She must inhale 3 times and exhale 3 times, causing her diaphragm to expand.
- The helper explains the mood chart and leave it as home practice for the next session and give an example of how to fill in the chart and checks if the mother understands the indications.

SECTION 9: PREREQUISITES FOR MOTHERS TO BE PART OF THE PROGRAMME

ACTIVITY 1:

Explain the following conditions to be part of Thinking Healthy and discuss in the plenary how the participants can address any challenges they think could arise related to these conditions. Inclusion criteria to be admitted:

- Have the time and ability to complete all sessions
- Pregnant woman (from month 4) and woman having delivered (lactating woman)
- Diagnosis of depression by a trained health worker in perinatal depression after a screening tool and conducting an interview with the patient
- Adult women of at least 18 years with ability to provide informed consent. An informed consent form should be developed by the organization
- Adult women in crisis settings, including humanitarian contexts, and contexts with high levels of poverty/ deprivation etc.



Who is involved in the Thinking Healthy programme ?

ACTIVITY 2:

Discuss the condition of the informed consent:

- To develop a standard document that will identify the aims of the programme; explain why women are selected and the length of the intervention
- It explains the importance of participation and attendance from the beginning to the end of the intervention and to respect the time assigned
- Importance of confidentiality and limits to confidentiality: if the helper believes the mother has plans to end their life in the near future or is a risk of hurting someone else, the helper must notify their supervisor, volunteer team leader and a medical staff member, regardless of whether the mother gives permission to or not
- Any other content discussed in the sessions must only be shared with others as family members, other health professionals, with the mother's permission
- Helper should ask permission from Thinking Healthy beneficiary for their supervisor to attend one of their sessions
- Remind the woman that the supervisor is bound by the same confidentiality requirements as the helper

ACTIVITY 3:

Go over the 3 options for admission. Divide the participants into three small groups. Each group reflects on one of the three options below and discuss the pros and the cons of the assigned option.

OPTION 1 FOR ADMISSION TO Thinking Healthy PROGRAMME: PHQ-9 screening tool (see Annex 3)

- Pregnant women visiting the health facility or women just having delivered (home visit), will have a doctor visit. After having the medical consultation, the nurse will receive the patient and explain she will ask some questions about her well-being and her baby's well-being
- The health worker then fill in the general information from the registration form.
Note: A registration form needs to be developed by the organization that is implementing TH
- The health worker will proceed to administer Patient Health Questionnaire 9 (PHQ-9 screening) tool. The PHQ-9 is available in many languages. Those who score 5 or higher will be admitted to the program. The result of the screening tool will be explained to the mother. Women who score positive in question 9 are deemed to be at risk will be referred to a doctor in order to receive the appropriate support.
Note: The organization implementing Thinking Healthy needs to have a referral form and the health worker needs to be trained on how to make safe referrals.
- Women who score 15 and above on the PHQ-9 and are not expressing suicidal thoughts will be referred to nurses or health worker trained on delivering the Thinking Healthy intervention.
- Women who score 15 and above on the PHQ-9 and who sign the consent form will be referred to nurses trained on delivering the Thinking Healthy intervention. They will start by conducting a small interview with sociodemographic information on the mother and child as well as a clinical assessment

Note: The information will be collected in the Thinking Healthy form needs to be developed by the organization implementing Thinking Healthy

- The helper starts session 0 to introduce the whole Thinking Healthy programme
- The health worker will close the interview and will provide a reminder form for next week's session.

Note: A reminder form with appointments, follow up, home practice, etc. to be developed by the organization implementing TH

OPTION 2: SAME STEPS AS THE PREVIOUS PROTOCOL EXCEPT FOR USING THE EPDS TEST INSTEAD OF THE PHQ-9 (see Annex 4)

- The Edinburgh Postnatal Depression Scale (EPDS) is a set of 10 screening questions that can indicate whether the mother has symptoms that are common in women with depression and anxiety during pregnancy and in the year following the birth of a child. This is not intended to provide a diagnosis – only trained health professionals should do this
- To complete this set of questions, the woman should select the number next to the response that comes closest to how they have felt in the past seven days. The total score is calculated by adding the numbers selected for each of the 10 items. If the parent's score is 10 points or above, they are admitted to Thinking Healthy programme

OPTION 3: COMMUNITY-BASED APPROACH AS AN ALTERNATIVE WAY TO RUN THE SESSION

- An awareness raising session in the community at health centre, mother-baby tent, health facility for all pregnant and new mothers and introducing session 0 with the 8 tasks: Doing session 0 as a group and not as individual home visit
- Then, in session 1, do the screening assessment tools. Admit to Thinking Healthy the programme the one whose score corresponds to depression

NOTE TO THE TRAINER

The three options for screening and admission to Thinking Healthy programme are suggested and each organization willing to implement Thinking Healthy can choose its own protocol. The tools can be found in the Annexes at the end of the document.

ACTIVITY 4:

Trainer and participants go through all the screening and assessment tools together and practice them on each other in pairs, with one playing the role of the helper and the other playing the role of the mother.

SECTION 9.1 BASIC HELPING SKILLS

ACTIVITY 5:

Explain that basic helping skills refer to the communication skills used to build a healthy relationship with those they support, which contributes to building trust and offer them support and comfort. Basic Helping Skills include verbal and non-verbal communication and should be the foundation of every session. Ask participants to give examples of basic helping skills. It is important that these elements are mentioned:

- Showing empathy
- Putting aside personal values and don't judge
- Not giving direct advice
- Validating mother's feelings and acknowledge how they are feeling, and any losses or important events they share with you, such as loss of home or death of a loved one. *"I'm so sorry..."*
- Stay near the person but keep an appropriate distance depending on their age, gender and culture
- Let them know you hear them, for example, nod your head and say... *"hmmmm."*
- Be patient and calm
- Provide factual information only if you have it. Be honest about what you know and what you don't know. *"I don't know but I will try to find out about that for you."*
- Give information in a way the person can understand - keep it simple
- Respect privacy. Keep the person's story confidential, especially when they disclose very private events. Respect privacy and keep the person's story confidential, as appropriate

ACTIVITY 6:

Hang two flipcharts up titled THINGS TO SAY AND DO and THINGS NOT TO SAY AND DO. In the plenary fill these and ensure the points below are covered.

DO's

- Be honest and trustworthy
- Try to find a quiet place to talk and minimize outside distractions
- Respect the mother's right to make their own decisions
- Be aware of and set aside your own biases and prejudices
- Make it clear to mothers that even if they refuse help now, they can still access help in the future
- Respect privacy and keep the person's story confidential, as appropriate
- Behave appropriately according to the person's culture, age, and gender

DON'Ts

- Don't pressure someone to tell their story.
- Don't interrupt or rush someone's story.
- Don't give your opinions of the person's situation, just listen.
- Don't touch the person if you're not sure it is appropriate to do so.
- Don't judge what they have or haven't done, or how they are feeling. Don't say... "You shouldn't feel that way." or "You should feel lucky you survived."
- Don't make up things you don't know
- Don't use too technical terms
- Don't tell them someone else's story
- Don't talk about your own troubles
- Don't give false promises or false reassurances
- Don't feel you have to try to solve all the person's problems for them
- Don't take away the person's strength and sense of being able to care for themselves

ACTIVITY 7

Role play in pairs: one participant (the mother) shares her problem with the other participant (the helper) who seems disinterested and not paying attention. Trainer asks the "mother" how she felt. Then, role play is performed again with the same people and the helper is listening with full attention. Discuss in the group the difference the "mother" felt in both situations.

SECTION 10: CLOSING OF THE DAY




- Passing a ball: Stand in a circle and everyone says one word about the day. Catch the ball, speak and then pass it on.
- Ask the group if there are any pending questions on the day's content and respond accordingly
- Respond to any issues posted on the "parking lot"
- Set out home practice tasks for the evening. This home practice will be essential for trainers to reinforce learnings from each day

DAY 3

“

The *mother-child* relationship starts during pregnancy where they *bond* and *interact*. The baby hears the mother's voice, her heartbeat and feels her emotions. The pregnant woman can feel her baby moving and its position touching her belly. That is why it is very important to pay attention to the feelings and emotional experience of a pregnant woman.

”

SECTION COVERED 	PURPOSE 	TIME 	WHAT 
------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------

8.30: Start the day with a recap

Write down the names of five different animals, one animal name/ piece of paper. Distribute the papers so that each participant has the name of an animal (they should be distributed discreetly so the participants cannot see what the other one has written on their paper). Ask the participants to make the noise of the animal written on their paper. They need to move around the room and find each other, by sound alone. Once they have found their animal group, they can discuss and reflect on the topics learnt over the previous day. What did they learn? What was new? What do they think was challenging?

Buddy talk: ARE YOU READY FOR THE DAY?

Section 11: The opening session (session 0): Engaging the family and introducing Thinking Healthy	The overall objective of the day is to enable participants to understand the opening session of Thinking Healthy and the 8 tasks	9.00 – 9.30 30min	Mood chart Picture A (Task 2), Picture A and B (Task 3), Picture D (Task 4), Pictures A, B, C D (Task 4), ground rules illustrations Health calendar
-------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------	----------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------

Section 12: The first introduction (Task 1)		9.30 – 10.00 30min	
----------------------------------------------------	--	-----------------------	--

Break 10.00 – 10.30

Section 13: Introducing the 3 areas of Thinking Healthy (Task 2)		10.30 - 11.00 30min	
-------------------------------------------------------------------------	--	------------------------	--

Section 14: Shifting the agenda of the family from problems to finding solutions (Task 3)		11.00 - 11.30 30min	
--------------------------------------------------------------------------------------------------	--	------------------------	--

Break 11.30 – 12.00

Section 15: Introducing the basic principles of Cognitive Behavioral Therapy (Task 4)		11.00 - 11.30 30min	
----------------------------------------------------------------------------------------------	--	------------------------	--

Lunch break 13.30 – 14.30 (1h00) Buddy checking In

Section 16: Ground rules for taking part in programme (Task 5)		11.00 - 11.30 30min	
-----------------------------------------------------------------------	--	------------------------	--

Section 17: Introducing the Health Calendar and practice work (Task 6)		12.00 - 13.00 30min	
Lunch break 13.00 – 14.00 (1h00) Buddy checking In			
Section 16: Ground rules for taking part in the programme (Task 5)		14.00 - 14.30 30min	
Section 17: Introducing the Health Calendar and practice work (Task 6)		14.30 - 15.00 30min	
Section 18: Identifying a family member or friend to assist the mother (Task 7)		15.00 - 15.30 30min	
Break 15.30 – 16.00			
Section 19: Explain practice work between sessions 0 and 1 (Task 8)		16.00 - 16.30 30min	
Section 20: Closing of the day and the Buddy talk: Are you ready to end the day ?	To ensure that all the covered topics to end the day are completed and well understood in a timely and organized manner	16.30 - 17.00 30min	Wrap up Key messages and learning points of the day

SESSION 11: THE OPENING SESSION (SESSION 0): ENGAGING THE FAMILY AND INTRODUCING TH

ACTIVITY 1:

Explain in the plenary:

- This introductory session has 8 tasks. It can be delivered in 1 or 2 home visits
- The purpose of this session is to engage the mother and family in the programme
- The approach and its components will be explained; as well as explaining to the mothers why they were selected and the length of the intervention
- The helper explains the importance of participation and attendance from the beginning to the end of the intervention
- The helper emphasizes why it is important to respect the time assigned
- The date and time are arranged between the mother and helper. It can be advised to create a routine by attending all the sessions the same day of the week at the same time

- Ground rules will be established for future sessions
- The required activities for the session will be carried out with small activities for the mother to practice at home in between sessions
- This session provides psychoeducation
- A standard document will be used to obtain informed consent

SECTION 12: TASK 1: THE FIRST INTRODUCTION

ACTIVITY 2:

Explain that in task 1 the **helper introduces the Thinking Healthy programme, the number of sessions and how they will be delivered**

Say: Let's imagine you are now implementing Thinking Healthy with a mother. Who can tell me in simple words what Thinking Healthy is? Play the role of the mother; some trainees can volunteer to play the role of the health worker administering TH. Trainees take turn and explain what it is. Next, the trainees practice 'the pitches' in pairs.

Then, trainer explains that now the **helper emphasises the importance of maternal psychosocial well-being:**

- **If the mother is pregnant:** The helper should explain that the mother-child relationship starts during pregnancy where they bond and interact. The baby hears the mother's voice, her heartbeat and feels her emotional condition. The pregnant woman can feel her baby moving and its position touching her belly. That is why it is very important to pay attention to the feelings and emotional experience of a pregnant woman.

The helper says that many expectant women, especially if they are in good health and with strong family support, find deep emotional satisfaction in their pregnancy. They feel happy and this can be seen in their faces and general health. After the delivery, internal and external emotions change rapidly and very often. The relationship with the family and the husband/partner/ father can change as well. This can impact women's feelings and make them worried about all the changes that might occur. However, in emergency contexts, crisis or adversity (to adapt according to the mother's context), the pregnancy is often a period full of emotional conflicts that can trouble the woman and family members, causing her to feel worried, tired, insecure or in doubt. Pregnancies in times of conflict exacerbate stress and anxiety and limits the capacity of a woman to relax as she may only focus on her fears, the most common are the fear of delivering a sick child, loneliness during the pregnancy and feeling that nobody understands her fears and that there is nobody to support her.

- **If the mother has already delivered:** The helper explains that breastfeeding does not only rely on physiological factors. There are various factors that can influence breastfeeding and the relationship between the mother and the newborn; some factors relate to the experience

of the pregnancy and others to physical or psychological factors, cultural beliefs, etc. It can take time and be difficult for some newborns and mothers. The helper reassures the mother that breastfeeding a newborn is a complex process and not a simple automatic one because some newborn can have more difficulties in suckling than others. It can also be the mother who has difficulty/pain/infections due to breastfeeding.

The helper makes the mother understand that some newborns are more active and initiate interaction with the caregivers and others less. Mothers have to keep in mind the child's uniqueness and that it cannot be compared with siblings. Each newborn has different needs and different demands.

ACTIVITY 3:

Participant practice in plenary or in pair this section: Explaining the aim of the intervention is about the well-being intervention for the mother and her baby

Explain that the helper needs to highlight the benefits of the programme for the baby:

The helper explains to the mother that newborns need a secure environment for their optimum growth and development. They also have emotional and psychological needs, such as the need for love, care, guidance and attention in addition to physical needs. Babies need to have a stable, interactive and warm relationship with their caregivers, physical protection and security within a stable family, community and social environment, structures and boundaries where the infant feels confident, and positive reinforcement when learning or interacting with the environment

Children with stressed or emotionally disturbed mothers face a greater risk of malnutrition and delayed growth and the risk of infant mortality increases because they will be interacting less with the mother and receive less feeding and stimulation. That is why it is important to support women after delivery and to be part of the Thinking Healthy programme. A lack of psychosocial stimulation has a big impact on children's development (cognitive, motor, language) and mental health. The first two years of life are critical. Nutritional and psychosocial deficits during this time period can result in lifelong impairment and disability.

The baby requires special care when it is in the mother's womb, and during the first year of life; therefore the mother is key to the infant's health and development during this period because her physical and mental health will determine how the baby will progress. The intervention will help the mother feel physically and emotionally well.

ACTIVITY 4:

Participant practise in plenary or in pairs: how to explain to the mothers the benefit of the programme to the child.

SECTION 13: TASK 2: INTRODUCING THE 3 AREAS OF THINKING HEALTHY



Introducing Thinking healthy to the mother

ACTIVITY 5:

Explain that helper will meet mother, baby and family 15 more times in the next year

Explain that the helper shows picture (flipcard) to mother and asks her to focus on image 1. Explain that mothers who are under stress often ignore their personal health, e.g., their diet and rest. Often, they do not have the energy or motivation to seek appropriate health or social care for themselves or their children. They get caught up in a cycle of inactivity, which further damages their health,

their mood and worsens their situation. Poor personal health increases the risk for low birth weight and other health problems in the infant. Therefore 5 out of 15 meetings will focus on the mother's personal physical and psychological health.

The helper asks the mother to focus on image 2 and explains that the quality of relationship between mother and baby is important for optimal health of both mother and infant. Aspects of this relationship include not just appropriate feeding but response to the infant's emotional needs, frequent physical interaction and creating a stimulating physical environment for the child. These activities make important contributions to the growth and well-being of the infant and young child.

Then, explain that the helper asks the mother to focus on image 3. The helper explains that the social network or support system available to the mother is important in determining the quality of care she is able to provide to her infant. Stressed or mothers living with depression often find it difficult to engage and maintain social networks. By losing out on this support, both mother and baby are at increased risk of stress and poor health. Therefore 5 out of 15 sessions will help the mother and family optimize the available support from her formal and informal networks.

Finally, explain that the helper has to ask the mother to focus on image 4 and to say that research has shown these 3 areas to be important for mother and baby's health and asks mother and family for their views and if they feel these areas are important. The helper asks if the family would like to know how this programme can help.

ACTIVITY 6:

Participants practise having the conversation between the helper and the mother in pairs, and then switch roles.

SECTION 14: TASK 3: SHIFTING THE AGENDA OF THE FAMILY FROM PROBLEMS TO FINDING SOLUTIONS



Shifting from problems to finding solutions

Explain that in this step the helper shows the mother, and the other family members, the two pictures for about 30 seconds and asks the mother which picture (left or right) she would prefer to be in. Almost always, mothers would prefer the picture on the right. Helper asks the mother the reasons for preferring the picture on the right and writes them on the activity workbook in the space provided.

The trainer explains that the helper hides the image on the left side and ask the mother about the image on the right side and ask what types of problems are there likely to be?

The helper adds that the image on the left shows a stressed mother who is weighed down by life's problems. Helper asks the mother if this is how she sometimes feels. Then, shows her the picture on the right side and asks her to note that the problems have not gone away. But the woman in the picture is up on her feet trying to balance life 's problems.

Explain that this programme has been designed to help mothers try to achieve this. It can help mothers and families to achieve better health for the mother and the baby. Life's problems will not go away but may seem more manageable after a while. The helper must give the mother time to look at the images. Don't be too directive. Give the women the opportunity to voice their opinions. Do not challenge at this stage. Listen sympathetically. Now ask the mother if they would like to know more about how the Thinking Healthy programme can help them achieve solutions.

ACTIVITY 7

Role play: The mother is refusing to take the intervention. The helper uses the basic helping skills and the three previous steps.

REMINDER NOTE: All mothers have the right to not take part in the programme. Mothers who do wish to be involved will not sign or formally give their consent.

SECTION 15: TASK 4: INTRODUCING THE BASIC PRINCIPLES OF COGNITIVE BEHAVIORAL THERAPY

ACTIVITY 8

Ask the participants to think about a problem they had to face in the past week and the way they felt and how they acted to respond to this problem.

State that the helper has to explain to the mothers that every action starts as a thought in our mind. The thought usually determines our feelings, actions and behaviour. The behaviour then has consequences. Add that stresses of everyday life, especially around pregnancy and birth, can affect the thinking styles of mothers, so that coping with life problems may seem difficult. These unhealthy thinking styles especially affect the three areas discussed, namely personal health, mother-baby interaction, and relationship with others. Help may be required when it becomes difficult to change

these styles of thinking, and the resulting feelings and behaviour starts to have undesired effects on these three areas. This programme can help mothers try to change these unhealthy styles of thinking and behaving into positive ones so that coping with life tasks, especially those of bringing up the baby, becomes easier.

STEP 1



Learning to identify unhealthy thoughts

STEP 2



Learning to replace unhealthy thoughts with healthy ones

STEP 3



Practicing thinking and acting healthy

How Cognitive and Behavioral Therapy approach is used in Thinking Healthy

After explaining the 4th task, the helper asks the mother and other family members if they have any questions and asks if they agree to take part in the programme. If yes, move to the remaining four tasks for this session. If they need more time to think about participating, end the session here and arrange another time to conduct the rest of the session.

ACTIVITY 9

Role play in groups of 3. Two practise introducing cognitive behavioral therapy; one observer gives feedback using ‘observed role play’ method. Next, rotate roles.

Note to the trainer: Trainer can use the WHO EQUIP Thinking Healthy programme competencies to assess skills and competencies participants (helpers) are acquiring and to see how they are putting them into practice.

SECTION 16: TASK 5: GROUND RULES FOR TAKING PART IN THE PROGRAMME

Explain that the objective of this task is to explain the rules that need to be observed by mother and family in order to take part in the programme. Here the helper goes through each of the rules (with accompanying picture) in the activity book and makes sure the mother understands and agrees.

ACTIVITY 10

Participants in a role play (groups of two) practise the four rules:

Rule 1: Active participation

The helper explains that the programme does not offer financial support or medical care but helps mothers to help themselves and their infants. In this sense it should be seen as a training programme. It can only succeed if the mothers actively participate, with the support of other family members.

Rule 2: Being on time

It is very important to make a commitment to the sessions and be available at the agreed time.

Rule 3: Practise the new skills you have learnt and activities in between sessions

Explain that practicing what is learnt in the sessions is an essential step. The mother should try, as best as she can, to practise the skills she has learnt by doing activities between the sessions. How she finds the activities and new skills are reviewed at the beginning of each session. Engage family members to support the mother to practise the skills and activities she has learnt

Rule 4: Tell your helper if you are unwell or have problems attending sessions

SECTION 17: TASK 6: INTRODUCING THE HEALTH CALENDAR AND PRACTICE WORK

ACTIVITY 11

Participants practise the following:

- Show the mother and family members the Health Calendar
- Explain that the pictures on the front will serve as reminders
- Monitoring charts will help mother and family monitor progress of the practice work between sessions
- It is important not to destroy or lose the Calendar

To make mother and family aware of the practical aspects of the programme; it is important to prepare a suitable environment for future sessions and introduce the family to the Health Calendar and monitoring instruments.

Explain that taking part in this ritual formally commits the mother and family to the programme. It also further reinforces the message that the programme requires the mother and family to be active participants rather than passive recipients.

ACTIVITY 12

Write in two flipchart papers:

- Introduction to the **Health Calendar**
- Designate an area as the **Health Corner**

And ask participants to move around and write on post-it notes what they understand when they read the following sentences (introduction to the health calendar and designate an area as the health corner). Then, explain:

Introduction to the Health Calendar:

Show the mother and family members the Health Calendar. Explain that the pictures in the front will serve as reminders of what was discussed in the first session while the monitoring charts will help mother and family monitor progress of the home practice in-between sessions. Explain it is important not to destroy or lose the Calendar, as at the end of the year, it will be a useful record of the mother and baby's health.

Designate an area as the Health Corner:

Ask the family to designate an area where the Health Calendar can be displayed. It should be an area that is visible but not accessible to younger children who might damage the calendar. This area would also serve as a resource where other health information could be kept for reference.

SECTION 18: TASK 7: IDENTIFYING A FAMILY MEMBER OR FRIEND TO ASSIST THE MOTHER

ACTIVITY 13

Participants practise in groups of two:





Helper asks mother to designate one or more persons in the family who can assist her with activities and home practice. Remind them that the activities in-between sessions are essential for the programme's success and will help her to retain the new skills she has learnt.

SECTION 19: TASK 8: EXPLAIN PRACTICE WORK BETWEEN SESSIONS 0 AND 1

The objective of this section is to teach how to make links between thoughts and feelings, and to monitor their mood on the mood chart between sessions

ACTIVITY 14

Show the mood chart and explain that the chart is a visual scale of emotional state that is represented by 5 different facial expressions ranging from “very well” to “very poorly”.

	<p>VERY GOOD</p>	MON	TUE	WED	THU	FRI	SAT	SUN
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<p>GOOD</p>	MON	TUE	WED	THU	FRI	SAT	SUN
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<p>NEITHER GOOD NOR BAD</p>	MON	TUE	WED	THU	FRI	SAT	SUN
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<p>BAD</p>	MON	TUE	WED	THU	FRI	SAT	SUN
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<p>VERY BAD</p>	MON	TUE	WED	THU	FRI	SAT	SUN
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Mood chart from WHO guide

ACTIVITY 15

Distribute the mood chart. Trainees are divided in groups of three: two participants practise the mood chart in pairs and the third participant observe and gives feedbacks. This introductory session ends with:

- The helper asks mother and family members if they have any questions about the issues discussed in this session.
- The helper gives mother a date for the next session and mark it on the designated space on the Health Monitoring Calendar.

ACTIVITY 16:

This session day ends with a role play of tasks 1 to 8 of the introductory session. Participants in pairs practice the role play and then, swap the roles.

Case story for the role play:

Juana was a worker from the Municipality of XXX who is in her seventh month of pregnancy. A month ago, the doctor told her that she would have complications in the delivery and her husband suggested that she stop working until she gives birth. Due to this, Juana feels very frustrated because she contributes to the household finances. Since she stopped working, she began to feel very sad and unmotivated. A couple of weeks ago, the community health worker called her for her second session and she commented that she felt “very bad”. In addition, she felt that her mood has changed, that is, she became very angry with her husband and locked herself in her room to cry. She has had headaches, difficulties with sleeping, has not wanted to leave her house, and has avoided talking to her friends. Juana commented in the previous session: “I wanted to continue working, but I think that this baby does not allow me to do anything and that makes me feel very frustrated and angry”. This has led to her having fights with her husband and she has sometimes thrown things at him.

Give constructive feedback and correct if necessary.

SECTION 20: CLOSING OF THE DAY

- Passing a ball: Stand in a circle and everyone says one word about the day. Catch the ball, speak and then pass it on.
- Trainer asks the group if there are any pending questions on the day's content and respond accordingly.
- Trainer responds to any issues posted on the “parking lot”.
- Trainer set out some home practice tasks for the evening. This home practice will be essential for trainers to reinforce learnings from each day.

DAY 4

“

Preparing for the baby and learning to
replace unhealthy thought patterns
with healthy ones

”

SECTION COVERED 	PURPOSE 	TIME 	WHAT 
------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------

8.30: Start the day with a recap

Different options to start the day with:

- Trainer to organise a quiz, based upon the topics the participants learnt yesterday.
- Participants prepare the quiz – each group makes two questions.
- The group is divided in two. Each group throws a ball to another group and ask them to explain one concepts from the previous day.

Buddy talk: ARE YOU READY FOR THE DAY?

<p>SECTION 21 Module 1: Preparing for the baby – pregnancy Session 1.1: Mother’s personal health</p>	<p>To enable participants to learn how to run session 1.1 as a standard model/ prototype as all other sessions are similar</p>	<p>9.00 – 11.30 90 min</p>	<p>Diet chart Mood chart Exercise chart Health calendar</p>
---------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------	--------------------------------	-------------------------------------------------------------------------

Break 11.30 – 12.00 (30 min)

<p>Continuation of session 21</p>		<p>12.00 – 13.30 90 min</p>	
------------------------------------------	--	---------------------------------	--

Lunch Break - 13.30 – 14.30 - Buddy check In 60 min

<p>SECTION 22 Barriers the mother can experience in accomplishing the tasks</p>	<p>To learn how we can break the barriers the mother can experience in accomplishing tasks with using a problem-solving approach</p>	<p>14.30 – 16.00 90 min</p>	
--------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------	---------------------------------	--

<p>SECTION 23 Closing the day and the Buddy talk: Are you ready to end the day ?</p>	<p>To ensure that all the covered topics to end the day are completed and well understood in a timely and organized manner</p>	<p>16.00 – 16.30 (30 min)</p>	<p>Wrap up Key messages and learning points of the day</p>
-----------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------	-----------------------------------	----------------------------------------------------------------

SECTION 21: MODULE 1: PREPARING FOR THE BABY – PREGNANCY

SESSION 1.1: MOTHER'S PERSONAL HEALTH

Explain that:

- Today they will learn how to run session 1.1 as a model/prototype for all other sessions
- They will learn a standard method and the 4 tasks
- All other sessions are similar as it is a repetitive intervention. Only the age group of the children change from one module to another

TASK 1: Health calendar

- Review the previous session
- Briefly summarise the key messages from the first session

TASK 2: Mood chart

- Go through the mood chart with the mother
- Ask if she noticed any particular unhealthy thoughts in the last week
- Ask how these thoughts made her feel and act
- Listen attentively and empathetically

ACTIVITY 1:

For TASK 1 and TASK 2:

- Provide the participants with this case story:
- Write the case fact and ask the participants to listen to the case with closed eyes/attentively and imagine how this would make them feel. Then, hand the full case to see if they could mentalize it. Next go on with the next step:

Case story: Anna works in a market near her home, she is 34 years old, and she is in her last month of pregnancy. Her partner works in a different province and only goes home every two weeks. A week ago, she started her Thinking Healthy sessions with a community health worker as she felt lonely, sad and worried. Anna told the helper that her mother died two months ago, which is why she is feeling sad and her whole family is going through a bad time.

"I could not say goodbye or take care of her. It's terrible that she left me right now". She reports that she cannot sleep as before, she thinks a lot about what she should have done for her mother, her appetite has decreased, she feels tired, she breathes very fast and cries when she talks about her mother. She says that her mother was very close to her, but since she herself moved to live in a different province and she was unable to visit her and that her sisters did not take proper care of their mother. In addition, she hoped her mother would teach her how to take care of her child,

something they will no longer be able to do together. Her partner does not know how she feels and has not called her for a month, so she is afraid that he has left her. This has increased her concern. She has only talked to one neighbor, who calls her every day in the afternoon to see how she is doing.

- Trainer role plays tasks 1 and 2 with one participant
- Trainer asks the participants to observe the role play, and write down the steps they see the trainer do
- Participants watch and list the steps
- Participants and trainer agree on the order of the steps
- Participants are asked to draw their own memory cards with the steps
- Participants practice in pairs

STEP 1



Learning to identify unhealthy thoughts

TASK 3: Thinking Healthy about the mother's personal health

ACTIVITY 2:

For this step:

- Role play a group discussion of a helper running a mother's group
- Participants note down the skills they have observed
- Next, participants practice in pairs

STEP 2



Learning to replace unhealthy thoughts with healthy ones

ACTIVITY 3:

For this step:

- Role play where the trainer acting "the helper" demonstrates with one participant acting "the mother" how to run this task
- All participants observe and write the steps of this techniques
- Then, participants practice in pairs and switch roles

STEP 3



Practicing thinking and acting healthy

This step is about diet, rest and relaxation and promotion of antenatal care. Here the helper and the mother: Prepare a balanced diet chart from foodstuff easily available in the household

- Prepare a rest and relaxation chart
- Educate about the importance of rest and relaxation
- Teach slow breathing and other ways to relax walking or taking a nap
- Discuss how to organize everyday chores in a way that the mother gets time for rest and relaxation

Promote antenatal care

- Give directions to the nearest antenatal health center and midwifery service
- Help the family plan how to reach it
- Educate mothers about problems that may occur in last trimester of pregnancy
- Instruct her on how to seek appropriate help for such problems

NOTE TO THE TRAINER

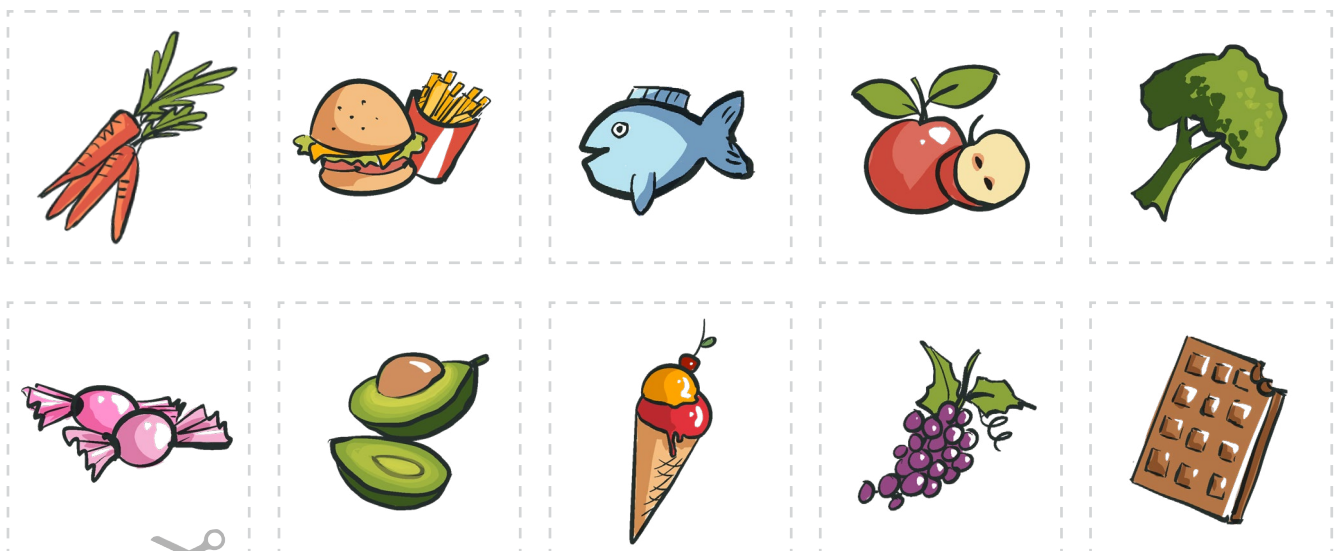
This step can be linked with the PM+ strategy 4 Strengthening social support

ACTIVITY 4:

For this step use the same scenario as tasks 1 and 2

- This step is a strengths-based approach (ask mother to think of alternative thoughts for examples described in step 1)
- This step is about psycho-education on importance of balanced diet, rest and relaxation
- Role play in plenary where the helper visits the mother
- Helper asks the mother to show him/her the food she is having at home - daily food intake (Refer to Annex 5)
- Distribute the small food cards (below)
- The helper provides psychoeducation
- Participants observe and discuss the role play in plenary
- In pairs, they practise and then, switch roles
- The helper works with the mother on a daily self-care plan.

Note to the trainer: Encourage the participant to use exercises from the [The well-being guide - Psychosocial Support IFRC](#) (pscentre.org)



SKELETON OF SESSION 1.1

AREA 1: MOTHER'S PERSONAL HEALTH

TASK 1 REVIEW KEY MESSAGES FROM PREVIOUS SESSION

Review the previous session
Briefly summarize the key messages from the first session

TASK 2 REVIEW THE MOOD CHART

The helper goes through the mood chart with the mother. Now, helper asks the mother if she has noticed any particular unhealthy thoughts in the last week. If yes, praise her for successfully completing the first step

The helper asks her how these thoughts made her feel and act. Helper notes these down. Helper listens attentively and empathetically

The helper asks if she had tried to replace these with alternative thoughts. If not, Helper discusses, and encourages her and other family members to come up with suggestions

The helper briefly explains the importance of the mother's personal physical and psychological health for the baby

TASK 3 CONDUCT 3 STEPS TO THINKING HEALTHY FOCUSING ON THE AREA DESIGNATED FOR THE SESSION

STEP 1: To identify negative thoughts

Learning to identify unhealthy thoughts about the mother's personal health. The helper shows the mother pictures A, B and C from the WHO manual page 33.

Picture A: Ask the mother to focus on the woman in this picture and describe the caption that reads out her thoughts. Discuss what these circumstances might be (poverty, displacement, domestic problems)

Picture B: Ask the mother to focus on this picture and discuss how these problems have induced a state of hopelessness and helplessness in the woman

Picture C: Discuss the consequences of giving up. Do not blame the woman in the picture. Say that this is a very natural human response to stresses and problems. However, it is important to identify the thinking styles and related feelings early, so that the actions and consequences can be changed

The helper asks the mother if she has had such thoughts. **Here the helper discusses with the mother the process of childbirth and how and which services would be provided.** The helper can also use the [Safe Childbirth Checklist](#) published by WHO.

STEP 2: To replace the negative thoughts with constructive ones

Learning to replace unhealthy thinking with healthy thinking. The helper shows picture D from the WHO manual page 35. Helper and mother discuss if the thought in Picture D is a better alternative to the one in Picture A. The helper asks mother if she can think of resources available to improve her mood. If the mother is unable to think of any resource, helper shows picture F from WHO manual page 35 and reminds her that the helper is there to support her

With picture F from the WHO manual page 35, helper discusses that it's important not to think in terms of "all or none". Even small changes can lead to a healthier family

Now the helper discusses the negative thoughts about personal health that mother may have described in step 1. The helper asks the mother to think of alternative thoughts and notes down her suggestions. If the mother is unable to think of any, the helper prompts her with some following alternative thoughts, feelings/actions, and consequences from the WHO manual page 36

STEP 3: To practice positive/constructive thoughts into positive actions. Practicing thinking and acting healthy

The helper explains to the mother that here they will be discussing the mother's nutrition. Together (helper and mother) they prepare the diet chart from foodstuff easily available in the household. The family can be engaged in this exercise. The helper explains that a balanced diet does not mean expensive or excessive diet. Once they have completed this part, the helper provides psycho-education on the importance of sleep and rest for the mother and the unborn baby

“ **Teach the mother deep breathing and relaxation techniques. Discuss with the mother and the family how they can *organize* everyday tasks in a way that frees time for *rest and relaxation*.** ”

TIME OF THE DAY

CHOICE OF FOOD

DAILY MONITORING



MON	TUE	WED	THU	FRI	SAT	SUN



MON	TUE	WED	THU	FRI	SAT	SUN



MON	TUE	WED	THU	FRI	SAT	SUN



MON	TUE	WED	THU	FRI	SAT	SUN



MON	TUE	WED	THU	FRI	SAT	SUN



MON	TUE	WED	THU	FRI	SAT	SUN

The helper teaches the mother deep breathing and relaxation techniques and discusses with mother and family members how to organize everyday tasks in a way that the mother gets time for rest and relaxation. The helper notes down these periods in the activity workbook. The helper reminds the mother and family that a small amount of time spent on her personal health will be beneficial for her and the unborn child.

Finally, the helper educates mother about problems that may occur in last trimester of pregnancy and instructs her on how to seek appropriate help for such problems. Helper gives directions to the nearest primary care centre and how to reach it

In this step:

- Prepare a rest and relaxation chart
- Educate about the importance of rest and relaxation
- Teach slow breathing and other ways to relax, walking or taking a nap. [Link to IFRC PS Centre Well-being Guide](#)
- Discuss how to organize the days
- Plan in a way that the mother gets time for rest and relaxation
- Promote antenatal care

- Give directions to the nearest antenatal health center and midwifery service
- Help the family plan how to reach it
- Educate mothers about problems that may occur in last trimester of pregnancy
- Instruct her on how to seek appropriate help for such problems

SECTION 22: BARRIERS THE MOTHER CAN EXPERIENCE IN ACCOMPLISHING THE TASKS

In a group, discuss what barriers the mother can experience in accomplishing the tasks

- Ask the participants how to break the barriers using a problem-solving approach
- Participants list together the barriers:
 - **Emotional barriers:** Lack of motivation, lack of confidence, high levels of stress, violence at home
 - **Physical barriers:** physical complaints, health issue, work commitments, financial constraints, age
 - **Social barriers:** Resistance from the family, lack of support, having other children to take care of, lack of empowerment, fear of stigma
- Participants are asked to pair and to think about 3 steps of the problem-solving approach:
 - Understanding the problem
 - Exploring the possible solutions
 - Making an action plan
- In plenary, trainer and participants discuss the likely solutions to the barriers

SECTION 23: CLOSING OF THE DAY

- Passing a ball: Participants and trainers stand in a circle and everyone says one word about the day (what were the most surprising, the most boring, and the most fun things you have experienced today?).
- Trainer asks the group if there are any pending questions on the day's content and respond accordingly.
- Trainer responds to any issues posted on the "parking lot".
- Trainer set out some home practice tasks for the evening. This home practice will be essential for trainers to reinforce learnings from each day.

DAY 5

“ *Child care practices* are the behaviors and practices of a caregiver that provides food, stimulation and emotional support which are necessary for the child development and well-being. These practices translate food security and health care into a child’s well-being. Not only the practices themselves, but also the way they are performed (with *affection* and with *responsiveness* to children) are critical to children’s survival, growth and development. It is impossible for caregivers to provide this care without sufficient resources, such as time and energy. ”

- (Engel, 2000)

SECTION COVERED 	PURPOSE 	TIME 	WHAT 
<p>8.30: Start the day with a recap Could be participants say what they did the day before, one participant writes the statements on a card (one/ card) and then the cards are distributed, and the participants have to put the cards in order</p> <p>Buddy talk: Are you ready for the day?</p>			
<p>SECTION 24: Care practices in maternal, newborn and child health</p>	<p>Participants understand the different components of psychosocial care practices</p>	<p>9.00 – 11.00 90 min</p>	<p>Ways to carry a baby See page 91</p>
<p>Break 11.30 – 12.00</p>		<p>30 min</p>	
<p>Continuation of Section 24</p>		<p>11.30 – 12.30 60 min</p>	
<p>Lunch Break - 13.30 – 14.30 - Buddy check In</p>		<p>60 min</p>	
<p>SECTION 25: Thinking Healthy implementation plan</p>	<p>To discuss the whole intervention and to enable the participants to prepare a proposal of an implementation plan of the Thinking Healthy intervention</p>	<p>13.30 – 15.00 90 min</p>	
<p>Break 15.00 – 15.30</p>		<p>30 min</p>	
<p>Continuation of Section 25</p>		<p>15.30 – 16.30 60 min</p>	
<p>SECTION 26: Closing the day</p> <p>Buddy talk: Are you ready to end the day</p>	<p>To ensure that all the covered topics are completed and well understood in a timely and organized manner</p>	<p>16.30 – 17.00 30 min</p>	<p>Wrap up Key messages and learning points of the day</p>

SECTION 24: CARE PRACTICES IN MATERNAL, NEWBORN AND CHILD HEALTH

This module will enable future Thinking Healthy helpers to support infants under 12 months and women during pregnancy and after delivery through psychosocial care practices.

Give the definition psychosocial care practices by saying:

"They are the behaviors and practices of a caregiver that provides food, stimulation and emotional support which are necessary for the child development and well-being. These practices translate food security and health care into a child's well-being. Not only the practices themselves, but also the way they are performed (with affection and with responsiveness to children) are critical to children's survival, growth and development. It is impossible for caregivers to provide this care without sufficient resources, such as time and energy." (Engel, 2000)

Explain that six care practices have been identified and are currently used as international standards by organizations in humanitarian contexts. They include:

- Care for women - During pregnancy and breastfeeding, reproductive and mental health, workload and education.
- Breastfeeding and feeding practices - Exclusive breastfeeding, weaning, complementary food, active feeding practices, adaptation to the family's feeding practices.
- Psychosocial care - Adaptation to the developmental steps of the child, attention, affection, autonomy, encouragement of exploration and learning, protection against violence and harmful practices.
- Hygiene practices - Personal and home hygiene.
- Meal preparation and conservation - Mode of preparation, food storage and hygiene.
- Home health practices - Home management of illnesses, utilization of services, home based protection.

Add that for the training the focus is mainly on the first three care practices that are care for women, breastfeeding and feeding practices and psychosocial care.

ACTIVITY 1

Divide the participants in 7 groups and asks them to prepare a psycho-education session on the following topics:

<p>PSYCHOEDUCATION 1 Psychosocial aspects of pregnancy</p>	<p>TARGET GROUP Young mothers</p>
<p>PSYCHOEDUCATION 2 How to provide support to pregnant women</p>	<p>TARGET GROUP Family members</p>
<p>PSYCHOEDUCATION 3 Psychosocial aspects of breastfeeding</p>	<p>TARGET GROUP Lactating mothers</p>
<p>PSYCHOEDUCATION 4 How to provide support for lactating women</p>	<p>TARGET GROUP Midwives, traditional birth attendants</p>
<p>PSYCHOEDUCATION 5 How to provide support during feeding time in cases of malnutrition</p>	<p>TARGET GROUP Community health workers/ community volunteers</p>
<p>PSYCHOEDUCATION 6 Psychosocial childcare practices</p>	<p>TARGET GROUP Fathers</p>
<p>PSYCHOEDUCATION 7 The first contact with the newborn and the early attachment</p>	<p>TARGET GROUP Pregnant mothers and caregivers</p>

Remind the participants that psychoeducation:

- Is a key service that helps to educate both the affected population, staff and volunteers on topics related to mental health and psychosocial well-being. It can be helpful before possible exposure to stressful situations or after exposure.

- Involves providing information to individuals and groups.
- Empowers people by encouraging them to share experiences and knowledge so that they can deal with challenges and take care of themselves and loved ones in a better way.
- Provides people with information that helps them better understand topics related to mental health and psychosocial well-being and thereby better understand their feelings and behaviour and those of people around them.

Common psychoeducation activities include the development and distribution of information and education materials related to mental health and psychosocial well-being.

NOTE

To know more about psychoeducation, please read the Awareness raising/ psychoeducation sessions - Guidance Note for Iraqi Red Crescent Psychosocial Staff and Volunteers developed by Danish Red Cross. See annex 6.

Groups are given 1 hour to prepare for their sessions. In plenary, each group present their work. Ensure that these elements are covered.

Psychoeducation session for young mothers on psychosocial aspects of pregnancy:

- The mother-child relationship starts during pregnancy where they bond and interact. The baby hears the mother's voice, her heartbeat and feels her emotional condition.
- The pregnant woman can feel her baby moving and its position touching her belly. That is why it is very important to pay attention to the feelings and emotional experience of a pregnant woman.
- Many expectant women (especially if they are in good health and with strong family support) find deep emotional satisfaction in their pregnancy. They feel happy and this can be seen in their faces and general health. After the delivery, internal and external emotions change rapidly and very often.
- The relationship with the family and the husband or the partner can change as well. This can impact women's feelings and make her worried about all the changes that might occur.
- In emergency contexts or when facing an adverse event, the pregnancy is often a period full of emotional conflicts that can trouble the woman and family members, causing her to feel worried, tired, insecure or in doubt. Pregnancies in times of conflict exacerbate stress and anxiety and limit the capacity of a woman to relax as she may only focus on her fears, the most common are the fear of delivering a sick child, loneliness during the pregnancy and feeling that nobody understands her fears and supports her.

For the psychoeducation session for family members on how to provide support to pregnant women:

- Emphasize that the mother is already doing well, focus on her strengths, what she can do.
- Support them to try as much as possible to avoid isolation and get support from family to share feelings and emotions.
- Advise them to have a sleep rhythm (although it can be difficult) and to adapt nutrition habits and balance their daily intake.
- Sensitize them on how to avoid heavy workloads.
- Help them to identify the new changes occurring in their lives and how to adjust to this new reality, although these changes can be difficult to accept.
- Teach them how to organize their daily work in different ways from before pregnancy.
- Reassure them about the fears they might have and that they are common reactions to a new situation.
- Encourage them and help the family members to encourage them to take care of themselves, physically and emotionally. This includes pre-natal visits, personal hygiene and having a clean environment, moderate physical exercise like walking and getting enough rest every day.
- Give practical advice, for example, “When you are lying down the baby gets more space and likes to move. You have to make sure you lie down during the day to rest your body and let the baby play on your stomach”.
- Advise them to avoid taking medicines without medical advice, smoking, chewing khat, lifting heavy weights and eating unsafe food (i.e. raw or expired food).

For the psychoeducation session on psychosocial aspects of breastfeeding to lactating mothers

- It is important to be able to support pregnant and lactating women in adopting good and healthy feeding practices for their infants and young children from birth up to 24 months of age. Breastfeeding is the best practice for the healthy and psychological growth and development of infants:
- Infants should be exclusively breastfed if possible, i.e., given only breast milk, and no other liquids or solids for the first six months of life to achieve optimal growth, development, and health.
- After six months of age, all babies require other foods to complement breast milk. However, when complementary feeding is introduced, breastfeeding should continue until two years of age.
- Advantages of breastfeeding on health - Breast milk is important as it protects babies' and mothers' health as it contains white blood cells and several anti-infective factors that help to protect against infections.
- Advantages of breastfeeding on psychosocial aspects - In addition to providing optimal

nutrition and immunological protection, breastfeeding also represents an excellent way to create and reinforce early attachment or bonding between mother and child. A lactating mother can interact and bond when providing care and feeding to her newborn. Therefore, breastfeeding helps the mother to form a very close emotional relationship.

- During emergency situations, the access to food, and the quality and quantity of it might be lacking, that is why breastfeeding should be encouraged and increased to provide the newborn's nutritional needs, as breast milk is the safest way to feed a newborn and it is cost-free.

For the psychoeducation session for midwives and traditional birth attendants on how to provide support to lactating women:

- Encourage midwives or traditional birth attendants to place the infant on the mother's breast within the first hour after delivery.
- Reassure the mothers that breastfeeding a newborn is a complex process not a simple automatic one because some newborns can have more difficulties in suckling than others.
- Support the mothers who have difficulties in breastfeeding by telling them that it does not only rely on physiological factors, it can take time and be difficult for some newborns and mothers.
- Explain to mothers that there are various factors that can influence breastfeeding and the relationship between the mother and the newborn; some factors relate to the experience of the pregnancy and others to physical or psychological factors, cultural beliefs, etc.
- Make mothers understand that some newborns are more active and initiate interaction with the caregivers and others less. Mothers have to keep in mind the child's uniqueness and that it cannot be compared with siblings. Each newborn has different needs and different demands.
- In an emergency context, lactating women might need more support in breastfeeding and in the relationship with their newborn. It is important to discuss the mother's difficulties and to help them to recognize the uniqueness of their child by underlying the positive aspects like the newborn's capacities, skills, and way to interact with the environment, but also recognizing the aspects that can be more difficult to handle.
- During the breastfeeding times, babies should be encouraged and stimulated; this is known as 'responsive feeding'.
- Midwives and traditional birth attendants have to listen to the mother's emotional complaints and provide adequate support for those who experience insufficient milk flow and require more support.

For the psychoeducation session for community health workers on how to provide support during feeding time in cases of malnutrition:

- Malnourished children need more care and encouragement during feeding time.
- Parents and caregivers need self-confidence, knowledge, resources, and time to reinforce the treatment in an efficient way, to prevent relapse, to avoid defaulting and to reinforce the mother/caregiver and infant relationship.

- Mothers and caregivers should be encouraged to take the time needed when breastfeeding or feeding their children.
- Children's rhythms should be respected during feeding times; feeding should not be forced. A quiet and secure environment has a positive impact on the child's food intake.
- Mothers and caregivers must communicate and interact and give encouragement and verbal support to the child during feeding time.
- Reinforce the relationship between the child and mother/caregiver by interacting, looking at, touching, smiling at, and cuddling the child. This will also help to prevent relapse and malnutrition.
- Reinforcement for the mothers/caregivers to gain self-confidence in their roles. Supporting them by positively emphasizing what they are doing and their involvement in taking care of the malnourished child.
- A massage can be very intrusive for the extremely sick and malnourished baby; Gentle stimulation of the skin, bathing, respecting the babies threshold for stimulation.
- Touching a baby born with a disability: physical stimulation through touching is very important for babies living with a visual impairment, verbalizing the contact is also important for babies living with disabilities.

For the psychoeducation session for fathers on psychosocial childcare practices:

- Newborns need a secure environment for their optimum and growth and development. They also have emotional and psychological needs, such as the need for love, care, guidance and attention in addition to physical needs.
- Babies needs to have a stable, interactive and warm relationship with their caregivers, physical protection and security within a stable family, community and social environment, structures and boundaries where the infant feels confident, and positive reinforcement when learning or interacting with the environment.
- Children with stressed or emotionally disturbed mothers face a greater risk of malnutrition and delayed growth and the risk of infant mortality increases because they will be interacting less with the mother and receive less feeding and stimulation. That is why it is important to support women after delivery.
- A lack of psychosocial stimulation has a big impact on children's development (cognitive, motor, language) and mental health.
- The first two years of life are critical. Nutritional and psychosocial deficits during this time period can result in lifelong impairment and disability.
- Fathers have to support mothers/caregivers on how to stimulate and respect the child in its development stages.

- Fathers encourage caregivers to adjust their behaviors to the child's development level by providing opportunities to learn and explore the environment, showing the child interest, attention, and affection.
- Raise caregivers' awareness to the fact that the child starts to develop the five senses during the pregnancy and is sensitive to the mother's emotions.



Cradle



Over the shoulder

Cradle: Turn the baby on their back with their head against your elbow, providing support for their back with your free arm.

Over the shoulder: Rest the baby against your shoulder, with your hand on their neck and head for support.



Kangaroo mother care technique

Show mothers and caregivers **the 'Kangaroo mother care' technique**, a skin-to-skin technique between the newborn and the mother that has many benefits, especially for premature newborns. It is highly advised that this technique is applied just after delivery. The baby is placed between the mother's breasts in an upright position, chest to chest. The newborn is secured with a binder. The head is turned to one side in a slightly extended position. The top of the binder is just under the baby's ear. This slightly extended head position keeps the airway open and allows eye-to-eye contact between the mother and the baby. Forward flexion and hyperextension of the head must be avoided. The baby's hips should be flexed and extended in a 'frog' position; and the arms should also be flexed. It is also beneficial for the newborn to have skin to skin contact with the father.

SECTION 25:

THINKING HEALTHY IMPLEMENTATION PLAN

In plenary, trainer and participants discuss:

ACTIVITY 1

- The whole intervention: screening, sessions, admissions, defaulters.
- Items that need to be adapted for Thinking Healthy implementation in their setting.

Divide participants into groups according to themes e.g., nutrition programmers, community health teams, ECD programmes, social care teams etc., and ask them to think about how to implement Thinking Healthy in their specific context, or with existing programmes/ services. Write their suggestions on a flip chart, and then all the participants walk around the flip charts that are hanging on the wall gallery walk, add their ideas and then discuss in plenary the different implementation approaches.

ACTIVITY 2

Ask the plenary group: What are the adverse events that Thinking Healthy Helpers will come across in their helping roles and need immediate attention? There may be several suggestions, focus on these:

- Women who have experienced sexual or gender-based violence
- Women at risk of ending their life

Remind the participants that because of these adverse events, a woman may suddenly interrupt the process or show no improvement or worsening of their mental health conditions.

ACTIVITY 3:

Women who have experienced sexual or gender-based violence:

In pairs, participants read the questions and discuss them:

- Have you had any experience in working with women who have been affected by sexual violence before?
- Have they openly talked with you about these experiences?
- What did you do to support them?
- What is the view of sexual violence in the community? Are there any stigmas and shame associated with it?
- Do people speak openly about sexual violence?

Then ask the plenary : From the discussion you had in pairs, what would you expect or assume some of the difficulties might be with women who have been affected by this type of adversity?

Ensure that the group identifies these types of difficulties:

- Trusting others
- Stigma and shame and being excluded from the community
- Fear of perpetrator finding out they have disclosed info and risking further violence.

Emphasize that for these reasons, confidentiality is one of the most important basic helping skills, when interacting with these women. Women should be told about confidentiality at the opening session (and can be reminded in each session, if necessary).

Confidentiality may be a new term for some participants. Explain clearly and in simple language what is meant by confidentiality. Says that confidentiality is keeping everything the mother tells you private. Family members or any other people cannot be told anything about the sessions without the mother's permission.

However, there are some limits to confidentiality:

- The helper is getting supervision – Confidential information will be only shared with the supervisor
- Women are at risk or have a plan or persistent thoughts to end their life
- Women are at risk of harming someone else (helper has to be very cautious when deciding that the mother is at risk of harming others)
- Women disclose a child protection issue (neglect, abuse, exploitation, violence)

Note to the trainer:

- As part of the protocol, when a woman is experiencing a sexual or a gender-based violence by a family member or a partner, the helper we will not let partners or others, accompany the mother in the session, if Thinking Healthy is being implemented outside of the house. Helper will not let the partners or others accompany attend the sessions (if Thinking Healthy is being implemented through outreach activities and home visits.
- The helper will always keep in mind that at the beginning they may not know if the women have experienced sexual or gender-based violence because many will not disclose this information at the beginning.

End this activity with explaining:

- Referral pathway and referral system. If the implementing organization does not have their own referral system in place, they should use the IASC referral form. Distribute the Inter-Agency Referral Form and Guidance Note (See Annex 7).

ACTIVITY 4:

Women at risk of ending their life:

Distribute 4 flipchart paper with one of these sentences on each:

- **Level 1 No risk:** Someone who does not have thoughts of ending their life.
- **Level 2 Low risk:** Someone who have thoughts of ending their life but do not want to act on these thoughts.
- **Level 3 Medium risk:** Someone who have thoughts of ending their life, do not want to act on these thoughts, but have tried to end their life in the past.
- **Level 4 High risk:** Someone who have thoughts of ending their life and either do want to act on these thoughts or are undecided if they want to act on these thoughts, and they may have (or have not) tried to end their life in the past.

Ask the participants what a Thinking Healthy helper needs to do to address these levels of risks. In small groups, participants discuss the helper's response. Give the answers at the end:

For level 1 No risk:

The helper does not have to do anything. The help keeps implementing the Thinking Healthy sessions

For level 2 Low risk:

- The helper needs to tell the supervisor during supervision
- The helper monitors the mothers' thoughts in every session.
- The helper asks the mothers if they are continuing to have these thoughts and whether they want to act on them

For level 3 Medium risk:

- The helper tells the supervisor or health professional such as a doctor or a nurse as soon as possible after the Thinking Healthy session.
- The helper monitors the mothers' thoughts in every session.
- The helper asks the mothers if they are continuing to have these thoughts and whether they want to act on them.

For level 4 High risk:

- The helper contacts the supervisor immediately.
- The supervisor does not leave the mother on her own or let her go home alone.
- The helper uses basic helping skills to give the mothers support while waiting for instructions from the supervisor.

DAY 6

“

Choosing to be a Thinking Healthy helper and assist mothers in difficulty may *expose* helpers to *challenges* which can lead to stress.

Today we are going to talk about *self-care* for Thinking Healthy helpers.

”

SECTION COVERED 	PURPOSE 	TIME 	WHAT 
<p>8.30: Start the day with a recap</p> <p>Appoint one or two scribes who will note down on a piece of paper what participants say about what they did the day before. One activity per piece of paper. Papers are distributed to participants, and a group is appointed to put the cards in order without speaking. At the end of the exercise go over the training plan from the previous day.</p> <p>Buddy talk: Are you ready for the day ?</p>			
<p>SECTION 27: Self-care, peer support and supervision:</p> <ul style="list-style-type: none"> • Maintaining professional boundaries • Self-care and supportive supervision 	<p>To enable participants to know more about Supervision.</p> <p>To consider work-related triggers of stress and to identify ways to improve self-care strategies</p>	<p>9.00 – 11.00 120 min</p>	
<p>Break 11.00 – 12.00</p>		<p>30 min</p>	
<p>Continuation of section 27</p>		<p>12.00 – 13.30 90 min</p>	
<p>Lunch Break 13.30 – 14.30 - Buddy checking In</p>		<p>60 min</p>	
<p>Continuation of section 27</p>		<p>14.30 – 16.00 90 min</p>	
<p>Section 28: Ending the training and the Buddy talk: Are you ready to end the day ?</p>		<p>16.00 – 17.00 60 min</p>	

SECTION 27: SELF-CARE, PEER SUPPORT AND SUPERVISION

27.1 SELF-CARE AND PEER SUPPORT

ACTIVITY 1

Start the session by saying that choosing to be a helper to assist mothers in difficult situations and in distress may expose to different challenges which can be stressful. Today we are going to talk about self-care for Thinking Healthy helpers.

Give each participant a piece of paper and pencil and instructs them to draw a picture of themselves holding a large umbrella and different sized raindrops falling around them. Draw it on the board or flipchart paper.

Explain that raindrops represent the individual's personal stressors or triggers of burnout or stress; for example, deadlines, conflict at work, seeing a lot of difficult cases, accumulation of tiredness and fatigue, etc. Ask the participants to write next to each raindrop their personal stressors and what kinds of things are likely to make them feel stressed. Then, encourage the participants to rank these stressors from the smallest to the largest effect on them.

Now, invite the participants to write their personal strategies for self-care in each panel section of the umbrella and explain that umbrellas act as protection for these triggers to prevent us from feeling overwhelmed or burnt out. Gives some examples: Sleeping well, eating healthy, getting supervision, taking time off, etc.

ACTIVITY 2

Ask the participants how a Thinking Healthy helper can cope with work-related stressors and write down the answers on a flipchart. In plenary, trainer and participants write the self-care strategies that can help to cope and maintain well-being and work balance:

- Scheduling breaks between mothers
- Identify when the distress is impacting on the ability to be a helper
- Reduce case load
- Take a break from helping
- Not seeing the most difficult cases all on the one day
- Leaving work on time and not taking work home
- Setting boundaries- saying 'no' to requests that cannot be achieved- this includes with

colleagues, supervisors and mothers

- Encouraging helpers to self-apply PM+ strategies that might be relevant to them personally (e.g. Managing Stress, Get Going Keep Doing)
- Encourage debriefing with colleagues and supervisors
- Let the your supervisor know
- See a mental health professional for additional support
- Maintain a healthy lifestyle outside of work- healthy eating habits, exercise, engaging in pleasant activities, healthy sleeping habits.

Next, Ask how many helpers practice what they know is good for them? Conduct a round asking: Stand up if you practice what you know is good for you. Trainer goes through the list of the obvious good ideas that are never practiced by helpers.

ACTIVITY 3

Place a chair at one end of the room for the mothers and another at the other end for the helpers. Ask participants to step into the area between the two chairs where they are to strike a silent pose representing a resistance to self-care when working with mothers. Next ask each participant to say out loud what their resistance is...Discuss why helpers very often don't practice self-care? What are their resistances? Can these resistances be overcome in anyway. What and who can help the helpers be better at caring for themselves?

Now, participants are divided in 5 groups and each group reflects on things they can do to help take care of themselves. Share these proven strategies after the group work:

STRATEGY 1: DAILY ROUTINE AT HOME AND AT WORK

- Maintain a daily routine as much as you can
- Give yourself permission to take regular breaks during your shifts.
- Eat and drink water at regular hours.
- Avoid using unhelpful coping strategies when you feel stressed like smoking, chewing qat, alcohol or another drug.
- Sleep is one of the most crucial ways to stay physically and mentally healthy.

STRATEGY 2: EXERCISE

- Plan regular exercise activities that make you feel good e.g. go for a daily 30-minute walk or run
- Breathing exercises reduce stress and help you to focus mentally. Take 10 minutes to do breathing exercises every morning or evening

STRATEGY 3: STAY CONNECTED

- Even though you have a lot of work, take time to stay in touch with your family and friends; even if you can't see them in person you can have video and phone calls.

STRATEGY 4: ACCEPT YOUR FEELINGS

- If you feel stressed or overwhelmed, know that there are ways to get support. It is ok to say you are not ok
- Reach out to your colleagues, your manager or someone else that you trust

STRATEGY 5: STAY HOPEFUL

- Try to think about strategies in the past that have helped you to cope with stressful situations
- Focus on what is in your control. Pay attention to things that are going well and share and celebrate the successes and small wins with your colleagues, friends and family.

End this section with one of well-being exercises from the IFRC PS Centre guide. The trainer can use some of the exercises throughout the training days and use them as energizers. The individual exercises can be found here: [The well-being guide - Psychosocial Support IFRC](https://www.pscentre.org/guide) (pscentre.org)

HUG YOURSELF CALM

When needing to de-stress emotionally, take a few moments to collect and hold yourself together by using your hands and arms. Many have found the calming hug useful when facing an overwhelming situation as for example before giving a presentation, taking a call in a call centre, or moving into the world again after a lockdown. Before or during an overwhelming situation, do this exercise to help yourself to be ready:

- Stand or sit upright with your feet solidly planted on the ground.
- Notice the support from the ground against your feet.
- Take a deep breath and breathe out slowly and consciously.
- Place your right hand, palm turning inwards, in your left armpit and the left hand on your upper arm below the shoulder.
- Press inwards with both hands and hold the firm grip for some seconds giving yourself a solid hug.
- Release the grip for five seconds and repeat twice more.
- Let the arms drop to the sides of the body and move on in daily life.



27.2: SUPERVISION

ACTIVITY 1:

Introduce the topic of supervision by reflecting with the participants on comments from previous role plays where participants were given feedback. Ask: How did it feel to receive feedback? How do you think you grew in your skills after that feedback?

Participants shares in plenary their experience with receiving feedback.

Then, ask How many of you have been in supervision before?

- Stand up if have been supervised before
- Thumbs up if you have and down if you haven't
- Supportive supervision is defined as:

SUPPORTIVE SUPERVISION

Creating a supportive relationship between supervisor and supervisee (i.e. helper receiving supervision) aims to promote regular skill development, joint problem solving, and supportive two-way communication. Supportive supervision promotes the well-being of staff and volunteers and improves the service delivery of MHPSS interventions, and, ultimately, improve the protection of, and service provision for populations affected by disasters and protracted crises.

Distinguish between day-to-day management/ support and Thinking Healthy supervision. From these comments, discuss the importance of supervision and what is expected of supervisors and helpers in supervision.

ACTIVITY 2

Ask the participants *What is supervision is and why is it important?*

Trainer ensures that the following key points are covered about the importance of supervision:

- It is essential for providing effective psychological treatment to people.
- The aim of supervision is to ensure that helpers are following Thinking Healthy protocols and using the implementation process appropriately.
- Helps ensure quality delivery of Thinking Healthy.
- It can prevent helper burnout, and helps people feel well supported and confident in managing challenging participant presentations and problems.

- Supervision requires the helper to talk about Thinking Healthy mothers and their progress and also if the mother is at imminent risk of harming themselves or someone else.
- Helper should seek supervision (from supervisor or peers) when they have challenges using their basic helping skills.
- Inform helpers that when they are not able to manage some reactions on mothers, they can seek for supervision as well.

Trainer says that part of your role as a Thinking Healthy helper may include supervising helpers when they begin delivering Thinking Healthy. Helpers should receive weekly group supervision as well as on demand support for example if they require urgent supervision regarding a mother's safety. Weekly supervision will comprise discussing the progress of their participants, challenges they are experiencing in the Thinking Healthy sessions, self-care and continued focus on training to improve the helper's competency and confidence in delivering Thinking Healthy.

Explain that before implementing Thinking Healthy, the organization needs to think about what type of support and ongoing supervision the Thinking Healthy helpers need to receive. It is recommended that the organization consult with mental health professionals with experience in Thinking Healthy or any other WHO scalable intervention. It is important to organize supportive supervision in case there are implementation challenges that need addressing.

ACTIVITY 3

Divide participants into two groups, give them flipcharts and markers and give each group one of the following topics:

- What are the responsibilities of a good supervisor?
- What are the responsibilities of a good supervisee?

Each group will have 20 minutes to reflect together and write their ideas on the flipcharts. After 20 minutes, trainer asks groups to swap their flipcharts. They now ten minutes to review the other group's ideas, add any new points, and select the three points they feel are the most important.

- Trainer asks one person from each group will present the top three ideas they selected
- Trainer lists the ideas on a flip chart without repeating points already listed by other groups
- Trainer goes through the full list of points and identify any responsibilities that are not relevant or appropriate for Thinking Healthy supervision and explains why

ACTIVITY 4

- Ask the larger group why having regular supervision is important?
- Explain what Thinking Healthy supervision involves
- Encourage each organization implementing Thinking Healthy to have a supervision form

- Gives details of supervision options:
 - Group supervision
 - Individual supervision
 - Supervision once a week
 - Supervisors must be available outside of supervision to provide individual support to helpers when needed, e.g. to manage a crisis situation with a participant.

SECTION 28 ENDING THE TRAINING

The trainer now explains that the training has come to an end, but before saying goodbye we have to complete the following:

- Parking lot
- Next steps after this training
- Post self-assessment
- Training evaluation
- Distribution of certificates
- Group photo

Parking lot: Address any remaining questions.

Next steps after this training: Remind participants that supervision is highly recommended to implement Thinking Healthy

The post self-assessment: Distribute the post self-assessment forms.

Training evaluation: Distribute the evaluation feedback forms and explains that they can be filled in anonymously if preferred. They have 10 minutes to complete the evaluation and hand the sheet back to the trainer.

Now ask participants to stand up in a circle and say one word that for them sums up their training experience.

Distribution of certificates and photo: Give each participant a certificate that is not their own and once everyone has one, participants take turns reading out the name on the certificate they were given and hands it to the person while congratulating them. After this a group photo is taken and participants may leave.

Trainer will ensure that everything have used from the trainer's toolbox is neatly returned to the box and if some items need to be replenished then make a list of these items and inform the person in charge.

Annex

ANNEX 1 - THINKING HEALTHY PROGRAMME COMPETENCIES

1. MOOD & ACTIVITY MONITORING

Check all behaviours that are demonstrated in each category.			
Unhelpful or potentially harmful behaviours	Basic helping skills	Advanced helping skills	
<input type="checkbox"/> Fills out activity monitoring sheet for client <input type="checkbox"/> Only uses client's negative feelings and behaviours in the chart	<input type="checkbox"/> Explains mood and activity monitoring chart <input type="checkbox"/> Practices with client in session and assigns home practice <input type="checkbox"/> <i>None of the above</i>	<input type="checkbox"/> <i>Completes all Basic Helping Skills (Level 3)</i> <input type="checkbox"/> Elicits feedback and ensures client understands (e.g., asks client to give example of how it works) <input type="checkbox"/> Discusses possible barriers and facilitators <input type="checkbox"/> Schedules next session for review	
Check the level that best applies (only one level should be checked)			
<input type="checkbox"/> Level 1 <i>any unhelpful behaviour</i>	<input type="checkbox"/> Level 2 <i>no basic skills, or some but not all basic skills</i>	<input type="checkbox"/> Level 3 <i>all basic skills</i>	<input type="checkbox"/> Level 4 <i>all basic helping skills plus any advanced skill</i>
Notes:			

2. PSYCHOEDUCATION ABOUT THOUGHTS, FEELINGS, & BEHAVIOURS

Check all behaviours that are demonstrated in each category.			
Unhelpful or potentially harmful behaviours	Basic helping skills		Advanced helping skills
<input type="checkbox"/> Agrees with client’s negative thoughts <input type="checkbox"/> Blames client for thoughts (e.g., “yes, you are messing everything up”)	<input type="checkbox"/> Explains how negative thoughts might influence feelings <input type="checkbox"/> Explains how negative thoughts might influence behaviours <input type="checkbox"/> <i>None of the above</i>	<input type="checkbox"/> <i>Completes all Basic Helping Skills (Level 3)</i> <input type="checkbox"/> Gives clear example or scenario of connections <input type="checkbox"/> Asks client if they understand concept and if they find it helpful	
Check the level that best applies (only one level should be checked)			
<input type="checkbox"/> Level 1 <i>any unhelpful behaviour</i>	<input type="checkbox"/> Level 2 <i>no basic skills, or some but not all basic skills</i>	<input type="checkbox"/> Level 3 <i>all basic skills</i>	<input type="checkbox"/> Level 4 <i>all basic helping skills plus any advanced skill</i>
Notes:			

3. LINKING THOUGHTS, FEELINGS & BEHAVIOURS: CONNECTING THOUGHTS & FEELINGS WITH PERSONAL EXPERIENCE

Check all behaviours that are demonstrated in each category.			
Unhelpful or potentially harmful behaviours	Basic helping skills		Advanced helping skills
<input type="checkbox"/> Blames the client for having ‘bad feelings’ <input type="checkbox"/> Blames client for having ‘bad/negative behaviours’	<input type="checkbox"/> Elicits personal experience from client <input type="checkbox"/> Facilitates client to connect thoughts and feelings <input type="checkbox"/> <i>None of the above</i>	<input type="checkbox"/> <i>Completes all Basic Helping Skills (Level 3)</i> <input type="checkbox"/> Uses multiple thought-feeling-behaviour connections (helpful and unhelpful) <input type="checkbox"/> Uses multiple thought-feeling-behaviour connections (daily and extreme situations)	
Check the level that best applies (only one level should be checked)			
<input type="checkbox"/> Level 1 <i>any unhelpful behaviour</i>	<input type="checkbox"/> Level 2 <i>no basic skills, or some but not all basic skills</i>	<input type="checkbox"/> Level 3 <i>all basic skills</i>	<input type="checkbox"/> Level 4 <i>all basic helping skills plus any advanced skill</i>
Notes:			

4. LINKING THOUGHTS, FEELINGS & BEHAVIOURS: CONNECTING FEELINGS WITH BEHAVIOURS

Check all behaviours that are demonstrated in each category.			
Unhelpful or potentially harmful behaviours	Basic helping skills	Advanced helping skills	
<input type="checkbox"/> Blames the client for having 'bad feelings' <input type="checkbox"/> Blames client for having 'bad/negative behaviours'	<input type="checkbox"/> Facilitates client to connect feelings with negative behaviours <input type="checkbox"/> Facilitates client to identify positive and negative feelings to behaviours <input type="checkbox"/> <i>None of the above</i>	<input type="checkbox"/> <i>Completes all Basic Helping Skills (Level 3)</i> <input type="checkbox"/> Uses an appropriate tool to draw out, visualize or other form of documentation	
Check the level that best applies (only one level should be checked)			
<input type="checkbox"/> Level 1 any unhelpful behaviour	<input type="checkbox"/> Level 2 no basic skills, or some but not all basic skills	<input type="checkbox"/> Level 3 all basic skills	<input type="checkbox"/> Level 4 all basic helping skills plus any advanced skill
Notes:			

5. IDENTIFYING MORE DIFFICULT & UNHELPFUL THOUGHTS

Check all behaviours that are demonstrated in each category.			
Unhelpful or potentially harmful behaviours	Basic helping skills	Advanced helping skills	
<input type="checkbox"/> Reinforces more difficult, unhelpful thoughts and feelings (e.g., 'it sounds like it was your fault, why didn't you stay to help? 'If you didn't talk back, you wouldn't get beaten', 'If you don't get this job, your family will see you as a failure)	<input type="checkbox"/> Identifies more difficult, unhelpful thoughts <input type="checkbox"/> Discusses ways to change the thoughts (e.g., giving examples of other people who might be responsible or asking what the client might tell a friend) <input type="checkbox"/> <i>None of the above</i>	<input type="checkbox"/> <i>Completes all Basic Helping Skills (Level 3)</i> <input type="checkbox"/> Uses specific techniques (e.g., responsibility cake, role-play) to identify and review links <input type="checkbox"/> Reviews options/ways to create an alternative thought <input type="checkbox"/> Asks client to practice this daily	
Check the level that best applies (only one level should be checked)			
<input type="checkbox"/> Level 1 any unhelpful behaviour	<input type="checkbox"/> Level 2 no basic skills, or some but not all basic skills	<input type="checkbox"/> Level 3 all basic skills	<input type="checkbox"/> Level 4 all basic helping skills plus any advanced skill
Notes:			

6. DEVELOPING NEW THOUGHTS, FEELING, BEHAVIOURS & ASSOCIATIONS: CREATING ALTERNATIVE THOUGHTS

Check all behaviours that are demonstrated in each category.			
Unhelpful or potentially harmful behaviours	Basic helping skills	Advanced helping skills	
<input type="checkbox"/> Reinforces unhelpful thoughts/feelings <input type="checkbox"/> Tells client what new thoughts to have <input type="checkbox"/> Does not offer /listen to client input	<input type="checkbox"/> Suggests other thoughts that may be more helpful to previous unhelpful, thought, feeling, behaviour links <input type="checkbox"/> Compares new links with those from the previous session <input type="checkbox"/> <i>None of the above</i>	<input type="checkbox"/> <i>Completes all Basic Helping Skills (Level 3)</i> <input type="checkbox"/> Checks-in on feelings <input type="checkbox"/> Praises client	
Check the level that best applies (only one level should be checked)			
<input type="checkbox"/> Level 1 <i>any unhelpful behaviour</i>	<input type="checkbox"/> Level 2 <i>no basic skills, or some but not all basic skills</i>	<input type="checkbox"/> Level 3 <i>all basic skills</i>	<input type="checkbox"/> Level 4 <i>all basic helping skills plus any advanced skill</i>
Notes:			

7. DEVELOPING NEW THOUGHTS, FEELING, BEHAVIOURS & ASSOCIATIONS: DIFFERENCES BETWEEN NEW & PREVIOUS THOUGHTS

Check all behaviours that are demonstrated in each category.			
Unhelpful or potentially harmful behaviours	Basic helping skills	Advanced helping skills	
<input type="checkbox"/> Reinforces unhelpful thoughts/feelings <input type="checkbox"/> Tells client what new thoughts to have <input type="checkbox"/> Does not offer /listen to client input	<input type="checkbox"/> Works to visualize new thoughts (e.g., through discussion or visual tool) <input type="checkbox"/> Clarifies differences between previous unhelpful links and new, more helpful links <input type="checkbox"/> <i>None of the above</i>	<input type="checkbox"/> <i>Completes all Basic Helping Skills (Level 3)</i> <input type="checkbox"/> Reinforces use of replacing thoughts daily <input type="checkbox"/> Praises client	
Check the level that best applies (only one level should be checked)			
<input type="checkbox"/> Level 1 <i>any unhelpful behaviour</i>	<input type="checkbox"/> Level 2 <i>no basic skills, or some but not all basic skills</i>	<input type="checkbox"/> Level 3 <i>all basic skills</i>	<input type="checkbox"/> Level 4 <i>all basic helping skills plus any advanced skill</i>
Notes:			

8. USING THOUGHT RECORDS WITH IN-SESSION PRACTICE

Check all behaviours that are demonstrated in each category.			
Unhelpful or potentially harmful behaviours	Basic helping skills	Advanced helping skills	
<input type="checkbox"/> Criticises or blames client for not understanding technique <input type="checkbox"/> Threatens client to use thought records (e.g., ‘If you don’t do this, I will tell your family what you said.’) <input type="checkbox"/> Asks client to put self in harmful situation for practice of tracking thoughts	<input type="checkbox"/> Explains use of tracking thoughts at home through a technique <input type="checkbox"/> Assigns practice homework <input type="checkbox"/> <i>None of the above</i>	<input type="checkbox"/> <i>Completes all Basic Helping Skills (Level 3)</i> <input type="checkbox"/> Practices technique with client in-session <input type="checkbox"/> Checks-with client s/he is comfortable with technique and at-home practice <input type="checkbox"/> Considers possible situations that will arise that week to support tracking thoughts	
Check the level that best applies (only one level should be checked)			
<input type="checkbox"/> Level 1 <i>any unhelpful behaviour</i>	<input type="checkbox"/> Level 2 <i>no basic skills, or some but not all basic skills</i>	<input type="checkbox"/> Level 3 <i>all basic skills</i>	<input type="checkbox"/> Level 4 <i>all basic helping skills plus any advanced skill</i>
Notes:			

9. REVIEWING THOUGHT RECORDS/HOMEWORK

Check all behaviours that are demonstrated in each category.			
Unhelpful or potentially harmful behaviours	Basic helping skills	Advanced helping skills	
<input type="checkbox"/> Blames client for challenges (e.g., ‘You’re not working hard enough, you should have at least been able to do this once.’) <input type="checkbox"/> Only talks about difficulties and not successes	<input type="checkbox"/> Reviews tracking thoughts at-home practice with client <input type="checkbox"/> Discusses difficulties with practice <input type="checkbox"/> <i>None of the above</i>	<input type="checkbox"/> <i>Completes all Basic Helping Skills (Level 3)</i> <input type="checkbox"/> Praises client for practice <input type="checkbox"/> Normalises difficulties discussed with client <input type="checkbox"/> Identifies ways to improve use of tracking thoughts (e.g., client-focused solutions to challenges)	
Check the level that best applies (only one level should be checked)			
<input type="checkbox"/> Level 1 <i>any unhelpful behaviour</i>	<input type="checkbox"/> Level 2 <i>no basic skills, or some but not all basic skills</i>	<input type="checkbox"/> Level 3 <i>all basic skills</i>	<input type="checkbox"/> Level 4 <i>all basic helping skills plus any advanced skill</i>
Notes:			

10. USING A ROLE-PLAY TO BUILD COMMUNICATION SKILLS & IMPROVE RELATIONSHIPS

Check all behaviours that are demonstrated in each category.			
Unhelpful or potentially harmful behaviours	Basic helping skills	Advanced helping skills	
<input type="checkbox"/> Forces client to role-play a distressful or traumatic experience <input type="checkbox"/> Humiliates client (e.g., forcing conversation with a sexual perpetrator/abuser)	<input type="checkbox"/> Explains to client how to do the role-play <input type="checkbox"/> Supports the client to act out both sides of conversation in role-play <input type="checkbox"/> <i>None of the above</i>	<input type="checkbox"/> <i>Completes all Basic Helping Skills</i> <input type="checkbox"/> Discusses perspectives of both sides of the conversation with client <input type="checkbox"/> Explains reasoning behind client acting both roles (e.g., this will help you to see both sides of the interaction)	
Check the level that best applies (only one level should be checked)			
<input type="checkbox"/> Level 1 <i>any unhelpful behaviour</i>	<input type="checkbox"/> Level 2 <i>no basic skills, or some but not all basic skills</i>	<input type="checkbox"/> Level 3 <i>all basic skills</i>	<input type="checkbox"/> Level 4 <i>all basic helping skills plus any advanced skill</i>
Notes:			

11. STRESS MANAGEMENT: INTRODUCING A NEW STRATEGY (THEN PRACTICE & REPEAT)

Check all behaviours demonstrated in each category.			
Unhelpful or potentially harmful behaviours	Basic helping skills	Advanced helping skills	
<input type="checkbox"/> Forces client to practice breathing strategy <input type="checkbox"/> Criticises client on performance ('That's all wrong, you need to do this way') <input type="checkbox"/> Rushes through practice or uses a loud or harsh voice <input type="checkbox"/> Gives nonspecific unhelpful suggestions (e.g., try breathing better)	<input type="checkbox"/> Introduces new technique (e.g., breathing) to willing client <input type="checkbox"/> Guides client through practice, checking-in along the way <input type="checkbox"/> Uses appropriate hand placement and gestures for demonstration <input type="checkbox"/> Appropriately paces instruction and breathing steps (e.g., paces count of 1,2,3,4) <input type="checkbox"/> <i>None of the above</i>	<input type="checkbox"/> <i>Completes all basic skills</i> <input type="checkbox"/> Ensures client doesn't feel need for perfection (e.g., this takes practice, you'll know what is comfortable for you) <input type="checkbox"/> Praises client for practicing and normalises any struggles <input type="checkbox"/> Adapts strategy as needed to ensure client's comfort <input type="checkbox"/> Uses metaphors (e.g., balloon metaphor) or helps client prepare body (shake your body out)	
Check the level that best applies (only one level should be checked)			
<input type="checkbox"/> Level 1 <i>any unhelpful behaviour</i>	<input type="checkbox"/> Level 2 <i>no basic skills, or some but not all basic skills</i>	<input type="checkbox"/> Level 3 <i>all basic skills</i>	<input type="checkbox"/> Level 4 <i>all basic helping skills plus any advanced skill</i>
Notes:			

Acknowledgement. These competencies were informed by research described in: Pedersen, G. A., Lakshmin, P., Schafer, A., Watts, S., Carswell, K., Willhoite, A., Ottman, K., van 't Hof, E., & Kohrt, B. A. (2020). Common factors in psychological treatments delivered by non-specialists in low- and middle-income countries: Manual review of competencies. *Journal of behavioral and cognitive therapy*, 30(3), 165–186. <https://doi.org/10.1016/j.jbct.2020.06.001>

ANNEX 2 - REPLACING UNHEALTHY THOUGHTS



ANNEX 3 - PATIENT HEALTH QUESTIONNAIRE - PQ9

Patient Name: _____

Date: _____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the <i>last 2 weeks</i> , how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Trouble falling/staying asleep, sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Trouble concentrating on things, such as reading the newspaper or watching television.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Thoughts that you would be better off dead or of hurting yourself in some way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?				
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PHQ-9* Questionnaire for Depression Scoring and Interpretation Guide

For physician use only

Scoring:

Count the number (#) of boxes checked in a column. Multiply that number by the value indicated below, then add the subtotal to produce a total score. The possible range is 0-27. Use the table below to interpret the PHQ-9 score.

Not at all (#) _____ x 0 = _____
 Several days (#) _____ x 1 = _____
 More than half the days (#) _____ x 2 = _____
 Nearly every day (#) _____ x 3 = _____

Total score: _____

Interpreting PHQ-9 Scores		Score	Actions Based on PH9 Score
Minimal depression	0-4	< 4	The score suggests the patient may not need depression treatment
Mild depression	5-9		
Moderate depression	10-14	> 5 - 14	Physician uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment
Moderately severe depression	15-19		
Severe depression	20-27	> 15	Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment.

ANNEX 4 - EDINBURGH POST NATAL DEPRESSION SCALE (EPDS)

Date: _____ Clinic Name/Number: _____

Your Age: _____ Weeks of Pregnancy/Age of Baby: _____

Since you are either pregnant or have recently had a baby, we want to know how you feel. Please place a **CHECK MARK (✓)** on the blank by the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**—not just how you feel today. Complete all 10 items and find your score by adding each number that appears in parentheses (#) by your checked answer. This is a screening test; not a medical diagnosis. If something doesn't seem right, call your health care provider regardless of your score.

Below is an example already completed.

I have felt happy:
 Yes, all of the time _____ (0)
 Yes, most of the time (1)
 No, not very often _____ (2)
 No, not at all _____ (3)

This would mean: "I have felt happy most of the time" in the past week. Please complete the other questions in the same way.

- I have been able to laugh and see the funny side of things:
 As much as I always could _____ (0)
 Not quite so much now _____ (1)
 Definitely not so much now _____ (2)
 Not at all _____ (3)
- I have looked forward with enjoyment to things:
 As much as I ever did _____ (0)
 Rather less than I used to _____ (1)
 Definitely less than I used to _____ (2)
 Hardly at all _____ (3)
- I have blamed myself unnecessarily when things went wrong:
 Yes, most of the time _____ (3)
 Yes, some of the time _____ (2)
 Not very often _____ (1)
 No, never _____ (0)
- I have been anxious or worried for no good reason:
 No, not at all _____ (0)
 Hardly ever _____ (1)
 Yes, sometimes _____ (2)
 Yes, very often _____ (3)
- I have felt scared or panicky for no good reason:
 Yes, quite a lot _____ (3)
 Yes, sometimes _____ (2)
 No, not much _____ (1)
 No, not at all _____ (0)
- Things have been getting to me:
 Yes, most of the time I haven't been able to cope at all _____ (3)
 Yes, sometimes I haven't been coping as well as usual _____ (2)
 No, most of the time I have coped quite well _____ (1)
 No, I have been coping as well as ever _____ (0)

- I have been so unhappy that I have had difficulty sleeping:
 Yes, most of the time _____ (3)
 Yes, sometimes _____ (2)
 No, not very often _____ (1)
 No, not at all _____ (0)
- I have felt sad or miserable:
 Yes, most of the time _____ (3)
 Yes, quite often _____ (2)
 Not very often _____ (1)
 No, not at all _____ (0)
- I have been so unhappy that I have been crying:
 Yes, most of the time _____ (3)
 Yes, quite often _____ (2)
 Only occasionally _____ (1)
 No, never _____ (0)
- The thought of harming myself has occurred to me: *
 Yes, quite often _____ (3)
 Sometimes _____ (2)
 Hardly ever _____ (1)
 Never _____ (0)

TOTAL YOUR SCORE HERE ►

* If you scored a **1, 2 or 3** on question 10, **PLEASE CALL YOUR HEALTH CARE PROVIDER (OB/Gyn, family doctor or nurse-midwife) OR GO TO THE EMERGENCY ROOM NOW** to ensure your own safety and that of your baby.

If your total score is **11 or more**, you could be experiencing postpartum depression (PPD) or anxiety. **PLEASE CALL YOUR HEALTH CARE PROVIDER (OB/Gyn, family doctor or nurse-midwife) now** to keep you and your baby safe.

If your total score is **9-10**, we suggest you **repeat this test in one week or call your health care provider (OB/Gyn, family doctor or nurse-midwife)**.

If your total score is **1-8**, new mothers often have mood swings that make them cry or get angry easily. Your feelings may be normal. However, if they worsen or continue for more than a week or two, call your health care provider (OB/Gyn, family doctor or nurse-midwife). Being a mother can be a new and stressful experience. Take care of yourself by:

- Getting sleep—nap when the baby naps.
- Asking friends and family for help.
- Drinking plenty of fluids.
- Eating a good diet.
- Getting exercise, even if it's just walking outside.

Regardless of your score, if you have concerns about depression or anxiety, please contact your health care provider.

Please note: The Edinburgh Postnatal Depression Scale (EPDS) is a screening tool that does not diagnose postpartum depression (PPD) or anxiety.

See more information on reverse. ►

Edinburgh Postnatal Depression Scale (EPDS) Scoring & Other Information

ABOUT THE EPDS

Studies show that postpartum depression (PPD) affects at least 10 percent of women and that many depressed mothers do not get proper treatment. These mothers might cope with their baby and with household tasks, but their enjoyment of life is seriously affected, and it is possible that there are long term effects on the family.

The Edinburgh Postnatal Depression Scale (EPDS) was developed to assist health professionals in detecting mothers suffering from PPD; a distressing disorder more prolonged than the “blues” (which can occur in the first week after delivery).

The scale consists of 10 short statements. A mother checks off one of four possible answers that is closest to how she has felt during the past week. Most mothers easily complete the scale in less than five minutes.

Responses are scored 0, 1, 2 and 3 based on the seriousness of the symptom. Items 3, 5 to 10 are reverse scored (i.e., 3, 2, 1, and 0). The total score is found by adding together the scores for each of the 10 items.

Mothers scoring above 12 or 13 are likely to be suffering from depression and should seek medical attention. A careful clinical evaluation by a health care professional is needed to confirm a diagnosis and establish a treatment plan. The scale indicates how the mother felt during the previous week, and it may be useful to repeat the scale after two weeks.

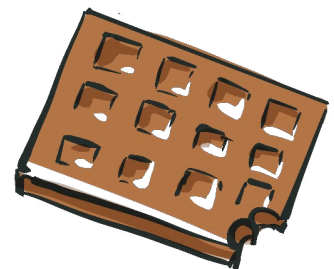
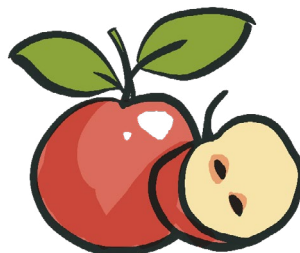
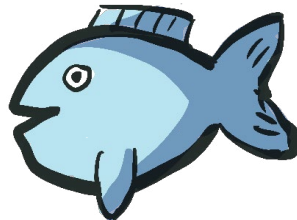
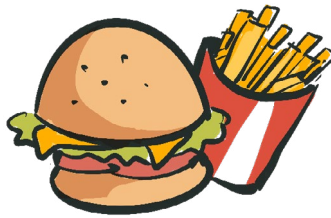
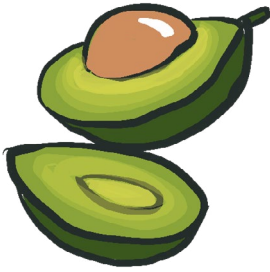
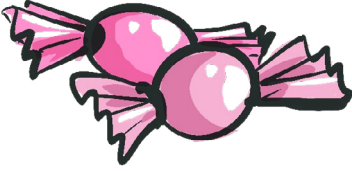
INSTRUCTIONS FOR USERS

1. The mother checks off the response that comes closest to how she has felt during the previous seven days.
2. All 10 items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others.
4. The mother should complete the scale herself, unless she has limited English or reading difficulties.
5. The scale can be used at six to eight weeks after birth or during pregnancy.

Please note: Users may reproduce this scale without further permission providing they respect the copyright (which remains with the *British Journal of Psychiatry*), quote the names of the authors and include the title and the source of the paper in all reproduced copies. Cox, J.L., Holden, J.M. and Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*, 150, 782-786.

Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*, 150, 782-786. The Spanish version was developed at the University of Iowa based on earlier Spanish versions of the instrument. For further information, please contact Michael W. O'Hara, Department of Psychology, University of Iowa, Iowa City, IA 52245, e-mail: mikeohara@uiowa.edu.

ANNEX 5 -
DIET CUTOUTS
SECTION 21
ACTIVITY 4



ANNEX 6 - AWARENESS RAISING/ PSYCHOEDUCATION SESSIONS

Guidance Note for Iraqi Red Crescent Psychosocial Staff and Volunteers

INTRODUCTION

This guidance note is developed for IRCS PS staff and volunteers who provide support to individuals, families, and communities affected by conflict, natural disasters, and other emergencies.

It provides clear guidance on how to conduct awareness raising and psychoeducation sessions for the community as well as for IRCS staff and volunteers.

WHAT ARE AWARENESS RAISING AND PSYCHOEDUCATION

Awareness raising is a key service that helps to inform individuals, families, and communities on different topics that are not necessarily linked to the subject of mental health and psychosocial support but contribute to their psychosocial well-being. For example, cholera is a health problem; however, when there is a cholera outbreak, it also affects the population's psychosocial well-being, as people become afraid of the disease, feels insecure about the future, and not knowing how to treat or prevent cholera. Awareness raising activities, therefore, include informing people about cholera (health aspect) and providing people with opportunities to voice their fears as well as share their concerns (psychosocial aspect).

Psychoeducation is a key service that helps to educate both the affected population and staff and volunteers on topics related to mental health and psychosocial well-being. It can be helpful before possible exposure to stressful situations or after exposure. Psychoeducation involves providing information to individuals and groups. Topics, could include stress and coping, post-traumatic stress, children's stress, psychosomatic reactions to stress, and what to do about them. It empowers people by encouraging them to share experiences and knowledge so that they can deal with challenges and take care of themselves and loved ones in a better way.

Common psychoeducation activities include the development and distribution of information and education materials related to mental health and psychosocial well-being, public awareness campaigns, lectures, discussion forums, scheduled talks with question and answer sessions, and training of staff and volunteers.

Topics for awareness raising or psychoeducation must be based on the identified needs of the affected community. These topics must be approved by the IRCS PS manager, and for each topic written guidance must be developed to guide staff and volunteers.

THE OBJECTIVE OF AWARENESS RAISING AND PSYCHOEDUCATION

The objective of awareness raising is to:

- Inform individuals, families, and communities on different topics that are not necessarily linked to the subject of mental health and psychosocial support but contribute to their psychosocial well-being;

The objective of psychoeducation is to:

- Provide people with information that helps them better understand topics related to mental health and psychosocial well-being and thereby better understand their feelings and behaviour and those of people around them.

THE TARGET GROUP FOR AWARENESS RAISING AND PSYCHOEDUCATION SESSIONS

The target group can be:

- Children or adults from host communities, IDPs, refugees or returnees affected by natural disasters, armed conflicts, disease outbreaks, war or daily stressors like lack of job opportunities, family violence, illness of a family member or other emergency situations.
- IRCS staff and volunteers are also exposed to emergencies and stressors and can therefore also benefit from awareness raising and psychoeducation.

WHO TO TARGET

If for example, there is a cholera outbreak, awareness raising has to be conducted for both children and adults. However, the way the information is conveyed needs to be timely, accurate, age-appropriate and relevant to the target group.

The same applies to psychoeducation; both children and adults will need timely, accurate and age-appropriate information about stress and how to cope with stress.

In some cases, it will make sense to conduct awareness raising/psychoeducation for specific groups, e.g. a group of caregivers who want to learn more about children's stress or a group of midwives or teachers who wish to learn more about early marriage.

AWARENESS RAISING AND PSYCHOEDUCATION SESSIONS

The sessions should be planned in consultation with the IRCS PS focal person. The frequency always depends on the needs of the affected population and the availability of trained PS staff and volunteers.

LENGTH AND NUMBER OF SESSIONS

Each session should last 60 to 90 minutes.

The number of participants may vary as it depends on the location and whether it is planned to conduct a session with a specific group. If for example, a session on stress is conducted in the waiting room of a clinic, people will come and go, and you can't control the movement of people. Try to target groups of 20 people.

WHO CONDUCTS SESSIONS

When doing an awareness raising/psychoeducation session, it is recommended that one male and one female volunteer conduct the session as a team. While doing an awareness raising / psychoeducation session with a family, the family members may prefer and feel more comfortable to talk with only a male or female. Accept and respect cultural norms

While conducting an awareness raising/psychoeducation session on a sensitive topic, i.e. personal hygiene or sexual violence, the participants might feel more comfortable with a trainer of a specific gender.

MATERIALS

- Print session description for the topic you will speak on.
- Bring a notebook and pen so you can write down your observation. Some participants might ask you for additional support, write down their personal information and needs and inform the IRCS PS focal point.
- If available, take posters on a relevant topic, e.g. stress management or disease prevention and put them in the venue so that participants can see them.
- If available, take leaflets on the topic, e.g. stress management or disease prevention and after the session, give them to participants. If you are with the family, share 1-2 leaflets.
- Bring, but it is not necessary, markers and flipchart papers to write down key discussion points.

THE PROCESS TO PLAN AND CONDUCT SESSIONS

Successful awareness raising/psychoeducation sessions depend on the knowledge on a specific topic, presentation skills as well as on the preparation.

Before

- Identify the target audience.
- Decide on date and times when you will do a session with the target group and add it in the IRCS branch PS Plan of activities.

- Check with the community if they would prefer a trainer of a specific gender.
- Identify a suitable location with enough space for people to be seated.
- If possible, ensure access to toilets.
- Ensure access to drinking water.
- Read the material on the topic and plan how you want to present it within the time frame. Make sure you understand the content and can explain it simply and clearly to the target group.
- Invite community volunteers to support you and start to build their capacity on how to conduct awareness raising/psychoeducation sessions within their communities.
- Purchase any material needed for the session, e.g. markers and flipchart paper, trash bags, water, and cups.
- Always arrive ahead of time to ensure that the space is available, clean, safe and accessible for the target group.
- If community volunteers help you, make sure they are clear about their roles and responsibilities.
- Be ready and present before the session begins. Set up space in a way where you can sit down and maintain eye contact with everyone in the space. Ideally, sit together with the participants in a circle and only stand up if you need to use a flipchart or demonstrate an activity

During

- Welcome the participants, introduce yourself, the community volunteers.
- Explain the purpose of the session and the duration of the session.
- Avoid using a lecturing tone and body pose. Remember, you can also learn from the group.
- Ensure that everyone is listened to and gets an opportunity to speak if they wish to.
- Keep the discussion focused on the main topic, but also give room for people to raise or address other issues if you can see this is of interest to the group.
- Encourage participants to share their experience and how they have managed to deal with the topic, e.g. bed wetting or leishmaniasis.
- Repeat and ensure that key messages are well conveyed to the participants
- If someone needs to be referred to the basic services and/or specialised services, follow the procedure for referrals.

- End the session by asking for feedback from the participants. What went well during the session? What could be done differently next time?
- Agree on time and place for the next session.
- Encourage participants to clean up space together with you.

After

- Write down a summary of the awareness raising/psychoeducation session in the report.
- Follow up on any cases that need a referral.

ANNEX 7 - INTER-AGENCY REFERRAL FORM AND GUIDANCE NOTE



© Inter-Agency Standing Committee (IASC) Reference Group for Mental Health and Psychosocial Support in Emergency Settings, 2017.

The Inter-Agency Standing Committee was established in 1992 in response to General Assembly resolution 46/182, which called for strengthened coordination of humanitarian assistance. The resolution set up the IASC as the primary mechanism for facilitating inter-agency decision-making in response to complex emergencies and natural disasters. The IASC comprises the heads of a broad range of United Nations and non-UN humanitarian organisations. For further information on the IASC, please access its website at: www.humanitarianinfo.org/iasc.

This publication is available on the IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings webpage at:

<https://interagencystandingcommittee.org/mental-health-and-psychosocial-support-emergency-settings>

Suggested citation:

Inter-Agency Standing Committee (IASC) Reference Group for Mental Health and Psychosocial Support in Emergency Settings, Inter-Agency Referral Form and Guidance Note, IASC, Geneva, 2017.

Frontcover Photo © Girls with lego: Michael McCauslin/ 2014/ International Federation of Red Cross and Red Crescent Societies. Afghanistan prosthesis: Ash Sweeting/ 2008/ Afghanistan/ International Committee of the Red Cross. Uganda referral: Victor Lacken/ 2012/ Uganda/ International Federation of Red Cross and Red Crescent Societies. Sahel nutrition: Sarah Oughton/ 2012/ Sahel/ International Federation of Red Cross and Red Crescent Societies. Shelter reconstruction: IFRC/ 2016/ Nepal/ International Federation of Red Cross and Red Crescent Societies

For feedback or suggestions for the improvement of this publication, please e-mail:

mhpss.refgroup@gmail.com

Acknowledgements:

The content of this publication was developed by the IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings. The task team leading its development included: Sarah Harrison (International Federation of Red Cross and Red Crescent Societies Reference Centre for Psychosocial Support, or IFRC Psychosocial Centre), Mark Jordans (War Child Holland and King's College London), Guglielmo Schinina (International Organisation for Migration), Mark van Ommeren (World Health Organisation) and Inka Weissbecker (International Medical Corps) .

The development of this publication was managed and funded by the IFRC Reference Centre for Psychosocial Support.

Inter-Agency Referral Guidance Note for MHPSS

What is an inter-agency referral?

A referral is the process of directing a client to another service provider because s/he requires help that is beyond the expertise or scope of work of the current service provider. A referral can be made to a variety of services, for example health, psychosocial activities, protection services, nutrition, education, shelter, material or financial assistance, physical rehabilitation, community centre and/ or a social service agency.

Who can use the referral form?

The referral form is intended to be used by humanitarian organisations working with persons with MHPSS problems. The referral form and guidance note are tools to facilitate inter-agency referrals, referral pathways, trainings and workshops, and as a means to document referrals in accordance with minimum standards. The referral form and guide can be used by any service provider for example, by a Doctor working in a primary healthcare centre referring a child to a child friendly space or a nutrition feeding programme, or a Case Manager referring a client for physical rehabilitation. It can also be used by persons providing Psychological First Aid, depending on the person's role/ responsibilities, after a distressing event.

The referral form is designed to facilitate referrals between and within all four levels of the IASC MHPSS Intervention pyramid¹. Case Managers and Community Workers may find the tool of particular use in their work with individual clients and their families.

The referral form is not a tool to detect persons with mental, neurological and/ or substance use (MNS) disorders, rather it can be used to refer persons to mental health care services for assessment and further management.

How can I make a referral?

At its most basic, the steps required to make a successful referral are:

1. **Identify the problem- what does the client need?** Identify and/or assess the client's problems, needs, and strengths with her/ him and/ or their caregiver (e.g. if the client is a minor or with severely impaired functioning requiring caregiver help).
2. **Identify which organization or agency can meet this need.** Identify and map other service providers who may be able to assist the client and/ or the caregiver with her/ his needs. Information about other services in your geographical areas can be obtained from service guides, 4Ws mapping reports or Coordination meetings². Check if the child is already included within the child protection management system (e.g., Primero platform)³
3. **Contact the service provider to confirm eligibility.** Contact the other service providers in advance to find out more about their services and eligibility criteria, unless the specific type of referral is commonly done with the service provider. Requested information should include what their referral protocol entails and whether or not they will be able to assist the client.
4. **Explain referral to the client.** Provide information about available services and explain the referral to the client and/ or caregivers (e.g. What services are provided? Where is the service provider located? How can the client get there and receive services? Why do you recommend the referral?). Keep in mind that the client can choose to not be referred.
5. **Document consent.** If the client agrees to the referral, obtain consent before the client's information is shared with others and agree with the client, which information can be shared. Parental/ care giver consent should be obtained if the client is a minor.
6. **Make the referral.** Fill out the inter-agency referral form in triplicate (x1 copy with referring agency, x1 copy with client/ caregiver, x1 copy to receiving agency). Provide the referral agency's contact information to the client and accompany them to the referral agency if needed. Referrals can also be made over the phone (if in an emergency), via e-mail or through an App or a database. See Annex 1 for the IASC referral forms.
7. **Follow up** with the client and the receiving agency to ensure the referral was successful and exchange information, where client consent allows for this. Areas for follow up include: did the client receive the planned services? What was the outcome? Was the client and/ or the caregiver satisfied with the referral process, and the services received?
8. **Storage of information and confidentiality.** All referrals forms and case files should be stored in secure (locked) cabinets to ensure the implementation of safe and ethical data collection, management and storage of information.

How can I work together with different agencies to coordinate referrals?

The successful implementation of an inter-agency referral system includes participating agencies to (1) endorse uniform referral documentation (e.g., a uniform referral form - see IASC referral forms and key in Annex 1 and Annex 2), (2) agree on specific referral pathways, procedures and standards for making referrals (e.g., which organisation will be best suited to serve which kind of clients), (3) train relevant staff on the use of documentation, standards and procedures, and (4) participate in coordination activities such as a 4Ws MHPSS service mapping (Who is doing What, Where and When), coordination meetings and referral workshops.

These steps should be coordinated through existing mechanisms, such as inter-agency MHPSS coordination groups or through relevant clusters/ working groups. It is recommended that this effort is cross-sectoral, including actors from sectors such as nutrition, camp coordination and camp management, education, protection, MHPSS, and health.

Monitoring and evaluating referrals and functioning referral systems

The success of an inter-agency referral system could be tracked using a variety of indicators, depending on the agencies' data and reporting needs. For example, at a basic level, agencies could report an increase in inter-agency collaboration through agreeing on a referral form to be used by all coordinating agencies, citing the number of agencies who have endorsed the form and committed to training their staff on its use. At a higher level, agencies could track an increase in their staff capacity to make successful referrals via pre-, post-, and delayed-post tests or the number of successful referrals documented through inter-agency quality and tracking measurements. Where relevant, all indicators should be sex and age disaggregated. Please see Annex 3 for a list of output and outcome indicators with corresponding means of verification to measure referrals and functioning referral systems.

¹ Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC, p11-13.

² The IASC 4Ws: Who is Doing What, Where and When in Mental Health and Psychosocial Support Emergency Settings maybe a useful guide when sourcing service providers.

³ <http://www.primer.org/>

Referring agency copy
 Routine Urgent Date of Referral (DD/MM/YY):

Referring Agency		
Agency / Org:	Contact:	
Phone:	E-mail:	
Location:		
Receiving Agency		
Agency / Org:	Contact (if known):	
Phone:	E-mail:	
Location:		
Client Information		
Name:	Phone:	
Address:	Age:	
Sex:	Nationality:	
Language:	ID Number:	
If Client Is a Minor (under 18 years)		
Name of primary caregiver:	Relationship to child:	
Contact information for caregiver:	Is child separated or unaccompanied? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Caregiver is informed of referral? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, explain)		
Background Information/Reason for Referral: (problem description, duration, frequency, etc.) and Services Already Provided		
Has the client been informed of the referral? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, explain below)	Has the client been referred to any other organizations? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, explain below)	
Services Requested		
<input type="checkbox"/> Mental Health Services	<input type="checkbox"/> Protection Support/ Services	<input type="checkbox"/> Shelter
<input type="checkbox"/> Psychological Interventions	<input type="checkbox"/> Community Centre/ Social Services	<input type="checkbox"/> Material Assistance
<input type="checkbox"/> Physical Health Care	<input type="checkbox"/> Family Tracing Services	<input type="checkbox"/> Nutrition
<input type="checkbox"/> Physical Rehabilitation	<input type="checkbox"/> Legal Assistance	<input type="checkbox"/> Financial Assistance
<input type="checkbox"/> Psychosocial Activities	<input type="checkbox"/> Education	
Please explain any requested services:		
Consent to Release Information (Read with client/ caregiver and answer any questions before s/he signs below)		
I, _____ (client name), understand that the purpose of the referral and of disclosing this information to _____ (receiving agency) is to ensure the safety and continuity of care among service providers seeking to serve the client. The service provider, _____ (referring agency), has clearly explained the procedure of the referral to me and has listed the exact information that is to be disclosed. By signing this form, I authorize this exchange of information.		
Signature of Responsible Party:		
(Client or Caregiver if a minor). Date (DD/MM/YY):		
Details of Referral		
Any contact or other restrictions? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, explain below)		
Referral delivered via: <input type="checkbox"/> Phone (emergency only) <input type="checkbox"/> E-mail <input type="checkbox"/> Electronically (e.g., App or database) <input type="checkbox"/> In Person		
Follow-up expected via: <input type="checkbox"/> Phone <input type="checkbox"/> E-mail <input type="checkbox"/> In Person. By date (DD/MM/YY):		
Information agencies agree to exchange in follow up:		

Client copy
 Routine Urgent Date of Referral (DD/MM/YY):

Referring Agency		
Agency / Org:	Contact:	
Phone:	E-mail:	
Location:		
Receiving Agency		
Agency / Org:	Contact (if known):	
Phone:	E-mail:	
Location:		
Client Information		
Name:	Phone:	
Address:	Age:	
Sex:	Nationality:	
Language:	ID Number:	
If Client Is a Minor (under 18 years)		
Name of primary caregiver:	Relationship to child:	
Contact information for caregiver:	Is child separated or unaccompanied? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Caregiver is informed of referral? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, explain)		
Background Information/Reason for Referral: (problem description, duration, frequency, etc.) and Services Already Provided		
Has the client been informed of the referral? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, explain below)	Has the client been referred to any other organizations? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, explain below)	
Services Requested		
<input type="checkbox"/> Mental Health Services	<input type="checkbox"/> Protection Support/ Services	<input type="checkbox"/> Shelter
<input type="checkbox"/> Psychological Interventions	<input type="checkbox"/> Community Centre/ Social Services	<input type="checkbox"/> Material Assistance
<input type="checkbox"/> Physical Health Care	<input type="checkbox"/> Family Tracing Services	<input type="checkbox"/> Nutrition
<input type="checkbox"/> Physical Rehabilitation	<input type="checkbox"/> Legal Assistance	<input type="checkbox"/> Financial Assistance
<input type="checkbox"/> Psychosocial Activities	<input type="checkbox"/> Education	
Please explain any requested services:		
Consent to Release Information (Read with client/ caregiver and answer any questions before s/he signs below)		
I, _____ (client name), understand that the purpose of the referral and of disclosing this information to _____ (receiving agency) is to ensure the safety and continuity of care among service providers seeking to serve the client. The service provider, _____ (referring agency), has clearly explained the procedure of the referral to me and has listed the exact information that is to be disclosed. By signing this form, I authorize this exchange of information.		
Signature of Responsible Party:		
(Client or Caregiver if a minor). Date (DD/MM/YY):		
Details of Referral		
Any contact or other restrictions? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, explain below)		
Referral delivered via: <input type="checkbox"/> Phone (emergency only) <input type="checkbox"/> E-mail <input type="checkbox"/> Electronically (e.g., App or database) <input type="checkbox"/> In Person		
Follow-up expected via: <input type="checkbox"/> Phone <input type="checkbox"/> E-mail <input type="checkbox"/> In Person. By date (DD/MM/YY):		
Information agencies agree to exchange in follow up:		

Receiving agency copy
 Routine Urgent Date of Referral (DD/MM/YY):

Referring Agency		
Agency / Org:	Contact:	
Phone:	E-mail:	
Location:		
Receiving Agency		
Agency / Org:	Contact (if known):	
Phone:	E-mail:	
Location:		
Client Information		
Name:	Phone:	
Address:	Age:	
Sex:	Nationality:	
Language:	ID Number:	
If Client Is a Minor (under 18 years)		
Name of primary caregiver:	Relationship to child:	
Contact information for caregiver:	Is child separated or unaccompanied? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Caregiver is informed of referral? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, explain)		
Background Information/Reason for Referral: (problem description, duration, frequency, etc.) and Services Already Provided		
Has the client been informed of the referral? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, explain below)	Has the client been referred to any other organizations? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, explain below)	
Services Requested		
<input type="checkbox"/> Mental Health Services	<input type="checkbox"/> Protection Support/ Services	<input type="checkbox"/> Shelter
<input type="checkbox"/> Psychological Interventions	<input type="checkbox"/> Community Centre/ Social Services	<input type="checkbox"/> Material Assistance
<input type="checkbox"/> Physical Health Care	<input type="checkbox"/> Family Tracing Services	<input type="checkbox"/> Nutrition
<input type="checkbox"/> Physical Rehabilitation	<input type="checkbox"/> Legal Assistance	<input type="checkbox"/> Financial Assistance
<input type="checkbox"/> Psychosocial Activities	<input type="checkbox"/> Education	
Please explain any requested services:		
Consent to Release Information (Read with client/ caregiver and answer any questions before s/he signs below)		
I, _____ (client name), understand that the purpose of the referral and of disclosing this information to _____ (receiving agency) is to ensure the safety and continuity of care among service providers seeking to serve the client. The service provider, _____ (referring agency), has clearly explained the procedure of the referral to me and has listed the exact information that is to be disclosed. By signing this form, I authorize this exchange of information.		
Signature of Responsible Party:		
(Client or Caregiver if a minor). Date (DD/MM/YY):		
Details of Referral		
Any contact or other restrictions? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, explain below)		
Referral delivered via: <input type="checkbox"/> Phone (emergency only) <input type="checkbox"/> E-mail <input type="checkbox"/> Electronically (e.g., App or database) <input type="checkbox"/> In Person		
Follow-up expected via: <input type="checkbox"/> Phone <input type="checkbox"/> E-mail <input type="checkbox"/> In Person. By date (DD/MM/YY):		
Information agencies agree to exchange in follow up:		

Annex 2: Description of key terms in the referral form

Section on the referral form	Explanation and examples ⁴
Location	Examples include the name of a specific camp, or a physical street address. The client/ care giver should be able to physically locate the receiving agency from this information.
Age	Can be written in a date of birth format (DD/MM/YYYY); or exact age written in years; or written as an estimated age if the information is not known by the client/ care giver.
Client has been informed of referral (Y/N)	If checking 'no', please explain why the client or caregiver has not been informed of the referral. The consent signature appears towards the end of the form.
Has client been referred to any other organizations (Y/N)	It is helpful for agencies to know about previous referrals to prevent one individual or family being referred several times by multiple agencies for the same service. It also helps guide any future referrals.
Mental Health Services	Category refers to the assessment and clinical management of mental, neurological and substance use (MNS) disorders (whether by specialised or non-specialised health care providers); and support to the caregivers of persons with MNS disorders. Please specify in the narrative box whether inpatient or outpatient services are requested. Of note, mental health services often also offer psychological interventions and psychosocial activities (see below).
Psychological Interventions	This includes psychological interventions such as individual, family or group counselling/ therapy.
Physical Health Care	Refers to physical health care by Doctors, Nurses, Midwives and Community Health Workers etc. Please specify in the narrative box whether inpatient or outpatient services are requested.
Physical Rehabilitation	This primarily includes physiotherapy, occupational therapy and prosthetics.
Psychosocial Activities	This includes community, group and family support activities; child, women and youth friendly spaces; assistance to vulnerable individuals and families; parenting classes, early childhood development and psycho-education for individuals and families.
Protection Support/ Services	Protection includes mine action and mine risk education, child protection and sexual and gender based violence. Protection support/ services also covers protection monitoring, specific services for persons with disabilities, survivors of sexual and gender based violence, survivors of torture, targeted programmes for children associated with armed groups/ forces, child labour and case management services for children and SGBV survivors.

⁴ IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings. (2012). Who is Where, When, and doing What (4Ws) in Mental Health and Psychosocial Support: Manual with Activity Codes (field test-version). Geneva.

Family Tracing Services	Restoring family links; reunification services; best interest assessment (BIA) and alternative care for unaccompanied and separated children.
Legal Assistance	Access to legal advice including through paralegals and lawyers; housing, land and property issues; and documentation (e.g., identification cards and certificates for: birth, death, marriage, divorce and educational qualifications etc.).
Nutrition	Mother-baby groups, promotion of breastfeeding practices, therapeutic-feeding for severe and/ or acute malnutrition and cognitive stimulation groups.
Any contact or other restrictions (Y/N)	This question relates to the protection of the client being referred and the principle of 'Do No Harm'. In some cases, (such as persons with mental health disorders, survivors of sexual and gender based violence, or in cases of child protection), there may be certain restrictions on how to contact the client and how to provide services/ support to ensure that you are not causing additional harm. This is important in protection-related cases when the perpetrator maybe a family or a community member, and when working with persons with mental health problems to minimise any related stigma and to ensure confidentiality. In such situations, the client may request that she/ he be contacted through a close friend, another relative or a trusted community member, or through another medium such as via e-mail, rather than through the telephone. Please write any such concerns or restrictions in the space provided on the form.
Information agencies agree to exchange in follow up	In functioning referral systems, there is often a need for an exchange of information between the referring agency and the receiving agency. In most situations this is just a confirmation receipt for a referral, but in other situations additional information exchange maybe required, whilst respecting the client's wishes for confidentiality (e.g., if one agency is providing case management services and is responsible for coordinating a client's referrals).

Annex 3: A table listing output and outcome level indicators and corresponding means of verification to measure inter-agency referrals⁵.

Output/ Outcome	Indicators	Means of Verification
Functioning referral system is established (Output)	Referral procedures established, including referral documentation and forms	Referral documentation forms & referral guidelines
	MHPSS 4Ws Service Mapping conducted	IASC MHPSS 4Ws: Who is doing What, Where and When Service mapping (could also be conducted by OCHA)
	# of inter-agency referral workshops (or trainings) conducted	Attendance sheets
	# of organisations and agencies participating in inter-agency referral workshops (or trainings)	Workshop reports
	# of MHPSS staff and volunteers providing direct services are knowledgeable of referral resources and procedures.	Staff/ volunteer activity records, referral tracking sheets or individual client files Activity space weekly report Clinic records/ register
	# and % of medical facilities, social service facilities and community programmes that have and apply procedures for the referral of people with MHPSS problems	Individual clinic or social service register Activity space weekly report Referral documentation forms Inter-Agency quality and tracking measurements
Increase in the frequency and quality of referrals (Outcome)	# of documented successful ⁶ referrals (made & received) disaggregated by service, gender and age.	Referral documentation forms Inter-Agency quality and tracking measurements Weekly/ monthly activity reports
	Level of satisfaction of people with MHPSS problems regarding the referral/ or referral process	Client satisfaction survey Feedback forms/ surveys
	# of clients (out of the total number of clients) who were successfully referred to other services. # and % of referrals received from other service providers.	Client files Referral documentation forms Monthly/ quarterly activity reports (take a baseline, mid and end-line to measure changes over time)
	Increase in staff and volunteers' knowledge and capacity to make successful referrals	Staff/ volunteer competency checklist Pre and delayed post tests Supervision sessions

⁵ Some examples of indicators were taken from the Inter-Agency Standing Committee (IASC) Reference Group for Mental Health and Psychosocial Support in Emergency Settings, A Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings, IASC, Geneva, (2017); and the International Federation of Red Cross and Red Crescent Societies' Reference Centre for Psychosocial Support (IFRC PS Centre), Monitoring and Evaluation Framework for Psychosocial Support Interventions, IFRC PS Centre, Copenhagen 2017: <http://pscentre.org/topics/m-and-e/>

⁶ Agencies are strongly encouraged to define 'successful referrals' in their monitoring and evaluation plans, and to ensure that any means of verification adhere to this definition.





Psychosocial Centre

**International Federation of Red
Cross and Red Crescent Societies**

Reference Centre for
Psychosocial Support
Blegdamsvej 27, DK-2100
Copenhagen
Denmark

Phone: +45 35 25 92 00 - E-mail: psychosocial.centre@ifrc.org - Web: www.pscentre.org
Facebook: www.facebook.com/ - Psychosocial.Center - Twitter: @IFRC_PS_Centre - Instagram: ifrc psychosocialcentre