

# SECTION J

## POSTNATAL DEPRESSION

### SESSION 35

#### *Post-Natal Depression*

Time required: 30 minutes

#### **Purpose**

The purpose of this session is to communicate the nature of Postnatal Depression.

#### **Objectives**

By the end of this session MM's will be able to understand what behaviours and feelings signal Postnatal Depression and understand that at times treatment may be required.

#### **Materials**

1. Board
2. Markers

#### **Preparation**

Prepare the lectures as outlined in this session and familiarize yourself with the content so that you can lead the lectures and discussions with confidence.

***Instructions to trainers:***

1. Ask MM what they know about depression and how it makes a person feel and behave.
2. Ask a few of the MM to volunteer examples of people they know or have heard of who they think have had depression.
3. Go through the following lecture content on 'Postnatal Depression', encouraging questions and clarifying for confusion as you go along.

**LECTURE CONTENT: Postnatal depression**

Postnatal depression is an illness, like diabetes or heart disease. It can be treated with therapy, support networks and medicines such as antidepressants. The symptoms of postpartum depression include:

- Feeling sad or down often
- Frequent crying or tearfulness
- Feeling restless, irritable or anxious
- Loss of interest or pleasure in life. It's hard for you to see the funny or good side of life
- Loss of appetite
- Less energy and motivation to do things
- Difficulty sleeping, including trouble falling asleep, trouble staying asleep, waking up early in the morning, or sleeping more than usual. You long for sleep, yet wake unrefreshed each morning
- Feeling worthless, hopeless or guilty. You see others organising themselves and their babies and think "I could never do that"
- Unexplained weight loss or gain
- Feeling like life isn't worth living
- Showing little interest in your baby
- You sometimes lose your sense of time - you can't tell the difference between ten minutes and two hours

Sometimes postnatal depression will go away with time but often people with postnatal depression need medication to get better. If you come across a mother in your neighbourhood who shows signs of postnatal depression, you need to listen and empathise with how much they are struggling, assure them that help is available, that you are there to support them and refer them for specialised treatment.

# SECTION K

## NEONATAL TRAINING

### SESSION 36

#### *Introduction to Neonatal Care: The Importance of Community Home-based Care for Mothers and Newborns Activities*

Time required: 30 minutes

#### **Purpose**

To help Mentor Mothers understand that the neonatal period constitutes an important time for mothers and children in their communities, and how their care can improve the health of mothers and newborns.

#### **Objectives**

At the end of the session the MM will be able to:

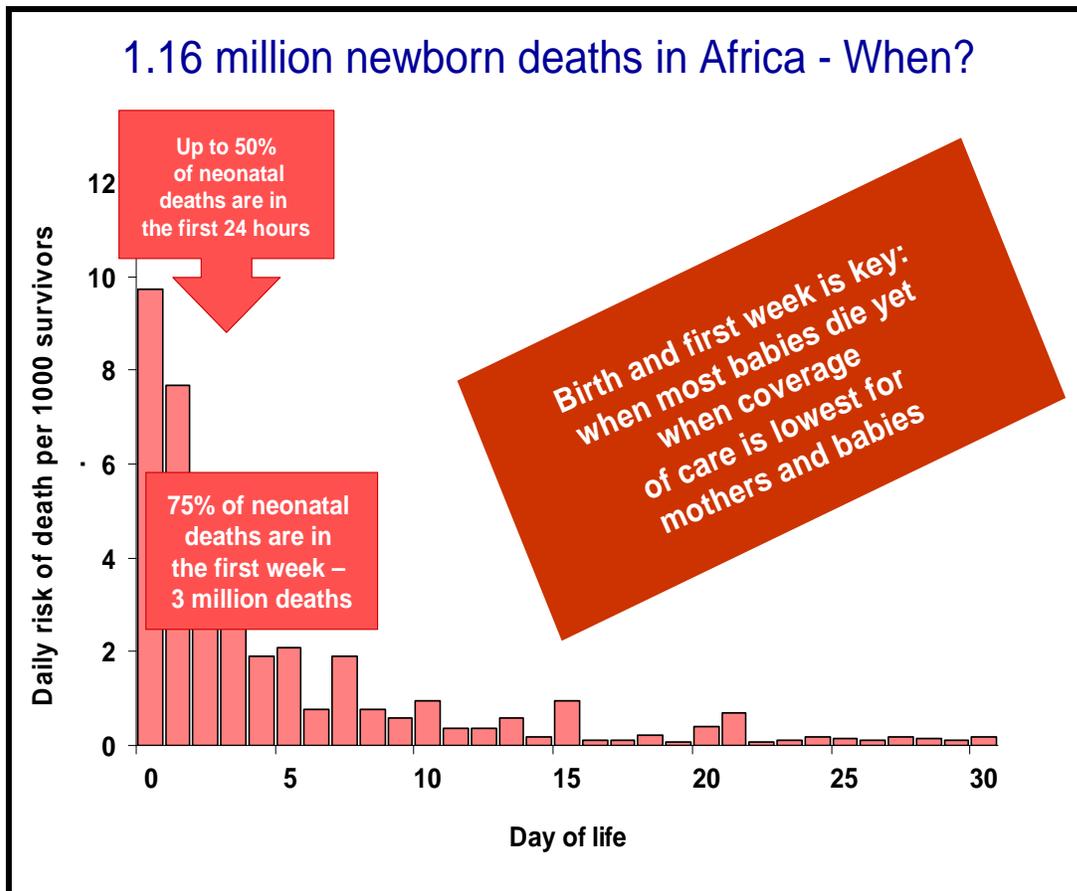
1. Explain why the delivery and the first month after delivery are important for the health of mothers and babies.
2. Describe, in general terms, the intervention in the neonatal period of the MM that will improve the health of mothers and newborns.

#### **Materials**

1. Black board / paper flip chart
2. Markers

**Instructions to trainers:**

1. Explain to trainees that the neonatal period is the first 4 weeks of a baby's life, and refer them to the graph below.



**Source:** Lawn JE, Kerber K Daily risk of death in Africa during first month of life based on analysis of 19 DHS datasets (2000 to 2004) with 5,476 neonatal deaths

2. Go through the graph with the MM's. The important thing for them to think about with this graph is how important the early neonatal period is. Almost 50% of the deaths of neonates occur in the first 24 hours. This is why supporting mothers during this time is so important.

**TRAINER NOTE:** It is very important for you to stress how important the first week is and that not only is it important for them to visit during that time but also why we are going to trying to convince mothers to go to visit the clinic when their

baby is one week old. As can be seen from the figure, birth and the first week is key when most babies die and when the coverage of care is at its lowest for mothers and babies.

### **Importance of home-care for mothers and newborns 20 minutes**

#### ***Instructions to Trainers:***

1. Start with a story (see Content Box 1).
2. Link the story to the need to develop a way to save mothers and newborn lives, and the objectives of this section on neonatal training.
3. For each of the following groups, give a brief summary of what they do in the project and how they work together: MM's, family members, trainers/supervisors, midwives, health staff and community leaders.

## Content Box 1

### WHY NEWBORN CARE IS IMPORTANT TO THE COMMUNITY

**Tell this story:** A woman in my neighbourhood, Buhle, was pregnant with her second child. She was very happy. Her first child, a lovely boy, was already four years old. Buhle's family was poor as others in their neighbourhood, and she was thin. She was not able to attend antenatal care regularly because the nurse in the nearby health centre had left. When labour started, Buhle called her mother. When the baby was born it was small and weak. Buhle's mother-in-law fed the baby sugar water. The baby got weaker and weaker, became cold, and died after three days. Buhle was very sad; she blamed herself and became unhappy. The whole family suffered. This story is not uncommon. Do any of you know of a similar story from your community? Have any babies died within one month after birth? Any mothers?

• **Trainer lets a few women tell their stories.**

**This is a fact:** Almost half of all deaths in children under 5 years occur during the neonatal period.

**Demonstration:** Use a stick and break it in half to show that half of the babies die, or fill a jar with rice and say these are all the children under 5 who die. Pour out half the rice; these children died in the first month.

**Tell this story:** Fundiswa went into labour and called her mother. She had a long labour and when the baby was born it didn't breathe for many minutes; there was no one to offer immediate assistance. Finally it took a weak breath. This baby lived but grew up mentally retarded and had fits. He was not able to live on his own and had to be taken care of by the family for the rest of his life. Everyone in the family was affected.

Because the baby didn't get treatment within minutes of being born, there was damage to his brain and he was not normal; those minutes changed the lives of many people.

• **Ask:** What health care resources are available in your communities? • **Conclude:** Women and babies are very vulnerable around the time of delivery and the first month and there is little help available.

**Ask:** What can be done?

**Discuss:** What actions could have been taken for the baby in the first story that would have saved his life? The mother could have received health education during pregnancy by a Mentor Mother (MM) so she would have eaten better, and taken iron and folic acid tablets (antenatal care). She could have been helped to breastfeed the baby right after delivery and could have been shown how to keep the baby warm. The baby could have had medicine if needed.

What actions could have been done for the baby in the second story to prevent his brain damage? The mother having prolonged labour could have been referred earlier to a hospital, with the help of her family, MM's and other community members. The MM would have cleared the baby's secretions, dried and stimulated him to help him breathe sooner, and referred him immediately to the health centre. In some places the MM may be trained to use a bag and mask to help the baby breathe, and then refer.

## SESSION 37

### ***Care of the Eyes, Umbilical Cord and Skin***

**Time required: 30 minutes**

#### **Purpose**

To orient MM's in providing care for newborns at the time of birth and in the first days after delivery to prevent infection.

#### **Objectives**

At the end of the session the MM will:

1. Know to refer babies with eye infections for antibiotic treatment.
2. Know how to provide umbilical cord care.
3. Know how to prevent and care for skin (nappy) rash.

#### **Materials**

None

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| <b>Presentation: Eye Care</b> |
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| <b>10 minutes</b> |
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#### ***Instructions to trainers:***

1. Explain that eye infections can occur if the mother had a vaginal infection, even without symptoms, during pregnancy, and for other reasons.
2. If MM's see that one of the mothers in their neighbourhood's babies has an eye infection, they need to refer them immediately to the clinic to have antibiotic ointment given to the babies.
3. Ask for any questions and clarify confusion.

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| <b>Discussion: Umbilical Cord Care</b> |
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| <b>10 minutes</b> |
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#### ***Instructions to trainers:***

1. Ask what, if anything, should be put on the cord? Write down the answers. (Answer: *Nothing should be put on the cord, not even soap and water. If stump becomes dirty, then gentian violet (or what the clinic has given) could be applied.*)
2. Remember, the most important thing is to keep the cord stump clean. Nothing else other than gentian violet (if really necessary) should be put on the cord stump.

3. During home visits after delivery, the MM should check the stump and make sure it is clean and dry; if it is red or with pus or smells, refer the baby to the health centre.

**Discussion: Skin Care (nappy rash)**

**10 minutes**

***Instructions to trainers:***

1. Ask the trainees if they have ever seen a baby with a skin rash between the legs, called 'nappy rash'. Ask them to explain what it looks like. *(Responses should include redness or breaking of the skin in the creases of the thighs.)*
2. Ask the trainees how they think this can be prevented. Listen to the answers and note them on the board. *(Answers: Keep the baby clean and dry; if the baby urinates, clean with water and dry with a clean cloth.)*
3. Ask the trainees how they think a rash should be treated. Listen to the answers; praise correct answers, and make sure all trainees know the treatment. *(Answers: Keep baby clean and dry; if not too cold, expose rash to the air for some minutes during the day. If not improved, use zink ointmen /Fissan paste - put on twice daily until improved. If very bad, refer to health facility.)*

## **SESSION 38**

### ***Understanding and Caring For Low Birth Weight and High-risk Babies***

**Time required: 1 hour**

#### **Purpose**

The purpose of this section is to train MM's in understanding and caring for LBW babies.

#### **Objectives**

At the end of the session the MM will be able to:

1. Determine if a baby is 'high-risk'
2. Define low birth weight (LBW) and explain the risks.
3. Explain the immediate care of the LBW baby after delivery.
4. Explain the skin-to-skin or Kangaroo Mother Care (KMC) method, and when and how it is used.

#### **Materials**

1. Training DVD Skill no. 11: Caring for the Small Baby – Positioning Skin-to-Skin (KMC). (optional)

## Presentation and Discussion: LBW & High Risk Babies

30 minutes

### ***Instructions to trainers:***

1. Ask the MM's why it is important to identify high-risk babies. Listen to their answers and praise correct ones. The answers should include:

- High-risk babies have a much higher likelihood of getting seriously sick and dying than healthy babies.
- High-risk babies may get cold quickly and need to be kept warm.
- High-risk babies may have difficulty feeding and may need more support to initiate and maintain effective breastfeeding.

2. Explain that in this project we will consider a newborn to be at high risk if the newborn:

- Is LBW
- Is born early
- If baby and mother have a breastfeeding problem on the first day

3. Ask, "Why does not breastfeeding well on the first day put the baby at risk?" Listen to the answers. (*Answer: Not breastfeeding means the baby is not getting adequate nutrition and could get weak. This puts the baby at risk of getting sick. Babies also need breast milk to grow.*)

4. Ask the MM's if they know how to define low birth weight (LBW). (*Answer: Weight less than 2500 grams or 2.5 kg.*)

5. Explain that most babies born too early are LBW but some babies at full gestation are also LBW. Being LBW at full gestation can be caused by a mother who:

- Is short and is underweight
- Eats inadequate food and/or food that is not nutritious during pregnancy
- Has an illness such as TB, HIV, etc.
- Has less blood (anaemia).
- Works too hard during pregnancy.

6. Discuss the risks of the LBW baby. Ask the MM's if they can mention any risks. Write them on the board or white paper. Fill in any gaps:

- LBW babies lose body temperature faster than normal babies as they have difficulty maintaining their body temperature (due to less body fat, thinner skin, bigger head that loses heat fast, and poorer capacity to generate body heat).
- LBW babies are more prone to infections such as pneumonia, germs in the blood, etc.

- LBW babies may have difficulty breastfeeding, leading to weakness, poor growth and ill health.
- Babies born too early are at risk of jaundice (turning yellow) and if very young, of bleeding in the head and of death.

7. Explain that LBW babies are at higher risk of dying. This can be seen from the following statistics:

- If the baby weighs 2.5 kg or more, the risk is comparable to 1 cent in 100 cents (1 out of 100).
- If the baby weighs between 2.0 to 2.5 kg, the risk is comparable to 10 cents in 100 cents (10 out of 100).
- If the baby weighs less than 2.0 kg, the risk is comparable to 36 cents out of 100 cents (36 out of 100).
- If the baby is born early, the risk is comparable to 36 cents out of 100 cents (36 out of 100).

8. Ask trainees to work on the following examples in their manuals:

### **Case Examples**

#### **Case 1**

Ndumi was born on 3 June, at 8 months 4 days gestation. She weighed 1.9 kg. Is she born too early? Why? What about her weight? Is she at any additional risk? What kinds of risks?

*Answer: Ndumi is born too early because she was born after less than 8 months and 14 days gestation; she is low birth weight at less than 2500 grams (2.5 kg). She also has an additional risk of hypothermia, sepsis (infection), problems with breastfeeding, developing jaundice and death.*

#### **Case2**

Themba was born at 8 months 24 days gestation and weighed 2.4 kg. Is he born too early? Why? Is he low birth weight? Why?

*Answer: Themba is not born too early because his gestational age is above 8 months and 14 days; he does have low birth weight because he is under 2500 grams.*

***Instructions to trainers:***

1. Ask the MM's to suggest what immediate care is needed for the LBW baby. You can give them a clue by saying that much of the care is the same as for the healthy baby, especially trying to keep them warm.

Answers should include:

- Keep room even warmer than usual.
- Dry baby immediately after delivery.
- Put skin-to-skin with mother, and cover or wrap and place close to mother.
- Start breastfeeding.
- If skin-to-skin, only put a nappy on baby and a hat. If not skin-to-skin, put on baby clothes, hat, and place in warm blankets or a warm bag close to mother.
- Observe extra hygiene.

2. Explain that small babies need to feed more often, every 2 hours. This means that if the baby is sleeping, the mother should wake up the baby for a feed. This should be done until the baby gains some weight and is stronger.

3. In the case of very small babies, explain that they are at greatest risk of getting cold and sick and having difficulty breastfeeding.

4. Ask the MM's what the name is of the method to take care of very small babies. (*Answer: Skin-to-skin or Kangaroo Mother Care.*) The Kangaroo Mother Care method is a very successful method of caring for small and early born babies. It keeps babies warm, and ensures frequent breastfeeding. Babies cared for this way grow well and develop well.

5. Review the Kangaroo Mother Care Method:

- Baby is placed upright with their chest against the skin of the mother and in between her breasts. Any member of the family can keep the baby this way to help relieve the mother from time to time.
- Mothers can wear a special blouse to hold the baby or secure the baby with a cloth.
- Baby is naked or with nappy, socks, and a hat on its head, and is covered by the mother's blouse and/or a shawl or sweater (if needed).
- Baby stays next to the mother as much as possible, ideally for 24 hours a day.
- The baby is breastfed often (every 2 hours). The Mother uses the opposite underarm position (see illustration in MM Manual) for more support. If unable to breastfeed, the mother expresses milk and feeds to baby in cup

or paladay. (More detailed information on this was covered in the previous section on feeding)

6. See content box below about extra care for small babies.

7. Ask for any questions and clarify confusion.

### **Content Box: Extra Care for Small Babies**

#### **Extra Care for Small Babies**

- A baby is put in the Kangaroo Mother Care position, skin-to-skin, to keep warm.
- A mother squeezes breast milk to feed a small baby from a cup.
- The small baby is warm; they are wrapped properly, wearing clothes, socks and a hat, and kept close to the mother.

#### **Make sure the woman understands the key points:**

- Preterm and low birth weight babies need to be fed frequently in small quantities.
- Some very small babies cannot suckle from the breast. Mothers can express their breasts and feed the baby with breast milk from a cup.
- Preterm and low birth weight babies need special care – warmth, cleanliness, and exclusive breastfeeding.
- If the baby is above 1500 grams (1.5 kg) and is healthy, the baby can be kept at home with extra care.
- Small babies get sick easily. If danger signs arise it is important to seek care immediately. Ask the woman what actions she will take
- Provide extra care to a preterm and low birth weight baby.
- Seek care immediately if a baby has any of the danger signs.

**Training DVD: Skill no. 11 on Caring for the LBW Baby –  
Positioning Skin-to-Skin (KMC) 10 minutes**

***Instructions to trainers:***

1. Play the Training DVD Skill no. 11. Ask for any questions and clarify confusion.

## SESSION 39

### *Postnatal Home Visits*

**Time required: 1 hour 30 minutes**

#### **Purpose**

The purpose of this session is to introduce the MM to her role during home visits after delivery.

#### **Objectives**

At the end of the session the MM will be able to:

1. Explain when she will visit each mother and newborn during the postnatal period.
2. Explain when she will use the referral note.
3. Explain the sequencing of tasks during each visit.

#### **Materials**

1. Sequencing of activities during the postnatal home visits (MM manual)

#### **Preparation**

Refer trainees to the 'Sequencing of MM activities during the home visit' list in the MM Manual.

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| <b>Presentation: Postnatal home visits</b> |
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| <b>40 minutes</b> |
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#### ***Instructions to trainers:***

1. Ask MM's if they remember the earlier session when we discussed deaths in the first month of life? What do they remember from that discussion? Listen to the answers. Fill in the following points if not mentioned:

#### Answers:

- Almost half of all deaths in children under-5 years occur during the neonatal period (the first month of life).
- Of these, almost half die on the first day of life.
- Three-quarters die during the first week.

2. Ask the trainees what this means in terms of when newborns should be visited in relation to risk of mortality. Listen to their answers. Encourage discussion.

Answer: The greatest risk is on the day of delivery and during the first week. MM's should visit during the time of greatest risk to prevent sickness and death. The MM must visit on Day 2, and then on Day 7 again. They will make further visits at 2 Weeks, 4 Weeks, 2 Months, and 6 Months. Certain mothers who are at greater risk than others (who have two or more of HIV, TB, alcohol use in pregnancy, or a previous LBW baby) will receive two extra visits before birth and two extra visits after birth.

3. Ask trainees how they will know a woman has delivered, in order to target the visits soon after delivery. Listen to the answers, and encourage discussion, which could include the following:

- The MM asks the family to inform her when the baby was born so she can visit as early as possible.

4. Ask for any questions, and clarify confusion.

## **Hand washing Discussion**

**5 minutes**

### ***Instructions to trainers:***

1. Ask trainees why they think that hand washing is important when conducting home visits.
2. Listen to and acknowledge a few answers.
3. Then go through the following content box on hand washing with trainees.

### **CORRECT HAND WASHING (MM manual)**

- Importance of hand washing: One of the most effective ways to limit illness from infection is through correct and frequent hand washing.
- When to wash hands: Hands should be washed thoroughly after using the toilet, before preparing food, and before touching a newborn or young baby. This means that when you enter a home to visit a baby, you must wash your hands before touching the baby, and again if the baby defecates and you clean the baby.
- Keep nails cut short: It is important to keep nails cut short so that dirt and germs do not collect under the nails.
- Once you have washed your hand, remember to either let your hands dry naturally in the air, or dry them using a very clean cloth so as to prevent them from immediately becoming dirty again.

## **Sequencing and content of MM activities during home visits** **45 minutes**

### ***Instructions to trainers:***

1. Refer trainees to the information below illustrating the core messages for each post natal visit. These lists discuss the various activities the MM has to do during the home visit, and gives ideas about the order in which she should do them. The order will depend on the situation in the home at the time of the visit.
2. Read through the lists with the trainees.
3. You may refer trainees to the field guide to briefly look at how each section is laid out in detail as well. Explain that as the training progresses they will learn how to use the field guide and how to address each of the key messages explained in this section, using the materials as indicated. At this stage you would just like them to have an idea of when they should be conducting each visit, and what the core messages they will be conveying are.

### **Contents of postnatal visit 1: General child health, infant feeding, hygiene, protection of child, mother care, danger signs, alcohol. (Field Guide)**

#### ***This visit should happen 48 hours after birth***

There are a number of areas that should be covered during the first postnatal visit. These are:

1. Observe child and mother and check for danger signs. Discuss danger signs and what to do in the event that they occur:
2. Weigh child and plot weight and age on road to health card and record on phone.
3. Observe breast feeding for mothers who have chosen to breastfeed.
4. Observe mixing of formula and cleaning of bottle with mothers who have chosen to formula feed.
5. Discuss cord care, general hygiene, keeping infant warm and protected.
6. For LBW infants, observe mother practicing Kangaroo Care and discuss special frequent feeding routine.
7. Assess mother's general condition - exhaustion, depression, support.
8. Stress importance of limited or no alcohol consumption.
9. For HIV+ mothers, check if infant received Nevirapine as necessary.
10. Advise about hygiene and good routines (to have a plan for the day).

**Contents of postnatal visit 2:  
General child health, infant feeding, growth monitoring, protection of child,  
mother care, TB, HIV, danger signs, alcohol. (Field Guide)**

***This visit should happen 7 days after birth***

There are a number of areas that should be covered during the second postnatal visit. These are:

1. Observe child and mother - check for danger signs. Again discuss danger signs and what to do in the event that they occur:
2. Observe feeding routines.
3. Weigh infant and plot on road to health card and enter information onto telephone, inform mother of age to weight interpretation and discuss implications of weight gain or loss as necessary.
4. For LBW infants, check on effectiveness of Kangaroo Care and special frequent feeding routine.
5. Assess mother's coping ability, sleep, hygiene, depression, support.
6. Stress importance of limited or no alcohol consumption.
7. Encourage good hygiene and good routines (to have a plan for the day).
8. Check on continuation of TB and ARV treatment if applicable.

**Contents of postnatal visit 3:  
General child health, infant feeding, growth monitoring, protection of child,  
mother care, TB, HIV, alcohol, danger signs. (Field Guide)**

***This visit should happen 2 weeks after birth***

There are a number of areas that should be covered during the third postnatal visit. These are:

1. Observe child for danger signs. Again discuss danger signs and what to do in the event that they occur.
2. Observe feeding routines.
3. Weigh infant and plot on road to health card and in folder on growth chart, inform mother of age to weight interpretation and discuss implications of weight gain or loss as necessary.
4. For LBW infants, check on effectiveness of Kangaroo Care and special frequent feeding routine.
5. Discuss how to protect child from infections.
6. Assess mother's coping ability, sleep, hygiene, depression, support.
7. Check on continuation of TB and ARV treatment if applicable.
8. Check on consumption of alcohol if indicated. Counsel if necessary.

9. Observe hygiene routines, discuss mother's routine/plan for the day.
10. Discuss with mother an infant's social responsiveness and ability to communicate with the mother.

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| <b>Contents of postnatal visit 4:<br/>General child health, infant feeding, growth monitoring, protection of child,<br/>mother care, danger signs, immunizations, TB, HIV, alcohol. (Field Guide)</b> |
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***This visit should happen 4 weeks after birth***

There are a number of areas that should be covered during the fourth postnatal visit. These are:

1. Observe child and check for danger signs. Again discuss danger signs and what to do in the event that they occur.
2. Observe feeding routines.
3. Weigh infant and plot on road to health card, explain the weight to age interpretation to the mother and discuss implications of weight gain or loss as necessary.
4. For LBW infants, check on effectiveness of special frequent feeding routine.
5. Discuss how to protect child from infections.
6. Observe hygiene routines.
7. Assess mother's coping ability, sleep, hygiene, depression, support.
8. Check on TB and ARV treatment if applicable.
9. Check on alcohol consumption if indicated. Counsel if necessary.
10. Discuss mother's routine/plan for the day.
11. Promote attendance at clinic at 6 weeks, for mother to have access to family planning and infant to receive immunizations, and for infants of HIV+ women be given cotrimoxazole and HIV testing.
12. Discuss with mother an infant's social responsiveness and ability to communicate with the mother.

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| <b>Contents of postnatal visit 5:<br/>General child health, infant feeding, growth monitoring, protection of child,<br/>mother care, danger signs, immunizations, TB, HIV, alcohol. (Field Guide)</b> |
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***This visit should happen 2 months after birth***

There are a number of areas that should be covered during the fourth postnatal visit. These are:

1. Observe child and check for danger signs.
2. Observe feeding routines.

3. Weigh infant and plot on road to health card and enter data into telephone, explain the weight to age interpretation to the mother and discuss implications of weight gain or loss as necessary.
4. Discuss introduction of solids at 6 months and stress importance of only introducing solids at 6 months.
5. For LBW infants, check on effectiveness of special frequent feeding routine.
6. Discuss how to protect child from infections.
7. Observe hygiene routines.
8. Assess mother's coping ability, sleep, hygiene, depression, support.
9. Check on TB and ARV treatment if applicable.
10. Check on alcohol consumption if indicated. Counsel if necessary.
11. Discuss mother's routine/plan for the day.
12. Check that clinic visit happened at 6 weeks, that immunizations were done and that HIV testing and cotrimoxazole was given if applicable (HIV+ mother).
13. Advise about family planning.
14. Assess mother and infant attachment.
15. Discuss with mother an infant's social responsiveness and ability to communicate with the mother.

**Contents of postnatal visit 6:  
General child health, infant feeding, growth monitoring, protection of child,  
danger signs, immunizations, HIV, TB, alcohol. (Field Guide)**

***This visit should happen 6 months after birth***

There are a number of areas that should be covered during the fourth postnatal visit. These are:

1. Observe child and check for danger signs.
2. Observe feeding routines.
3. Weigh infant and plot on road to health card and enter the data into the telephone, explain the weight to age interpretation to the mother and discuss implications of weight gain or loss as necessary.
4. Discuss introduction of solids, frequent feeding of solids, importance of balanced diet and continuation of breast feeding for two years and beyond.
5. Check that immunizations have been done, that HIV results are known and appropriate action has been taken regarding treatment for child.
6. Discuss how to protect child from infections. Observe hygiene routines.
7. Discuss how to make the home safe for a child as the child grows and starts moving around. .
8. Assess mother's coping ability, sleep, hygiene, depression, support.
9. Check on TB and ARV treatment if applicable.
10. Check on alcohol consumption if indicated. Counsel if necessary.

11. Check on family planning.
12. Assess mother and infant attachment.
13. Discuss with mother an infant's social responsiveness and ability to communicate with the mother.

**NEED TO ADD SCHEDULING AND CONTENT OF EXTRA POST NATAL VISITS HERE**

## **SESSION 40**

### ***Helping with Kangaroo Care of Low Birth Weight Babies***

**Time required: 20 minutes**

#### **Purpose**

To enable MM's to assist mothers with kangaroo care of LBW babies.

#### **Objectives**

At the end of the session the MM will be able to explain the Kangaroo method and when to use it.

#### **Materials**

None

**Presentation: Assisting mothers having difficulty initiating breastfeeding** **20 minutes**

**Instructions to trainers:**

1. Ask participants to explain the Kangaroo Mother Care (KMC) method. (see Content Box below). Fill in any missing points.

**Content box: Kangaroo Mother Care (KMC) method**

**Kangaroo Mother Care (KMC) method**

This is a method for very small babies, usually weighing less than 2000 grams. The baby is placed in an upright position in between the mother's breasts, with the skin of the baby touching the skin of the mother. The baby is covered with the mother's clothes and a cloth or shawl. The baby is kept there most of the day and night. The advantages of the Kangaroo method include the following:

- Baby stays warm. This is important since small babies get cold quickly; this can lead to infection.
- Baby is close for frequent breastfeeding (small babies need to feed more often).
- Increases mother's confidence and ability to care for vulnerable baby.

**Breastfeeding tips**

**For small babies who can suckle:**

- Try the underarm hold for more support or the alternate underarm hold.
- If sleeping, wake baby every 2–3 hours for breastfeeding.

**For small babies unable to suckle at first:**

(Babies less than 1500 grams may not be able to breastfeed at first.)

- Place in Kangaroo position.
- Express milk and feed baby with paladay or cup.
- Express the milk every 2–3 hours to keep the milk supply up.
- Put the baby to the breast to let him lick the nipple and perhaps suckle a little.
- Once the baby can suckle, he should be put on the breast frequently to stimulate milk production. Continue feeding with cup and paladay until the baby can get all it needs directly from the breast.

**IMPORTANT NOTE: For mothers who have chosen to formula feed, low birth weight babies need special formula which is more rich in nutrients than standard formula milk.**

## **SESSION 41**

### ***Identifying Danger Signs and using Referral Notes during Postnatal Visits***

**Time required: 2 hours 15 minutes**

#### **Purpose**

To foster ability in identifying danger signs and making referrals during home visits during the early postnatal period.

#### **Objectives**

At the end of the session the MM will be able to:

1. Use the below information to screen newborns and mothers for danger signs during postnatal home visits.
2. Use the Referral Note or write a short note for the health centre staff when referring newborns and postpartum mothers to the health facility because of the presence of danger signs.

#### **Materials**

1. Blackboard or white paper/flipchart paper
2. Markers
3. Referral Notes
4. Model Role Play Script— Identifying danger signs during Postnatal Home Visit
5. Community Resource Guides

|   |                   |
|---|-------------------|
| <b>Presentation and discussion: Danger signs in mothers and newborns after delivery</b> | <b>75 minutes</b> |
|---|-------------------|

#### ***Instructions to trainers:***

1. Have participants look at the information below on danger signs.
2. Danger signs are presented in 3 different sections:
  - (i) for pregnant women and during delivery,
  - (ii) for newborns after delivery and
  - (iii) for mothers after delivery.
3. Since the MM's have already learned about danger signs in pregnant women and during delivery, we will now focus on screening mothers after delivery and on newborns.
4. Explain that MM's will use this information during every postnatal home visit (after delivery) to screen for problems in mothers and newborns. If a problem

exists, the MM will either refer the mother or newborn, or if the problem is not serious, will provide health education advice and management.

5. Point out the section on danger signs in mothers after delivery (postpartum).

## **A. Danger signs in mothers after delivery (postpartum)**

### **Ask and Observe, Meaning & What to Do**

Excessive vaginal bleeding. Danger of death. Refer immediately

#### **Ask and observe:**

- Ask the mother how much bleeding she is having (it should be less than the day before, and getting less red each day after delivery).
- Ask her if her womb feels 'hard'. This hardness is actually the womb, and it should be getting smaller each day after delivery (until it disappears).
- If she says she is bleeding a lot, ask to observe. If the blood would fill a bowl (500 ml —remember the bowl with coloured water during the last training) then she should go immediately to the hospital.

**Meaning:** Danger of death.

#### **What to do:**

- Refer to hospital immediately. Postpartum haemorrhage can be life threatening—a woman can die in 2 hours.
- Sometimes there is bleeding from a cut or laceration. This blood is usually very bright red. In either case, the woman needs to be sent to the hospital immediately. In the meantime, there are a few things you can do to try and help:
- You can put the baby to the breast to try and contract the womb.
- You can try and get the woman to urinate (this sometimes helps the womb to contract).
- You can rub the top of the womb.

### **Ask and Observe, Meaning & What to Do**

High fever. Danger of death. Refer immediately

#### **Ask and Observe:**

Fever is a sign of infection. Postpartum infection is one of the top causes of maternal death after delivery. A foul-smelling discharge can be a sign of postpartum infection. Fever can also be a sign of a breast or urine infection.

- Ask if the mother feels hot or feverish.
- If it seems that she has a fever then refer.
- Ask if the mother has a foul-smelling discharge.
- If the mother has any one or more of these two danger signs (high fever, foul discharge), she must go to a health facility immediately.

**Meaning:** Danger of death.

#### **What to do:**

- Refer to hospital immediately.

### **Ask and Observe, Meaning & What to Do**

Breast problems. Problem to mother and baby. Counsel/Refer.

**Ask and Observe:**

The problems can include feeling she “doesn’t have enough milk”, engorgement, cracked nipples, difficulty with latch-on, and others we have discussed previously. Observe a breastfeed, diagnose and manage the problem.

- Observe if the baby is suckling well.
- Observe if she has engorgement, cracked nipples, etc.
- Note if the baby is low birth weight. Weigh baby. Note if the baby has picked up or lost weight. Reassure if child is gaining satisfactory. Counsel if not and follow up.

**Meaning:** Problem to mother and baby.

**What to do:**

- Observe a breastfeed and decide what the problem is.
- Counsel the mother in how to resolve problem. Observe if she can practise what you have counselled her about. If not resolved in a day or two, refer to the health facility.

**Ask and Observe Meaning What to Do**No problems

Doing well Praise, reassure mother; continue with health education.

## **B. Use of Referral Notes (15 of 75 minutes)**

Instructions to Trainers:

1. Have participants look at the Referral Notes (see below). Explain that if a danger sign is found with the mother, the MM fills in her name and age, and describes the problem.
2. Explain that the MM completes both sections of the Referral Note (two identical referral notes), then tears off one and gives it to the family to present at the health facility. The other section is kept for the MM record (and for the supervisor to review).
3. Spend 5 minutes for each trainee to practise filling out a referral note.
4. Refer trainees to the Community Resource Guide, and explain its purpose which is to help the MM to look up which facilities she should refer participants to for certain health difficulties. Explain that this booklet also contains emergency referral information which MM's will use in emergencies (eg. if they find an abused child or critically sick participant or family member). Explain that MM's will receive special training on referrals and emergency protocols and procedures in a separate session.

**PHILANI NUTRITION CENTRES**  
*HEALTHY SOUTH AFRICAN FAMILIES RESEARCH STUDY*

**TELEPHONE NUMBERS**

Office: 387 5124/5  
Fax: 387 5107  
E-mail: philani@telkomsa.net  
Site B: 361 2696  
Site C: 387 1142  
Town 2: 361 5144  
Crossroads: 386 1112  
Brown's Farm: 371 6389



**POSTAL ADDRESS**

P.O. Box 40188  
Elonwabeni  
7791  
Cape Town  
South Africa.

**MAIN OFFICE SITE ADDRESS**

Idada Street  
Khayelitsha  
Cape Town.

Main Website: [www.philani.org.za](http://www.philani.org.za)

Flagship Website: <http://users.iafrica.com/j/ja/jakrubby/philani.htm>

Dear Sister / Doctor

During a recent home visit to the following client's home we found a health problem that appears to require follow-up by a certified health provider.

1. Name of Client: \_\_\_\_\_

2. Age of Client: \_\_\_\_\_

3. Referred to (name of clinic/hospital): \_\_\_\_\_

4. Description of the problem \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Referred by: Name \_\_\_\_\_ Address: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Neighbourhood Number: \_\_\_\_\_ Date of referral: \_\_\_\_\_



## C. Danger signs for the newborn

### **Ask and Observe, Meaning & What to Do**

Not able to feed & drowsy and can't wake up. Danger of death. Refer immediately.

#### **Ask and Observe:**

- Ask if the baby is not feeding or feeding much less (half of what s/he fed before) and for how long the baby has not been feeding properly.
- Observe and try to help the baby breastfeed.

**Meaning:** Danger of death.

#### **What to do:**

- Refer to hospital immediately if baby has not taken any food for a day or more.
- If the baby has not wanted to feed for one or two feeds, observe, counsel and encourage the mother.
- In areas where the MM can treat for infection, she should start treatment.

### **Ask and Observe, Meaning & What to Do**

Too cold or feverish. Danger of death. Refer immediately.

#### **Ask and Observe:**

- Ask the mother and observe if the baby feels colder or hotter than normal.

**Meaning:** Danger of Death

#### **What to do:**

- Refer to hospital immediately.

### **Ask and Observe, Meaning & What to Do**

Rapid, laboured breathing (60 respirations or more/ minute). Danger of death. Refer immediately.

#### **Ask and Observe:**

- Observe by counting respirations when the baby is quiet and observe if child is in distress and struggling to breathe.
- Repeat the count if rate is 60 or more.

**Meaning:** Danger of death.

#### **What to do:**

- A rate of 60 or more breaths per minute could be a sign of pneumonia.
- Refer immediately.

**Ask and Observe, Meaning & What to Do**

Umbilical discharge with redness extending to surrounding skin. Danger of death. Refer immediately.

**Ask and Observe:**

- Observe if navel is red or has pus.
- The MM could ask but should always observe. If she asks and the mother says the navel is fine, she should still observe.

**Meaning:** Danger of death.

**What to do:**

- If only with pus around umbilicus, this is a sign of local infection.
- Refer for treatment as it could worsen and become life threatening.

**Ask and Observe, Meaning & What to Do**

Convulsions. Danger of death. Refer immediately.

**Ask and Observe:**

- Ask the mother if baby has had any fits.

**Meaning:** Danger of death.

**What to do:**

- If the child has had fits the child should be referred for investigation. If the child is fitting, refer immediately.

**Ask and Observe, Meaning & What to Do**

Eyes with pus. Danger. Refer for treatment or treat if trained.

**Ask and Observe:**

- Observe if the baby has pus in its eyes. This can be a sign of local eye infection.

**Meaning:** Danger.

**What to do:**

- Refer for treatment or treat if trained, and observe next day.
- If not improved, refer.

**Ask and Observe, Meaning & What to Do**

Baby born early/very small. Danger. Start Kangaroo care (KMC).

**Ask and observe:**

- Observe and weigh baby. Assess growth progress since birth and observe feeding.

**Meaning:** Danger.

**What to do:**

- If baby in distress, then refer immediately; if not, assist with feeding if needed and encourage KMC.

**Ask and Observe:**

A baby weighing less than 2500 grams (2.5 kg) has low birth weight (LBW). Babies born early are generally LBW. LBW babies are at greater risk of infection or feeding problem due to small size

- Give extra care.

**Meaning:** Danger.

**What to do:**

- Start Kangaroo/skin-to-skin (KMC).
- If baby in distress, then refer immediately.
- If not, assist with feeding if needed and encourage KMC.

***Instructions to trainers continued:***

1. Ask MM's if they have any questions on newborn danger signs. Answer any questions.
2. Remind MM's that they will use this information to screen for these problems during each home visit. If there is a LBW baby, or a problem feeding, they can try and solve the problem but if improvement isn't visible in one day, the baby should be referred immediately.
3. Have participants look at the Referral Notes. Let each of them practise filling in a referral note. Walk around and assist where necessary.
4. Ask for any questions.

***Instructions to trainers:***

1. The trainers should role play the script below. The focus here is on communication techniques for screening for danger signs.
2. After viewing the role play, ask participants for their reactions. What did they feel was good. What could have improved?
3. Ask for questions and clarify for any confusion.

**Model Role Play Script: Screening for danger signs**

*Note: Do not read the words in italics. They are either explanations or instructions.*

**MM:** Nomawethu, what seems to be the problem (*makes eye contact but looks concerned*)? I got a message that you need to see me urgently. What is the matter?

**NOMAWETHU:** I'm worried about the baby. He is not breathing well, and my mother-in-law wants to send for the medicine man, but I remembered that if I called you, you will come.

**MM:** Yes, So what have you done so far?

**NOMAWETHU:** I have just tried to breast feed him, but he is not feeding well.

**MM:** Not feeding well. Let me wash my hands and check the baby.

**MM:** You were right to have called me, sometimes these things happen (*empathy*). I have to check his chest. (*MM examines baby, including counting breathing, watching chest for indrawings. There is positive chest indrawings on breathing.*)

**MM:** (*MM refers to MM manual on danger signs, above*). Nomawethu, the baby is very sick. The baby has fast breathing, chest indrawings, is hot, and as you said, he is not feeding well. The baby has a number of danger signs. We have to go to the hospital very fast.

**NOMAWETHU:** Can I make a meal for the family first?

**MM:** No Nomawethu, there is no time to make food. We must get to the clinic as fast as possible.

***Instructions to trainers:***

1. Divide the participants into groups of four.
2. Have each group review the information on danger signs above (mothers after delivery and newborns) and referral notes so they are familiar with them.
3. Write the following scenarios on white paper or the blackboard (do not write the 'Note to trainer' part).
4. Have each group perform role plays so that each participant has a chance to use the information to identify and refer danger signs. Fill out any Referral Notes as part of the role play.
5. After the role plays, the trainer circulates in the room, observes the groups and gives feedback as suggested in the 'Note to trainer' paragraphs after each scenario below.
6. Finally, call the groups back together. Have each small group perform one role play for the whole group (5 minutes to perform, 5 minutes for comments). Discuss after each play. Praise the good points first and then give constructive suggestions for improvements.

**Scenarios****Scenario 1:**

Nyameka gave birth to her first baby at the clinic. She returned home on Day 2. The MM visits that day. Both mother and baby are fine.

*Note to trainer: In this visit the MM must cover all the topics for postnatal visit one, and she must ask about and observe all possible danger signs. Observe breastfeeding in particular, if mother has chosen to breastfeed. If mother has chosen to formula feed, observe as mother prepares formula milk for the baby.*

**Scenario 2:**

Zimkitha gave birth to her seventh baby, and you are visiting a few hours after the delivery. While covering all the main content areas of postnatal visit one and the screening for danger signs, you find she is bleeding profusely. The baby is fine.

*Note to trainer: Immediate referral of mother to clinic for bleeding. Help family arrange transfer, together with the baby, who can be in KMC position for the move to stay warm. Fill in Referral Note and help family get immediate transport. Go with family if possible. Return to complete visit the next day.*

## **SESSION 42**

### ***Practice Home Visiting***

**Time required: 1 hour**

#### **Purpose**

To give MM's the opportunity to practise home visiting to mothers and newborns after delivery, using the communication tools, Field Guide and Referral Notes.

#### **Objectives**

At the end of the session the MM will be able to conduct home visits to mothers and newborns using the communication tools and field guide effectively.

#### **Materials**

1. Blackboard or white paper/flipchart paper
2. Markers
3. Field guide
4. Referral Note

#### **Preparation**

Ask all participants to have their field guide booklets ready.

***Instructions to trainers:***

1. Divide the participants into groups of four. Refer participants to the case studies in their manuals. (See below).
2. Have two MM's perform a role play while the other two watch. The role play should include using the tools (Field guide, Information learned above about danger signs, and Referral Note (if needed)). Focus is on use of communication and recording materials.
3. After each role play, the group of four discuss what was done well and what needs improvement. Have MM's take turns playing the MM and the mother.
4. After 30 minutes, call the groups together and go over all the cases. Have participants compare what they did in the role plays with the 'suggested activities'.
5. Discuss and clarify any confusion.

**Case Study Exercises****Case 1**

**First visit on Day 2:** You are visiting Nokwanda. It is her first baby, delivered yesterday. She has chosen to breastfeed. Mother is fine. Baby is fine, weighs 3 kg, and is breastfeeding well. Nokwanda was drinking alcohol in her pregnancy and was able to cut down, but did not stop drinking completely. Nokwanda is HIV negative.

***MM should cover the following:***

- *Weighs baby – 3kg*
- *Check mother and baby for danger signs – all ok*
- *Observe breastfeed*
- *Discuss cord care, general hygiene, keeping infant warm and protected.*
- *Tell mother when you will return for second visit*
- *Stress importance of limited or no alcohol consumption.*
- *Advise about hygiene and good routines (to have a plan for the day).*

**Second visit on Day 7:** Nokwanda is fine. The baby feels hot.

***MM should cover the following:***

- *Examine and weigh baby*
- *Observe breastfeed*
- *Screen mother and baby for danger signs*
- *Assess mother's coping ability, sleep, hygiene, depression, support.*
- *Stress importance of limited or no alcohol consumption.*
- *Encourage good hygiene and good routines (to have a plan for the day).*
- *Explain baby has danger sign.*

- *Refer to clinic and complete the Referral Note*
- *Tell mother when you will return for next visit*

## **Case 2**

**First visit on Day 2:** Khanyisa delivered a baby boy two days ago. The baby weighed 2800 grams (2.8 kg) at birth and was given immediate care. Today the baby is fine, but the mother is bleeding heavily. Khanyisa is HIV positive and has chosen to formula feed. She is on ARV's. Before the birth, Khanyisa managed to stop her alcohol consumption.

***MM should cover the following:***

- *Screen mother and baby for danger signs - Mother bleeding heavily*
- *Refer to clinic; complete Referral Note*
- *Have baby go with mother skin-to-skin if possible to keep warm*
- *Tell mother you will return to check on her and baby and complete visit*

**Second visit on Day 7:** Khanyisa was kept in hospital for 2 days for postpartum haemorrhage. She is now back home. Mother and baby are fine.

***MM should cover the following:***

- *Examine baby – all ok*
- *Weigh baby and plot on growth chart*
- *Observe mother preparing formula milk*
- *Assess mother's coping ability, sleep, hygiene, depression, support.*
- *Stress importance of limited or no alcohol consumption.*
- *Encourage good hygiene and good routines (to have a plan for the day).*
- *Check on continuation of ARV treatment.*
- *Explain when you will visit again*

# SECTION L

## CHILD HEALTH

### SESSION 43

#### *Social Factors in Child Health*

**Time required: 15 minutes**

#### **Purpose**

The purpose of this session is to create awareness about the risk factors in Cape Town informal settlements which create challenges for child and infant health.

#### **Objectives**

At the end of this session MM will know what characteristics of informal settlements make it harder to protect children from ill health.

#### **Materials**

None

**The Socio-economic context of Child Health in SA 15 minutes**

#### ***Instructions to trainers:***

1. Ask the MM trainees what they think the biggest illnesses facing children in Cape Town informal settlements are? Answers should include:
  - Gastroenteritis (dehydration)
  - Respiratory diseases (pneumonia, flu, bronchitis)
  - Malnutrition
  - TB & TB Meningitis
  - HIV
  - Skin problems (Scabies, Eczema, Thrush (Candida), Aphthous Ulcers)
2. Explain that in this section we will learn about the causes and symptoms of each of these illnesses, and how each should be handled.

3. Ask trainees why these illnesses are so prevalent in their communities and why they are so hard to deal with? Listen to their answers. Make sure you cover the following:

- Overcrowding increases the spread of airborne diseases like TB and bronchitis.
- Damp in houses and pollution (from paraffin and coal fires) contributes to respiratory infections.
- Many houses don't have running water and flush toilets so lots of germs are around the house.
- Contaminated food given to children can make them get diarrhoea.
- Tobacco smoke increases children's' risk of developing lung diseases such as asthma.
- Clinics are often understaffed and are hard to access.
- Paraffin in houses without electricity is responsible for childhood poisoning.
- Having poor housing with little space, fresh water and warmth makes it harder to care for children and keep them healthy.
- Low maternal education about how to care for children.
- Lack of support from extended family in peri-urban areas.
- Many skin and eye problems are related to not having enough clean water.
- Mothers with a very low salary may struggle to feed their children enough healthy foods to give them all the vitamins and minerals they need to stay healthy.
- Other?

4. Explain that these are the reasons why it is so important to help mothers care for their children's health as well as possible, and that this is the focus of the remainder of this session.

5. Refer trainees back to the referral note covered in previous sections. Remind them that if they come across a child who needs to be seen by a doctor or sister at the clinic, they should use these referral notes to describe the problem and give them to mothers to use in taking their children for treatment. Remind them again that they will always need to fill out two identical copies of the referral note – one for the mother and one for the MM's own records.

## **SESSION 44**

### ***Growth, Development and Nutrition***

**Time required: 4 hours**

#### **Purpose**

The purpose of this session is to teach MM's the key causes and symptoms of malnutrition, as well as how this condition can be prevented and monitored.

#### **Objectives**

At the end of this session, MM will:

1. Know how to use growth charts to monitor children's' growth.
2. Understand the important link between growth and health.
3. Understand what causes malnutrition, how to prevent it and how to rehabilitate a malnourished child.

#### **Materials**

1. Growth Charts
2. Pencils and erasers
3. Board / flipchart
4. Markers

#### **Preparation**

Familiarise yourself with the content of the session below before it begins.

## Discussion: Growth, Development and Malnutrition 45 minutes

### *Instructions to trainers:*

1. Go through the lecture content below on malnutrition, growth and development. Ask for questions and encourage participation as you go along.

### **LECTURE CONTENT: Growth, Development and Malnutrition**

Watching how children grow can tell us many things about their health. Children with TB and children who are malnourished, for example, do not grow well and are usually smaller than healthy children who are the same age as them. Normal growth in children, on the other hand, is a sign of health.

There are many ways to measure a child's growth. These include:

- Weight
- Height
- Head circumference

When we measure these characteristics of a child, we can learn many things about how they are growing:

- When a child is **underweight** for their age we say that the child is suffering from malnutrition.
- If a child is not a normal **height** for their age, it might be because their parents are also not very tall (because height is genetic) but it also can mean that a child is stunted or suffering from chronic malnutrition..
- **Head circumference** tells us about brain development. A head which is very small can signal an illness called microcephaly which is often caused by malnutrition. If a baby's head is very large, it can signal hydrocephalus which means that there is too much fluid around the brain.

### **How do you know if a child's weight is too low, or too high, or normal?**

When you weigh a child of a certain age which you know, you can look at a chart (called a **growth chart**) which will tell you if the child's weight is normal or if it is too low or too high, for their age. Later in this session, we will learn how to use the growth chart.

### **Weighing children frequently is important**

It is important to weigh children often to make sure they grow properly. It makes it possible to discover early if they do not pick up enough weight or if they lose weight. If a child is born with a low birth weight it is especially important to monitor their weight frequently. We will weigh children at every visit in this project.

### **What does it mean to be malnourished?**

A child who is malnourished is not getting enough nutrients and vitamins so his or her body does not grow properly. This might be because the child is not eating enough or eating the wrong food which is not nutritious enough, or he or she has an illness which prevents the body from utilising the nutrients they are eating. A low birth weight child (LBW ) is born weighing under 2.5kg..

### **How can malnutrition be prevented in children?**

1. Pregnant mothers need to eat the right foods so that their children get enough nutrients to grow properly before they are born. This will allow them to gain enough weight inside the mother's womb. Eating healthily during pregnancy was covered previously in the antenatal section of this training.
2. Exclusive breastfeeding.
3. Improvement of complimentary feeding from 6 – 24 months of age.
4. Preventing and treating childhood illness effectively.

### **What should infants and young children eat to stay well nourished?**

(Instruction to trainer: In this discussion you will refer back to the session in antenatal care which discussed the 3 food groups, and explained what each food group does for the body.)

- **Babies 0 – 6 months of age:** Exclusive breast milk or formula feeding.
- **Children 6 months – 2 years of age:** At 6 months children need to start eating a variety of solid foods as well as continuing to drink breast milk or formula milk up until 2 years and beyond. This is a time when a child is at risk for catching illness because there is a possibility that the food they are given is either unhygienic and therefore can pass germs to the baby, or that it does not have enough nutrients and energy for the baby to stay healthy, or the baby is not fed often enough. It is best to start introducing solids to a baby with small amounts of foods at a time. One should start with pureed fruit, vegetables, cereals and porridges. Never give a baby full cream milk before they are 1 year old. As feeding continues, mothers should progress to feeding babies a mixed diet in a mashed form at least 5 times a day as a child's stomach is small. Some foods like porridge will satisfy a child's hunger because they are bulky foods, but these foods are not enough to give a child the energy, protein and nutrients that they need to stay healthy. Mothers need to add small amounts of animal proteins (meats), vegetables (beans, carrots, peas, broccoli), to the babies porridge or samp.
- **Children 2 – 5 years of age:** Young children of this age need to start eating a similar diet to adults, but in smaller quantities. Children should eat 3 small meals a day and 2 small snacks in-between the meals (such as half a banana or an apple). Refer back to the session in antenatal care which discussed the 3 food groups, and explained what each food group

does for the body. Children need to eat a combination of these food groups like adults do, but in smaller amounts.

### **What to do if a child is malnourished**

- All underweight for age children should be referred to a clinic for a check-up and TB testing. Underweight babies are much more likely to have TB and other illnesses than are children of a normal weight for their specific age, because a malnourished child has a weakened immune system. Correcting any illnesses they have is the first step to getting them healthy.
- Some children who are very underweight will need to be referred to hospital until they have recovered and are able to eat properly again, but in many instances this is not necessary and the right feeding program and treatment of any illnesses can bring a child back to a healthy weight for their age.
- A child who is underweight for age needs to be given an intensive feeding program to be rehabilitated from malnutrition. They need to be given frequent small amounts of food to begin with. Giving them too much food at one time immediately after they have not eaten much for a long period of time is not good for the child. Smaller, more frequent meals are much more effective.
- Undernourished children need food which is high in energy, vitamins, nutrients and energy. It is therefore important to mix their base food with oil, minerals and vitamin sources. For example, they should eat porridge with peanut butter, samp with beans and margarine, or meals with vegetables mixed into it.

***Instructions to trainers:***

1. Hand out a growth chart to each trainee.
2. Explain to the class how the growth chart works and how percentile scores can be interpreted. Make sure you cover the following:
  - Explain how percentiles work.
  - Give one or two examples of percentiles (For example, for a child whose weight falls on the 3rd percentile, 3% of normal children at the same age as that child weigh the same or less than that child. Similarly, for a child whose weight falls on the 40th percentile, 40% of children in the same age category weigh the same or less than that child.)
  - Explain that a child below the 3rd percentile is considered underweight for their age.
  - A child whose weight is above the 97th percentile is considered overweight.
  - Children who fall between the 3rd and 97th percentiles are considered of normal (healthy) weight for their age.
3. Ask trainees to look at the examples below. For the first 20 exercises, trainees need to use the weight and age of each child to plot the child on the growth chart. For each example they need to say if the child is underweight for their age or not.
4. Then for the short case studies, ask them to find the percentiles of each child using their growth charts, and interpret what this means for the child's health.
5. After the case studies, there is a short role play. Trainees must form groups of three, where one person is the MM, one person is the mother being visited, and one person observes and gives feedback. Repeat the role play three times until each person has had a chance to be the MM.

**Growth Chart Plotting Exercises:**

*The answers are in brackets for the trainer.*

1. Thandi is 4 years and 4 months old. She weighs 14kg. (Normal weight for age)
2. Bongani has turned 2 years old. He weighs 12kg. (Normal weight for age)
3. Nokwanda is 3 months old. She weighs 4 kg. (Underweight for age)
4. Nosipho is 8 months old. She weighs 7.5kg. (Normal weight for age)
5. Nandipha is 16 months old. She weighs 9kg. (Normal weight for age)
6. Bulelwa is 5 months old. She weighs 4.5kg. (Underweight for age)
7. Thebo is 1 week old. He weighs 2.2kg. (Underweight for age)
8. Sandile is 10 months old. He weighs 8.5kg. (Normal weight for age)
9. Yanga is 12 months old. He weighs 6.5kg. (Underweight for age)
10. Zukiswa is 12 months old. She weighs 10kg. (Normal weight for age)
11. Lindelwa is 5 months old. She weighs 8kg. (Normal weight for age)

12. Luvo is 4 years old. He weighs 15kg. (Normal weight for age)
13. Ntombizodwa is 3 years and 7 months old. She weighs 11kg. (Underweight for age)
14. Loyiso is 15 months old. He weighs 12.5kg. (Normal weight for age)
15. Nomonde is 2 years and 2 months old. She weighs 9kg. (Underweight for age)
16. Nyameka is 8 months old. She weighs 4kg. (Severely underweight for age)
17. Khanyisa is 22 months old. She weighs 11kg. (Normal weight for age)
18. Nosiswe is 18 months old. She weighs 8kg. (Underweight for age)
19. Zodwa is 4 years and 3 months old. She weighs 11.5kg. (Underweight for age)
20. Sive is 4 months old. She weighs 3kg. (Severely underweight for age)

## Short Case Studies

### **Case 1**

Nosiswe is 2 months old. She weighs 5kgs.

*Interpretation: Nosiswe falls on the 50th percentile. This means that 50% of children her age weigh the same or less than she does. Her weight is normal and healthy. Encourage mother to continue feeding the baby as is.*

### **Case 2**

Bongani is 2 years old. He weighs 8.5kg.

*Interpretation: Bongani falls below the 3rd percentile which means that less than 3% of all other children his age weigh the same or less than him. He is underweight for his age and might be ill. Refer him to the clinic. Find out what mother is feeding him and educate her on healthy eating for underweight children. Follow up to check his progress.*

### **Case 3**

Loyiso is 6 months old. He weighs 3.5kgs.

*Interpretation: Loyiso is severely underweight. He falls well below the 3rd percentile. Ask the mother what he has been eating and how frequently and how much he eats. Find out the reason he is malnourished (eats too little, not enough of the right foods, no income to buy food etc.) Educate the mother on healthy eating for underweight for age children. Refer (using the referral note) the baby to the clinic or to Philani Intensive Rehabilitation. Follow up on the baby.*

## Role Play Script: Underweight for Age Babies

**MM:** Knock, knock  
**GRANNY:** Come in.  
**MM:** How are you granny?  
**GRANNY:** I am fine and you?  
**MM:** I am fine. How is baby Sisipho?  
**GRANNY:** Not well. She is sleeping all the time and her mouth had thrush. She is not sucking well.  
**MM:** Are you ok?  
**GRANNY:** *(Silent. Crying)*  
**MM:** Where is the mother of the baby?  
**GRANNY:** She passed away last month in Johannesburg with poison of the stomach. *(Tells whole story. Crying)*  
**MM:** I am sorry Granny. May I weigh Sisipho?  
**GRANNY:** Yes its fine.  
**MM:** *(Undresses baby and weighs her, then while Granny dresses the baby, she plots the weight on the growth chart).* Granny the child weighs 3.9kg. Her weight has dropped. Why has the weight dropped?  
**GRANNY:** She was with her mother in Johannesburg. When her mother got so sick there was no one caring for the baby.  
**MM:** What kind of food is the baby eating now?  
**GRANNY:** She has formula milk mixed with Nestam.  
**MM:** What about solid foods?  
**GRANNY:** I have no money to buy vegetables and fruit. We depend on my husband working part time. *(Crying).*  
**MM:** *(Goes to car to fetch formula milk).* Granny, let me show you how to mix the formula milk. You must not mix it with Nestam. Feed Nestam separately. *(Mixes bottle of formula in front of granny).* You see first you must wash your hands and the bottle with soap and a brush. Measure 250mls of boiling water. Once the water is cool, then you pour 8 level scoops of the formula into the water. You shake well, and then when it is cool you feed the baby. Feeds baby *(baby sucking a little bit).*  
**GRANNY:** Ok thank you. Now I know what to do.  
**MM:** I notice the baby has got some thrush on her mouth. She is not sucking well because her moth is sore. *(puts the baby who is now sleeping down).* Tomorrow morning you must take this baby to Site C to see the doctor at 9am. Take the clinic card and go early.  
**GRANNY:** Ok I will take her.  
**MM:** Good. I suppose I will go now. I will come back to see how you and the baby are doing. Take care.  
**GRANNY:** Thank you. See you soon.

***Instructions to trainers:***

1. Ask trainees to divide into small groups of 3 – 4 people. Ask them to discuss the following in their groups.
  - Why are we worried about malnutrition?
  - What does it do to a child?
  - We can recognise severely malnourished children; they often look very thin and sick. Why do we worry about mild to moderately malnourished children who often do not look very different from well nourished healthy children.
  - Why is growth monitoring so important?
2. After 10 minutes, call the groups back together and discuss their answers together.

## SESSION 45

### *Childhood Immunizations*

**Time required: 15 minutes**

#### **Purpose**

The purpose of this session is to teach the importance and scheduling of standard childhood immunizations.

#### **Objectives**

At the end of this session MM will know which diseases children need to be immunized against and when each immunization should occur.

#### **Materials**

None

|                     |                   |
|---------------------|-------------------|
| <b>Immunization</b> | <b>15 minutes</b> |
|---------------------|-------------------|

#### ***Instructions to trainers:***

1. Ask trainees why they think immunizations are important. If they do not already know, make sure you explain that immunizations protect children from developing serious illnesses which are hard to treat and can result in death.

2. Explain the public health impact of immunizations.

- Immunization goes beyond simply protecting the individual, important as that is. It also aims to improve the health of entire communities by limiting the spread of infectious disease among children and adults.
- Immunization has eradicated Smallpox completely. Before, small pox was responsible for huge amounts of deaths, and the illness put tremendous strain on health care systems with limited resources.
- Polio has almost been eradicated as a result of immunizations.
- Only by educating mothers and families, will it be possible to increase the coverage of immunizations given to children. It is important to provide answers to people's concerns about the safety, quality and benefits of vaccines.

3. Explain that in South Africa there are immunizations for 8 illnesses which government has focused on. Ask for suggestions on which illnesses these are?

Answers should include:

- Measles
- Poliomyelitis
- Diphtheria

- Whooping Cough
- Tetanus
- Tuberculosis
- Hepatitis B
- Haemophilus Influenzae B

4. Refer trainees to the following immunization schedule in their manuals for when each immunization should be given to children. Ask for any questions and clarify any confusion.

| <b>Immunization Schedule</b> |  |
|------------------------------|--|
| <b>AGE</b>                   | <b>VACCINE</b>   |
| <b>Birth</b>                 | <b>BCG (Tuberculosis)<br/>TOPV (Trivalent Oral Polio Vaccine)</b>  |
| <b>6 Weeks</b>               | <b>DPT1 (Diphtheria, Pertussis, Tetanus)<br/>TOPV1<br/>HBV1 (Hepatitis B)<br/>HiB1 (Haemophilus influenza B)</b> |
| <b>10 Weeks</b>              | <b>DPT2<br/>TOPV2</b>  |
| <b>HBV2<br/>HiB2</b>         |  |
| <b>14 Weeks</b>              | <b>DPT3<br/>TOPV3<br/>HBV3<br/>HiB3</b>  |
| <b>9 Months</b>              | <b>Measles Vaccine 1</b>   |
| <b>18 Months</b>             | <b>Measles Vaccine 2<br/>DPT4<br/>TOPV4</b>  |
| <b>5 Years</b>               | <b>DT (Diphtheria, Tetanus)<br/>TOPV5</b>  |

## **SESSION 46**

### ***Gastroenteritis in Children***

**Time required: 30 minutes**

#### **Purpose**

The purpose of this session is to teach MM's the causes, symptoms and treatment of gastroenteritis and severe diarrhoea, so that they are equipped to help mothers in their neighbourhoods in caring for ill children and infants who suffer from this condition, and help families and communities to prevent gastroenteritis.

#### **Objectives**

At the end of this session MM will know:

1. The causes and symptoms of gastroenteritis.
2. When treatment needs to be sought for gastroenteritis with severe diarrhoea.
3. How to mix a home made re-hydration fluid and to use this to re-hydrate dehydrated children.

#### **Materials**

1. Container of 1 litre
2. Teaspoons
3. Salt and sugar

***Instructions to trainers:***

1. Ask trainees what they know about diarrhoea in young children and infants - does anyone know how one gets diarrhoea, what it does to the body of young children (dehydration), and how young children with diarrhoea can be cared for? How dangerous do they think diarrhoea is? Listen to their answers and correct any misconceptions.
2. Using the lecture content below as a guide, fill in all the gaps in their knowledge and lead a discussion about gastroenteritis in young children, how it can be prevented, and how it needs to be managed and treated. Encourage questions and participation as you go along.
3. When you get to the section on oral re-hydration, hand out the materials mentioned above and supervise the trainees while they practise making a home made oral re-hydration solution. Stress that the rehydration with the oral fluid must start after the first diarrhoea and a cup must be given after every stool to prevent dehydration. The mother can and should start rehydration at home but needs to go to the clinic if the child does not take the fluids or vomits.

**LECTURE CONTENT: Gastroenteritis****What is Gastroenteritis?**

Gastroenteritis is an inflammation of the lining of the intestines caused by a virus, bacteria (germs) or parasites, which causes diarrhoea, vomiting and pains and chills. It is very contagious, and is the most important cause of diarrhoea in children under the age of 5 years. Gastroenteritis frequently causes children to become dehydrated which is what makes it dangerous. Untreated dehydration is the source of death in many babies and young children. It is therefore crucially important that mothers are educated to manage dehydration.

**What are the symptoms of Gastroenteritis?**

Symptoms of **Gastroenteritis** include:

- Diarrhoea with or without vomiting
- Dehydration
- Headache, fever, chills, and
- Abdominal pain

The symptoms can clear within 2 days, or they can persist for as long as 10 days.

**Dehydration** happens when the body loses fluids and important salts and minerals. It happens as a result of diarrhoea and vomiting.

Symptoms of **dehydration** are:

- Severe weakness or lethargy
- Excessive thirst (in a baby or child, can not tell this)
- Poor skin turgor sunken eyes and fontanell
- Dry mouth
- Little or no urine or dark yellow urine
- Decreased tears
- Dizziness or light-headedness (though children would not volunteer this information).

### **Causes of Gastroenteritis?**

The bacteria and germs which cause gastroenteritis are found in food which is not properly cleaned or well cooked, or is old. The bacteria is found in meats, chicken, eggs and un-pasteurised dairy products. The germs may also be found in dams and unclean water sources. Pets and animals may also carry the bacteria.

One can get the illness from others by sharing cooking and eating utensils and straws, and by eating out of the same plate.

### **Risk factors which increase the likelihood of gastroenteritis:**

- No inside tap
- No flush toilet
- Poor refuse removal and sanitation
- No electricity
- Low income
- Poor maternal education

### **How can one protect children from the illness?**

- Wash your hands thoroughly before preparing any food, and especially after changing nappies
- Keep food preparation surfaces, cooking pots and cutlery clean. Cover leftovers and keep in fridge if possible. Do not eat or give children leftovers not kept in fridge.
- Teach children to wash their hands with soap after using the toilet
- Sterilize nappies of a child with gastroenteritis
- Keep children away from other children or adults who have gastroenteritis.
- There is a strong relationship between measles and serious diarrhoea. Immunisation for measles is therefore a good precaution for children.

## Treatment

Children with diarrhoea should be started on home made oral rehydration at once at home. The most important part of treatment is managing dehydration by providing children with re-hydration fluids. A simple and cheap home made re-hydration fluid can be made by mixing 8 teaspoons of sugar and 1/2 teaspoon of salt into 1 litre of boiling water. Once this cools, children should be given a cup after each loose stool until they are re-hydrated. Continue to feed the child. Children with very severe diarrhoea who are vomiting or refusing oral rehydration may need to be admitted to hospital until they recover.

### **The following steps are recommended for young children and infants with gastroenteritis:**

Seek health immediately if the child has the following symptoms:

- Severe diarrhoea and vomiting
- Stops eating
- Is dehydrated
- Bloody diarrhoea
- Abdominal pain
- Fever (temperature above 38°C)
- Behaviour changes, including sleepiness

*(Instruction to trainer: ask trainees to get into pairs and practise preparing a solution of home made re-hydration fluid, using salt, sugar and boiling water.)*

3. Continue feeding with foods which are easy to eat like toast, rice, and fruit. Because severe diarrhoea can cause malnourishment, give children foods with extra vitamins and minerals in them and feed more frequently.

4. Avoid foods like dairy and fatty foods until the child feels better.

**NOTE:** Children with HIV are much more likely to suffer from severe gastroenteritis.

## **SESSION 47**

### ***Skin Problems: Scabies, Eczema, Thrush (Candida) and Aphtus Ulcers***

**Time required: 30 minutes**

#### **Purpose**

The purpose of this session is to teach MM to be able to identify the most prevalent skin problems in children, and how each should be dealt with.

#### **Objectives**

At the end of this session MM's will:

1. Know how to identify Scabies, Eczema, Thrush and Aphtus Ulcers in young children (nappy rash was covered previously in neonatal care).
2. Be able to give advice to mothers about how to prevent skin problems, and when to refer children to clinics for treatment.

#### **Materials**

1. Black board / paper flip chart
2. Markers

***Instructions to trainers:***

1. Ask trainees what kinds of skin problems they have seen in children under 5 years old. Listen to their responses. Ask what they know about the different skin problems they might have seen and ask how they think each condition can be handled.
2. Go through the following information about causes, symptoms and treatment of Eczema, Scabies, Thrush and Aphthous Ulcers. As you go, ask the trainees for suggestions about how they think each condition should be handled, should they come across a child with a skin problem.

**LECTURE CONTENT: Scabies, Eczema, Thrush (Candida) and Aphthous Ulcers****What is Thrush (Candida)?**

Thrush is a yeast infection caused by *Candida*. It is often found in newborns and infants, since their immune system is not developed enough to fight infections. Babies with thrush usually contract the infection during delivery, when they pass through a vagina infected with yeast. Symptoms appear as oral thrush within seven to 10 days after birth.

Thrush is a very common condition in patients with risk factors (i.e. impaired immunity), and it is an opportunistic infection for people living with AIDS. Thrush may recur often in people with chronic illnesses and those with impaired immunity.

**Is Thrush contagious?**

- Thrush is contagious, so care needs to be taken to keep from passing it on to others.
- If a mother is breastfeeding an infant who has oral thrush, they both need to be treated. Otherwise, they may pass the infection back and forth.

**Symptoms of Thrush**

- Creamy, white patches on the tongue, sides of the mouth, gums, back of the throat or tonsils.
- Reddened, raw areas that are painful.
- Irritation in mouth prevents baby from eating
- Difficulty swallowing

**Treatment of Thrush**

Clinics can provide anti-fungal medications to treat thrush in both mothers and babies.

### **Prevention of Thrush**

- Pregnant women should be checked for vaginal thrush to prevent oral thrush infection of their newborn babies.
- Sterilize all bottles, pacifiers, nipples, nappies, when there is thrush in the house.
- Use antibiotics only as prescribed by a doctor.
- Follow a healthy diet with lots of fruit and vegetables.

### **What are the symptoms of Aphthous Ulcers?**

- Ulcers in the mouth, often on the tongue and lips
- Pain in mouth
- Drooling

### **Treatment of Aphthous Ulcers?**

Aphthous ulcers can recover within 10 days without treatment. Give vitamins and a teaspoon of Panado ½ hour before meals to reduce the pain to make it easier for the child to eat.

### **What is Scabies?**

Scabies is an itching reaction to mites that burrow into the skin. The mites lay eggs under the skin which hatch and cause an itchy allergic reaction. The disease often affects areas of skin folds, especially in the groin, fingers, toes, wrists and underarms.

### **Is Scabies Contagious?**

It is highly contagious and easily passed on by close physical contact, sharing of clothes and sharing of bedding.

### **Symptoms of Scabies**

- Itchy skin which is often worst at night
- Wavy lines in the skin which are caused by the burrows of the mites under the skin
- The scabies mite is more common in certain areas - scabies is almost always found in the webs between the fingers and underneath the wrist. Other areas commonly infected are the elbows, in the armpits, around women's nipples, on men's genitals, and in the buttocks area.

### **Treatment of Scabies**

Children suspected of having scabies must be referred to a health facility. Medical staff can easily diagnose scabies by looking at skin scrapings under a microscope to see if the mites and their eggs are present. Scabies is treated with an ointment which is rubbed all over infected areas after bathing. Calamine lotion or antihistamine medicines can also be used to relieve itching. The whole family must be treated for Scabies if any one member is infected because it is

very contagious and often takes a month after one gets infected to show up on the skin. All bedding and linen needs to be thoroughly washed and aired.

### **What is Eczema?**

Eczema is term for a group of medical conditions that cause the skin to become inflamed or irritated. Eczema is common in people who are prone to developing other allergic conditions as well, such as asthma and hay fever. Eczema is particularly common in infants and children. Many children outgrow the eczema by the time they reach their second birthday, but some children have it for most of their lives. With the right treatment, eczema is manageable.

### **Is Eczema contagious?**

Eczema is not contagious.

### **Symptoms of Eczema**

- Itching
- Rash (commonly on the knees, face, hands or feet)
- Skin is dry, thickened and / or scaly.
- In light skinned people, affected areas often go red or brown.
- In darker skinned people, affected areas change colour to be either lighter or darker.

### **Eczema “Flare-ups”**

Eczema is commonly found in families with a history of other allergies or asthma. Some people may suffer "flare-ups" of the itchy rash in response to certain substances or conditions. For some, coming into contact with rough or coarse materials may cause the skin to become itchy. For others, feeling too hot or too cold, exposure to certain household products like soap or detergent, or coming into contact with animal dander may cause an outbreak. Upper respiratory infections or colds may also be triggers. Stress may cause the condition to worsen.

### **Treatment of Eczema**

Children with Eczema should be referred to the clinic for treatment. Clinic staff will easily be able to diagnose if eczema is present. There is no direct cure for eczema, but treatment will relieve and prevent itching, which can lead to infection. Since the disease makes skin dry and itchy, lotions and creams are recommended to keep the skin moist. These solutions are usually applied when the skin is damp, such as after bathing, to help the skin retain moisture.

## SESSION 48

### *Respiratory Diseases in Early Childhood*

Time required: 50 minutes

#### **Purpose**

The purpose of this session is for MM to learn the danger signs and symptoms of common respiratory diseases so that they will know when children need urgent referral for treatment.

#### **Objectives**

At the end of this session MM will:

1. Understand the symptoms of the most common respiratory diseases and TB.
2. Know why respiratory illnesses spread so quickly in Cape Town informal settlements.
3. Understand the importance of referring children who show signs of respiratory trouble for treatment immediately.

#### **Materials**

None

|                                     |
|-------------------------------------|
| <b>Common Respiratory Illnesses</b> |
|-------------------------------------|

|                   |
|-------------------|
| <b>30 minutes</b> |
|-------------------|

#### ***Instructions to trainers:***

1. Explain that respiratory illnesses such as TB, common colds and pneumonia are responsible for many deaths in children and infants in Cape Town. Protecting children from respiratory illness can mean saving their lives and the lives of those around them. Ask the class for examples of respiratory diseases that they know of. Answers should include:

- Common colds
- Tonsillitis
- Influenza
- Pneumonia
- TB
- Bronchitis
- Asthma

2. Explain difference between upper and lower respiratory tract infections.

Answer:

- An upper respiratory tract infection is an infection of the nose, throat, or tubes leading to the lungs (bronchial tubes). Common symptoms are a runny or stuffy nose and a cough.
- Lower respiratory tract infections are usually more serious. They affect the breathing tubes and the lungs. Bronchitis, acute bronchiolitis and pneumonia are all types of lower respiratory tract infections.

3. Ask for suggestions on why these illnesses are so common in our communities and why we need to take extra care to prevent and treat them properly? Answers should include:

- Many areas in the townships are overcrowded which makes it easier for respiratory illnesses to spread quickly from person to person.
- When children do not get enough vitamins and nutrients from their diet, their immune systems become weak and so they catch illnesses more easily than children who are well nourished.
- Houses are not insulated to keep them warm in winter and so children are likely to get cold and are then more likely to catch a respiratory illness.

4. Explain that the symptoms of many of these illnesses are similar and that sometimes it can be hard for a mother to distinguish between the many different illnesses. Mothers whose children are showing signs of illness should be taken to the clinic for examination so that any developing illness can be prevented.

Signs of respiratory illness include the following:

- Nasal discharge which does not clear after a few days of eating healthily and staying warm.
- Coughing for more than a few days which does not clear with eating healthily and staying warm.
- Wheezing (tight chest)
- Sore / enflamed throat
- Rapid breathing (more than 60 beats per minute for infants under 2 months old, more than 50 beats per minute for children aged between 2 and 12 months, more than 40 beats per minute for children aged between 1 and 5 years)
- Flaring nostrils
- Not able or wanting to drink anything
- Eating little or nothing
- Fever (over 38 degrees)
- Grunting
- Chest indrawing (when the ribs pull in when the child is breathing in)
- Severe sweating

5. Now ask trainees for suggestions on how mothers can best try to protect their children from developing respiratory illnesses? Answers should include:

- Good nutrition to keep the immune system strong
- Keeping children as warm as possible in winter

- Exclusive breastfeeding to keep the immune system strong
- Vitamins and minerals (either from food or supplements and vaccines)
- Not smoking around children
- Keeping the household as clean as possible.
- Not cooking over open fire close to children or inside.

***Instructions to trainers:***

1. As trainees to think back to the session on TB and ask them what they remember about the signs and symptoms of TB in children. Make sure you reiterate the following. Any child suspected of having TB needs to be referred for investigation immediately.

**TB Symptoms in Children**

Children have the usual symptoms of TB such as coughing and night sweats. Many will also have trouble gaining weight. It is important to monitor a child's weight gain, which you can do using a Road to Health Card. Failure to gain weight is a good reason to suspect TB. Children with TB may also wheeze or have enlarged lymph glands that are not painful. Another sign is if a child has a fever, especially if it lasts for more than seven days. Since children often develop extra-pulmonary TB, you should also be aware of the symptoms of extra-pulmonary TB. These include: swollen lymph glands, meningitis and skin rashes.

**TB Meningitis in Children**

This is a very serious form of TB that often affects children and HIV-positive adults. Pulmonary TB is a serious problem for children. But for children with healthy immune systems, pulmonary TB usually takes a long time to develop, if it develops at all. TB meningitis though, is very dangerous. If not caught and treated, this form of TB can develop quickly and have very serious effects like blindness, delayed development or even death. Signs of TB meningitis include headache, convulsions, drowsiness, irritability, neck stiffness and trouble breathing if going into a coma. Children showing these symptoms need to be treated immediately.

***Instructions to trainers:***

1. Go through the following information about asthma in young children, asking for questions and providing clarity as you go along.

**LECTURE CONTENT: Childhood Asthma****What is Asthma?**

Asthma is characterized by recurrent wheezing, high pitched breathing from obstructed airways, and coughing. However, these symptoms overlap with symptoms of many other respiratory diseases which is why asthma often goes undiagnosed. If a child has repeated symptoms of respiratory illness which persist on an ongoing basis, asthma should be suspected. Asthma can be precipitated for different children by many factors which include exercise, household mites, pet hair, food allergies (commonly sulphur dioxide in soft drinks), emotional factors and pollens in the air.

**Managing and treating asthma**

There are many medicines available which can either relieve the symptoms of asthma or otherwise prevent them from occurring. Treatment of children with asthma depends on the severity of the condition, the age of the child, if seasonal or not, and whether the asthma is triggered by certain situations such as exercise or not. Most cases of asthma can be treated with medication which is inhaled, but in very serious situations, children will need to be admitted to hospital.

**Emergencies from severe asthma**

Children suffering from severe asthma may need to be taken to hospital for treatment immediately. Emergency situations include:

- Unconsciousness
- Convulsions
- Failure to make eye contact
- Lethargy and floppiness
- Severe chest indrawing (when the ribs pull in when the child is breathing in)
- Dehydration

# **SECTION M**

## **CHILD ABUSE AND NEGLECT**

*Acknowledgement and thanks: This section on Child Abuse and Neglect draws on information provided by the Child Welfare Information Gateway, 2007.*

### **SESSION 49**

#### ***Identifying and Protecting Children from Child Abuse***

**Time required: 3 hours**

##### **Purpose**

The purpose of this section is for MM to learn and understand how to identify and deal with cases of child abuse and neglect.

##### **Objectives**

At the end of this session MM will be able to:

1. Know what signs in both children and adults are possible indicators of abuse.
2. Understand what circumstances and social situations foster environments where there is less risk of child abuse occurring.
3. Know what to do in the event that they come across cases of child abuse during their work on this project.

##### **Materials**

1. Blackboard or white paper/flipchart paper
2. Markers
3. Emergency Protocols and Procedures

|   |                   |
|---|-------------------|
| <b>Group Discussion: Children's rights and the importance of learning about child abuse</b> | <b>15 minutes</b> |
|---|-------------------|

***Instructions to trainers:***

1. Ask participants why they think it is important that we are learning about child abuse and neglect. Answers should include:
  - It is quite likely that MM's may come across an abused child at some point during their work on this project and so it is important to be aware of child abuse and of how to deal with it.
  - We hope in this project to have some role in supporting mothers and families and thereby in preventing abuse from occurring to begin with.
  - Dealing with child abuse correctly is crucially important because the long term physical and psychological effects of child abuse are very severe.
  - Adults have a legal and moral obligation to report child abuse to Social Services.
2. Go through the following content box on children's rights as they relate to abuse and neglect. The second three points of number 1 relate to child abuse and neglect.

### ***Children's Rights in South Africa***

#### ***The following children's' rights are documented in the South African Bill of Rights enshrined in our Constitution***

1. Every child has the right
  - a. to a name and a nationality from birth;
  - b. to family care or parental care, or to appropriate alternative care when removed from the family environment;
  - c. to basic nutrition, shelter, basic health care services and social services;
  - d. to be protected from maltreatment, neglect, abuse or degradation;
  - e. to be protected from exploitative labour practices;
  - f. not to be required or permitted to perform work or provide services that
    - i. are inappropriate for a person of that child's age; or
    - ii. place at risk the child's well-being, education, physical or mental health or spiritual, moral or social development;
  - g. not to be detained except as a measure of last resort, in which case, in addition to the rights a child enjoys under sections 12 and 35, the child may be detained only for the shortest appropriate period of time, and has the right to be
    - i. kept separately from detained persons over the age of 18 years; and
    - ii. treated in a manner, and kept in conditions, that take account of the child's age;
  - h. to have a legal practitioner assigned to the child by the state, and at state expense, in civil proceedings affecting the child, if substantial injustice would otherwise result; and
  - i. not to be used directly in armed conflict, and to be protected in times of armed conflict.
2. A child's best interests are of paramount importance in every matter concerning the child.
3. In this section "child" means a person under the age of 18 years.

***Instructions to trainers:***

1. Using the content below as a guide, lead a discussion/ lecture which explains the signs of child abuse and how to discover it.
2. As you go through the content, first ask trainees what signs they feel are possible indicators of child abuse. After listening to and acknowledging their answers, fill in any missing signs of abuse which are explained below.
3. Encourage trainees to discuss any situations they know of or have heard about which are relevant to this topic. Their learning will be facilitated by the concrete examples which are discussed in the class together.

**LECTURE CONTENT: Recognizing Child Abuse**

One of the best ways of discovering child abuse is through observation in the household and knowing what to look for. The following signs may signal the presence of child abuse or neglect:

**The Child:**

- Shows sudden changes in behaviour or school performance
- Has not received help for physical or medical problems brought to the parents' attention
- Is not receiving enough food in a household where food is available – underweight for age / stunted
- Has learning problems (or difficulty concentrating) that cannot be attributed to specific physical or psychological causes
- Is always watchful, as though preparing for something bad to happen
- Lacks adult supervision
- Is overly compliant, passive, or withdrawn
- Comes to school or other activities early, stays late, and does not want to go home

**The Parent:**

- Shows little concern for the child
- Denies the existence of—or blames the child for—the child's problems in school or at home
- Asks teachers or other caregivers to use harsh physical discipline if the child misbehaves
- Sees the child as entirely bad, worthless, or burdensome
- Demands a level of physical or academic performance the child cannot achieve
- Does not enrol child in school

- Looks primarily to the child for care, attention, and satisfaction of emotional needs
- Does not cook for or feed the child, not seeking healthcare when child is ill

### **The Parent and Child:**

- Rarely touch or look at each other
- Consider their relationship entirely negative
- State that they do not like each other

### **Types of Abuse**

The following are some signs often associated with particular types of child abuse and neglect: physical abuse, neglect, sexual abuse, and emotional abuse. It is important to note, however, that these types of abuse are more typically found in combination than alone. A physically abused child, for example, is often emotionally abused as well, and a sexually abused child also may be neglected.

### **Signs of Physical Abuse**

Consider the possibility of physical abuse when the child:

- Has unexplained burns, bites, bruises, broken bones, or black eyes
- Has fading bruises or other marks noticeable after an absence from school
- Seems frightened of the parents and protests or cries when it is time to go home
- Shrinks at the approach of adults
- Reports injury by a parent or another adult caregiver

Consider the possibility of physical abuse when the parent or other adult caregiver:

- Offers conflicting, unconvincing, or no explanation for the child's injury
- Describes the child as "evil," or in some other very negative way
- Uses harsh physical discipline with the child
- Has a history of abuse as a child

### **Signs of Neglect**

Consider the possibility of neglect when the child:

- Is frequently absent from school
- Begs or steals food or money
- Lacks needed medical or dental care, immunizations, or glasses
- Is consistently dirty and has severe body odour
- Lacks sufficient clothing for the weather
- Abuses alcohol or other drugs
- States that there is no one at home to provide care

Consider the possibility of neglect when the parent or other adult caregiver:

- Appears to be indifferent to the child
- Seems apathetic or depressed
- Behaves irrationally or in a bizarre manner
- Is abusing alcohol or other drugs

### **Signs of Sexual Abuse**

Consider the possibility of sexual abuse when the child:

- Has difficulty walking or sitting
- Suddenly refuses to change for gym or to participate in physical activities
- Reports nightmares or bedwetting
- Experiences a sudden change in appetite
- Demonstrates bizarre, sophisticated, or unusual sexual knowledge or behaviour
- Becomes pregnant or contracts a venereal disease, particularly if under age 14
- Runs away
- Reports sexual abuse by a parent or another adult caregiver

Consider the possibility of sexual abuse when the parent or other adult caregiver:

- Is unduly protective of the child or severely limits the child's contact with other children, especially of the opposite sex
- Is secretive and isolated
- Is jealous or controlling with family members

### **Signs of Emotional Maltreatment**

Consider the possibility of emotional maltreatment when the child:

- Shows extremes in behaviour, such as overly compliant or demanding behaviour, extreme passivity, or aggression
- Is either inappropriately adult (parenting other children, for example) or inappropriately infantile (frequently rocking or head-banging, for example)
- Is delayed in physical or emotional development
- Has attempted suicide
- Reports a lack of attachment to the parent

Consider the possibility of emotional maltreatment when the parent or other adult caregiver:

- Constantly blames, belittles, or berates the child
- Is unconcerned about the child and refuses to consider offers of help for the child's problems
- Overtly rejects the child

***Instructions to trainers:***

1. Using the content below as a guide, lead a discussion/ lecture which explains how certain circumstances can help to minimize the risk of child abuse.
2. Again, first ask trainees what situations they feel will help to buffer the development of child abuse. After listening to and acknowledging their answers, fill in any missing information from the below.

**LECTURE CONTENT: Protective factors**

Protective factors are conditions in families and communities that, when present, increase the health and well-being of children and families. These attributes serve as buffers, helping parents to find resources, supports, or coping strategies that allow them to parent effectively, even under stress.

The following protective factors are linked to a lower incidence of child abuse and neglect:

**Nurturing and attachment**

A child's early experience of being nurtured and developing a bond with a caring adult affects all aspects of behaviour and development. When parents and children have strong, warm feelings for one another, children develop trust that their parents will provide what they need to thrive, including love, acceptance, positive guidance, and protection.

Research shows that babies who receive affection and nurturing from their parents have the best chance of healthy development. A child's relationship with a consistent, caring adult in the early years is associated later in life with better academic grades, healthier behaviours, more positive peer interactions, and an increased ability to cope with stress.

**Knowledge of parenting and of child and youth development**

There is extensive research linking healthy child development to effective parenting. Children thrive when parents provide not only affection, but also respectful communication and listening, consistent rules and expectations, and safe opportunities that promote independence. Successful parenting fosters psychological adjustment, helps children succeed in school, encourages curiosity about the world, and motivates children to achieve.

**Parental resilience**

Parents who can cope with the stresses of everyday life, as well as an occasional crisis, have resilience; they have the flexibility and inner strength necessary to bounce back when things are not going well. Multiple life stressors, such as a family history of abuse or neglect, health problems, marital conflict, or domestic or community violence—and financial stressors such as unemployment, poverty, and homelessness—may reduce a parent's capacity to cope effectively with the typical day-to-day stresses of raising children.

### **Social connections**

Parents with a social network of emotionally supportive friends, family, and neighbours often find that it is easier to care for their children and themselves. Most parents need people they can call on once in a while when they need a sympathetic listener, advice, or concrete support. Research has shown that parents who are isolated, with few social connections, are at higher risk for child abuse and neglect.

### **Concrete supports for parents**

Many factors affect a family's ability to care for their children. Families who can meet their own basic needs for food, clothing, housing, and transportation—and who know how to access essential services such as childcare, health care, and mental health services to address family-specific needs—are better able to ensure the safety and well-being of their children.

Partnering with parents to identify and access resources in the community may help prevent the stress that sometimes precipitates child maltreatment. Providing concrete supports may also help prevent the unintended neglect that sometimes occurs when parents are unable to provide for their children.

|  |                   |
|--|-------------------|
| <b>What to do when you suspect child abuse</b> | <b>30 minutes</b> |
|--|-------------------|

#### ***Instructions to trainers:***

1. Ask the trainees what they think is important to do when they suspect a child may be being abused or neglected. Possible answers should include:
  - Speak to your supervisor and ask for advice. Together with your supervisor, decide how the situation should be managed.
  - Continue to visit the house and ask questions to try and get clarity on if abuse is present.
  - As a mentor mother, you are obligated to report cases of abuse to social services who may refer the case to the police.
  - Assure the mother or child you are dealing with that you have their and child's best interest at heart.
  - Avoid negative remarks or looks. These reactions are likely to increase the parent's anger and make matters worse.

2. Dealing with abuse cases can be very difficult. It is always important to remember to use the counselling and communication skills that were taught at the start of this manual. Always remember to consult your supervisor.

3. Refer trainees to the emergency protocols and procedures and go through the section on Child Abuse/Neglect together.

## **Case Scenarios: Dealing with Child Abuse & Neglect**

**45 minutes**

### ***Instructions to trainers:***

1. Divide the class into groups of 4-5 people. Ask each group to review the following two scenarios, and to discuss how they think a MM should handle such situations.
2. After 20 minutes, call the groups back together, and discuss how each scenario could be dealt with as a class.
3. Ask for questions and clarify for confusion.

### **Case Scenarios**

#### **Case 1**

You are visiting Zukiswa. She is 19 years old and is HIV+. She works for a large cleaning company part time. It is the middle of winter and is very rainy and cold. Zukiswa's sister passed away 4 months ago and Zukiswa has since been looking after her sister's child who is 3 years old. When you arrive after not visiting for a few months, you notice that the child is outside the house by herself. She is wearing only a small dress, and it is clear she has not washed for a long time. You can see she has diarrhoea, and she is trying to clean herself. She is very weak. You go inside and ask Zukiswa what is wrong with the child and how long she has been ill for. She tells you it has been 3 weeks. When you ask if she has taken the child to see a doctor, she says no.

#### **Case 1: notes to trainer:**

- *Explain dehydration risks and how it results from diarrhoea.*
- *Help to prepare oral rehydration fluid.*
- *Bring the child inside and ask the caregiver to help you wash the child and dress her in something clean.*
- *Call supervisor and ask for advice.*
- *Contact social worker and apply for child's placement elsewhere.*
- *Continue following up with social worker if needed.*
- *Explain to Zukiswa why you are speaking to social worker – that it necessary for the child to receive care elsewhere until she is able to care for her again; that she may visit the child as often as she wants to.*

## **Case 2**

You are visiting Thandiwe. When you arrive at the house you find she is drunk. She does not want you to come inside and is hostile when you ask her why not. You can see from outside that there is a small child inside with Thandiwe's baby. The small child has several small bruises on his face and what looks like burn marks on his arms. When Thandiwe sees you looking inside she shoves you to leave.

### **Case 2: notes to trainer:**

- *Apologise for disturbing and back away from the house.*
- *Leave the premises but call your supervisor immediately and ask for help.*
- *Together, contact social worker to report situation.*
- *Child needs to be removed immediately to safe house for 24 hours – continued follow up with social worker.*
- *Thereafter plan a way forward with supervisor.*

# SECTION N

## THE FIELD GUIDE AND THE PROCESS OF HOME VISITING

### SESSION 50

#### *The Field Guide and the Process of Home Visiting*

**Time required: 2 hours**

#### **Purpose**

The purpose of this session is to explain to trainees exactly how they will use the field guide to assist them during home visits.

#### **Objectives**

At the end of this session MM's will understand how to use the field guide to support them and guide them through each of their home visits.

#### **Materials**

1. Field Guide

|   |                |
|---|----------------|
| <b>The Field Guide: Practical Session</b> | <b>2 hours</b> |
|---|----------------|

#### ***Instructions to trainers:***

1. Refer trainees to the field guide and explain its content and purpose in an informal discussion. Trainees will be familiar with the field guide from previous sessions.
2. Allow time for the trainees to read through the guide and ask any questions they might have.
3. Divide trainees into pairs. Each trainee should choose one of the characters outlined below. She will pretend to be this character, while her partner will act as the MM visiting her. Trainees should use the field guide to deliver the home visit covering all areas outlined in the field guide. Allow 30 minutes for practise in pairs.
4. For the remainder of the session, ask each pair to role play one or both (time depending) of their scenarios for the class to watch and give feedback on.

## **Characters:**

### **Character 1: Nkolie**

Nkolie is 4 months pregnant. She is unemployed. She has not been to the clinic to book for antenatal care, even though this is the second home visit she is having. She has not tested for HIV and is afraid to have the test, which is partly why she did not go to register her birth yet. Her husband has HIV. She has no other children yet. She plans to give her baby formula milk and breastmilk when he/she is born.

### **Character 2: Bulelwa**

Bulelwa is 5 months pregnant. She is a domestic worker one day per week. This is the first visit she is receiving from a MM. She is HIV negative. She is currently on TB treatment but it makes her very ill and she wants to stop taking it because of that. She has been to the clinic to register for antenatal care and to book her birth. She has not decided how she will feed her baby yet. She has 2 other children. One of them was LBW when he was born. Nkolie drinks a few beers every weekend. She knows what people say about alcohol in pregnancy but all her friends drink too and their babies are fine.

### **Character 3: Ntente**

Ntente has just given birth to her baby boy. He is 2 days old and this is the first postnatal visit. Ntente is HIV positive. She has decided to breastfeed. The baby was born weighing 2800g. Ntente managed to stop drinking alcohol during pregnancy.

### **Character 4: Thandeka**

Thandeka gave birth to her baby 8 weeks ago. She is HIV negative and has chosen to breastfeed her baby. She says that previously she was managing to breastfeed quite well, but the baby now has got diarrhoea and is refusing to eat. He weighs 3.5kg. Last time the MM visited he also weighed 3.5 kg.

### **Character 5: Fundiswa**

Fundiswa gave birth to her baby 6 months ago. Fundiswa is HIV positive. She has chosen to formula feed. The baby does not want to eat. The baby has got creamy white sores in her mouth. The baby weighs 6kg. Fundiswa is otherwise well and shows no danger signs herself.

# SECTION O

## SELF-CARE

### SESSION 51

#### *Self-care for Mentor Mothers*

**Time required: 3 hours**

#### **Purpose**

The purpose of this session is to encourage and enable self-awareness and stress management in Mentor Mothers.

#### **Objectives**

At the end of this session MM's will:

1. Be able to recognise the warning signs of burnout in themselves and /or others.
2. Be aware of their thoughts, feelings, and behaviours during periods of stress.
3. Recognise their somatic warning signs.
4. Have an understanding of the importance of balancing work, health, family, friends and spiritual aspects of their lives.
5. Understand the importance of supportive relationships within the Mentor Mother group.
6. Know what they can do for themselves if feeling over-whelmed by their work.
7. Know what to expect from Philani+ in terms of support and supervision.
8. Know how to manage their stress on a day to day basis.

#### **Materials**

1. Flipchart and pens
2. Ball of wool
3. Paper for participants to write on
4. CD player and music

***Instructions to trainers:***

1. Explain that an inescapable aspect of being a Mentor Mother is being exposed, often on a daily basis, to suffering and desperation – that on a day to day basis, MM's make a difference in the mothers the visit's lives. Unfortunately a human consequence of knowing, caring, and facing the reality of hardship in other people's lives is that the helpers often forget the need to care for themselves. The result can be damaging for that person, their family and their professional life.
2. Explain the following warning signs of burnout to trainees.

**SIGNS OF BURNOUT**

The following characteristics are signs of burnout:

- High absenteeism
- Poor quality work
- Low motivation
- Lack of energy
- Disconnecting from family and friends
- Cynicism and despair
- Desensitisation
- Interpersonal conflict
- Emotional outbursts

3. Explain that taking care of oneself as a Mentor Mother is both 'YOUR' responsibility and 'OUR' responsibility. Discuss the MM's role in caring for themselves.

***Instructions to trainers:***

Following the guide below, go through the four components of self care together with the class. Each component is accompanied by practical exercises which you will do together.

**Remember your ABC's**

- A** = Awareness (of self)
- B** = Balance (of life)
- C** = Connection (with others)
- D** = Day to Day (management of stress)

**A = Awareness**

Awareness means being in tune with your needs, limits, emotions and resources. It means knowing yourself, your thoughts, feelings and behaviours.

**Exercise 1a**

Close your eyes and think of a day that was incredibly stressful for you. The Trainer writes up on a flipchart as the participants call out possible answers. What kinds of thoughts might you be having? Trainer to give examples by saying, "I might be thinking, this kind of thing always happens to *ME* or I've messed up again!" Then the Trainer asks for other examples.

What are some of the feelings you would be experiencing? Trainer again to start by giving some examples, such as, hopelessness, anger and sadness. She then asks participants for suggestions.

Lastly, participants are asked how they might behave under such stressful conditions. Examples could be given such as, shouting at one's children in frustration or being short with a colleague. Participants give their own examples.

The trainer reflects on our thoughts, feelings and behaviours and how these three areas are all linked. How we think, effects how we feel which in turn can affect the way we behave. We are not always aware of ourselves or these processes but they are happening inside us all the time.

### Exercise 1b

The trainer draws up a picture of a person on the flipchart and asks participants where on their body they show/experience signs of stress. Again examples can be given to start off, for example, “when I feel stressed I tend to get lots of headaches, does anyone have any other examples?” After the brainstorm the trainer talks briefly about the link between the mind and the body. The body waves big red flags in our faces to tell us that we are stressed and need to do something to de-stress. We often ignore these signs or take pills to numb the pain.

### Summary

Exercise 1a and 1b show us how important it is to be aware of ourselves in order to pick up any warning signs of being over-whelmed quickly so that we can take action to slow down or get some help.

### **B = Balance**

Balance refers to maintaining balance among activities, especially work, health, family, friends and spirit.

It is very important to try and have some level of balance between these five aspects of one's life. How balanced are you?

### Exercise 2: The starfish

Starfish are amazing animals, they have five 'legs', for this exercise we are going to see each leg as representing one aspect of our lives, work, health, family, friends and spirit.

There are two amazing things about starfish:

1. They have a circle in the centre of their body that coordinates in which direction the legs will move. They have shown in research that if this circle is cut the starfish will pull itself apart because each leg moves in a different direction. In our lives we need a similar coordinating centre that will decide which area of our lives we are going to concentrate on and when.
2. If one of the legs gets cut or damaged, it can grow back. This is similar to us, if we have neglected one area of our lives, we still have the opportunity to grow and develop it.

Knowing all of this the trainer then asks the group to sit by themselves and draw what their starfish would look like. For example, if one works 12 hours a day and has no time for family, friends or a spiritual life then the starfish would have a long work leg but short family, friends and spirit legs.

The group is then asked to break into pairs and share with their partner which part of their lives would they like to start paying more attention to and growing. The Trainer goes around helping the pairs.

### **C = Connection**

Connection to others and to something greater than ourselves is very important in life. Communication is a vital aspect of connection.

#### Exercise 3

The trainer hands one participant a big ball of wool, she holds the end of the wool, calls another participant's name and while holding that end throws the ball to the person whose name she has called. That person holds onto her piece of wool and throws the ball to another participant by calling her name. This continues until all participants are holding at least one piece of the wool. The wool must be taut.

The Trainer then observes how together this group makes up a very important support network, a web of knowledge, experience, kindness and guidance that will sustain them as a group through tough days. The trainer asks the group to look around and remember this picture in their heads.

She then asks one participant to let go, then four participants to let go of their string. The effect is dramatic as the web disintegrates in front of everyone's eyes. The Trainer makes the point that each and every person is needed in this team, if one drops the ball it will affect everybody.

### **D = Day to Day Management of Stress**

Referring to the previous exercise the trainer points out that sometimes people drop the ball because the work is feeling too much; it is over-whelming, just too sad or because they are going through their own personal difficulties. We are going to focus on some of the things that we can do for ourselves to manage our stress.

Day to day management of stress falls into three categories: self-care, nurturing yourself and escaping.

- Self-care i.e. exercise, healthy eating, sleeping, relaxation
- Nurturing activities i.e. giving back to yourself e.g. taking a day off and or going to visit to good friend.
- Escape i.e. "getting lost" e.g. watching a movie or reading a good book.

#### Exercise 4

Ask the group to brainstorm some things that they may already be doing to relieve their stress or some new ideas given what has been covered so far today. The group is asked to write down any suggestions that individuals have come up with that may be of use to them at some point.

The trainer then reminds the group what was said at the beginning of the session; that “self-care is MY responsibility as a Mentor Mother and OUR responsibility as project staff”. The Trainer asks the group:

1. What kinds of things do you think PHILANI+ could put in place to help you as a Mentor Mother?

All the suggestions get written down on the flipchart; the trainer is to highlight the particularly useful suggestions. In terms of what Philani+ could do it would be important to highlight that:

- Supervision and line management will be offered
- Referrals will be provided for anyone in need of external assistance for personal problems
- Debriefing sessions will take place every two weeks to talk through how MM are feeling and coping
- Informal collegial support and guidance

#### **Conclusion**

**40 minutes**

#### ***Instructions to trainers:***

1. Draw the main points of the day together.
2. Then explains that relaxation exercises can often help us to de-stress even in the most trying times. The Trainer then takes the group through a relaxation exercise while soft, gentle music is playing in the background. The guide for the relaxation exercise is in the box below.

Sit comfortably upright in your chair, with your hands loosely joined on your lap and feet flat on the floor. Close your eyes...

- Clench your toes tightly inside your shoes...then let go.
- Tighten your calf muscles...let go.
- Tighten your buttocks...let go.
- Pull your tummy in hard...let go.
- Clench your fingers tightly together...let go.
- Stick your elbows hard into your sides...let go.
- Stiffen your shoulders...let go.

- Tighten the muscles of your neck and under your chin...let go.
- Screw your eyes tightly shut...let go.
- Now just sit quietly, relaxed, for a few minutes (5 minutes).

Okay, I want you to start to bring yourself back into the room, listen to the noise around you, feel your back against the chair, your feet against the floor, breathe in deeply. When you are ready open your eyes.

3. The Trainer asks how that exercise felt for the group and tells them that it is an exercise that anyone can use on their own to relax. She thanks them for all their participation and hard work and wishes them well on their journey as Mentor Mothers.

# SECTION P

## ROLE PLAY ASSESSMENTS

### SESSION 52

#### *Role Plays*

**Time required: 1 day**

#### **Purpose**

To assess what trainee MM's have learned over the course of this training and how well they are able to apply their knowledge in a practical situation.

#### **Objectives**

The objectives of this session are for you, the trainer, to assess the extent to which MM's have grown throughout the training course, and to assess the extent to which they are able to put their learning into practice.

#### **Materials**

1. Video recorder
2. MM need to have their field guides with them
3. Doll

#### **Preparation**

A member / several members of the research staff are to prepare several case situations in which they will act as a mother receiving a home visit from each MM trainee in this session. There should be one different case situation per MM trainee.

**Practical Evaluations****1 Day**

This is a practical session. Each trainee will have 20 - 30 minutes for their evaluation. They will perform a role play in which they are to act as a MM performing a home visit with a pregnant or new mother. Using their field guides, the trainees will conduct a home visit role play with a research staff member who is pretending to be a 'mother to be' or a new mother with a baby (doll). Trainees will be given a background history to their case before the evaluation begins.

A video recording will be taken while the trainee performs the role play. Thereafter, all trainees will watch the role play together and provide feedback on the strengths and weaknesses that the MM displayed. A formal evaluation will be given by the training facilitator/s.

# SECTION Q

## POST TEST AND CONCLUSION

### SESSION 53

#### *Post-test and Skills Assessment*

**Time required: 3 hours**

#### **Purpose**

To measure how much MM's have learned since the beginning of the training, and to assess their competency and skills.

#### **Objectives**

At the end of the session the MM will be able to:

1. Complete the Post-test satisfactorily.
2. Competently carry out newly learned skills.
3. Mix a bottle of formula milk correctly.
4. Make an oral rehydration solution correctly.

#### **Materials**

1. Salt
2. Sugar
3. Water
4. Measuring cup, bowl or jug to mix rehydration solution
5. Formula feed
6. Baby bottle
7. Post-test Handout
8. Answers to Post-test (trainer only)

**Practical Session****90 minutes*****Instructions to trainers:***

1. Ask each trainee individually (in a separate room from the rest of the class) to prepare a bottle of formula milk and an oral rehydration solution, explaining to you as she goes how it should be done (as if you were a 'mother to be').
2. If done correctly, add 5 points for each of the formula milk and rehydration solution to the post test result. (10 points if both done correctly).
3. If done incorrectly, do not add any points to the post-test result, but demonstrate to the MM again how each should be done. Then ask her to prepare them again in front of you until she does so correctly.

**Assessment: Post-test****90 minutes*****Instructions to trainers:***

1. Distribute Post-test.
2. Each trainee completes the test individually.
3. Trainers collect the test and mark it.
4. Tests are returned to the trainees at next meeting.
5. Discuss each question and clarify any confusion.