PHILANI

Maternal, Child Health and Nutrition Project

Healthy mothers raising healthy children

Mentor Mother Training

Trainee Manual

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SECTION A
INTRODUCTION TO TRAINEES

Welcome to the Mentor Mother training course!

This course is designed to equip you with the skills and knowledge necessary to perform your role as a Mentor Mother. You will learn about various aspects of maternal care during pregnancy, and about infant and child care following birth. You will also learn important counselling and communication skills so that you are able to deal with sensitive and difficult situations in your day to day work.

This manual is your guide to the training. It is written to accompany the trainer's manual which your facilitator will use. Please bring the manual with you every day to this training course. You will need it to perform the role plays and to participate in the activities which will take place during the training.

Enjoy!

SECTION B
WELCOME TO TRAINING

SESSION 1: Introduction to Training

Time required: 2 hours

Purpose

- To welcome trainees to the training, and explain to them the training schedule and training objectives.

Objectives

- At the end of this session MM's will:
  - Understand the structure, purpose and schedule of the training to follow, and how this will translate to their work on this project.
  - Have agreed upon a certain set of rules and a code of conduct for the duration of the training.
  - Understand the importance of dress code during their work.

Ice breaker and Introductions — 20 minutes

The trainers will guide this session.

Training Logistics — 20 minutes

The trainers will guide this session.

Code of conduct and dress code — 20 minutes

The trainers will guide this session.

SESSION 2: The Pre-training Evaluation

Time required: 30 minutes

Purpose

- The purpose of this session is for training to get an idea of how much you know about certain subjects so that they can better focus the training.

Objectives

- At the end of this session trainers will be able to review the current knowledge of the MM trainees. Understand the structure, purpose and schedule of the training to follow, and how this will translate to their work on this project.

Materials

- Pre-training evaluation handouts

Pre-training evaluation 30 minutes

The trainers will guide this session.

SECTION C
COUNSELLING AND COMMUNICATION SKILLS

SESSION 3: Counselling and Communication Skills for Home Visits

Time required: 6 hours and 30 minutes

Purpose

- To strengthen your ability to listen to, communicate with, and counsel the women in the communities effectively.

Objectives

- At the end of this session you will:
  - Understand the values and skills that are important for communicating with and counselling women.
  - Understand what counselling is and the difference between counselling and advising.
  - Use non-verbal and verbal techniques to encourage a mother to talk without asking too many questions.
  - Respond to mothers feelings with empathy.
  - Be able to use these tools throughout the training in all role plays and in the field.
  - Work in a respectful and empowering way with mothers and their children.

Introduction to Counselling and Communication 1 hour

COMMUNICATION

One of our biggest needs as people is to interact with others and to build relationships that are supportive and meaningful. In order for these relationships to grow we communicate with each other. Communication involves:

- 2 or more people
- The development of a relationship which is based on reciprocity i.e. give and take, equal levels of sharing of information and feelings etc.
- Periods of talking (and)
- Periods of listening

Training in counselling means taking these natural communication skills that we all have and making us aware of how we use them and why so that we can grow and develop them further for the benefit of our clients.

How is counselling different from a relationship with a friend or family member?

There are a number of important differences:

- The biggest difference is that in counselling the client is the central focus of attention, the entire conversation is about the client and NOT the counsellor.
- The counsellor actively and consciously uses her professional values and skills to guide her intervention with the client.
- She tries to truly understand what things must be like for her client (empathy) and offers her the emotional space to think, and talk, through her difficulties.
- To sum up, the counsellor listens to the client in a way that encourages her to talk, and talks to the client in a way that encourages her to listen.

So in order for us to find out how she does this we need to reflect on the concept of counselling in more detail.

INTRODUCTION TO COUNSELLING

The Purpose of Counselling

The purpose of counselling is to be:

- **Supportive:** giving clients the space to talk through their thoughts and feelings with a non-judgmental listener.
- **Informative:** ensuring that clients have a clear understanding of the facts that will enable them to make informed decisions.
- **Preventive:** increasing the clients' awareness on measures they can take to protect themselves and others, such as problems in pregnancy, stopping or cutting down on alcohol, HIV, and other.

What is Counselling?

Counselling is a helping relationship. It is usually one-to-one communication specific to the needs of the individual. When you counsel a mother, you

- listen to her,
- try to understand her situation,
- help her to understand the choices that she has to make,
- provide her with relevant information,
- help her to decide what to do, and
- help her to develop confidence to carry out her decisions.

Counselling means more than advising. Often, when you advise someone, you tell him or her what you think they should do. Counselling also means more than education and providing information. Providing information may be part of counselling, but not the only part.

A counsellor does **NOT** make a decision for a woman, nor push her towards a particular course of action, nor enforce a health policy.

Counsellors need to accept that a woman may find it difficult to make a decision. She may change her mind and need to discuss issues with her family members. The counsellor needs to support and assist a woman through this process.

Remember that a counsellor cannot take away all a woman's worries, and is not responsible for a woman's decisions.

What are the main attitudes and values of Counselling?

- Confidentiality: this means that any information you receive from your client(s) should not be spoken about to others outside of this project.
- Acceptance: this refers to the ability to accept others' feelings, beliefs and decisions even when this is in opposition to our own.
- Individualisation: each and every person deserves to be treated as an individual, with their own life experiences, thoughts and feelings.
- Non-judgmental: this means not judging a person for what they are saying, what they have done or intend to do. It means believing that life is complicated and that none of us should stand in judgement of another.
- Self-determination: Is the understanding that our clients are separate from us, it is NOT your problem to solve; clients are capable of making their own decisions.
- Control of emotional involvement: this work can be hard; our clients' stories can leave us feeling helpless and over-whelmed. If we, as counsellors, feel this way then we need to seek help ourselves from our peers or managers in the project. It is NOT acceptable to talk about our own feelings with a client.
- Purposeful expression of feelings: Any expression of feeling towards the client must be done in a well-thought through way and it must be in the client's best interests, for example, reflecting that a situation feels difficult.

HOW DO I BUILD A RELATIONSHIP WITH MY CLIENT?

When we talk about building a trusting relationship with a client we are talking about the need to build rapport or a connection with her. It is only when our client feels a sense of safety and trusts us that they will begin to talk about what is troubling them. Rapport is developed right from the moment you greet your client until the moment you bid her farewell and can be strengthened throughout the session by what you do and what you say.

We are going to focus on three main areas of counselling that will help you develop a relationship with your client, namely:

1. Empathy
2. Listening skills
3. Building confidence and giving support

Before doing this, however, let us first talk about two ways that we communicate with people even though we may not always be aware of them, verbally and non-

verbally. Verbal communication refers to what we say, non-verbal communication on the other hand is everything that we don't say with our mouths but "say" with our bodies, for example, facial gestures, eye contact and body posture.

It is important to remember that we need to be aware of our clients' non-verbal communication as well as our own. By this we mean that what you say in words must also be communicated by your body. For example, if you are telling your client that you want her to tell you more about her difficulties but you keep looking at your watch and yawning then you are "telling" her that you are actually bored and not interested.

Helpful non-verbal communication

The easiest way to remember your non-verbal communication is to remind yourself of the word **SOLER:**

S	• **SQUARELY:** face your client squarely
O	• **OPEN:** keep your posture open; don't cross your arms or legs
L	• **LEAN:** towards the client at times
O	• **EYE CONTACT:** maintain good eye contact without staring
R	• **RELAXED:** try to appear relaxed by smiling appropriately and sitting comfortably without fidgeting.

Activity 1: Listening skills — 45 minutes

Your facilitator will explain how this exercise is to be done.

Discussion: Counselling skills — 30 minutes

1. Empathy

Empathy is one of the most important building blocks in relationships as it provides the foundation for rapport. It takes place when we listen to someone who has a need to talk and be understood by another. The listener shows a willingness to truly understand the thoughts, feelings and beliefs of the client. When this is communicated to the client she will feel accepted and understood, this is incredibly powerful when a person feels over-whelmed, helpless and alone in their pain.

Hints on how to empathise:

- You need to listen very carefully to what the client is telling you.
- You need to become aware of your own feelings and those around you.
- Remember that the basis of all empathy is respect and genuineness.

2. Listening skills

Listening is not simply a matter of sitting and taking note of what the person is saying. It is an active exercise; it is an art, a skill and a discipline that requires an ability to be comfortable with silence, keep your own needs outside of the session, and to concentrate attention on someone else with a spirit of humility.

Keys to attentive listening:

- **Ask for clarification**: Asking friendly questions when something is unclear allows you to get more information and shows your interest and concern. "Please tell me more about that?" "Can you give me an example?" Even a simple "mm…hmm" will encourage the speaker. Some people feel threatened by questions, so make your probing gentle and supportive.
- **Ask open questions**: Ask questions that encourage the client to tell you more about something. Avoid closed questions that just require a yes/no answer.
- **Empathetic silence**: We are often uncomfortable with silence but it is important not to fill up emotional spaces with talking just to cover our awkwardness. If you are comfortable with silence it can give your client the opportunity to reflect on what they have said and to continue.

- **Use responses and gestures which show interest**: Nodding, smiling or using expressions such as, “Oh…”, “I see…”, “Mm mm…”, “Really?”, and “And then?” can encourage the person to carry on talking as she gets the message that she is being heard.
- **“Tell me more” techniques**: These are ways in which one encourages another person to tell us more about her problem, “yes, tell me more.”, “Would you like to talk about it?” “I would like to hear what happened next.”
- **Reflect content**: This means telling the client what you have understood by what they have said, “So you are saying that baby is keeping you awake a lot at night”.
- **Reflect feelings**: Let the person know that you have heard the feelings behind the content. What is the person feeling but not saying? Try empathy and think to yourself “If I were in that situation how would I be feeling?” Watch for body language; posture, eye contact, facial expressions, as these often reveal underlying emotions. Then check out your guesses. “You seem very disappointed?”

3. Building confidence and giving support

When a client has to confront a difficult situation, or change their behaviour in some way, it can be difficult and emotionally draining. It is important to build a client’s confidence and support them through this process.

These are some things you can do:

- **Accept** what a mother thinks and feels
- **Recognise and praise** what a mother is doing well
- Give **practical help**
- Give a **little, relevant** information
- Use **simple** language
- Make one or two **suggestions**, not commands

Activity 2: Empathy, Listening and Building Confidence Skills
45 minutes

The trainers will guide this session.

LECTURE CONTENT: Counselling and Communication for Home Visits
90 minutes

The most crucial aspect of the Mentor Mother intervention is <u>counselling</u> and <u>support:</u>

DO'S

- Be warm and friendly with mothers and their families
- As far as possible make sure that the physical setting is private, safe and comfortable
- Actively listen to what is being said
- Be aware of non-verbal communication (hers and yours)
- Ask clarifying questions
- Respond in a way that encourages the mother to talk more
- Try to understand what mothers are saying and feeling
- Reflect what you are hearing back to them.

DON'TS

- simply tell the mothers what to do
- interrupt
- answer calls from your cell phone unless it is urgent
- look down upon mothers and have an attitude that says: "I know it all"
- provide too much information at once
- provide irrelevant information
- talk all the time, without listening to the exact concerns of the mother or her family
- divert the conversation to yourself

Communication Tips for Mentor Mothers During Home Visits

<u>ALL VISITS:</u> Basic communication skills to create a caring environment

- Greetings
- Explain why you are visiting today
- Act with confidence
- Speak in a gentle tone of voice
- Act respectful

- Ask the woman if she has any questions
- Answer simply
- Thank her for the visit and say when you will return

Difficult situations

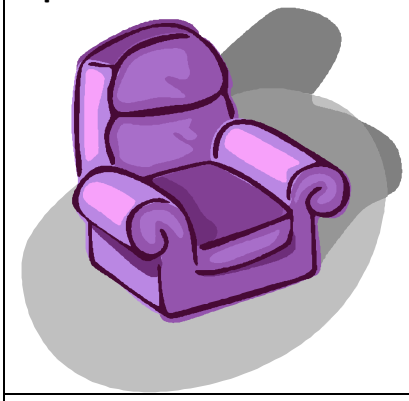
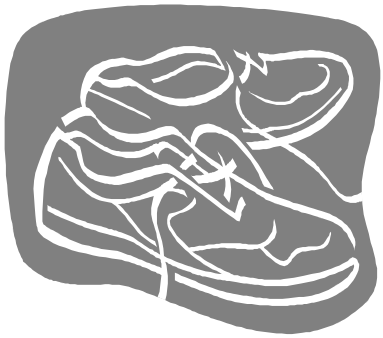
- If the woman is shy
  - Speak of general things to 'warm her up'
  - Encourage the woman to speak
  - Praise the woman, to give her confidence
  - Repeat the question

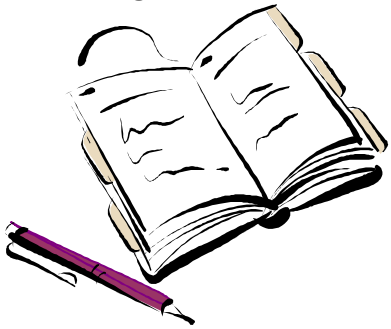
- If the woman is argumentative
  - Praise the woman
  - Sympathize with her complaints (if any)
  - Do not push if the woman is still not receptive

- If the woman is inquisitive
  - Answer her questions simply
  - Explain that you will be coming to visit more often so you can talk again

- If the woman is not friendly
  - Listen to the woman
  - Be friendly
  - Try and praise her
  - Explain that you are there to help
  - Do not push if the woman is still hostile

What would a typical Mentor Mother visit look like?

STEP	TIPS
STEP 1: **Create a safe and comfortable space** 	• Introduce yourself and address the client by her name.
	• Explain your role again.
	• Explore and clarify expectations of the day's visit (content, length of session etc).
	• Ensure confidentiality.
	• Maintain supportive contact through your voice or touch but do not invade space without their permission – be respectful.
	• Take your lead from the client.
STEP 2: **Develop a trusting relationship** 	• Frame your session by explaining what you are planning to deal with in the session, how the session runs and how long it takes. Empower your client by letting her know what to expect from you.
	• Tune in/warm up to the person's experience.
	• 'Walk in their shoes' – empathise. Show you care.
	• Respond to the person with respect, care and dignity. Do not take over or be judgemental.
	• Remember the mother's and baby's needs come first.
	• Be reliable, always do what you say and be on time for appointments.

STEP 3: **Listen** 	• Encourage the person to tell you how they are doing in any way that feels comfortable.
	• Listen carefully and ask for details where appropriate.
	• Empathise with the mother.
	• Use all your listening and responding skills.
	• Check out what she does to cope, for example, sleep, drink alcohol or talking to friends.
	• Find out if she feels supported by family, friends or the community.
STEP 4: **Providing relevant information** 	• Acknowledge the mother's difficulties and highlight that together you will work towards a solution.
	• Discuss ways of coping that may be useful to the mother.
	• When appropriate provide relevant information.
	• Ask her if she has understood what you have told them.
	• Ask her if she has any questions or would like more information.
STEP 5: **Saying goodbye**	• Check if there are any other issues worrying the mother from this session.
	• Arrange for a follow-up appointment.
	• Discuss how she can mobilise support from friends, neighbours and spouse.
	• Direct client to medical, legal, religious or social support.
	• Bid the mother goodbye and wish her well.

Activity 3: Demonstration of a Role Play 10 minutes

The trainers will act out a typical scenario while demonstrating the 5 step counselling model.

Activity 4: Practise, Practise, Practise ! 90 minutes

The trainers will guide this session.

Scenario

MM: Empathise, support and listen to the mother (no information sharing is necessary in this session).

MOTHER: Share with the MM that you are feeling like you are not coping with your newborn baby who cries a lot and rarely sleeps. You are a single parent with two other young children and feeling like running away from your problems.

OBSERVER: On a piece of paper take notes about what skills are being used by the MM, what she is doing well and how could she have done it differently.

Activity 5: Closure and Affirmations 20

The trainers will guide this session.

SECTION D
NEGOTIATING ENTRY

SESSION 4: Negotiating Household Entry

Time required: 2 hours and 40 minutes

Purpose

- The purpose of this session is to equip MM trainees with the skills they will utilise to negotiate entry effectively and non-invasively into the houses they will be visitin.

Objectives

- At the end of this session MM trainees will be able to:
  - Understand the importance of gaining entry with acceptance into clients' houses.
  - Understand several ways to facilitate being accepted by clients.
  - Understand why rejection occurs and how to deal with rejection.
  - Understand how to handle difficult situations.

Materials

- Board/flipchart and paper
- Markers
- Philani Mentor Mother Training DVD

Discussion: Gaining Acceptance and Trust 40 minutes

The trainers will guide this session.

"As a Mentor Mother (MM), your key function is conducting successful home visits. In many instances your first home visit will determine the success of the follow-up visits. It is therefore important that you plan in advance what tips will assist you to gain access to the home. You need to remember that an invitation to talk with the client is dependent on how you present yourself. The client has no obligation to listen to you but you have an obligation to convince her that you are worth listening to."

Gaining acceptance and trust:

- Observe the **dress code** of the community you are serving.
- Observe the current circumstances and if they are **conducive** to a home visit. If they are not (e.g. if the client is very busy with other commitments, there are other people visiting, she is in a hurry to go somewhere etc), request an appropriate time to come back and talk with her.
- Indicate up front **how much time you need** to talk with her, so that she can decide if she has time for you.
- Observe **norms and practices of seeking access** to a home where you are not well known (e.g. which door to knock on, greeting, respect to the elders, keeping or taking shoes off, shaking hands, enquiring on the wellness of family members before stating the reasons of your visit, when is the right time to introduce yourself, waiting to be invited inside the house etc),
- **Introduce yourself** and the organisation you work for, as well as the reasons for your visit.
- Give time to clients to **understand why you are visiting** and have their concerns addressed before you start the conversation. In some instances you might have to ask if there are concerns they want you to address before you talk with them in order to strengthen credibility.
- If you cannot address the clients concerns, write them down and tell her that you will contact her as soon as you get the answers (please remember it is very important to get back to her).
- You need to **remain composed** even in situations where major interruptions may interfere with the conversation.
- Observe the clients **body language** and listen for cues of disinterest and try to draw the client back into the conversation.

- **Do not outstay your welcome** unless the client has other pressing issues she wants you to assist with or share with you (some may be looking for a 'listening ear').
- Do not give **false information or make promises** you are unable to fulfil.
- When you are through with the conversation/ discussions **thank the client for her time** and indicate when you plan to visit again. If the day/ time you are suggesting is unsuitable to the participant, negotiate an alternative day and time.

Discussion: Rejection during Home Visits — 20 minutes

The trainers will guide this session.

DVD Session: The Mentor Mother Introduction — 20 minutes

The trainers will guide this session.

Role Play: The Introduction — 20 minutes

Role Play Script: The Philani Introduction

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

MM: *(Knocks on door).*

NOMSA: Hello.

MM: Hello, my name is Fundiswa.

NOMSA: Hello.

MM: I live at *(gives address)*. I am working as a mentor mother for *(insert organisations nam*e). Do you know that you can receive home visits from a Mentor Mother while you are pregnant and after your baby is born?

NOMSA: No I didn't know that.

MM: I am the Mentor Mother working in this area, and I can visit you several times before and after your baby is born to support you through the antenatal care and birth process, and in the first few months after your baby is born. Would you like that?

NOMSA: Oh, come and sit down. *(They sit together).* That would be very nice. How often will you come to visit me?

MM: Thank you. I will come to see you four times before your baby is born, and then I will come again 6 times after your baby is born. *(pauses to give opportunity for questions).* If you would like me to stop making visits, please tell me. However, I hope you find these visits enjoyable and helpful.

NOMSA: What exactly are you going to do here?

MM: We will do many things. Before your baby is born, I will make sure that you have all the information you need to stay healthy during your pregnancy. There are certain things you need to eat and drink while you are pregnant, and other things you need to avoid while you are pregnant to keep your baby healthy. It is also important to test for certain illnesses while you are pregnant and to get treatment if necessary. You also need to visit the clinic to book for your birth and to register for antenatal appointments. Then there are certain decisions to make about how you will feed your baby after your birth, so I will help to provide you with all the information you need to make those decisions as well. I will also help you once the baby is born to learn when your baby is healthy, and when he or she needs to visit the clinic. I will weigh your baby each time I visit you so that we can see how he/she is growing and if he/she is gaining enough weight.

NOMSA: That is good. Thank you.

MM: You must also know that anything we discuss when I am here will just stay between you and me. I will not going to talk about you and your personal information to anyone else in your house or this neighbourhood unless you ask me to. You can trust me to keep everything confidential.

NOMSA: Okay.

MM: Would it be alright for me to ask you a few questions about yourself?

NOMSA: Yes, that is fine.

MM: Thank you. If you have any questions as we go, you must ask me. I would like to answer any questions you might have.

Role Play: Using a flower to gain acceptance 20 minutes

Role Play Script: Using a Flower to gain Acceptance

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

Thandiwe and Kanyisa (MM & supervisor) arrive at Zukiswa's home at around 12 pm. Zukiswa seems to be at home, although the door is locked, the windows are open. Khanyisa approaches the house and knocks on the door. Zukiswa does not respond. Thandiwe tries her luck and knocks again – Again Zukiswa refuses to respond. Khanyisa tries again with a softer knock.

ZUKISWA: I am very busy, I am cooking! *(In a sharp voice. Do not open the door).*

THANDI & KHANYISA: Good morning Zukiswa. We are sorry to have disturbed you. We will leave you now to your cooking. Good bye. (W*alk to the next 2 homes and interact with the participants).*

Thandi and Khanyisa return from their other visits and on their way back, they pass by Zukiswa'a home.

KHANYISA*:* *(admiring Zukiswa's flowers*). Zukiswa, your flowers are so beautiful.

ZUKISWA: Thank you.

THANDI: Would you perhaps mind if I took one of your flowers' seedlings home to my garden to plant? I would love to grow flowers like these.

ZUKISWA*:* *(opens the door).* Yes that is fine. You may pick any two seedlings you wish and take them home with you to plant.

Khanyisa walks towards Zukiswa's neighbours home, this prompts Zukiswa to start explaining her neighbour's whereabouts.

ZUKISWA: She is a nurse and she works long hours. If she is not at work she is in a choir (Joyous Celebration). She is a good singer. It is very difficult to find her at home.

Thandi and Khanyisa listen tentatively about Zukiswa's neighbour's whereabouts.

THANDI & KHANYISA: Oh, that is why she is seldom home. Thank you very much for your seedlings and your time. Would it be possible to make another appointment to come back and visit you at a time that suits you better? Perhaps when you are not so busy cooking?

ZUKISWA: Yes that will be fine. You can come anytime on Wednesday afternoon. Today I am too busy.

MS NZIMANDE: Thank you, we understand. We will come back on Wednesday then. Thank you for your time.

ZUKISWA: You are welcome. Good bye**.**

THANDI & KHANYISA: Good bye.

Discussion: How to deal with difficult situations 20 minutes

Tips on how to deal with a difficult situation:

- Take the challenge positively and do the prayer with the family.
- Ask the participant if the prayer should be directed to a special request or it should be a general one.
- Keep the prayer as short as possible but to the point.
- Try and stay as focussed as possible, keeping in mind the purpose of the visit.
- Assess if the family members still need to continue praying together with the Mentor Mother, keep assessing if the home visit could still go ahead after the prayer.
- If the family still requires continuing with prayers the Mentor Mother should re-schedule the appointment, and continue to do other visits as required for the day.
- The Mentor Mother should not appear to be fed up because the visit did not take place as scheduled.
- Leave the house on a very positive note and a date agreed upon by both parties for the next visit.
- Do the next visit as arranged and probably ask how the participant felt after the prayers that MM participated in. (This inquiry will help to show that the Mentor Mother is sensitive to other peoples feeling and beliefs)
- If the schedule visit does not occur on the second day, reschedule again.
- Make a visit again as arranged and collect the data that you initially wanted to obtain.
- Establish the necessary rapport and stay on course and obtain all the required information.

DVD Session: Dealing with Difficult Situations effectively 20 minutes

The trainers will guide this session.

SECTION E
REPRODUCUTIVE HEALTH

SESSION 5: Introduction to the reproductive system

Time required: 45 minutes

Purpose

- To give an overview of human reproduction, menstruation and pregnancy.

Objective

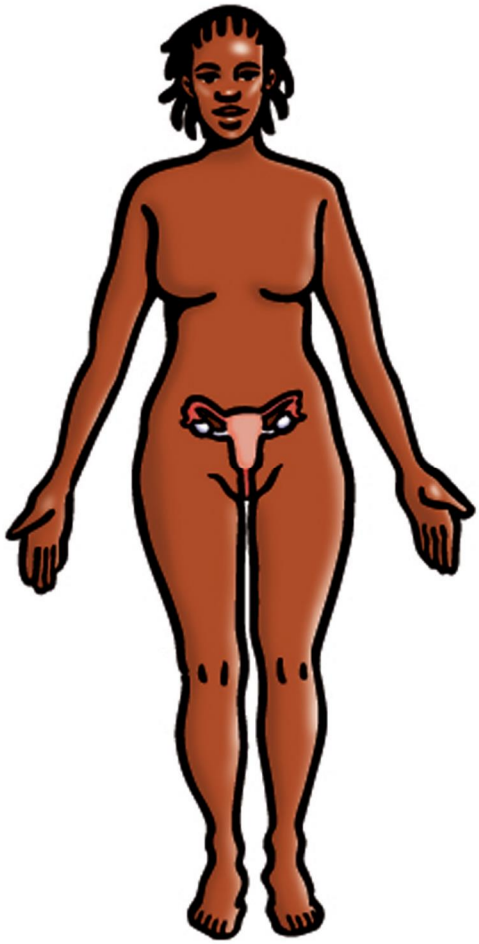
- At the end of the session the MM will:
  - Have a basic understanding of male and female anatomy.
  - Have an understanding of menstruation.
  - Be able to explain how pregnancy occurs.
  - Know the signs of pregnancy.

Materials

- PowerPoint slides
- Board/flipchart and paper
- Markers
- Choice Kit
- Disposable pregnancy tests and plastic container
- Oil-based lubricant (Vaseline)
- DVD: Inside Pregnancy

The Female Reproductive System 45 minutes

The function of the female reproductive system is to make eggs, and to provide the environment for a baby to grow.



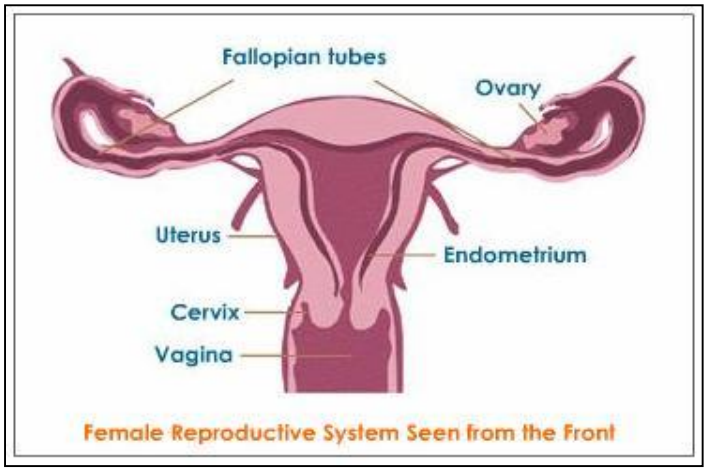
The following parts make up the female reproductive system:

• Two **ovaries** which are found near the middle of the woman's body. Each ovary is about as big as your thumbnail. The ovaries make the egg cells, as well as the female reproductive hormones. After the egg is pushed out by the ovary, the open end of the **fallopian tube** catches the egg and slowly transports this egg to the uterus (womb).

• The **uterus** is an organ the size of a fist situated behind the pubic bone. It has a lining and is mainly made up of muscles. When the egg is released from the ovary, the uterus starts to prepare for pregnancy by developing a thick lining. If the egg is not fertilised (joined together with the sperm), the uterus will get rid of the lining and this blood is what is known as the monthly menstruation or monthly period. This process continues from her teenage years until she is between 46 and 56 years old.
Sometime between the ages of 46 and 56 the making of female hormones stops. This means that a woman's menstrual periods will become less and will eventually stop. This is the end of a woman's fertile years and she is no longer able to have children. This process is called menopause, or "change of life".

• The **cervix** forms the bottom end of the uterus. It is also known as the "mouth of the womb". The cervix is usually tightly closed and it only opens during childbirth to allow the baby to pass through.

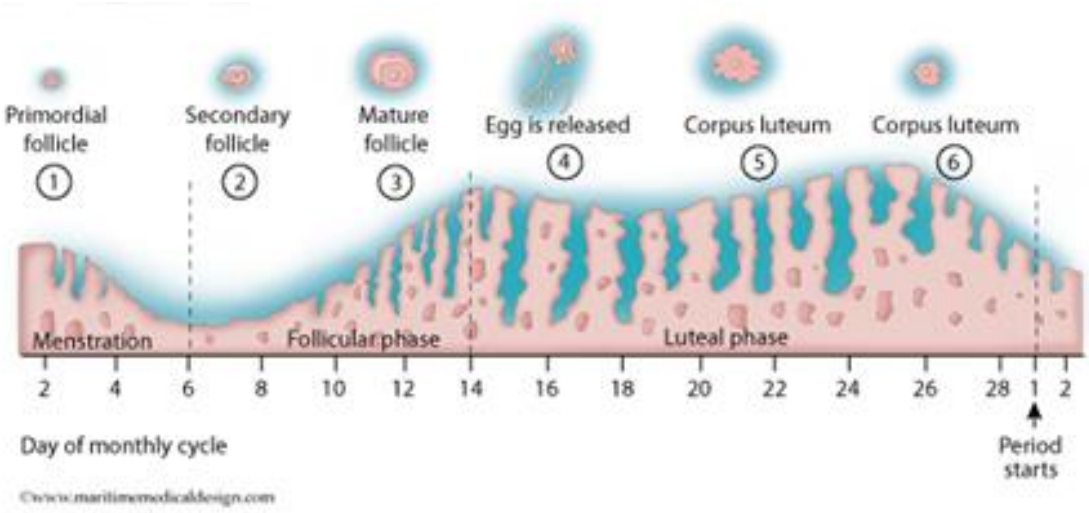
• The **vagina** is a passage that gets bigger during childbirth to allow the baby to be born. The vagina has glands that create lubricating mucus when having sex. A thin sheet of tissue with one or more holes in it called the hymen partially covers the opening of the vagina. Hymens are often different from person to person. Most women find their hymens have stretched or torn after their first sexual experience, and the hymen may bleed a little and this may cause a little pain.



The Menstrual Cycle and Menstruation

The **menstrual cycle** involves the development of a lining in a woman's uterus that will cushion and nourish a developing foetus if pregnancy occurs. If it does not occur, this lining is released in what is known as menstruation, or a menstrual period.

The length of a women's menstrual cycle varies in time but is most commonly between 23 and 35 days.



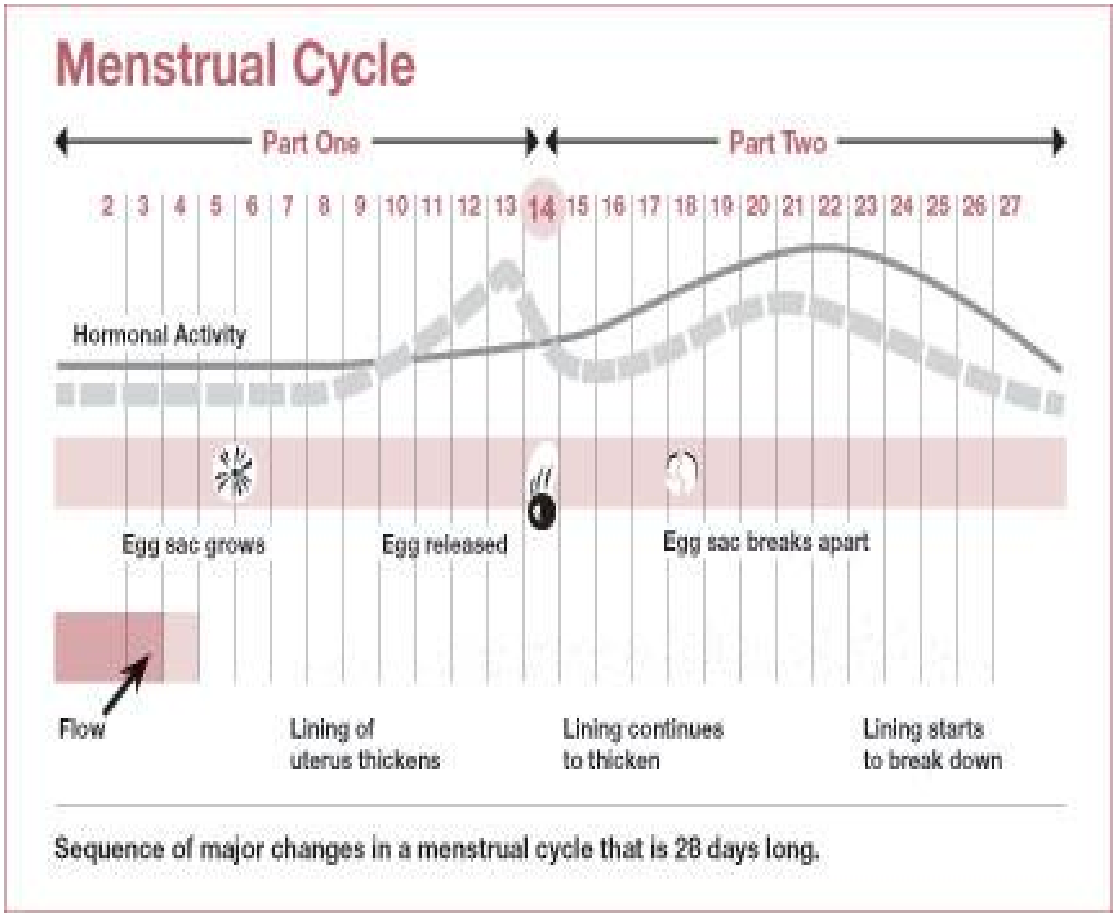
Menstruation is the periodic discharge of blood and tissue from the lining of the uterus through the vagina. Menstruation begins when a girl reaches puberty and stops during or close to menopause.

Menstruation is commonly called your "period", your "monthly", your "date", "xesheni" and last for 3 to 7 days.

Symptoms of menstruation include stomach cramps, lower back pain and headaches and are normally worse during the first few days.

Having sex during menstruation does not cause damage but woman's bodies are more vulnerable during this time. Because of chances to the vagina and the uterus during this time, women are at higher risk of infections and STI transmission during this time.

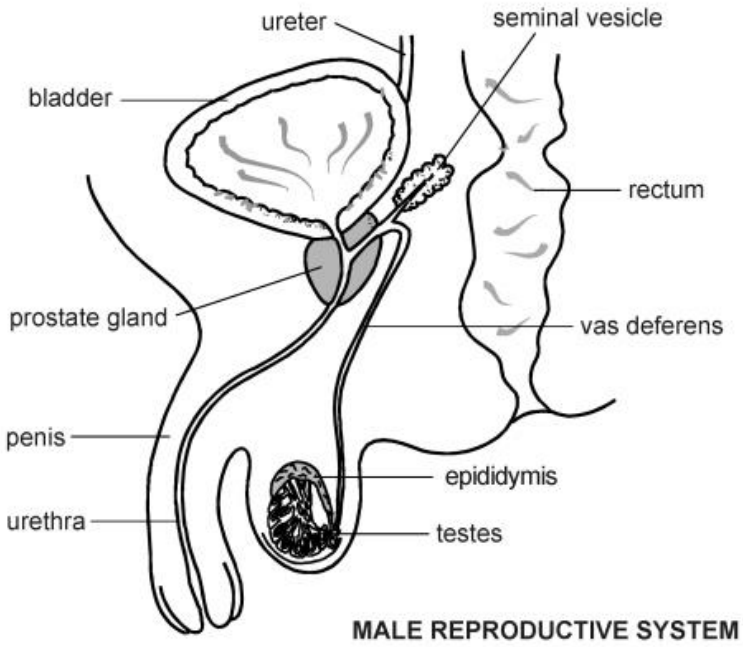
Women usually stop menstruating during pregnancy and while breastfeeding. If menstruation stops for more than 90 days but you are not pregnant or breastfeeding, you should go to the clinic.



Sequence of major changes in a menstrual cycle that is 28 days long.

The Male Reproductive System

The function of the male reproductive system is to make sperm.



MALE REPRODUCTIVE SYSTEM

The male reproductive system is made up of:

• The **scrotum** is a "bag" made of skin with a thin layer of muscle under the skin. The scrotum contains the testicles.

• The **testicles** make male hormones as well as sperm. They are in the scrotum, outside the body, so that they can move lower in warm weather and closer to the body in cold weather. Sperm is very sensitive to temperature.

• The **sperm** is made in the testicles and carried through tubes called the **vas deferens** to the penis. Semen is the fluid containing sperm that is made by a man during sex.

• The **penis** is an organ used by the body for passing urine as well as for transporting semen. It is made up of spongy tissue that easily fills up with blood. If this happens, the penis becomes hard and it is known as an erection. An erection is important to transport sperm into the female body. Muscles contract to push out some of the semen with the sperm into the vagina of the women. This is called ejaculation.

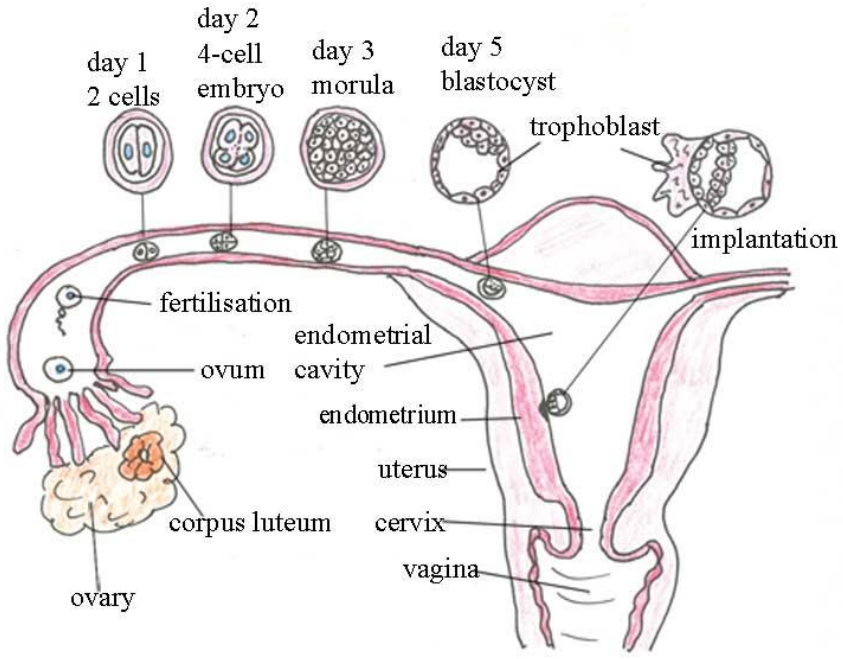
• The **urethra** is a tube that runs from the bladder, through the penis to the outside of the body. The urethra allows urine and semen to leave the body.
• The **prostate** gland helps makes semen that transports the sperm during sexual intercourse.

Pregnancy

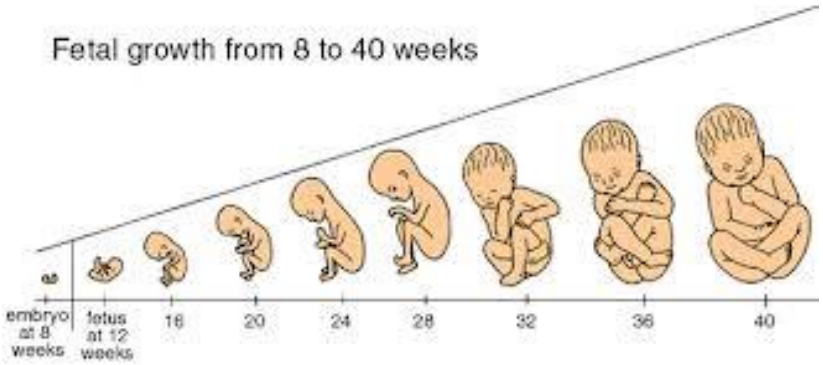
Pregnancy occurs if the sperm and the egg join to make a baby. The egg meets the sperm inside the fallopian tube, where they join and start growing. It travels into the uterus, where it is implanted into the lining of the uterus, and the baby starts to grow.

Sperm fertilising an egg.

The development of the embryo:



The baby is attached to the mother through the umbilical cord and the placenta.



The mother's blood brings nutrients and oxygen to the baby so that it can grow well. If the mother does not have enough food to eat, then the baby will not be able to grow well. If the mother drinks of alcohol or takes drugs, this will also pass through her blood to the baby, causing damage to the baby.

How to recognise pregnancy

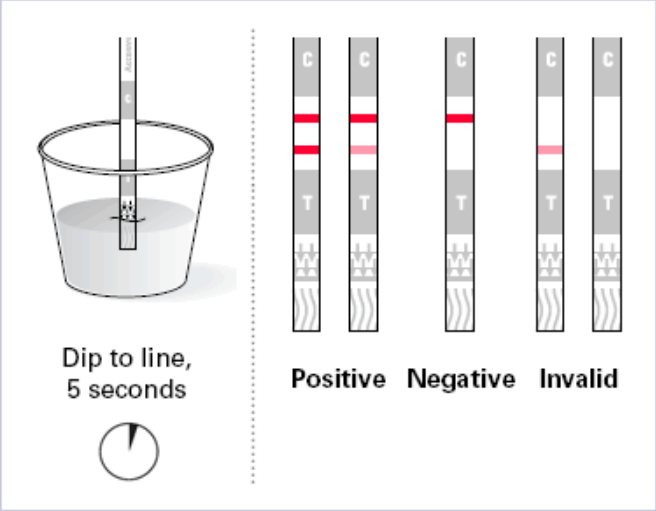
There are several signs for pregnancy which generally occur after 4-6 weeks of pregnancy although it may not apply to all women.

- **Missed period is the most common sign of pregnancy**, especially if there is a regular menstrual cycle
- Nausea and vomiting at any time of day, but especially in the mornings, is another common sign during the first three months of pregnancy
- Constant low energy levels/feelings of tired, especially towards the end of the day or late afternoon
- Experiencing sensitive breasts or nipples
- An increase in the number of times a woman urinates

As soon as a woman misses a period she should have a pregnancy test.

Practical demonstration: Pregnancy Test 15 minutes

Pregnancy can be confirmed by doing a urine test at the clinic, or by a mentor mother at a home visit. The mother needs to give a urine sample in a clean container. An early morning urine sample is the best.



One line indicates that the test is working (control line) and the woman is not pregnant. **Two lines indicate that the woman is pregnant.**

If the control line does not show up, it means that the test has not worked, and must be repeated.

DVD: Inside Pregnancy 15 minutes

The trainer will show you a DVD which demonstrates the process of conception and pregnancy.

SESSION 6: Family planning and Sexually Transmitted Infections

Time required: 2 hours and 45 minutes

Purpose

- To give an overview of different methods of contraception.

Objectives

- At the end of the session the MM will:
  - Be able to discuss the benefits of family planning.
  - Understand the different methods of contraception.
  - Understand which methods can prevent pregnancy as well as infection with STIs and HIV.
  - Understand what “safer sex” is. Understand what risky sex is.
  - Be able to demonstrate the use of male and female condoms.
  - Have an understanding of sexually transmitted infections.

Discussion: Family planning and safer sex 1 hour

The trainers will guide this session.

Lecture content: Family planning

Why is family planning important?

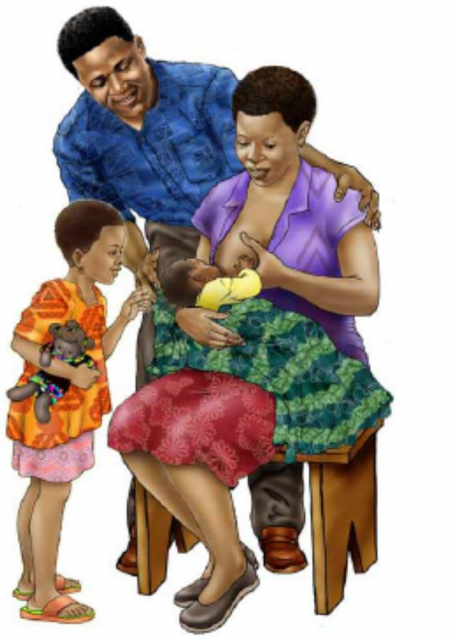
Family planning makes it possible for a woman to be able to plan when and how many babies she would like to have. Family planning methods, like contraceptives, allow men and women to plan when they will have children, and to enjoy intercourse without being worried about pregnancy. However, no contraceptive method is 100% effective and without risks. Family planning is the responsibility of both partners in the relationship. It is important that both the man and the woman have the correct information so that they can make the best choice for their family.

Family planning has many benefits:

• If a woman can plan when she wants to fall pregnant she will lower the chances of having unwanted pregnancies and pregnancies that are dangerous for herself and her baby.
• If the mother has a disease that could make pregnancy dangerous and she decides to have a baby, then it is important that she plans this so she is as healthy as possible before falling pregnant.
• The mother can decide how much time to leave between pregnancies. This will make sure that her body has enough time to recover and that she has a safe and healthy pregnancy for herself and her baby
• Having children at the right time helps the parents to plan so that the family can have enough money for food, clothing and education for each child
• Family planning should be used by all women and girls who are sexually active to prevent pregnancy. Teenage girls who become pregnant put themselves at risk as their bodies are not mature enough to handle pregnancy and giving birth
• In communities that encourage and use family planning, there are more and better opportunities for jobs, education and healthcare

Methods of family planning

It is important that the woman is helped to choose the family planning method that would be best for her. It also depends on whether the woman wants a temporary or permanent method.



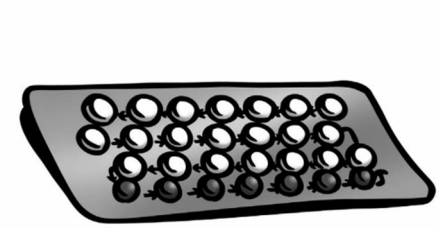
Temporary methods:

1. Hormonal methods:

These methods will prevent pregnancy, but will not protect against STIs and HIV.

- **The pill**

These are pills that have low doses of female hormones which are taken every day. They stop the woman's ovaries from making a fertile egg each month. If these pills are taken regularly, this is a very good method of preventing pregnancy. Women who want to have children later on should think about using this method as it is one of the methods that are fairly quick to reverse should she want to fall pregnant.



- **The Injection**

This is a hormone injection that is given every three months. It works very well but when a woman chooses to fall pregnant it can take a few months for her body to start making fertile eggs again.

- **Sub-dermal implant:**

  A small flexible rod is inserted under the skin by a trained healthcare professional. This form of contraceptive is one of the most effective birth control methods. The implant can prevent pregnancy for up to three years but does not protect against HIV infection or STIs. The implant can be removed when a women is ready to have a baby.

2. Barrier methods:

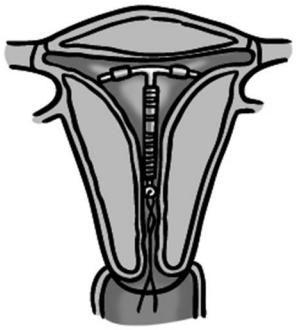
These are methods that stop the sperm entering the vagina like male and female condoms as well as diaphragms and cervical caps. If used correctly, these methods are quite good but are not perfect.

- **Condoms**

Condoms are the most used barrier method.

Condoms are the only method that provides protection against HIV and other STIs as well.

3. Intra – Uterine Contraceptive Device (IUCD):
This is a device that is inserted into the womb and prevents the fertilised egg from attaching to the wall of the womb. It is not a common method in South Africa and is only available at some clinics. This is also known as the "loop".



4. Withdrawal method:
This is when the man withdraws the penis from the vagina before ejaculation. It is not a very good method to stop pregnancy as some sperm can enter the vagina even before ejaculation. It also does not protect against STIs or HIV.

5. Termination of Pregnancy (TOP):
A TOP can occur spontaneously, in which case it is often called a miscarriage, or it can be induced. TOP is not a form of contraceptive and if performed by a trained healthcare professional is a safe and effective method of ending an unwanted pregnancy.

Permanent methods:

The only way to provide permanent family planning is an operation. These methods are meant for people who never want to have a child, or they do not want more children. Both men and women can have an operation.

- **Female sterilisation - Tubal ligation or "tying tubes"**

A woman can have her fallopian tubes tied (or closed). This means the fallopian tube is cut so that the egg does not reach the uterus. The procedure can be done in a hospital. The woman can go home the same day of the surgery and carry on with her normal activities within a few days. It is important to note that this method cannot easily be reversed if a couple later want to have a baby.

- **Male sterilisation – Vasectomy**

This operation is done to block the sperm from moving into the penis during ejaculation. This operation is simpler than tying a woman's tubes. The man can go home the same day. Recovery time is less than one week. After the operation, a man visits his doctor for tests to count his sperm and to make sure the sperm count has dropped to zero. It takes about 12 weeks for the sperm count to drop to zero, and during this time another form of birth control should be used.

It is important to note that a woman cannot be forced to have a tubal ligation nor can a man be forced to have a vasectomy.

Emergency Contraceptive Pills ("Morning After Pill"):

Emergency contraception is NOT a regular method of birth control. She must take the pill within 120 (5 days) hours of having unprotected sex. Emergency contraception should only be used in emergencies. It is not intended for regular use. The earlier the client takes the pill the more effective it is.

Emergency contraception can be used when:
• The woman has had consensual unprotected sex and her normal contraception has failed, e.g. a condom slipped or she missed her pill or injection
• She was raped and no contraceptive method was used

Best contraceptive methods for an HIV-positive person: People with HIV, AIDS, STIs or those who are on antiretroviral medicines (ARVs) can use most contraceptive safely. Advantages and disadvantages of some methods are listed below:

• **Condoms, non-penetrative sex and abstinence:** these methods can prevent pregnancy and infection with HIV and STIs.

• **Oral contraceptives and injections:** these methods can prevent pregnancy but cannot prevent infection with HIV and STIs. Women on ARV therapy should seek medical advice before using oral contraceptives and injections as some ARVs may reduce how well they work.

• **Intra-Uterine Devices:** this method can be used by an HIV-positive woman provided she is clinically well. It will prevent pregnancy but cannot prevent infection with HIV and STIs.

No-one should have sex with someone if the person's HIV and STI status is not known to them.

What is safer sex?

Safer sex means the person does not get their partner's semen, blood or vaginal fluids on or in their body.

Safer sex is:

- Using condoms
- Non-penetrative sex
- Abstinence

What do condoms do?

Condoms prevent the male and female body fluids (semen and vaginal fluids) from mixing.

Condoms can prevent:

• Semen from entering the woman's vagina

• Contact with body fluids like semen and vaginal fluids, in which the HIV virus lives

• The spread of sexually transmitted infections (STIs)

Risky sexual practices

• **"Dry sex"** is when products (such as baby powder) or herbs are used to lower the natural fluid that is produced by a woman during sex and make it more likely for the woman to become infected with HIV because she may get small cuts and tears in her vagina

• **Unprotected anal sex** has a greater risk of HIV infection compared to vaginal sex as the cells in the anus are easily damaged

• **Sex without a condom**

• **Having many sexual partners**

• Having sex without a condom when there are **sores on the penis or vagina** can increase the risk of getting and passing on HIV. An open sore or injury to the skin makes it easy for the HIV and bodily fluids to enter the blood stream

What is the importance of using a condom when one or both of the sexual partners are HIV-positive?

It is very important to use a condom even when both partners are HIV-positive because they may have different types of HIV. This means that a person can get

re-infected with a different type of HIV and the amount of the virus in the body an increase. Their partner may also be resistant to ARVs and then they can get infected with resistant HIV. It also means that both partners will be protected against STIs

Practical demonstration: How to use a condom 30 minutes

How to use a condom

- It is important to select and use the right size condom.
- If the condom is too large it may slip off during intercourse.
- If the condom slips off during intercourse, a new one should be used.
- A new condom should be used each time there is sexual intercourse.
- It is important that oil-based lubricants are not used with condoms as these will cause the condom to break up. This will mean that the condom will no longer offer any protection

A CONDOM SHOULD NEVER BE USED MORE THAN ONCE!

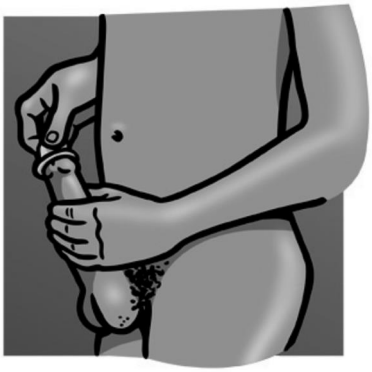
Using the male condom

Step 1

- The condom packet should be sealed.
- Condoms from an open packet should not be used.
- If the date stamped on the condom packet has passed, then it has expired and should not be used because the rubber will not be protective.
- Condoms should not be left in the heat or in direct sun.
- When opening the condom care should be taken not to damage the condom. Avoid tearing it with the teeth or sharp fingernails.

Step 2

- The condom should only be put on when the penis is erect.
- Check which way the condom will unroll, then hold the condom at the teat/tip and squeeze the air out of the teat/tip.
- Leave the small section at the top for the semen to fill.
- The condom should be gently unrolled down the full length of the penis, making sure there are no air bubbles because they may cause the condom to break during the sexual intercourse.

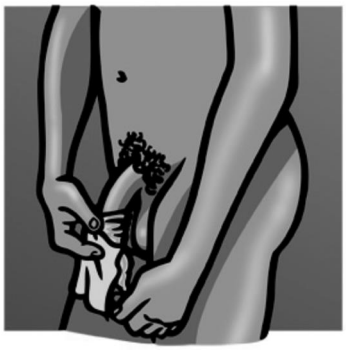


Step 3

- After sexual intercourse, the penis should be slowly removed from the partner while it is still erect.
- Hold the condom at the base of the penis to prevent it from slipping off.

Step 4

- A knot should be tied in the condom to prevent the fluid from spilling, and then it should be wrapped in a tissue and thrown away in the bin or burned.
- It should never be left lying around where children and other people can come into contact with it.
- The man should wash his hands.



Using the female condom

The female condom is a long tube of thin plastic. It has a small closed end and a large open end and each end contains a flexible ring. It can be inserted up to half an hour before intercourse if necessary.

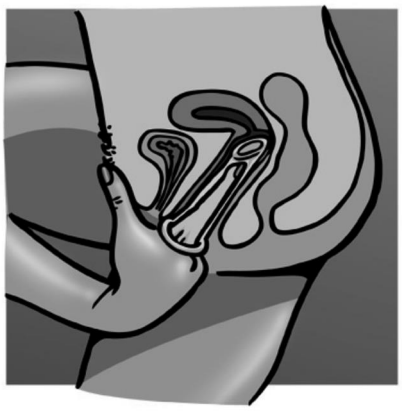
Step 1

- Check the expiry date on the condom packet.
- Check the condom package to make sure that there are no cracks, holes or open sides by placing the condom casing between the thumb and forefinger and pressing gently.
- Gently push the condom inside the package to one side to allow room to tear open the package. Carefully remove the condom using the fleshy part of the fingers and not fingernails.

Step 2

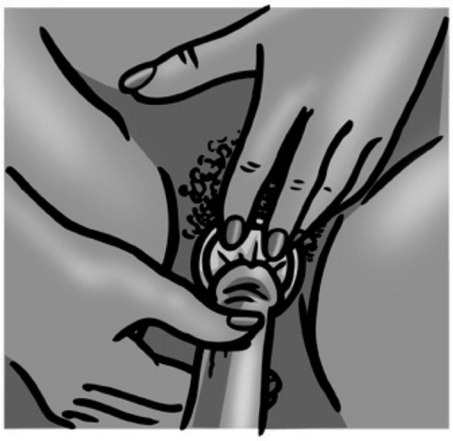
- The outer ring covers the area around the opening of the vagina.
- The inner ring is used for insertion and helps to hold the sheath in place during sexual intercourse.
- Grasp the closed flexible inner ring and squeeze it with the thumb and second and middle finger so that it becomes long and narrow. Push the condom into the vagina, making sure that the outer ring stays outside and is flat.

- To make insertion easy, the woman can squat or lie on her back or put one foot on a chair.



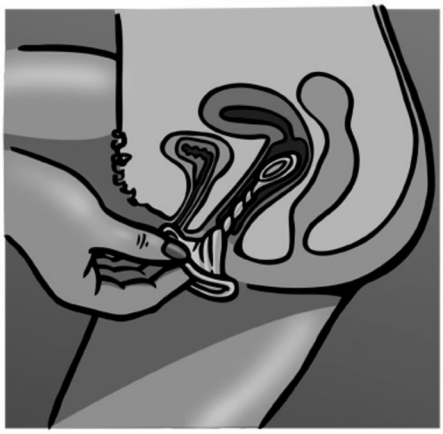
Step 3

- Guide the erect penis into the condom, making sure it does not enter around the side.
- The female condom is loose-fitting and will move during sexual intercourse. If it feels like the outer ring is being pushed in while having sex, stop and pull the outer ring back to its original position.



Step 4

- To remove the condom, twist the outer ring to keep the sperm inside then gently pull the condom out of the vagina.
- Wrap it in a tissue and dispose of it appropriately by throwing it in a waste bin.
- Do not flush the condom down the toilet.
- Do not use the condom again. Always use a new condom every time they you sex.



Group Discussion: Condom Use 30 minutes

The trainers will guide this session.

Lecture/Discussion: Sexually transmitted infections 45 minutes

What does STI mean?

- STI stands for **S**exually **T**ransmitted **I**nfection.
- It is an infection that can be passed on from one person to another person by having unprotected sex, like anal, oral or vaginal sex.

Why are STIs dangerous?

- STIs can become very serious if they are not treated. Some types of STIs can attack the organs in the body and may even cause death.
- A mother can pass the STI on to her baby during pregnancy. STIs can cause the baby to have severe abnormalities. Therefore, it is important for her and her partner to use condoms every time they have sex.
- STIs can also cause infertility in both men and women, meaning that they cannot have children.
- Some STIs can be lifelong infections, with symptoms coming back every so often. This can be prevented with medicines obtained from the clinic.

How are STIs transmitted?

- They are passed from one person who has an STI to another person during sex.
- Some STIs can be passed from a mother to a baby during pregnancy or childbirth.

Is HIV an STI?

Yes, HIV is an STI. But while other STIs can be cured, HIV cannot be cured.

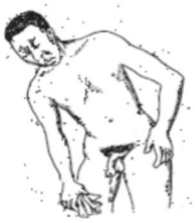
Do STIs make it easier to get HIV?

Yes, **it is more than 5 times easier to get HIV from someone with HIV if you already have an STI.** This is because STIs can cause sores or small cracks in the skin and lining of the vagina and on the tip of the penis, which makes it easier for the HIV virus to enter the body.

Encourage people who have STIS to get tested for HIV.

What are the signs of an STI?

- Discharge from the penis or vagina, which may be purulent (thick like pus) or green, yellow or grey colour, and foul smelling
- Frothy or cheese-like discharge in females
- Pain or burning on passing urine
- Pain during vaginal intercourse in female
- Itchy private parts
- Visible sores with or without pain
- Warts on private parts



Discharge from penis

Vaginal itching

Pain during sex

Burning during urination

Sore on penis or vagina

Abdominal pain

How can you prevent getting an STI?

- Use a condom every time you have sex.
- If you or your partner has an STI, you need to get treated as soon as possible. **Always use a condom.**
- Being faithful to one partner, who is also faithful to you in turn, and make sure that neither partner has an STI.
- Not having sex at all (abstaining).

What should a person do if they think they have an STI?

- Start using a condom straight away for all sexual activity. Condoms must be used every time you have sex.
- Go to the nearest clinic and get tested as soon as possible.
- Your partner must also go to the clinic to get tested and treated. Even if they have no symptoms, they must still get treatment.
- The medicine should not be shared with your partner if both have an STI.
- While you are at the clinic you should ask for an HIV test.

Why is it important for a person to tell their partner(s) if they have an STI?

- It is very important that to tell your partner so that he/she can also go to the clinic to be treated.
- As a person may have more than one sexual partner, it is very important that **all partners** go to the clinic and get treatment. If this does not happen, the infection will continue to be passed between them.
- Once the partner knows or suspects an STI, then a condom should be used every time they have sex and safer sex must be practiced at all times.

SECTION F
ANTENATAL CARE

SESSION 7: Importance of Antenatal Care (ANC) and Understanding Basic Terms

Time required: 70 minutes

Purpose

- To help the MM understand the importance of ANC, basic terminology and why they should encourage women to attend the antenatal clinic.

Objectives

- At the end of the session the MM will be able to:
  - Explain the importance of ANC and its key components.
  - Define key words and terminology.
  - Motivate mothers to attend antenatal care.

Material

- PowerPoint slides
- Board/flipchart and paper
- Markers
- Ball
- Maternal, Child Health and Nutrition Booklet
- Food Flash Cards

Discussion: Importance of Antenatal Care 20 minutes

Main components of ANC:

Antenatal care can **prevent illness** of mother and baby and improve health. The components of care include:

- Iron and folic acid tablets to prevent anaemia.
- At least two tetanus toxoid immunizations to prevent tetanus.
- Nutrition and care advice for mothers during pregnancy.
- Importance of immediate and exclusive breastfeeding for contracting mother's uterus and for newborn nutrition.

Antenatal care can **identify problems** and **treat** them:

- High blood pressure. It is important to identify elevated BP so that care and treatment can be given, if necessary.
- Maternal infections (syphilis, urine infection, STDs, HIV, etc.). A check-up will identify these and treatment and care offered as needed.
- Blood group testing. It is important to know the mother's blood group and Rhesus factor. All rhesus negative mothers need to receive treatment to prevent damage to the baby.
- Determine foetal lie or twin pregnancy

Antenatal care can help families **plan for the birth** and be aware of **danger signs**. This can also be done by a MM.

- Women and families can be made aware of danger signs during pregnancy and delivery and be informed on when to seek immediate care

Visits	Weeks of pregnancy
1	As soon as possible (should be less than 14 weeks)
2	20 – 24 weeks
3	26 – 32 weeks
4	34-36 weeks
5	40 weeks

Mothers with complications may need more visits at the clinic.

Activity: Ball Game — 10 minutes

The trainers will guide this session.

Interventions at health centre or outreach, with proven effect on reducing neonatal deaths:

Tetanus Toxoid immunisation
Iron and folic acid tablets
BP check
Foetal lie
Rhesus (blood group) testing
Syphilis detection and treatment
PMTCT
Detection, management and referral of obstetric complications
Nutrition counselling

Practice: Role play in small groups — 30 minutes

The trainers will guide the session.

Key words and terminology 10 minutes

Gestation:	The duration of pregnancy. It is normally 40 weeks or 280 days.
Abortion:	Baby dies before 22 weeks of gestation. An abortion can occur naturally (miscarriage) or it can be performed by a medical person. (Medical Termination of Pregnancy – TOP). Sometimes unqualified people also perform abortions. (This is dangerous).
Still Birth:	Baby is born without breathing, crying or moving limbs (and is more than 22 weeks gestation, or 500g in weight).
Live Births:	Baby born after more than 22 weeks gestation, and shows any one of the signs of life at birth (even briefly): breathing, crying, movement of limbs.
Premature Birth:	Baby born before 37 weeks.
Neonatal Death:	If a baby dies between birth and 28 days of life (and if the gestation is more than 6 months and 15 days). Even if the baby only breaths once and then dies, this is still a neonatal death.

SESSION 8: Screening for Danger Signs and Using the Referral Note

Time required: 1 hour and 50 minutes

Purpose

- The purpose of this session is for MM's to learn how to screen pregnant mothers for danger signs and use the Referral Notes when necessary.

Objective

- At the end of the session the MM will be able to:
  - Use the knowledge from this training to identify danger signs in pregnant women during home visits, and have a basic understanding of why they are danger signs.
  - Use the Referral Note when referring pregnant women to the clinic or hospital due to the presence of danger signs.

Material

- Board/flipchart and paper
- Markers
- Referral Note
- Community Resource Guide
- Philani Mentor Mother Training DVD
- Maternal, child health and nutrition booklet

Presentation and Discussion: Danger signs 10 minutes

Danger signs during pregnancy:

- Vaginal bleeding (possible sign of problem with the placement of placenta or a possible sign of threatening miscarriage)
- Waters breaking before the expected time
- Smelly discharge from the vagina or vaginal sores
- Severe headaches and fits (due to high blood pressure)
- High fever (possible sign of infection)
- Severe abdominal pain (sign of internal bleeding; ectopic pregnancy)
- Decreased foetal movement
- Very pale (a possible sign of anaemia due to lack of iron and folic acid)
- Swelling of hands face and feet (due to high blood pressure).
- Excessive vomiting

Referral Notes:

- Each referral booklet contains triplicates of each page in the same way as an invoice book.
- If a danger sign is found, fill in the name of the person being referred and describes the problem.
- Tear off one and give it to the family to present at the health facility.
- The second copy is kept in the folder and the third remains in the referral book.

Activity: Identifying danger signs 30 minutes

The trainers will guide this session.

Scenario 1:
A mother is 36 weeks pregnant and complains of burning stomach pain which goes up into the chest, the pain is worse after eating or when lying down. The mother is otherwise well. What would you advise a mother to do?

Answer:

Scenario 2:
A pregnant woman complains of swelling of her legs and headache. She has had a headache for more than 2 days and says it is quite severe and persistent. What must you do?

Answer:

Scenario 3:

A. A woman is 8 weeks pregnant with twins and complains of nausea and vomiting which is worse in the morning. What advice would you give the mother?

Answer:

B. If after a few days this mother is still vomiting and not able to keep down much food even after she has tried all your suggestions. What would you do now?

Answer:

Scenario 4:
During a visit your client who is 34 weeks pregnant, she says she has been bleeding for the last day. She also has stomach pain and is worried the baby is not moving as well as before. What would you do in this situation?

Answer:

Scenario 5:
A mother who is 18 weeks pregnant says to you that she is hot and has a smelly vaginal discharge. When you look at her she looks weak and unwell. What do you do?

Answer:

Role Play: Danger signs and Referral Note — 30 minutes

The trainers will guide this session.

Scenario

MM: You are visiting a 7 month pregnant women who is not feeling well. By asking the mother questions, find out if she has any danger signs and write a referral note if you think it is necessary.

Busisiwe: You are 7 months pregnant and have a bad headache that has lasted a few days and hurts all the time. You are worried about not being able to do your household chores. You also have swollen feet.

DVD Session: Danger Signs in Pregnancy — 40 minutes

The trainers will guide the session.

SESSION 9: Nutritional Health in Pregnancy

Time required: 2 hours and 30 minutes

Purpose

- The purpose of this session is to equip MM's with the knowledge they will need to teach pregnant mothers in their neighbourhoods to eat healthily, so that they are able to produce healthy and well-nourished babies.

Objective

- At the end of this session MM's will:
  - Understand the importance of healthy eating and the consequences of not doing so (malnourishment and obesity).
  - Know the 3 food groups, be able to give examples of each of them, and be able to explain what each food type does for the body and how regularly one needs to eat it.
  - Know which foods should be avoided and why (sugar, unhealthy fats, salt, soda drinks etc.)
  - Be able to give tips on how to eat healthily on a small budget.

Materials

- PowerPoint slides
- Board/flipchart and paper
- Philani Mentor Mother Training DVD
- Food Flash Cards

Discussion: Healthy eating — 30 minutes

The 3 food groups

Building Foods: Proteins

Energy Foods: Carbohydrates

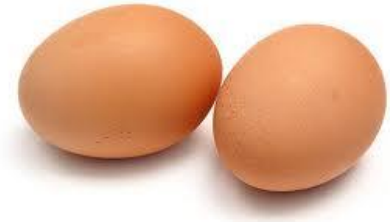
Protecting Foods: Vitamins and minerals

1. Building Foods - Protein

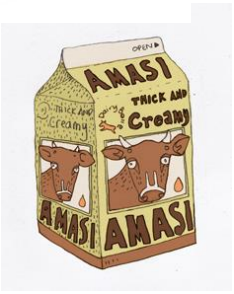
What does protein do for the body?

- Builds your bones, muscles, brain, teeth and blood
- Especially important for growth in children and for pregnant and breastfeeding women

Examples: Chicken, fish, meat, milk, maas, eggs, dry beans, split peas, soya mince and lentils





Important points:

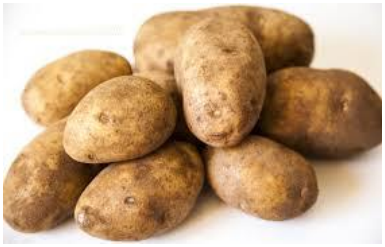
- Lentils, peas, dry beans, soya mince and split peas can be eaten daily
- Eggs are an inexpensive, value for money and a good source of protein
- Eggs can be eaten often
- Meat, chicken and fish can be eaten less often

2. Energy Foods - Carbohydrates

What do carbohydrates do for the body?

- Carbohydrates provide energy for the body
- They make one feel full and less hungry

Examples: Maize (mielie) meal, bread, rice, sorghum (mabella), samp, potatoes, sweet potatoes, pasta (macaroni, spaghetti), porridges, breakfast cereals and cake flour



Important points:

- Buy bread and mielie meal which displays this logo. These foods contain extra vitamins and minerals
- Energy foods should make up the basis of most meals
- Mix with foods from the other food groups at every meal
- Unrefined (coarse) starches are best. For example maize meal or brown bread
- Porridge made from sorghum or maize meal is better than processed cereal

3. Protecting Foods – Vegetables and Fruit

What do protecting foods do for the body?

- Help eyesight
- Help to fight against infections like colds, diarrhoea, and tuberculosis
- Protect against illness such as heart disease, stroke, and certain types of cancer

Examples:

- Cabbage, tomato, carrots, beetroot, spinach, beans, squash, butternut, peas, onions, broccoli etc…
- Bananas, apples, oranges, peaches, naartjies, pears, grapes, melon, pineapple etc…

Important points:

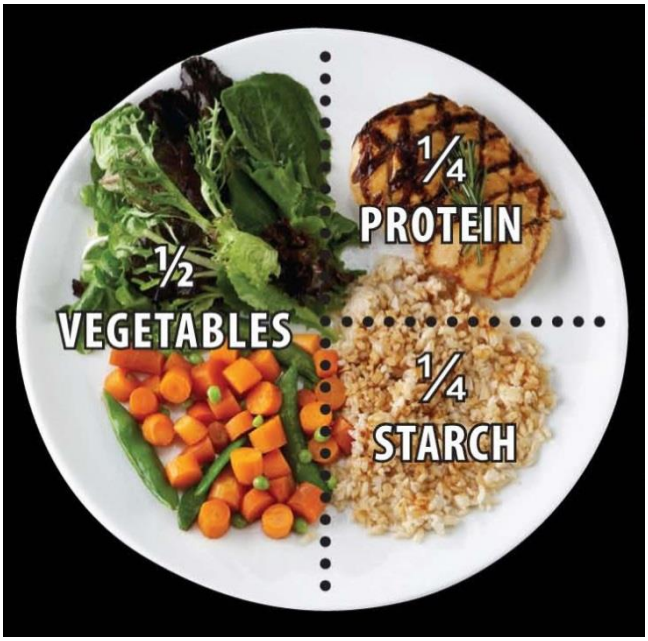
- Eat fruits and vegetables everyday
- As a guideline, eat 5 portions of fruit and vegetables per day
- Eat a fruit as a snack between meals and instead of pudding
- Eat raw vegetables like shredded carrots, cabbage, or tomatoes

Your body also needs small amounts of vitamins and minerals which are found in various foods from all 3 food groups and are especially important during pregnancy and breastfeeding and for children.

Vitamin or mineral	What does it do for your body	Examples
Vitamin A	Strengthens your immune system Protects children from eye diseases	Spinach, chicken, liver, egg, full cream milk, fish, offal and all yellow fruits and vegetables
Calcium	Builds your bones and teeth	Milk, maas, cheese, yoghurt and soft bones from fish like sardines and pilchards
Iron	Protects against tiredness and certain illnesses	Red meat (especially liver and kidney), spinach, dried beans and fortified mielie meal and bread

Activity: Identifying food groups 30 minutes

The trainers will guide this session.



It is important to eat healthy during pregnancy:

- Avoid illness because the right nutrients from food keep our immune system strong.
- Eating healthily during pregnancy will allow one's baby to gain enough weight and get all the nutrients the baby needs to grow strong and healthy.
- Be more productive at work.
- Won't get tired easily.

Eating unhealthily can result in being:

- Underweight which influences your ability to fight infections
- Overweight which can lead to serious illnesses such as diabetes mellitus, heart disease, hypertension and stroke.

DID YOU KNOW?
Obesity increases the risk for the mother as well as her baby.

Risks to the mother:

- Diabetes and high blood pressure in pregnancy
- Caesarian delivery

Risks to the baby:

- Prematurity and low birth weight
- Still birth
- Congenital abnormality such spinal cord defects, cleft palate and heart problems
- Childhood obesity

Risks during delivery:

- Big babies are prone to birth injuries

Discussion: Unhealthy eating – Things to avoid 10 minutes

Salt should be limited to small amounts

- Eating too much salt can worsen illnesses such as high blood pressure, heart disease, stroke, and kidney failure.

Fatty and oily foods should only be eaten sparingly –

- Some fats like vegetable oil (canola oil and sunflower oil) avocado and oily fish (sardines and pilchards) are healthy for the body in small amounts because they help children and babies to grow.
- But too much fat is unhealthy for the body and can make people overweight.
- Foods that contain too much fat include: chocolate, pies, deep fried food, 'vetkoek', biscuits, chicken skin, ice cream, chips, polony, russians and frankfurters
- Tips:
    - Cut visible fat off from meat before you cook it.
    - Boil, stew, grill or braai meat as opposed to frying it. Frying it in oil means it absorbs too much fat.

Foods which contain a lot of sugar should be eaten only on occasion

- Examples of foods which contain added sugar are cold drinks, cake and cookies, white and brown sugar, chocolates and ice cream, syrup and honey and jam, lime and orange squash.

Sodas and drinks which contain lots of sugar should be avoided as much as possible

- Many people think that sodas like Coke, Fanta, Stoney, Sprite and concentrated juice are healthy, but in fact these drinks contain lots of sugar. It is much better to drink water or small amounts of pure fruit juice diluted with water instead. Fruit juice also contains lots of sugar and should only be taken in small amounts

DVD Session: Nutritional Health in Pregnancy — 20 minutes

The trainers will guide this session

Role Play: Healthy Eating during Pregnancy — 20 minutes

The trainers will guide this session.

Scenario

MM: Ask the mother what she has eaten in the last 24 hours. Depending on her response, provide her with some advice about things she can add to or remove from her diet to make it healthier.

NTOMBI: You are 16 weeks pregnant and eating mainly energy foods (porridge, rice, bread, samp and potatoes) and fizzy drinks.

Practical: Planning a menu — 20 minutes

Plan a day's menu for a pregnant woman – remember to include all the food groups and 2 healthy snacks.

SESSION 10: Avoiding Alcohol during Pregnancy

Time required: 4 hours

Purpose

- The purpose of this session is for MM to learn the dangers of drinking during pregnancy, and how they can play a role in supporting pregnant mothers to either stop or limit their alcohol intake.

Objectives

- At the end of this session MM will understand:
  - What the dangers of drinking during pregnancy are for the unborn baby, and the importance of stopping or limiting alcohol use during pregnancy.
  - What 'risky situations' may encourage pregnant women in their neighbourhoods to drink, and the importance of finding ways to deal with each risky situation.
  - How they should approach alcohol use with pregnant women using the content of the field guide.
  - How to deal with difficult situations they may come across during their home visits.

Material

- PowerPoint slides
- Board/flip chart and paper
- Markers
- FAS doll & normal doll
- Community Resource Guide
- Philani Mentor Mother Training DVD

Discussion: Using Alcohol during Pregnancy — 45 minutes

Trainers will guide the session.

A Mentor mother was visiting a pregnant woman, who had a drinking problem. Many times she came to her house to visit, but the mother was not there. One day she decided to go down to the local shebeen, to look for the mother. She found her there, and persuaded her to come home with her. She talked to her many times about the problems of drinking in pregnancy. The mother did not want to give up drinking, and did not think that she would be able to stop. However, she eventually agreed to try to stop drinking, but only while she was pregnant. After a while, the MM noticed that she was buying small things for her house, as she was not spending money on alcohol anymore. She complimented her on the improvements to her home. Finally, after the baby was born, the mother realised how much better her life was without drinking, and she never went back to it.

Foetal Alcohol Syndrome

The Western Cape has the highest level of Foetal Alcohol Syndrome in the world. 46 to 89 children per 1000 are affected, compared to 10 per 1000 in the United States of America.

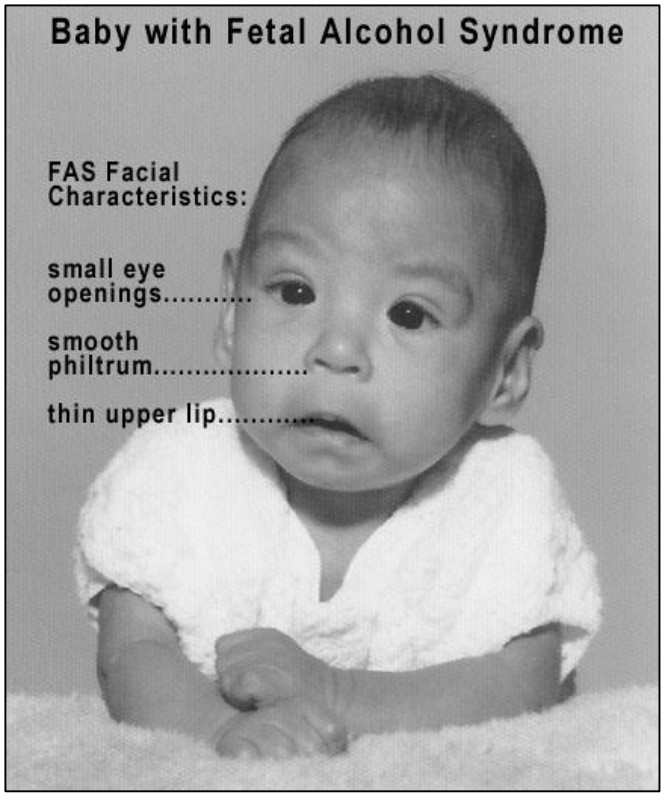
Drinking alcohol in pregnancy causes specific problems in the baby:

- Poor growth (height and weight)
- Small eyes, smooth edge of upper lip, and smooth skin between upper lip and nose
- Poor growth of the brain (small head circumference)
- Problems with learning
- Behavioural and social problems

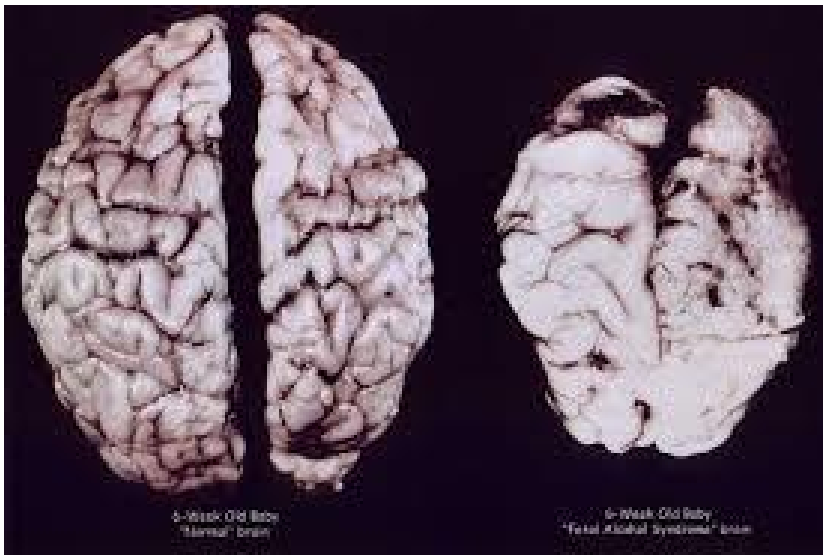
How severe the FAS is related to the amount of alcohol the mother drinks, and especially by binge drinking, which creates high levels of alcohol in the blood. Drinking in early pregnancy is also particularly harmful to the baby, as it is the time when all the organs of the body are developing.

Foetal alcohol syndrome is likely to be worse if a mother is:

- Underweight and undernourished
- Older
- Of low socio-economic status
- In an unstable relationship with her partner; or an alcoholic male partner
- Smokes tobacco or takes drugs



An infant with facial features of FAS.



Comparison of the brain of a normal 6 week old baby and a baby with FAS

Risky situations:

- Drinking on the weekend
- Drinking at a party
- Drinking following an argument
- Drinking when feeling uptight or stressed
- Drinking when feeling angry
- Drinking when smoking
- Drinking when friends are drinking
- Drinking when your partner is drinking
- Drinking when feeling hopeless
- Drinking when feeling sad
- Drinking to take away pain
- Drinking to forget about problems
- Drinking to forget about something specific
- Drinking to help you sleep

How to **cope with risky situations:**

- Go for a walk
- Talk to a friend who does not drink
- Drink a glass of water or milk
- Listen to music
- Play with children
- Do something that you enjoy doing

The goal of this intervention is to encourage abstinence first, however, for many women, this may not seem possible and their goal will instead be to try and cut down how much they drink to begin with. Ways to cut down include:

- Eat food when you drink
- Add water to hard liquor and spirits
- Measure your drinks
- Do not drink straight from the bottle
- Do not drink more than one drink per hour

How to talk about Alcohol in a Home Visit 30 minutes

The trainers will guide this session.

Facilitators Model Role Plays: Alcohol & Antenatal Home Visits 45 minutes

Model Role Play Scripts: Dealing with alcohol during antenatal home visits

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

ROLE PLAY 1: ABSTINENCE

Background to this visit:

Zanele, the Mentor Mother, went to visit Phumla on Monday. Phumla is two months pregnant. When Zanele arrived she could hear loud music and laughter coming from inside Phumla's house. Zanele knocked on the door and Phumla had answered, it looked like she was drinking alcohol with her friends . Phumla's friends were shouting that she must tell Zanele to leave because they were busy and she was interrupting them. Zanele told Phumla that she could see that it wasn't a good time for a visit so she would come again Tuesday morning.

ZANELE: Good morning Phumla, it is lovely to see you! Is this a good time for me to visit?

PHUMLA: Hello Zanele, I have been hoping you would come and visit me again. I am so sorry about Monday, I feel bad about it, I thought you wouldn't come again.

ZANELE: Of course I would keep visiting you, don't make yourself feel bad about Monday, can we talk about what happened?

PHUMLA: Yes.

ZANELE: Were those women your friends?

PHUMLA: My neighbours, yes.

ZANELE: Do they often come and socialize at your house?

PHUMLA: Yes.

ZANELE: You said that you feel bad about Monday, what part of it do you feel bad about?

PHUMLA: I was rude to you by not inviting you in.

ZANELE: Phumla, don't worry about my feelings. My job is to get to know you and to give you information so that you can have a healthy pregnancy.

PHUMLA: It is?

ZANELE: Yes. Phumla, my job is to support and help you in being the best mother you can be to your baby. I can see so many wonderful things about you that are going to make you a fantastic mother. You are so warm, so thoughtful and considerate of others. But did you know that part of being a good mother begins even before the baby is born? Sometimes the things that we do during pregnancy can affect how the baby will develop. These things include good nutrition, exercise, and not smoking or using alcohol. Would it be okay if I talk to you today about the effects of alcohol on the unborn baby, Phumla? I know that life can be hard, but I also know that with the right information you can make healthy choices for you and your baby.

PHUMLA: I would really like it if you could tell me more.

ZANELE: Okay, please stop me if anything I am saying is confusing or if you want to ask a question. *(Shows fetal alcohol doll)* This baby has Fetal Alcohol Syndrome which can happen to your baby if you drink while pregnant. You can see that the baby is small and has skinny arms and legs. The baby also has some things wrong with its face – see how small the eyes are, the flat space below the nose and the top lip is thin. See how different a healthy baby looks *(Shows the normal doll).* Alcohol is very dangerous for babies, it usually means that when they are born they struggle to suck properly, they cry a lot, are hard to soothe and have problems sleeping. When they grow they are slow to learn to walk, talk and run. At school they may have trouble paying attention, problems remembering what they are taught, problems with school work, and problems making and keeping friends. Many of these problems can be caused by using alcohol when you are pregnant. *(pauses for a response).*

PHUMLA: Oh, I never knew that! That is terrible!! What have I done to my baby?!!! *(Starts crying)*

ZANELE: *(Consoles Phumla, gives her tissues and rubs her arm soothingly)* Phumla, I am not telling you this to scare you, I am telling you this because the wonderful thing is that if you stop drinking today then your baby will have a better chance of being healthy. The best advice I can give you is to stop drinking today. Do you think that is something that you would want to do?

PHUMLA: Yes, I would like to. But I don't think I know how to.

ZANELE: Phumla, you are not alone, I am here to help you, that's what I do, we can talk about this together.
Let's talk about what I call 'risky situations', times when a person will probably drink. Can you think of times that are risky for you?

PHUMLA: When I feel hopeless, I have no job, no money, I am bored, and when I am with my friends.

ZANELE: Those are all great examples, you are not alone in this, many people drink to forget their problems or to fit in with their friends. I can see that life is hard for you but I guess the reality is that drinking may bring many more problems knocking on the door. Can you think of any?

PHUMLA: Well, what you were saying earlier about the baby.

ZANELE: Often there are things that we can do to avoid these 'risky situations', like keeping yourself busy by volunteering somewhere, remind me to tell you later about Philani and what you could do there if you were interested. It can also help to visit a friend.

PHUMLA: I have many friends who drink so I would need to go to see a friend who doesn't drink I guess?

ZANELE: You are so right, have you got friends who don't drink?

PHUMLA: I do actually, my old church friends, they live down the road. Maybe I should pop in later to see them?

ZANELE: What a great idea! You see you came up with a solution yourself! Phumla we are giving each pregnant woman who wants to have a healthy pregnancy a card that says she is a member of Healthy South African Families. On this card it says that the woman will eat healthy, go to her prenatal appointments, not smoke and not drink alcohol. This card shows that you are trying to do the best for your baby. Would you like to have a card to show your friends and family?

PHUMLA: Yes, that would be good.

ZANELE: Phumla, can we agree for the next week that you will not drink alcohol? Can we shake hands in agreement? *Shakes hands and gives Phumla the card.*

PHUMLA: Yes, I really want to try! Thank you Zanele, I know this may not be easy but I am going to try my best!

ZANELE: You are right it may be hard, but it will become easier. And I am here to help. I will come and visit you next week if I may.

ROLE PLAY 2: CUTTING DOWN

Background to this visit:
Zanele, the Mentor Mother, is visiting Bulelwa today early in Bulewa's pregnancy. Even though she does not know whether or not Bulelwa is drinking, she begins to talk to her about the importance of not drinking alcohol during pregnancy. Duringthe visit, Bulelwa tells Zanele that sometimes she does drink a little bit of alcohol.

ZANELE: Bulelwa, my job is to support and help you in being the best mother you can be to your baby. I can see so many wonderful things about you that are going to make you a fantastic mother. You are so kind and considerate. But did you know that part of being a good mother begins even before the baby is born? Sometimes the things that we do during pregnancy can affect how the baby will develop. These things include good nutrition, exercise, and not smoking or using alcohol. Would it be okay if I talk to you today about the effects of alcohol on the unborn baby, Bulelwa? Maybe with some more information you can make healthy choices for you and your baby.

BULELWA: I don't smoke and I eat well but I do drink sometimes. I would really like it if you could tell me more.

ZANELE: Okay, please stop me if anything I am saying is confusing or if you want to ask a question. (Shows fetal alcohol doll) This baby has Fetal Alcohol Syndrome which can happen to your baby if you drink while pregnant. You can see that the baby is small and has skinny arms and legs. The baby also has some things wrong with its face – see how small the eyes are, the flat space below the nose and the top lip is thin. See how different a healthy baby looks (Shows the normal doll). Alcohol is very dangerous for babies, it usually means that when they are born they struggle to suck properly, they cry a lot, are hard to soothe and have problems sleeping. When they grow they are slow to learn to walk, talk and run. At school they may have trouble paying attention, problems remembering what they are taught, problems with school work, and problems making and keeping friends. Many of these problems can be caused by using alcohol when you are pregnant (pauses for a response).

BULELWA: I wonder if my drinking will affect my baby.

ZANELE: Well, one thing we know is that if you stop drinking today then your baby will have a better chance of being healthy. The best advice I

can give you is to stop drinking today. Do you think that is something that you would want to do?

BULELWA: Yes, I would like to. But I don't know if I can. I have tried to stop before and it was very hard.

ZANELE: Bulelwa, you are not alone, I am here to help you, that's what I do, we can talk about this together. Let's talk about what I call 'risky situations', times when a person will probably drink. Can you think of times that are risky for you?

BULELWA: I drink when I am alone and feeling sort of sad,

ZANELE: I hear these reasons a lot from other women. Many people drink when they feel lonely and sad. I can see that life is hard for you but I guess the reality is that drinking may bring many more problems knocking on the door. Can you think of any?

BULELWA: Well, what you were saying earlier about the baby. And drinking does not make me feel any happier, just sadder.

ZANELE: Often there are things that we can do to avoid these 'risky situations', like keeping yourself busy by volunteering somewhere, remind me to tell you later about Philani and what you could do there if you were interested. It can also help to visit a friend or a relative who you like.

BULELWA: I really like my sister-in-law. We have fun chatting and she doesn't drink. She also makes me happy because she is always laughing and joking. She knows that I drink and she does not condemn me. She lives very near, I could see if she would like to come over or go for a walk this evening.

ZANELE: What a great idea! You see you came up with a solution yourself! Bulelwa do you think that you can stop drinking during this pregnancy?

BULELWA: No, I would like to stop drinking all together but it's so hard for me to stop. I have tried in the past and couldn't.

ZANELE: It is hard. Although stopping drinking completely is the healthiest thing to do. Maybe if you find it too hard to stop completely you could start by cutting down? Would you be willing to give that a try? Maybe it would be easier this time because I am here to support you.

BULELWA: Yes I want to try again. Just to cut down a bit.

ZANELE: That is excellent. What kinds of alcohol do you usually drink?

BULELWA: Only beer.

ZANELE: How many beers do you drink each day?

BULELWA: No I don't drink everyday. Just on some weekends… maybe 4 - 5 beers … something like that.

ZANELE: So you normally drink just on the weekends?

BULELWA: That's right usually just on weekends.

ZANELE: What would you like as a drinking goal for the next 3 weekends?

BULELWA: Maybe I could try just drinking only on Saturday night instead of Friday and Saturday.

ZANELE: That sounds like a good idea, would you like to cut down on the number of drinks you will drink on the weekend?

BULELWA: I think I could probably only have 2 beers instead of 4 or 5.

ZANELE: That sounds like a plan. So you will only drink two drinks on Saturday night, is that what you want to do?

BULELWA: Yes.

ZANELE: And also as you said, it would be good to visit your sister-in-law and explain to her what you are doing. It will help to have her support as well.

BULELWA: Yes I think she will be happy to help.

ZANELE: Bulelwa, here are some ways that may help you cut down on your drinking so that you can reach your goal. You could drink only 1 beer every one or two hours, you could try drinking other kinds of drinks like juice or water, you could sip your drink slowly, or eat food when you drink. Remember your goal is to cut down on your drinking. Tell your drinking goal to helpful people like your sister-in-law, think each day about the reasons you are changing your drinking, if you want a drink and do not drink, feel happy with yourself. Some people have days when they drink too much. If this happens to you, start the next day fresh and return to your goal. Do not give up. Do you have any questions before I go?

BULELWA: No not now. I know where to find you if I need you.

ZANELE: That is excellent. We can talk more next time I am here. I will be back for your next visit on Wednesday the 9th of May.

BULELWA: Ok. I will see you then. Go well.

ZANELE: Stay well. Good bye.

Follow up visit

ZANELE: Bulelwa, I am glad to see you again. How are you doing? How is your pregnancy going?

BULELWA: Yes, I am feeling very well. I feel better now that I am not drinking as much. I am having fun with my sister-in-law and with another friend who likes to sew with me on weekends. We are making ourselves new clothes for when we are no longer pregnant. She is pregnant too and does not drink.

ZANELE: That sounds like a good time. I am sure that you and your friend will be very well dressed.

BULELWA: I am also proud of myself because I was able to only drink one beer last weekend. I really felt like having more but I remembered what we talked about and it was not as hard as I thought it would be. I had a soda instead of another beer.

ZANELE: Congratulations, you did better than you thought you would. Would you like to set a goal for next time?

BULELWA: Yes I would like to try drinking just one drink on the weekend, I think I can do it.

ZANELE: That is a great goal. Remember I am here to help you meet your goal. Next time we meet, we can talk some more about how you are working to have a healthier pregnancy.

ROLE PLAY 3: REFERRAL

Background:
This is the third time that Zanele, the Mentor Mother, is visiting Nosiswe. In the previous visit, Zanele had conducted the Brief Alcohol Intervention with Nosiswe, and Nosiswe had said she was going to try and cut down her drinking to only drink 1-2 drinks every 4 days. This is a follow up visit. This role play takes place half way through the visit. In the first half of the visit, Zanele and Nosiswe were talking about the antenatal clinic, and about PMTCT, because Nosiswe had been to book for her birth the week before, and she had some questions about protecting her baby from HIV. In this next half of the visit, Zanele begins to talk about alcohol again, following up on Nosiswe's goal to try and cut down her drinking.

ZANELE: Last time I was here you remember we spoke about using alcohol during pregnancy, and you wanted to see if you were able to cut down to help your baby stay healthy. How did that go these last few weeks?

NOSISWE: *(Pause).* The thing is I did try. I really did. The first week after you left I did only drink a little bit, but then I wasn't able to carry on. It's very hard for me. Like I told you, my friends and my neighbours are always here and there is always drink, and I just can't say no all the time. It's too hard. *(Looks down)*

ZANELE: Nosiswe, you are not alone in having trouble stopping drinking. Many women have to try many times before they manage to stop completely or even cut down. Don't feel bad because you didn't get it right the first time. Tomorrow is a new day, and there still time for you to help your baby stay healthy. Do you think you would like to try cutting down again?

NOSISWE: I would like to but I don't believe I can anymore. I think I am addicted to alcohol. I don't think I can stop. I can say I will try again to you now, but I know deep inside it is not going to work.

ZANELE: I understand. If you are having trouble with your drinking and it is too hard to just stop or cut down without real help. If you would like, we can call together and make an appointment at a place in Khayelitsha called SANCA. They offer counselling and support for women like you who have a problem with alcohol. Have you ever heard of SANCA before?

NOSISWE: No, I don't know them.

ZANELE: SANCA stands for South African National Council on Alcoholism and Drug Dependence. They have an office here in Site E (in Scott Street), and you can go there for help if you would like to. I can even go with you to your first appointment if you want. They will ask you to come for 8 different sessions with them, and they will explain to you how it all works and answer any questions you might have.

It is completely up to you, but I think they might really be able to help you. They have years of experience in helping people who want help with their alcohol use. Should we call them together now?

NOSISWE: Yes please.

ZANELE: That is good. *(Calls and makes an appointment for Nosiswe).*

NOSISWE: Thank you.

ZANELE: You are very welcome. I am so glad you are willing to give this a try. Sometimes the first step to dealing with an alcohol problem is admitting that you have one. Do you have any other questions you would like to ask me?

NOSISWE: No, not now thank you. I know where to find you if I need you.

ZANELE: Alright. Thank you for this visit. I will be back on the 18th to go with you to your appointment. I will get here at 10am.

NOSISWE: Yes it's fine.

ZANELE: Good. See you then. Good bye.

NOSISWE: Good bye.

Discussion: Dealing with Difficult Situations 50 minutes

The trainers will guide this session.

Concerns when discussing Alcohol use during Home Visits

1. Concern: If a woman gets angry with me or demands that I leave, what must I do?

Responses:

- If a woman is very angry and wants you to leave, leave her house and come back the next day instead. Do not pressure her into talking with you about alcohol while she is hostile.
- Next time you visit, start by focussing on the positive things she is doing. Notice and compliment if her children look well, if she is preparing a healthy meal, if the house looks nice etc. Ask her how she is and what she needs help with, tell her you are there to help her through the pregnancy.
- Ask her if she is willing to talk about alcohol use during pregnancy.

2. Concern: Will women become upset with me, if I start talking about their alcohol use?

Responses:

- Reassure the woman that the discussion about alcohol during pregnancy is for education purposes and for the health of the unborn child.
- Women who become upset when you talk about their alcohol use during pregnancy probably have personal or family problems associated with alcohol. As long as you are caring and say that you understand why they might be upset, you can usually calm them down.

3. Concern: Who should be advised not to drink at all?

Responses:

- Pregnant women
- Women who are trying to become pregnant - damage to the foetus can occur before the woman even knows that she is pregnant.
- Women who are not using effective contraception - chances of an unplanned pregnancy for someone who is drinking are quite high, so it is best to advise women to use effective contraception if continuing to drink

- Women who are breastfeeding - alcohol can be passed to the infant in breast milk

4. Concern: What do I do if a woman states that she would like to stop drinking, but does not believe she can?

Responses:

- Talk to her about trying to stop drinking during her pregnancy for the health of her baby
- Provide information about FAS
- Help her to identify risky situations and coping mechanisms
- Ask her if she would like to get help for her drinking.
- If she agrees to seek help, make a referral.

5. Concern: What if the woman says she does not want to stop drinking when I am discussing alcohol in pregnancy with her?

Responses:

- Explain that it is her choice to drink alcohol but there is a big risk to her baby if she continues to drink.

6. Concern: What if a woman is worried that it is too late to stop drinking because the harm has already been done to her baby.

Responses:

- Explain that it is never too late to stop drinking and the sooner she stops, the better the outcome for the baby. If she is worried about the baby, after it is born, she can take the baby to the clinic to see how the baby is doing.

7. Concern: What if a woman says that her best friend drank throughout pregnancy and her child is fine.

Responses:

- Say that woman may have been lucky. Different women keep alcohol in their systems for shorter or longer times. The alcohol is carried through the bloodstream to the foetus. We know for sure that if you don't drink alcohol the baby will be healthier. The best advice is not to drink at all during pregnancy.

8. Concern: What should I tell my friends/partner/family when they offer me a drink?

Responses:

- You could suggest mother says, "I am pregnant and drinking alcohol during pregnancy is not safe for my baby. I am sure that you want the best for me and my baby."

9. Concern: I don't really want to stop drinking.

Responses:

- I understand that you do not want to stop, how about trying to stop until we meet again and we will talk about how you feel then. It may not be as hard as you think to make a change.
- You will only be pregnant for XX more weeks; that is not a long time to stop when compared to the lifetime of problems your child might have because of your drinking.

10. Concern: I drink because I have no hope (no job, no money, drinking husband, abuse, depression)

Responses:

- You are the hope for your child. Your child will have a better life if you do not drink while you are pregnant. I will talk to you some more about your problems.

11. Concern: I drank throughout my last pregnancy and my child does not look like the Fetal Alcohol Syndrome baby.

Responses:

- The effects of alcohol are greater with each new pregnancy. The first child may not have as many problems but the second or third child is at greater risk of having problems because you are getting older and alcohol stays in your system longer as you age. You may be drinking more now than you did with your other child (children). Also, even though your child may not have the foetal alcohol face, the damage to the child's brain may still be there.

12. Concern: What if I get asked, "What should I do if I get the urge to drink?"

Responses:

- Remember the coping steps we went over when we talked about risky situations.
- Try practicing those steps until we meet again.
- If you do have a drink, don't be discouraged. Start each day anew and tell yourself that you will not drink today. Take it day by day.
- If you have the urge to drink and you do not drink, reward yourself and be proud that you are doing the right thing for your baby.

13. Concern: What if I get asked, "Do you think I should have an abortion if my baby is already damaged from my alcohol use?"

Responses:

- Having an abortion is a personal choice but it is important to stop drinking now to minimise any problems to your baby.

14. Concern: What must I do if I find a child alone in a house with an adult who is misusing alcohol?

Response:

- You must contact your supervisor. You will need to report the situation and may need to have the child removed temporarily from the home.

15. Concern: Can part time drinking (infrequent) affect the child?

Response: Yes there is no safe amount of alcohol that can be consumed during pregnancy. One episode of heavy drinking at a special occasion like Christmas can have a serious effect. This is called binge drinking.

16. Concern: Does all alcohol including red wine (which people state is healthy if you only drink one or two glasses a day) have a negative effect on the unborn child?

Response: Yes, wine, like beer and hard liquor has alcohol in it and should be avoided during pregnancy. There is no type of alcoholic drink that is safer than any other, they all contain alcohol.

17. Concern: If a woman is a heavy drinker and stops drinking all at once could this affect the unborn baby?

Response: If the woman is a heavy drinker and/or is alcohol dependent, she should stop drinking under the care of a doctor. There can be significant problems with withdrawal that may lead to seizures or other health problems if she stops abruptly and is not supervised in a medical setting. The baby will also go through withdrawal but will be better off the sooner in pregnancy the woman stops drinking.

18. Concern: When women are in labour, they usually have very sharp pains and taking spirits is usually advised.

Response: If the woman takes alcohol for labour pains, the baby is exposed to the alcohol and will go through withdrawal at birth. The baby will be jittery, irritable and have problems sleeping.

19. Concern: If a woman is an alcoholic, how long should she wait after she stops drinking before she tries to conceive?

Response: All women are different. At the very least, she should go through detoxification and treatment before she tries to conceive. She should be under a doctor's care and receive good nutrition and vitamins.

Alcohol Myths

1. Myth: "Hot Stuffs" spirits increases your CD4

Response: Alcohol actually decreases your CD4. On the other hand, exercise increases it.

2. Myth: When you are pregnant you crave alcohol even if you have never touched alcohol before your pregnancy

Response: Most women stop drinking spontaneously when they are pregnant. Pregnant women often report that the smell of alcohol makes them feel sick and they no longer like the taste.

3. Myth: You forget your problems when you drink excessively

Response: You may get temporary relief but we know that excessive use of alcohol interferes with sleep patterns, is bad for your health, and increases anxiety and depression. Alcohol also does not make problems go away but can make them worse.

4. Myth: You enjoy sex more if you drink alcohol

Response: That may be true but you also increase your chances of getting an STI or of having an unplanned pregnancy.

DVD Session: Avoiding Alcohol in Pregnancy 40 minutes

The trainers will guide this session.

Case example: Practising counselling 30 minutes

Role plays: Alcohol Use during Pregnancy

Scenario 1

MM: You are visiting Thandeka, who is 6 weeks pregnant. She has two older children, aged 2 and 5. The 2 year old has been slow to walk and talk. She is unemployed and drinks most days with her friends at the shebeen. In the weeks when grants are given, you hear that she spends the entire week drinking at the shebeen. Initially when you arrive, she is hostile and insists that you leave immediately the moment you mention alcohol. Try to find out what she knows about the dangers of alcohol during pregnancy, and see if you can help her reduce or stop drinking.

Thandeka: You have just found out that you are 6 weeks pregnant. You have two older children, aged 2 and 5. You have noticed that your 2 year old has been slow to walk and talk. You are unemployed and drink 3 to 4 drinks most days with your friends at the shebeen. When you receive the grant, you spend the entire week drinking at the shebeen. You have heard that drinking can be bad for babies, but all your friends who have had children have also drunk throughout their pregnancies and their children seem to be healthy. So you are not sure you believe that alcohol really does too much damage. You do not want to stop drinking. When the MM arrives at your house, you are not keen to talk to her. You get angry with her when she mentions alcohol, and tell her to leave. Eventually you agree to cut down on your drinking to 1 drink a day.

Scenario 2

MM: You are visiting Nkolie, who is 4 months pregnant. This is her first pregnancy. She is a domestic worker. Ask her about her drinking habits, listen to her concerns, and give her the appropriate advice.

Nkolie: You are 4 months pregnant. You do not drink at all during the week because you have a job as a domestic worker, but on weekends you drink between 3 and 5 beers on Friday and Saturday nights with your neighbours. You drink when you want to socialise or feel part of a group. You would like to stop drinking if it will help your baby. But you are afraid that your neighbours will not want to spend time with you on the weekends if you decide to stop drinking with them. After talking to the MM you agree to try to abstain from alcohol.

SESSION 11: Sequencing of Antenatal Home Visits

Time required: 30 minutes

Purpose

- To help the MM plan antenatal home visits to pregnant women and to review what they will be doing during these home visits.

Objectives

- At the end of the session the MM will be able to:
  - Explain how they will determine when to visit pregnant women.
  - Explain what they will be doing during those visits.

Material

- PowerPoint slides
- Board/flipchart and paper
- Markers
- Field guide

Discussion: Sequencing of Antenatal Home Visit — 30 minutes

The trainers will guide this session.

Antenatal Home Visit Outlines – Before Birth

Each Mother will receive a minimum of 4 antenatal visits. The time for these visits depends on how far the pregnancy has progressed when the Mother to Be (MtB) enters the intervention programme. An additional 2 visits will be made for mothers with two or more risk factors.

Antenatal visit 1:

- Building a relationship
- Encourage mother to attend the antenatal clinic

General

- Greet the mother and introduce the intervention programme, explaining when you will visit.
- Has she been pregnant before or is this her first pregnancy?
- Is the father of the child present in the household, - if not is there another partner or person who supports the MtB?
- What is the socio-economic situation?
- Discuss resources in the community and make sure the mother knows what services are available to her.
- Talk about setting goals for next visit. Explain when you will return for the next visit.

Interventions

- What does the mother know about staying healthy throughout her pregnancy- alcohol, diet, smoking?
- Discuss the process of booking at the antenatal clinic and the importance of booking early.
- Blood tests, immunisations, micronutrient supplementation.
- Encourage the MtB to ask her partner to go with her to book and test for HIV.
- Discuss danger signs during pregnancy.

Antenatal visit 2:

- Building a relationship
- Nutrition
- General health
- Alcohol and smoking

General

- Start the session by following up any issues raised in the previous visit.

Interventions

- Find out if the MtB has booked for ANC, and encourage her if she hasn't.
- Find out what the mother knows about diet, work, smoking and drinking during pregnancy and how this relates to her life.
- Stress the link between maternal nutrition and low birth weight babies – explain the life outcomes of low birth weight babies (diabetes, obesity etc.)
- Focus specifically on the danger of alcohol during pregnancy and start the brief alcohol intervention.
- Remind the mother about danger signs in pregnancy.

Explain when you will return for the next visit.

Antenatal visit 3:

- HIV/TB

General

- Start the session by following up any issues raised in the previous visit.

Interventions

- Discuss HIV test results from booking visit.
- What does the MtB know about HIV? Listen and fill in with basic information.
- If HIV negative, educate about how to stay negative.
- If positive discuss PMTCT programme, CD4 count, if on ARVs check knowledge about medication side effects etc.
- Discuss partner situation if his status is known –negative or positive.
- What does MtB know about TB? Ask about history, symptoms and signs, contacts, importance of treatment adherence, prophylaxis, treatment during pregnancy and breastfeeding.
- Ask about and discuss danger signs.

Explain when you will return for the next visit.

Antenatal visit 4:

- Preparing for delivery
- Infant feeding options

General

- Start the session by following up any issues raised in the previous visit.

Interventions

- Talk about signs of labour and when to go to the hospital. Give information about delivery & support during delivery, PMTCT routine.
- Ask about and discuss danger signs.
- Discuss feeding options and choices. Why exclusive breast feeding? Inform about the danger of introducing solids early.
- Stress especially that the mother knows best, respect her intuition, empower the mother to believe in herself when making choices. Tell mother that children do cry for many reasons. Discuss traditional beliefs and try to stress no traditional medicines before 6 months. Stress danger of enemas at any age.
- Discuss family planning options.
- Talk about the importance of mother-child communication and bonding.

Explain when you will return for the next visit.

Two extra prenatal visits will be done if a MtB has two or more of the following risk factors: HIV, TB, excessive alcohol intake, previous LBW child.

Antenatal visit 5 & 6:

- Extra support:
- HIV
- TB
- Alcohol
- Nutrition
- Danger Signs

Intervention

- Do a 24 hour recall to understand what the mother eats. Discuss her diet – what needs to change, what needs to be added, and what is she doing well. Explain why.
- Stress importance of taking vitamins, iron and folate during pregnancy.
- Explain dangers of smoking during pregnancy, and stress importance of stopping.
- Again go through the damage alcohol does to the baby (FAS doll) and also to the mother. If the mother is drinking, establish how much the mother drinks at present and negotiate decreased intake if she can not stop. Do short alcohol intervention.
- If mother is drinking, find out why. Discuss counselling and support structures available in the community. Encourage mother to go for counselling if she is unable to stop drinking. Help her book and go with her for the first counselling session.
- Continue the discussion about HIV from session 3 guided by the mother's knowledge and questions. Discuss partner situation if his status is known – negative or positive.
- If mother is positive, help her to disclose to family or if she has disclosed meet with family members to answer questions and give information.
- Inform about disability grant and the process of application.
- Discuss again the symptoms and signs of TB, importance of prophylaxis for contacts especially children, importance of treatment adherence, danger of MDR and XDR TB, treatment during pregnancy and breastfeeding.
- Ask about and discuss danger signs.

Explain when you will return for the next visit.

SESSION 12: Role Plays - Supporting Mothers to Attend ANC

Time required: 30 minutes

Purpose

- The purpose of this session is to give MM's the opportunity to practise counselling pregnant women about receiving antenatal care.

Objectives

- At the end of the session the MM will be able to conduct antenatal home visits to pregnant women using the communication tools effectively.

Material

- Board/flipchart and paper
- Markers
- Referral Note
- Case study exercises

Role Plays: Home visits during Pregnancy — 30 minutes

Scenario:

MM: You are visiting Zodwa, who is six months pregnant with her first baby. She has not been to book at the clinic yet. She has also never tested for HIV before. Role play a home visit with her.

Zodwa: You are six months pregnant. You tried to book at the clinic, but the queues were so long, that you left. You are feeling very well, and think it is not necessary to attend the clinic. You are scared to test for HIV.

SECTION G
HIV AND AIDS

SESSION 13: Introduction to HIV and AIDS

Time required: 4 hours

Purpose

- The purpose of this session is to give MM trainees an overview of HIV/AIDS and to clear up any uncertainties and misconceptions.

Objectives

- At the end of this session, MM's will:
  - Know the difference between HIV and AIDS and understand how the disease is contracted.
  - Be familiar with terminology as it relates to HIV/AIDS such as 'CD4 count', 'window period', 'VCT' and 'ARV's'.
  - Know that it is possible to prevent HIV transmission from mother to child, and how this is possible.
  - Have cleared up any uncertainties or misconceptions they have previously held about HIV/AIDS.
  - Know that once a person starts ARV medication, they have to take it everyday for the rest of their lives.

Materials

- PowerPoint slides
- White board / flipchart and paper
- Markers

Quiz: An overview of HIV/AIDS 1 hour

FAST FACTS ABOUT HIV AND AIDS

What is HIV?

HIV stands for **H**uman **I**mmuno-deficiency **V**irus. It is called HIV because:

- it infects **humans**;
- it attacks the **immune** system (which is the body's system for fighting off infections and illnesses); and
- it is a **virus** (a type of germ).

HIV attacks a person's immune system and makes it harder for their bodies to fight off germs and illness. This means they are more likely to become ill with many normal illnesses like flu, diarrhoea, and TB than a person who does not have the virus.

Where is HIV in the body?

HIV is only found in human blood and other body fluids such as semen, vaginal fluid, saliva and breast milk.

Can you see when people have HIV?

No. When people are first infected with HIV they can remain healthy for a number of years which makes it impossible to see that they have the virus. However, they can still infect other people with the virus.

What is AIDS?

AIDS stands for **A**cquired **I**mmune **D**eficiency **S**yndrome. AIDS is caused by the HIV virus, which weakens and finally destroys the body's immune (defence) system, making a person vulnerable to having many illnesses at one time. Illnesses which attack the weak immune system are called opportunistic infections. AIDS is a syndrome which is made up of many symptoms of opportunistic infections which vary from person to person.

Who is more likely to get HIV?

Anyone can get HIV. Those most vulnerable to HIV:

- Women (biological, social and economic reasons)
- People with more than one sexual partner in the last 12 months
- People with sexually transmitted infections
- Orphans without anyone to care for them
- Widows who do not have a lot of power in the household

• Men who have sex with men
• Sex workers and their clients

How do you get HIV?

- unprotected sexual intercourse
- from HIV positive mother to her child (in the womb, at birth or sometimes through breast milk)
- blood transfusions
- contact with HIV positive blood through open wounds or broken skin
- sharing contaminated needles or blades

Can you get infected with HIV in any other way?

NO! You can not get HIV through normal everyday contact. HIV is NOT contracted by any of the following ways:

- Hugging
- Kissing
- Sharing a drink or the same spoon to eat with an HIV positive person
- Coughing
- Mosquito bites
- Sweat
- Swimming together with an HIV positive person
- Sharing a room with an HIV positive person
- Shaking hands with an HIV positive person
- Working with an HIV positive person

What is VCT?

VCT stands for '**V**oluntary **C**ounselling and **T**esting.' When you decide to have an HIV test, you should receive counselling and information about HIV both before you have your test and after you receive your results. This counselling should include information about emotional, medical and practical aspects of HIV/ADS so that you are best equipped to deal with your results whether they are positive or negative.

How do people know when they have AIDS?

The only way to properly diagnose AIDS is through a blood test. The symptoms of AIDS are different in different people. When people have AIDS they become ill from many other illnesses and so you cannot tell if someone has AIDS unless they have an HIV test.

How can HIV be prevented?

- practise safe sex (use condoms)
- delay first sexual relationship for as long as possible
- be faithful to one partner
- avoid having many sexual partners at the same time
- treat sexually transmitted infections early
- prevent needlestick injuries; and never use needles that have been used by others
- prevent transmission from mother to child

Can HIV /AIDS be cured?

No. At the moment there is no cure for HIV/AIDS.

Can HIV /AIDS be treated?

YES! There are many medications available to help people who are infected to stay healthier for longer. These are called Antiretroviral Drugs (ARV's). Normally one only starts taking these drugs when your body starts to become weak. If taken properly, ARV's fight HIV directly and give your immune system a chance to become strong again. There are many things you must know before taking ARV's, including that they must be taken everyday for life.

How do you take ARV's?

ARV's are lifelong treatment. You must take three different ARV medicines together. This is called combination therapy or HAART (**h**ighly **a**ctive **a**nti**r**etroviral **t**herapy). Sometimes you can take one pill containing all three ARV's once a day. But often you have to take more than one pill.

Do ARV's work for everyone?

No. Some people start too late and their immune system cannot recover. They start becoming sick with AIDS again. However, ARV's do work for the vast majority of people who become sick with AIDS. It is important to get tested early and have your CD4 cells counted.

Must children take ARV's?

Yes. Children usually take smaller doses than adults. Instead of taking pills, they might take ARV's as a syrup, which is often easier for them. Generally, children progress from HIV infection to AIDS quicker than adults, so they need to start ARV's sooner. Children born with HIV should start antiretroviral treatment as soon as possible.

What happens if you skip taking your ARV's for a while or you stop taking them?

If you miss doses regularly, the virus will learn to defeat the ARV's sooner, and then they will no longer work. When this happens it is called resistance. This is why it is critically important that once a person starts taking ARV's, that they take them every day for the rest of their lives.

Why do people often stop taking their ARV's?

ARV's can cause side effects such as diarrhoea, tiredness and headaches, even if they are taken correctly. This is why many people struggle to take medication. This does not mean that the drugs are not working. If you experience some of these side effects, discuss it with your doctor or clinic sister who will help to manage the side-effects. Always consult your doctor or sister before making any changes to your treatment.

Drinking alcohol, taking drugs, depression and other problems in a person's life, are all things that can make it hard for people to stick to their treatment.

Can a pregnant mother do anything to protect her baby from HIV?

Yes! There is medication available for mothers during pregnancy and at birth which she can take and give to the baby, which can prevent the child from getting infected. (This is covered in further detail in the following sessions).

What can people with HIV or AIDS do to stay healthy for longer?

There are many things a person with HIV can do to stay healthier for longer. Eating enough healthy food and living a healthy lifestyle can make a big difference to keeping your body healthier for longer. (This will be covered in greater detail later in the training). It is also very important to use condoms to prevent re-infection – being infected again will cause you to become sicker more quickly.

Can a healthy diet take the place of ARV's?

No. But people with HIV, whether or not they take ARV's, need to eat well to give the immune system the energy it needs to fight the virus. Be careful of people who claim that particular foods such as garlic or African potato treat AIDS. There is no food that is known to treat AIDS. Eat normal healthy foods. Try to drink as little alcohol as possible or none at all.

If I take ARV's, do I still need to take other medicine?

Yes. People with HIV get sick with diseases called opportunistic infections. They are more likely to get TB and they also get unusual diseases like systemic thrush

(severe fungal infections of the throat, stomach or vagina), cryptococcal meningitis (infection of the brain caused by a fungus) and pneumonia. ARV's do not treat these diseases. You have to take other medicines to treat them. However, ARV's strengthen your immune system and reduce the risk of you getting these diseases.

What can you do to stop passing on HIV to others?
Taking ARV's do not stop you from passing on HIV. If you do not take your ARV's properly you can develop resistance to the drugs, which means you could pass on a drug resistant form of the virus. Or, if your partner is not taking their ARV's correctly, they may re-infect you with a resistant form of HIV. You must use a condom every time you have sex. Be aware that other sexually transmitted infections, such as warts and herpes, as well as genital irritation and menstruation increases the transmission of HIV.

Lecture/Discussion: Understanding HIV/AIDS — 1 hour

UNDERSTANDING HIV

HIV is a virus that gets into a person's blood, where it attacks the white blood cells called CD4 cells.

What are CD4 cells?
CD4 cells are cells in the body which help to fight off illnesses like flu, colds and TB. HIV attacks and destroys the CD4 cells, which makes it hard for the body to fight off illnesses.

What is a CD4 count test?
A CD4 count test tells you how many CD4 cells are still working well in your body. A strong immune system has a CD4 count of 500 to 2000. If the CD4 count is below 200 the immune system is very weak, and you have AIDS. You are then at risk of developing an opportunistic infection. It is best to start antiretrovirals before this stage to strengthen your immune system. You should have a CD4 count test every 12 months so that your health worker can monitor your illness and make the best decisions to keep you healthy.

What are ARV's?
ARV's stands for medication called **A**nti**r**etro**v**iral Treatment. If taken properly, ARV's fight HIV directly and give your immune system a chance to become strong again. There are many things you must know before taking ARV's, including that they must be taken everyday for life. A person will only be advised to take ARV's once their immune system is already weak, or if they are showing signs of AIDS. Adults should be advised to start ARV's when their CD4 count drops to 350.

What is a viral load test?
The viral load test measures the amount of HIV virus in the blood. It helps to show how effective the ARV's are in fighting the virus.
VERY IMPORTANT: When a person has been taking ARV's, and the ARV's are working well, you will not detect the virus in their blood anymore. This does not mean that they no longer have the virus. It is still imperative that they take ARV's everyday for the rest of their lives. You should have a viral load test every 6 months.

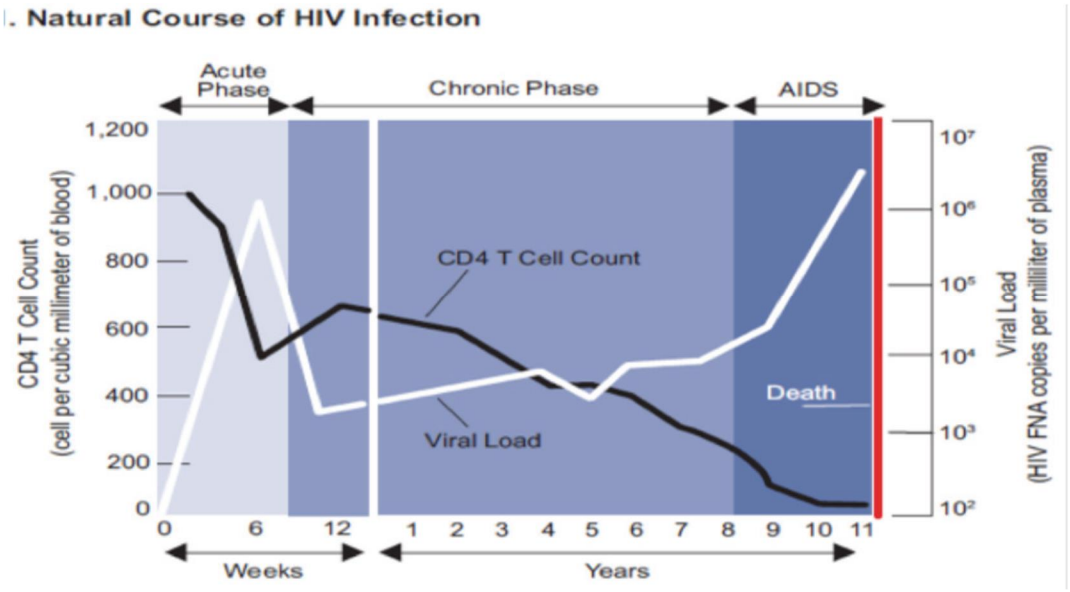
What is the window period?
The window period refers to the 3 month time interval from when a person gets infected to when they test positive on an HIV test. This is because the HIV test looks for antibodies to HIV in the blood, and it takes a few months for the body to produce antibodies.
It is a dangerous time because people can easily pass on the virus thinking they are negative.

What is an opportunistic infection?
An opportunistic infection takes advantage of the fact that the body's normal defences are down, giving it an opportunity to cause disease. Normally, a healthy immune system would fight off these illnesses. Examples of opportunistic infections are TB, thrush, some types of meningitis, diarrhoea and pneumonia.

Stages of HIV infection

As HIV attacks and weakens the body's immune system, the person goes through different clinical stages.

This graph shows the progression of HIV without treatment. As the CD4 count drops over time, the viral load increases, and the symptoms of disease worsen.



Stage 1:

Primary HIV infection

- This starts from the time of infection.
- The virus multiplies rapidly and the person can pass on the virus easily if they do not use a condom,
- The person may feel like they have the 'flu, have swollen glands and a rash.
- Most of the time, a person who has just been infected does not know that they are sick.
- After the time of infection, there may be a period of many years where there are no symptoms, but the CD4 count is gradually dropping.

Stage 2:

Symptomatic phase

This stage is characterised by **upper respiratory infections** and **rashes**.

- Fungal infections, oral ulcers, stomatitis, skin rashes
- Shingles
- Recurrent upper respiratory infections
- Unintentional weight loss

Stage 3:

In contrast to stage 2, this stage is characterised by **lower respiratory infections**, more **serious bacterial infections** and candida (thrush) infections.

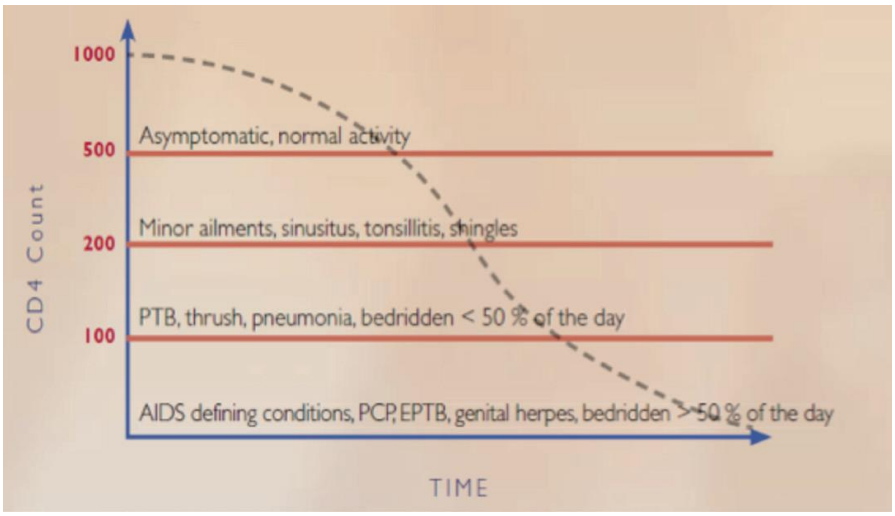
- Oral thrush, persistent vaginal thrush
- Oral hairy leukoplakia (a white infection on the sides of the tongue)
- Chronic diarrhoea
- Pulmonary TB
- Bacterial infections
- Unintentional weight loss

Stage 4:

Onset of AIDS

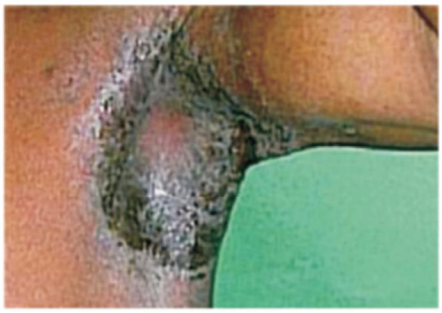
Patients develop opportunistic infections.

- HIV wasting
- Pneumocystis infection of the lungs
- Toxoplasmosis infection, particularly of the brain
- Cryptococcal infection
- Chronic diarrhoea – caused by fungal infections
- Viral infections such as CMV, Herpes
- Extra-pulmonary TB
- Lymphoma, Kaposi's sarcoma
- Recurrent pneumonia
- Severe thrush infections



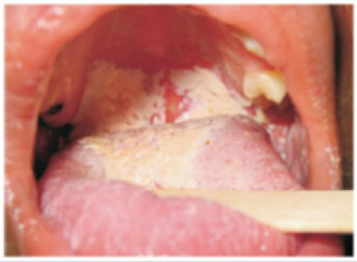
Opportunistic Infections

Seborrhoeic dermatitis



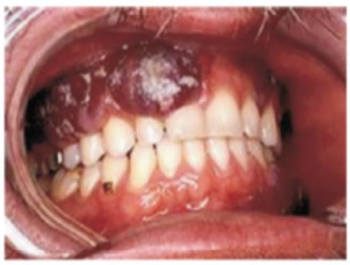
***Seborrhoeic dermatitis*:** This is a very common skin rash that looks scaly and dry (it can sometimes appear yellowish and greasy). Rashes are commonly found in hairy areas and can include the eyebrows, hair margin of the scalp, behind the ears, upper back and groin area. This is treatable.

Oral Thrush



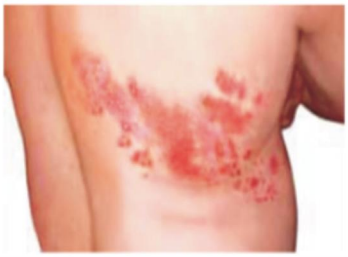
***Oral Thrush*:** Will cause white patches on the tongue and inside the mouth, and may also affect the palate (roof of the mouth). *Oral thrush* can be treated but it is important that it is noticed early so you can start treatment as soon as possible.

Kaposi's Sarcoma



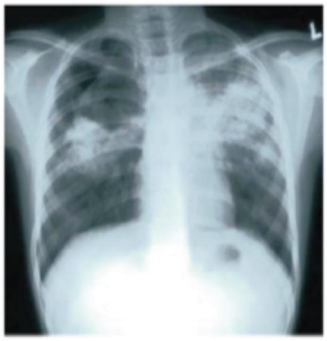
Kaposi's Sarcoma (when it presents in the mouth)*:* You will know if you have this condition because you will have black or dark patches (usually violet in colour) on your gums or on the inside of the top of your mouth. (In the early stages these patches are pink in colour). You will need to see a doctor as soon as possible as this requires early treatment.

Shingles



***Shingles*:** These are painful blisters, which run in a straight line or in a circle, on one area of your body. Once diagnosed, the blisters can be treated but the pain and the scars from the blisters may not go away. Shingles is known as *'ibanda'* (the belt) in many South African communities. Common myths include the notion that if the 'belt' meets or if your pain crosses over the 'belt' you will die. These myths are not true.

TB



TB stands for tuberculosis and is a disease caused by bacteria called *Mycobacterium tuberculosis*. The bacteria can attack any part of your body, but it usually attacks your lungs. TB is spread through the air when people who have the disease cough, sneeze or spit.

TB is the most common **opportunistic infection** among people living with HIV and is a leading cause of death among South Africans who are HIV positive.

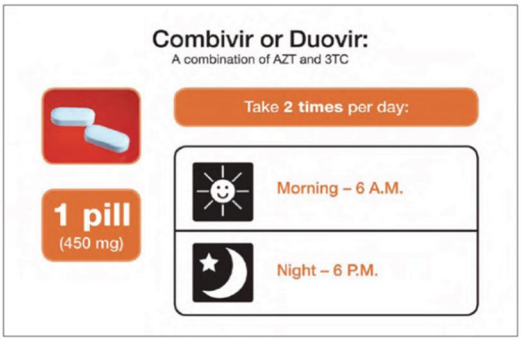
Treatment of HIV

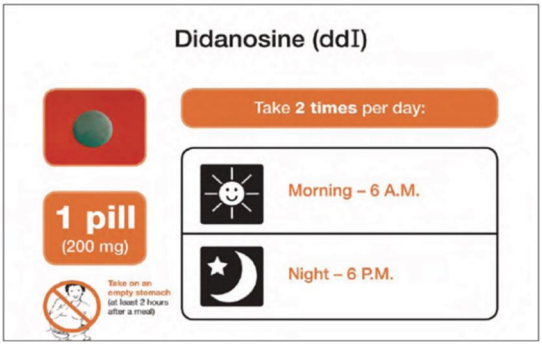
A combination of drugs is used to treat HIV, as the virus quickly becomes resistant to the treatment if only one or two drugs are used.

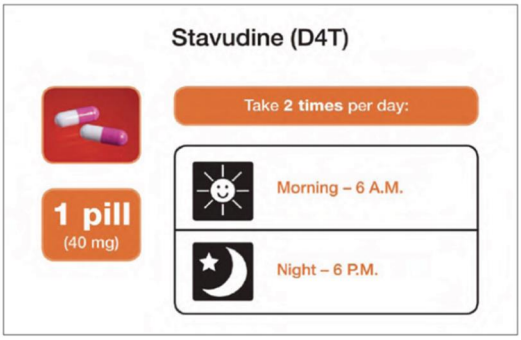
These symbols are used to explain to people how to take their medicines.

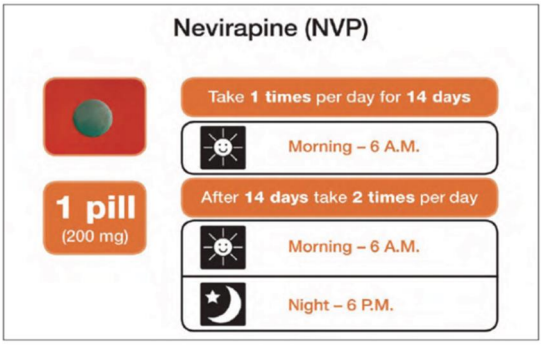
Take the medicine in the morning (a.m.) or evening (p.m.)

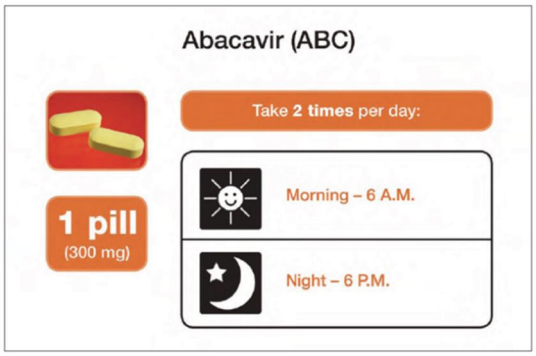
The following medicines are used to treat HIV:

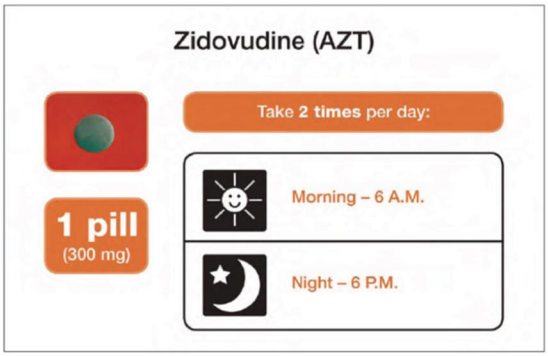


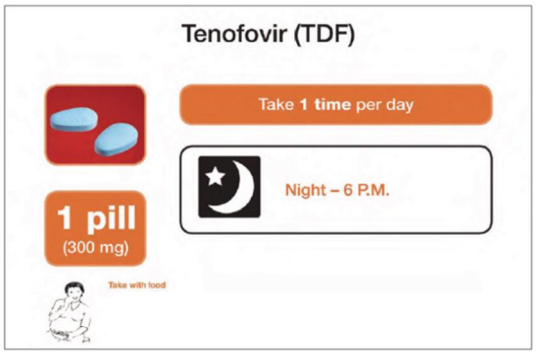


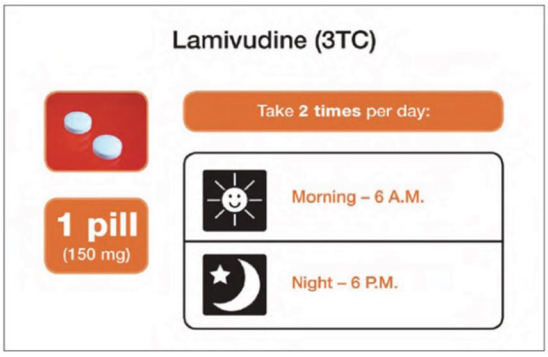


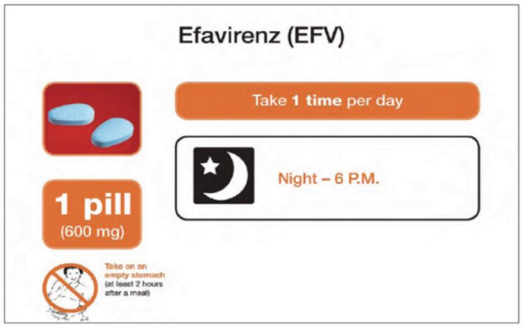


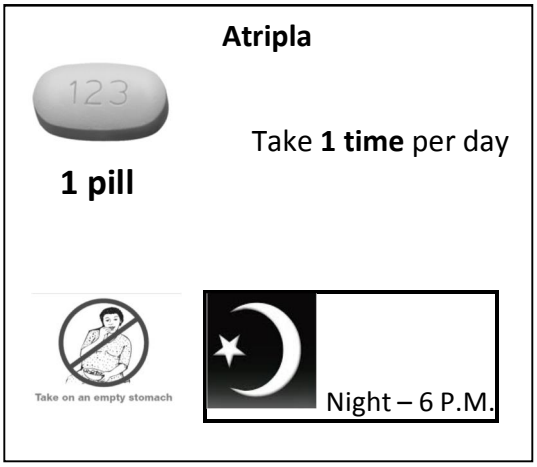


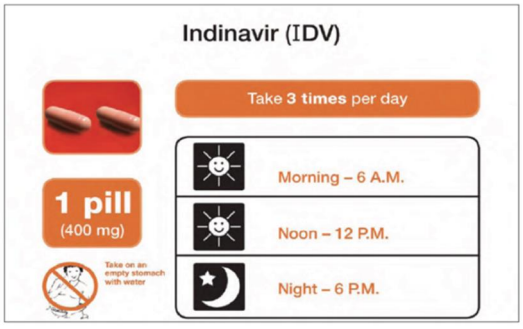












Atripla is a fixed dose combination of Efavirenz, Tenofovir and Emtricitabine. This means you can take all three drugs together in one pill, once a day.

HIV treatment guidelines for adults:

Who	ARVs
All new patients needing treatment, including pregnant women	TDF + 3TC/FTC + EFV/NVP
Currently on d4T based regimen with no side-effects	d4T + 3TC + EFV/NVP
Cannot use TDF (because of problems with the kidneys)	AZT+ 3TC +EFV/NVP

Some common side effects of ARV's are:
skin rashes, fever, nausea, tiredness and burning pain in the feet.

More serious side effects are:
anaemia, liver problems, fat changes, and high cholesterol – these would be detected by blood tests.

Prevention of opportunistic infections

1. TB preventive therapy (prophylaxis).

INH can be used to prevent HIV positive people from becoming sick with TB. It is important to make sure that the person does not have active TB that would require treatment. It is used in patients who are not yet on ARV's.
All HIV positive people with no signs and symptoms of TB, a positive skin test (Mantoux), or contact with a person with TB should get INH prophylaxis. INH is given daily for 6 months, together with the vitamin pyridoxine.

2. Cotrimoxazole prophylaxis.

Cotrimoxazole (Bactrim) is used to prevent pneumocystis pneumonia, toxoplasmosis and diarrhoea. Patients with a CD4 count below 200 or with 2, 3 or 4 stage disease would qualify for treatment. Treatment is stopped when the CD4 count is above 200, or the patient is well. It is safe in pregnancy. The dose is 2 tablets (160/800mg) daily.

3. Fluconazole prophylaxis.

Fluconazole is an anti-fungal drug used to prevent cryptococcal meningitis and also severe thrush infections. It is usually used in patients with very low CD4 counts (below 100), until their CD4 counts are above 200.

Discussion: The Importance of Adherence to Treatment 20 minutes

What is adherence?

Adherence means taking drugs exactly as they are prescribed. This includes taking them at the right time, and not forgetting any doses. **Remember, ARVs need to be taken for the rest of the person's life.** When a person stops taking their ARVs they have defaulted treatment.

Why is adherence important?

Not taking your treatment can mean problems for you and all of the people around you. Without treatment, the virus will continue to multiply and cause disease. You will continue to pass the virus on to sexual partners, or if pregnant, to your baby.
If you do not take the medicines properly, the HIV may become resistant to the drugs, which can make you very ill, and make the HIV very difficult to treat.

What makes adherence difficult?

- All drugs have **side effects** that can make life uncomfortable and make you want to stop taking treatment.
- Using **alcohol** and street **drugs** can also make it difficult to stick to treatment.
- You may feel better and think you do not need the treatment any longer.
- Sometimes you cannot get to the clinic to collect your treatment.
- You may **move away** to another area and need to transfer to a new clinic.

Support for patients on ARVs, and their families, is very important. Mentor mothers can help by providing emotional support, encouragement and giving information when needed.

Disclosure exercise — 30 minutes

Telling other people about personal information is not always easy. In pairs or small groups, get participants to think of something about themselves that is difficult to share with the group members, e.g. something they do not want others to know about them, or something they did that they regret. Take turns in sharing. Afterwards discuss who was able to disclose and who was not. Also discuss how hard it is to disclose something important to you or your reputation.

Activity: Stigma and discrimination — 20 minutes

Discuss the following pictures:

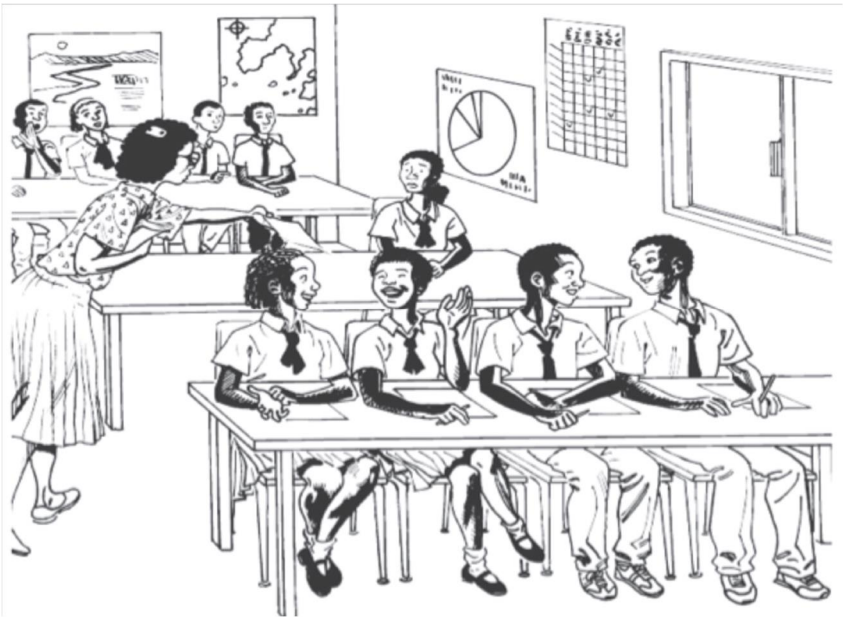
1) The woman in the picture, Marie, is on her way to the market. Her partner was recently diagnosed as HIV-positive. He has been quite ill. Community members suspect that he is HIV-positive.

- What do you think the community members sitting on the chairs are thinking? Why would they think that?
- What do you think Marie is thinking?
- How do you think Marie feels in this situation?
- What are the effects of such thoughts on people living with HIV/AIDS?

2) Look at the pictures and describe what you can see.

What are the results of stigma and discrimination toward people living with HIV/AIDS, their families, and their communities?

3) Negative attitudes about different groups of people can lead to discrimination. For example, Anna is in Grade 7 and is the best performing pupil in her class. Her father recently died of AIDS and her mother and baby brother are HIV-positive.



- What is happening in this picture?
- Why are Anna's classmates treating her this way?
- How do you think Anna feels in this situation?
- How do you think Anna will react to such a situation?

Activity: True or false? Disucss your answers 30 minutes

Statement	Answer
If a person has HIV, their sexual partner also definitely has HIV.	
If two people have HIV it makes no difference if they have unprotected sex or not.	
A mother with HIV will always give birth to an HIV positive baby.	
The main way people get infected with HIV is through having sex without a condom.	
You shouldn't share a plate of food with someone who is HIV positive.	
Breastfeeding an HIV positive baby is bad.	
If you already have a sexually transmitted disease, you are 5-10 times more likely to contract HIV.	
You can not get HIV through ordinary daily contact such as hugging, working together, shaking hands or breathing the same air as someone who is HIV positive.	
You can see if a person has HIV by the way they look.	
Most symptoms of AIDS are symptoms of other diseases too.	
You can get free HIV counselling and testing from your clinic.	
If you follow a healthy eating plan and lifestyle, you can live a healthier life for longer even though you have HIV.	
When taking ARV's, you can stop them when you feel better.	
When you are on ARV's, and the viral load test shows that the HIV virus cannot be detected, it means you are cured.	
If someone insists on using condoms,	

that person is HIV-positive.	

SESSION 14: Nutrition and HIV

Time required: 30 minutes

Purpose

- The purpose of this session is to understand why it is important for HIV positive people to eat a healthy balanced diet.

Objectives

- At the end of this session, MM will understand:
  - What HIV positive people need to eat to remain healthy.
  - Why it is difficult for HIV positive people to eat well.
  - What tips can be given to people who are struggling to eat or gain weight

Materials

- Powerpoint Slides
- Black board / paper flip chart and paper
- Markers

Lecture/Discussion: Nutrition and HIV **30 minutes**

LECTURE CONTENT: Nutrition and HIV

Six Nutritional Messages for people living with HIV

1. Eat a balanced diet

All foods fall into one of the following three groups:

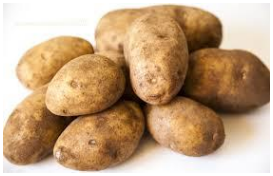
- Body-building foods (protein): beans, soya, peanuts, eggs, meat, fish and chicken.
- Energy-giving foods: maize, millet, rice, potatoes, sugar, oils and fats.
- Foods with vitamins that protect against infections: fruit and vegetables

Try to eat food from each of these groups every day for a balanced diet.
Eat three to five times a day.

2. Eat lots of energy foods to prevent wasting

- Your body needs more energy to fight HIV as well as other infections.
- Foods like pap, bread, rice, potato and mngqusho, as well as fats and oils, contain lots of energy.
- When your body runs out of these energy rich foods it will use up protein (stored in muscle) to get extra energy. If you do not eat enough, you will lose muscle and not fat. This is called wasting.
- Eating enough energy rich foods regularly will prevent your body from losing protein.






3. Eat lots of fruit and vegetables

- Your immune system needs vitamins to function well.

- Your body gets vitamins from fruit, vegetables and meat.

4. Eat at least three meals a day

- It is good if one meal includes some proteins, like soya, beans, lentils, eggs, fish, chicken, meat, liver or offal.

- Try to eat some snacks like fruit, nuts, sour milk, mageu, or peanut butter sandwich in-between meals.

5. HIV causes poor nutrition - poor nutrition makes HIV worse - a vicious cycle

- HIV weakens your immune system.
- HIV reduces absorption of food, which weakens the body's ability to resist all kinds of diseases.
- HIV can interfere with the way your body digests milk products. This can lead to a bloated feeling or diarrhoea after eating milk products, called lactose intolerance.
- Poorly nourished people are much more likely to get severe diarrhoea, TB and other infections.
- Good food helps prevent disease, and also helps the sick body to fight diseases and recover. Don't stop eating when you get sick.
- Women who are pregnant or breastfeeding also need more foods.

6. Drinking alcohol and smoking should be discouraged

- Alcohol like beer, wine and spirits provide some sugars which make you feel full, but provide no real nutrition.
- Alcohol weakens the immune system.
- Heavy drinking is bad for our health, especially for people living with HIV.
- Drinking a lot can make it hard to remember to take your medicines.
- Smokers get more chest infections.
- Smoking reduces your appetite.

Why eating can be hard for people living with HIV

People living with HIV find it difficult to eat enough.
Here are some reasons why HIV positive people eat too little. Knowing about these reasons may help you to overcome them.

- You might be too tired or depressed to cook or to go shopping. There might also be no money.
- You could decide to drink alcohol to forget about HIV instead of eating well.
- You might have loss of appetite or feel like vomiting.
- Food often does not taste good when you are sick.
- You might have a toothache or have sores in the mouth.
- Thrush infection can make it painful to swallow.
- Your liver might be swollen, causing it to press on the stomach. This makes it difficult to eat big meals.
- Medication you are on may cause diarrhoea or loss of appetite.

Nutritional hints for people who have trouble eating or maintaining their weight and strength

Here are a few hints to try and help people who are struggling to eat, to eat more:

- Eat the foods you like eating. Eat the same foods you have always eaten.
- Make meals sociable events.
- Take your time when eating and relax.
- Eat small amounts often. Eat with your fingers when you feel weak.
- Mix vegetable oil, margarine or peanut butter into porridge.
- Eat cooked vegetables. They are easier to eat than raw vegetables.
- Liquid and soft foods (mageu, amasi) are easier to swallow.
- If you have diarrhoea, continue to eat foods that do not irritate you.

- Drink oral rehydration solution (salt, sugar and water) when you have diarrhoea. (There is a detailed section about how to prepare this solution later in the training).
- Take vitamin tablets.
- Go to a clinic for advice and medications for specific problems.

SESSION 15: HIV/AIDS and Pregnancy: Keeping You and Your Child Healthy

Time required: 3 hours

Purpose

- The purpose of this session is to explore why it is important to encourage pregnant women to test for HIV, and what is available from clinics for pregnant mothers with HIV so that they can best protect their unborn children.

Objectives

- At the end of this session, MM's will:
  - Why it is important for pregnant mothers to know their status as early as possible during their pregnancies.
  - Some of the obstacles to disclosure, and possible ways to address them.
  - What is available to help pregnant mothers with HIV prevent passing the disease on to their children. (PMTCT, CD4 counts, and medication).
  - What difficulties prevent mothers from getting tested.

Materials

- PowerPoint slides
- Flip chart and paper
- Markers

Discussion: Knowing your Status and Protecting your Child
90 minutes

1**. Why is it important for pregnant mothers to know if they have HIV?**

- Being well-informed is the first step to taking control of your health and supporting those you care about.
- If a mother is HIV positive, she can get help in the form of both support and medicine to live a longer healthier life with her child.
- A mother who knows her status can take steps to protect her child from getting the virus as well. She can never guarantee that her child will not get HIV because sometimes HIV is transmitted during pregnancy, but this happens infrequently and there is a good chance that if she follows all the clinic's instructions, she will be able to have a healthy baby. Even if a woman is unlucky and her baby does become ill, she can feel good knowing that she did everything she could have to protect her baby.
- If a mother finds out that she is HIV negative, she can take extra precautions (such as always using condoms) to make sure that she stays negative forever.
- A mother living with HIV can choose to share this information with her MM if she wants to, and then the MM will be able to give better support and advice throughout the pregnancy.
- Access to grants from the government.
- You can use condoms and take other steps to make sure you protect others from getting HIV, as well as protecting yourself from being re-infected with HIV.
- Gain support for reproductive health choice and feeding practice choices.
- Improve access to care and support, for example a mother can join a care group or support group for HIV positive women.

2. **What services are available to pregnant mothers living with HIV?**

- HIV testing in pregnancy is part of ANC work-up. Clinics will offer HIV counselling and testing to pregnant mothers, and they will also provide the medical care that expecting mothers and their children will need.
- Counselling will include provision of all information about various treatment options, how treatment works, and how effective it is likely

to be. It will also include information about how to protect your child from getting the virus.

- Women must be given nutritional information (eating well, taking iron and folate) in order to stay healthy. A mother with HIV who is malnourished or underweight is more likely to have an underweight baby who is more likely to get the virus than a stronger healthier baby.
- Expecting mothers with HIV will be given medicines to prevent the baby from becoming infected with HIV. This is called PMTCT (prevention of mother to child transmission).
- **All HIV positive women who are pregnant or breastfeeding should be offered antiretroviral treatment**. This will consist of three antiretroviral medicines taken everyday for the rest of her life. These medicines will help the mother to live a much longer, healthier life, and is the best way to prevent transmission to the baby.

3. What is available to HIV positive mothers after their babies are born?

- Child support grants are available for mothers once their children are born (see more detail about the child support grant in the child health section later on in this training).
- The clinic should test newborn babies for HIV when they are six weeks old. The clinic should use what is called a PCR test. This will test whether there is HIV in the baby's blood.
- Clinics must provide information about how to feed your baby. It is a mother's choice to either give her baby only formula milk or only breast-milk. She should not give both because this increases the chance of her baby getting HIV. (This is further discussed in much detail in the section on 'baby feeding').
- Breastfed babies should be re-tested for HIV 6 weeks after stopping breastfeeding.
- The clinic should test babies for HIV again at 18 months.
- Mothers should take their baby to the clinic if he or she gets diarrhoea.
- If the baby has HIV, the clinic should provide him or her with antiretroviral treatment. Children with HIV progress much more rapidly than adults, and so it is important for all HIV positive babies to begin treatment as early as possible. This can help HIV positive children live much longer and have a more normal life.
- All HIV positive mothers should have been started on ARVs during pregnancy. In the Western Cape all breastfeeding mothers should also be started on ARVs.

Lecture: Prevention of Mother to Child Transmission (PMTCT)
90 minutes

With **no** treatment, **30%** of babies born to HIV positive mothers, will be HIV positive.

With treatment, only **2 – 5%** of babies will be HIV positive.

How is HIV transmitted from mother to child?
There are three ways in which a mother can transmit HIV to her baby:

- during pregnancy
- during childbirth
- through breast feeding

The risk of HIV infection to the baby occurs mostly **during delivery**.
There is a lower risk from breastfeeding and a small risk during pregnancy itself.

<u>During pregnancy</u>
There is a higher chance of passing HIV on to the baby if:

- The mother is infected with HIV just before or during pregnancy
- The mother has advanced AIDS

<u>During childbirth</u>
There is a higher chance of passing HIV on to the baby if:

- The mother has a high number of HIV viruses in her body at the time of delivery (This can happen if she is recently infected or is not taking medicines to decrease the number of viruses)
- If there is a long and complicated delivery

There is less chance if:

- The mother is already on ARV medicines
- The mother is enrolled and committed to the PMTCT programme

Through breastfeeding

There is a bigger chance of passing HIV to the baby during breastfeeding if:

- The mother has cracked nipples or swollen, painful breasts
- The mother is not exclusively breastfeeding for the first six months after the baby is born (She is giving the baby other milk, foods or liquids)
- The mother becomes infected with HIV after the birth of her child and while breastfeeding.

An HIV-positive grandmother can also pass HIV on to a baby if she breastfeeds the baby.

A baby can get HIV if an HIV-positive mother puts her breast milk in the baby's eyes.

What is PMTCT?

- PMTCT stands for **P**revention of **M**other-**T**o-**C**hild **T**ransmission of HIV.
- To prevent HIV from passing from the mother to the baby, the mother must take antiretroviral (ARVs).
- She must take it during pregnancy, childbirth and while she is breastfeeding.
- ARVs will not hurt the baby.

The PMTCT programme has four stages:

1. Primary prevention of HIV (**before pregnancy**)

- Practice safe sex (e.g. using condoms).
- Use contraception to prevent unwanted pregnancies and plan when you want to become pregnant, especially HIV positive women.
- Get tested for HIV.
- Know your partner's HIV status.
- If you are HIV-positive, have regular checks of your CD4 cell count and start ARV treatment when advised. Get information on how to prevent passing HIV on to your baby.
- Have any STIs treated.

2. Antenatal Care (**during pregnancy**)

- Pregnant women must be booked at the clinic on the first day they attend.
- Women who are pregnant and HIV-positive should be identified as early as possible **before 14 weeks (3months) of pregnancy** so that they can enrol in the PMTCT programme and get medicines to prevent passing on HIV to their babies.
- **HIV negative women should get tested for HIV again at 32 weeks** (8 months of pregnancy) to make sure they have not become HIV-positive during the pregnancy.
- The woman's partner should be tested for HIV.
- Always practice safe sex (use a condom) during the pregnancy.
- It is important for the mother to test for an STI as it may be passed on to the baby and may cause serious health problems for the baby. Most STIs, if detected and treated early, can be cured.

ARVs are now recommended for all HIV positive women who are pregnant or breastfeeding. The CD4 count is no longer used to decide on starting ARVs.

3. **Labour and Delivery**

- The mother should go to the clinic as soon as the signs of labour begin.
- If the mother is already on ARVs she must continue taking the medicines given to her by the nurse at the clinic. She must take her medicines with her to hospital.
- If the mother did not test before, or was HIV negative, and now tests HIV positive in labour ward, she must be given ARVs.

4. Postnatal Care **(after birth**)

- All breastfeeding mothers must use condoms correctly every time they have sex, until they have stopped breastfeeding their babies. This is so that they will not get HIV during breastfeeding and risk passing it on to the baby.
- All HIV positive mothers who are breastfeeding must be started on lifelong ARVs.
- All HIV negative mothers must be re-tested at the 6 week infant visit, and then every three months after that. **Mothers who become HIV infected while breastfeeding are at high risk of transmitting HIV to their infants.**
- Babies of HIV positive mothers should receive Nevirapine.

PMTCT Medication: Mother

All pregnant women who are HIV positive	Tenofovir + Efavirenz + Lamivudine (3TC) or Emtricitabine (single dos	Start lifelong ARV's from 14 weeks of pregnancy
Sensitivity to Tenofovir	AZT + Lamivudine (3TC) + Nevirapine	
Mother currently on ARV's	Continue ARV's	
Mother who tests HIV positive in labour	Single dose of Nevirapine Single dose of Truvada + AZT 3 hourly during labour	Start mother on lifelong ARV's before discharge from hospital

PMTCT Medication: Infant

Baby on exclusive formula feeding,	Nevirapine at birth, then daily for 4- 6 weeks*	
Breastfed baby: Mother on lifelong ARV treatment, or started on ARVs during pregnancy and has received more than 8 weeks treatment	Nevirapine at birth, then daily for 4- 6 weeks	Check mother's Viral load before stopping infant Nevirapine.
Breastfed baby: Mother started on ARVs during pregnancy, but for less than 8 weeks before delivery	Nevirapine at birth, then daily for 12 weeks.	Check mother's viral load before stopping infant Nevirapine.
Mother did not get any ARV's before or during delivery	Nevirapine as soon as possible and daily for 6 weeks. Continue as long as any breastfeeding	Assess whether baby is eligible for ARV's within 2 weeks. Mother must be started on ARVs.
Unknown maternal status, orphaned or abandoned baby	HIV test. Give immediate Nevirapine if baby is HIV positive** (i.e. HIV exposed)	Follow up 6 week PCR test for HIV

*New Western Cape policy advises 4 weeks of Nevirapine. Other provinces may still be using Nevirapine for 6 weeks.
**If the baby's HIV test (not PCR) is positive it means that the baby has the mother's antibodies to HIV in its blood. This means that the mother is HIV positive. The baby will have to have PCR test at 6 weeks to check the baby's status.

When can infant Nevirapine be stopped?

- Mothers should only stop giving Nevirapine when told do so by a healthcare professional
- If the baby's PCR test is positive, the baby needs ARVs, so NVP is stopped.
- If the baby is bottle fed, NVP can be stopped at 6 weeks, as there is no risk of HIV being passed on through breast milk.
- If the mother is on ARVs and her viral load is low (below 400), then NVP can be stopped at 6 weeks, as the risk of the baby getting HIV through the breast milk is very low.

SESSION 16: HIV in Home Visits

Time required: 90 minutes

Purpose

- The purpose of this session is to prepare MM for how HIV should be handled in home visits.

Objectives

- At the end of this session, MM will:
  - Have a better understanding of the issues around disclosure.
  - Know how to approach HIV during home visits.
  - Know what to say to mothers depending on their status.
  - What elements of counselling are important when supporting pregnant mothers living with or without HIV.

Materials

- Blackboard or white paper/flipchart and paper
- Markers
- Philani Mentor Mother Training DVD

Group Work: Disclosure — 30 minutes

The trainers will guide this session.

Discussion: HIV in Home Visits — 20 minutes

HIV IN HOME VISITS

Testing:

- Discuss importance of testing.
- Testing with one's partner.

Protecting yourself:

- Discuss safe sex practices.
- Important for HIV negative **and HIV positive** people.
- Find out how much the woman knows about HIV, and give more information as needed.

HIV positive mothers:

- Focus on how to stay healthy and how to protect one's baby.
- If the woman is on ARV's ask about side effects, and discuss adherence.
- If the woman is not on ARV's, explain the future role of ARV's and importance of CD4 count tests
- Find out if mother has joined PMTCT programme.
- Explain the probabilities of mother to child transmission at different stages (pregnancy, birth, breastfeeding).
- Explain that the mother must ensure she takes her own medicine to the clinic when she goes into labour.
- Explain when testing is necessary for baby (6 weeks &18 months).
- Discuss feeding options.
- Find out if she has tested for TB, and if not, encourage her to do so.

DVD Session: PMTCT & Antenatal Clinics: 20 minutes

The trainers will guide this session.

Role Plays: PMTCT 20 minutes

Role Play: PMTCT

MM: You are coming back to visit a pregnant mother. During the last home visit you encouraged her to go and book at the antenatal clinic. At that time, she confided that she was afraid of testing for HIV.
Role-play a follow-up visit. What are the important issues you need to cover? Remember to be sensitive and encouraging.

ZANELE: You are in early pregnancy. You were visited by the MM 1 month ago. She encouraged you to book at the antenatal clinic and to be tested for HIV, even though you were very afraid to do this. You booked at the clinic, and found out that you are HIV positive. You have not told anyone about the result yet, and you are worried about your baby getting HIV. Role-play the next visit with the MM.

Remember not to overload the mother with too much information at one time. Rather cover the important topics over several visits. Always attend to the issues that are worrying the mother at the time.

SECTION H
TUBERCULOSIS

SESSION 17: What is TB? Signs and Symptoms

Time required: 1 hour and 45 minutes

Purpose

- The purpose of this session is to teach trainees about TB and how it can be identified in adults and children.

Objectives

- At the end of this session, MM will be able to:
  - Understand what TB is.
  - Know the social factors that have contributed to the TB epidemic in SA.
  - Know the signs and symptoms of TB in both adults and children.

Materials

- PowerPoint slides
- Board/Flipchart and paper
- Markers
- Adherence cards from clinic

Knowledge and Beliefs about TB — 15 minutes

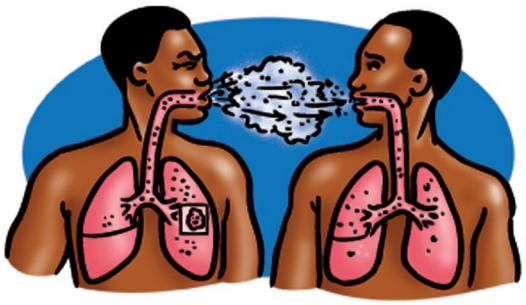
The trainers will guide this session.

Lecture/Discussion: TB and its Symptoms — 70 minutes

LECTURE CONTENT: TB and its symptoms

What is TB?

Human tuberculosis is an infection caused by the bacteria (germ) called Mycobacterium tuberculosis. TB is spread from person to person through the air by droplets which are produced when a person with TB coughs, sneezes or spits. These droplets are very small and are highly infectious. They reach the smallest spaces in the lungs, where the bacteria multiply.



TB is a Socio-economic Disease

TB has been known to humans for thousands of years. It has been around for a long time in South Africa, but the numbers of infections in recent years has increased dramatically, leaving South Africa in the middle of a tuberculosis (TB) epidemic.

Factors contributing to the spread of TB in South Africa:

- **HIV and AIDS -** TB has become worse in places where there is a lot of HIV. HIV weakens the immune system, and thus people are more likely to become sick with TB. 70% of patients with TB are also HIV positive. High levels of active TB in HIV positive people are a high risk to the general community.
- **Housing -** TB spreads easily in overcrowded, unventilated conditions. TB also thrives in damp and dirty conditions. Living in the same house with

someone with undiagnosed, untreated, active TB is not good, especially if you share a room and/or a bed. Children are particularly at risk. Improving ventilation, by opening windows, is very important in reducing the spread of TB.

- **Poverty -** Malnourished or undernourished people (people who do not have enough food to keep their bodies strong and healthy) are at risk of getting TB.
- **Alcoholism and illegal drugs -** Alcohol can make those who drink a lot more vulnerable to TB infection. These kinds of addictions can make people forget to take their medicines. Alcohol and illegal drugs can also damage the liver.
- **Prisons -** Prisoners are at high risk for TB, as prisons are overcrowded with inadequate ventilation. Many prisoners have HIV, which frequently goes untreated.
- **Mines -** Conditions down the mines contribute to TB and poor lung health. Overcrowding in hostels and a very high prevalence of HIV among miners contributes to high rates of TB.

HIV and TB

TB and HIV are a deadly combination, causing many deaths in SA.
10% of people infected with TB will get sick with TB in their lifetime, whereas **50% of HIV positive people will develop TB**. HIV causes an increase in the number of TB cases, and also more cases of extra-pulmonary TB. It is often more difficult to detect in HIV positive people, due to suppressed immunity.

People can be infected with TB although it remains dormant (sleeping) in their bodies; this is known as inactive TB. This means they are not sick and cannot spread the illness to others. The dormant bacteria in these people can become active (awake), especially if they have HIV, and make them sick. People with HIV who have inactive TB can take Isoniazid (INH) – a drug that is used for treating TB. INH prevents reactivation of TB and is useful in patients who have not yet started ARV's. It is given for 6 months.

TB in South Africa

In South Africa, Tuberculosis (TB) attacks one out of every 100 people overall. **The TB problem in South Africa is one of the worst in the world.** About 10 000 people die from TB every year.

TB is the single most deadly infectious disease in our country.
According to the WHO's latest world report, South Africa has the highest incidence of TB in the world (940 cases per 100,000 people). Compare this to the incidence of TB in Africa at 363 cases per 100,000 people. Even if we compare South Africa to the 22 countries in the world most affected by TB, our incidence rate is 5 times higher.

In Khayelitsha, one in every 70 (14 per 1000) people has tested positive for TB. TB is especially bad in the Western Cape, where it is colder and wetter than in other parts of the country. However, TB is bad in every province. TB is often difficult to diagnose, particularly in children.

How can TB be prevented?

- Make sure all babies are vaccinated against TB. BCG vaccine is given at birth and helps protect babies against TB and TB meningitis.
- Wash hands regularly.
- Family and friends who are in close contact with someone who has TB, must watch out for the signs of TB and visit the clinic if they start to cough.
- All children under five years old who come into contact with a person who has TB must be taken to the clinic so that they can be given medicine to prevent TB.
- Build the immune system by eating properly and getting daily exercise.
- You should get tested if you are in close contact with an infected person or if you have been coughing a lot for more than 2 weeks.
- People with TB should cover their nose and mouth when they sneeze or cough to help stop the spread of the disease.
- People with TB should not spit in public.
- People should keep all the windows in their house open to let in the fresh air.

Fresh air and sunlight make it harder for TB germs to stay alive.
The fresh air scatters the germs and the sunlight kills them.

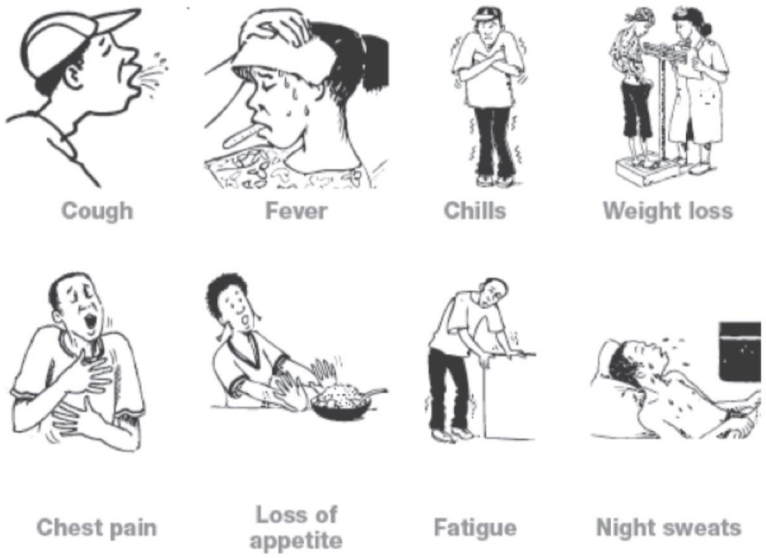
Infection with TB

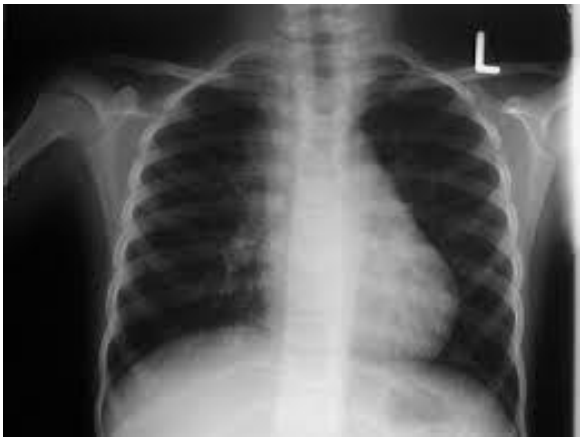
Primary infection is the first exposure to TB. This usually happens in childhood, and the immune system controls the infection. The person is unaware that they have been exposed to TB. Some bacteria may remain in the glands or scar tissue in the lungs, and can re-activate at a later stage if the person's immunity is depressed. Occasionally, at the time of this first exposure, TB will spread into the blood stream and lungs and cause illness.

Post-primary TB occurs after re-activation of bacteria from the primary infection or from re-infection from an infectious contact. 80% of TB infection affects the lungs, and is called pulmonary TB. However, TB can affect any part of the body, and is then called extra-pulmonary TB. Pulmonary TB is the infectious form of the disease.

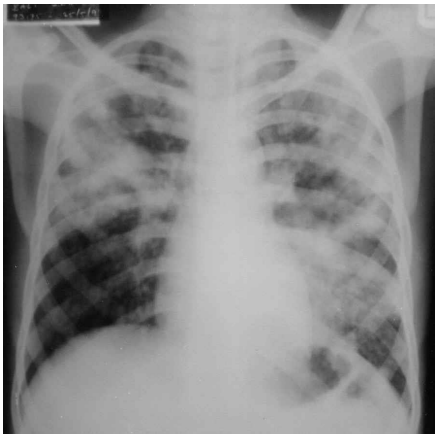
Signs and symptoms of pulmonary TB:

- Coughing for two weeks or more
- Coughing up sputum – a thick liquid the lungs make that can be yellow or green
- Coughing up blood in the sputum
- Chills and fever
- Drenching night sweats
- Weight loss and not feeling hungry
- Problems breathing
- Chest pain
- Feeling tired or weak





A normal chest X-Ray



X-Ray of a person with TB

Extra-Pulmonary TB

- Extra-pulmonary TB is TB that occurs outside of the lungs, in other parts of the body.
- The symptoms of extra-pulmonary TB can also include night sweats, feeling tired, weight loss, not feeling hungry and fevers.
- Extra-pulmonary TB is common in children and people who are HIV-positive.
- Extra-pulmonary TB is often hard to detect because the symptoms are not very easy to spot or pick up with diagnostic tests.

Here are some examples of extra-pulmonary TB and the symptoms they may cause:

Part of the Body	**Symptoms**
Lymph nodes	Large hard glands mainly in the neck. Not painful and may have pus. Inside the chest, glands may block the airways causing wheezing.
Bones and joints	Swelling, pain, tenderness
Brain (meningitis)	Fever, headache, stiff neck, nausea, drowsiness, feeling sleepy, coma
Abdominal cavity	Tiredness, swelling, tenderness, sharp pain, chronic diarrhoea
Spine	Pain, collapsed vertebrae, leg paralysis

TB in Children

Children are at risk of getting TB if they are:

- In close contact with an adult with TB
- Under 5 years of age
- HIV positive
- Malnourished

Young children (under 5 years) tend to get more serious forms of TB, like meningitis and miliary TB. Children can be protected by having BCG vaccination at birth. This does not prevent TB infection, but protects children from the severe forms of TB. Children can also be given INH prophylaxis for 6 months, if they are in close contact with someone with TB or if they are HIV positive.

In any child who has TB it is important to look for people in the household, or close contacts of the child, who may also have TB. All children in the household should be tested for TB. It is also important to exclude HIV infection.

Symptoms in children

The most common symptoms in children are:

- Cough that does not improve after 2 weeks
- Fever that does not settle after 2 weeks
- Unusual tiredness
- Trouble gaining weight

Young children often do not have the usual symptoms of TB, thus it is important to monitor a child's weight gain, which you can do using a Road to Heath Booklet. **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. 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. If not detected early 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:

- **headache**
- **vomiting**
- **convulsions**
- **drowsiness**
- **irritability**
- **neck stiffness**
- **trouble breathing** if going into a coma

Children showing these symptoms need to be treated immediately.

Miliary (disseminated) TB in Children

This occurs when the TB bacilli get into the blood stream and spread all over the body. Signs of miliary TB are high fever and an enlarged spleen. It is more common in children, and can be life threatening.

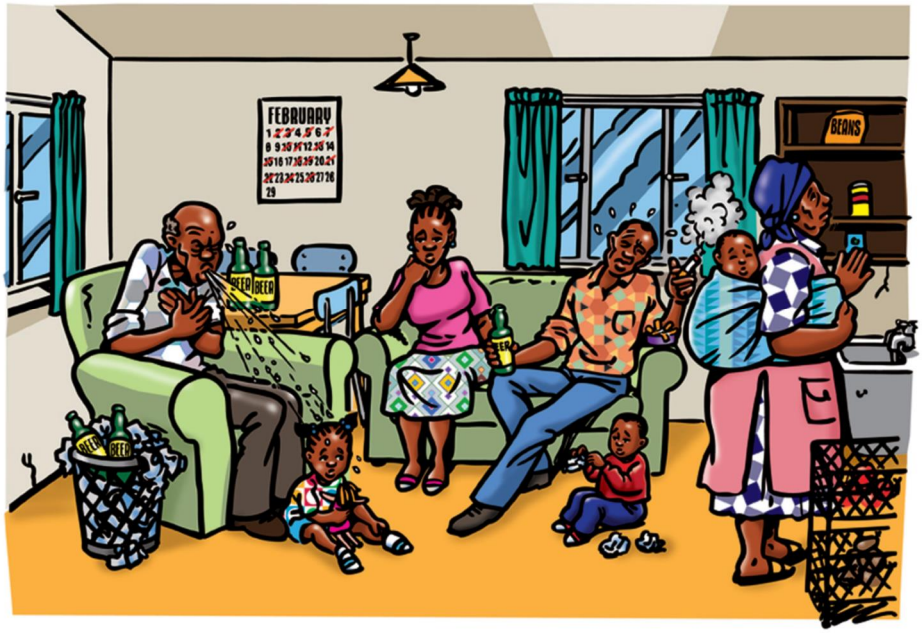
Danger signs in children

These require immediate referral to hospital, as they indicate life-threatening forms of TB:

- Headache, vomiting, drowsiness, neck stiffness, fits (signs of TB meningitis)
- High fever, child very tired and ill
- Swollen abdomen
- Breathlessness and swelling of legs
- Severe wheezing not responding to nebulisation (blockage of wind pipe by swollen glands)
- Sudden onset of bending of the spine and backache (TB of the spine)

Activity: Small Group Discussion 20 minutes

The trainers will guide this session.



SESSION 18: Diagnosing and Treating TB

Time required: 1 hour and 30 minutes

Purpose

- The purpose of this session is for MM's to learn how TB is diagnosed and treated.

Objectives

- At the end of this session, MM will be able to:
  - Understand the importance of getting tested for TB and starting treatment as soon as a diagnosis of TB has been made.
  - Understand what test results are needed before a decision can be made about treatment.
  - Understand the difficulties and importance of adherence to treatment.
  - Know the consequences of not following a full course of treatment.

Materials

- PowerPoint slides
- Board/flipchart and paper
- Markers

Lecture/Discussion: Diagnosing and Treating TB 90 minutes

LECTURE CONTENT: Diagnosing and treating TB

Diagnosing TB

The following methods are used to test for TB:

1. Sputum test (smear microscopy) -This is the most commonly used test available. Patients cough up sputum, and it is analysed to see if it contains TB bacteria. Three samples are taken. If TB bacteria are found, it means the patient has smear-positive TB and must start treatment immediately.

2. TB culture test - TB culture test is the most accurate test for TB, but it takes a long time to get results.
Culture tests should be offered to people who are:

- Smear-negative, but still show signs of TB
- Suspected of having extra-pulmonary TB, if a sample can be collected
- Suspected of having drug-resistant TB

1. GeneXpert test – this is a new test which looks for TB in a sputum sample. It can also tell if the TB is resistant to one of the TB drugs (i.e. if the person has MDR TB). It can give results in 2 days, which is much better than the culture test.

4. Chest X-ray - If you have symptoms of active TB, but are diagnosed smear-negative, you should then have a chest X-ray. Chest X-rays are very important for diagnosing TB in children. They are also useful for patients who have symptoms of TB and who are unable to produce a sputum sample, and for diagnosing extra-pulmonary TB (e.g. pleural or pericardial effusions).

5. Tuberculin skin test – The best TST is the **Mantoux**. A modified form of the TB bacteria is injected into the skin of the forearm. The body will develop a reaction if it has been exposed to TB bacteria, or if you have had a BCG vaccination. It does not tell if you have active TB. The Mantoux is helpful for diagnosing TB in children.

However, a negative Mantoux does not exclude TB.

A negative Mantoux may occur even when there is TB infection, if the patient is unable to mount an immune response due to the following conditions:

- Malnutrition
- HIV infection
- Viral infections - such as measles, chicken pox
- Severe disseminated TB infection

6. Other tests – sometimes a biopsy, a small piece of tissue, will be taken from a part of the body where TB is suspected, e.g. a lymph node. Fluid can also be drained with a needle and syringe and tested for TB.

Diagnosing TB in children

Diagnosing TB in children can be difficult.
All children should be tested for TB if there is someone in the household with TB.
When testing children for TB, the most important tests are the Mantoux and a chest X-ray.
Sometimes, children will have a nasogastric aspirate done to look for TB. A tube is put into the stomach and the fluid drawn out and tested for TB bacilli, as children swallow sputum rather than cough it out.

Sputum test are often negative in children because:

- small children can rarely give good sputum samples
- their TB is extra-pulmonary (not in the lungs)
- the number of bacteria in their body is much less than that in an adult.

The Mantoux test is an injection done into the skin on the forearm. 48-72 hours later (usually 3 days) the child must return to the clinic to measure the skin reaction. A positive result is swelling of 10mm or more, or 5mm or more in an HIV positive child.

Who should be tested for TB?

- A person who has symptoms of TB
- A person who is in close contact with someone who has TB
- All HIV positive people
- All household members, if an adult or child has TB

Treating TB

If the results come back positive or your clinic sister or doctor thinks you have TB based on your symptoms, he or she will tell you to begin treatment immediately. Starting treatment immediately and taking it properly is crucial for your health and survival. If you do not take your medicine correctly and for the full time, you are at risk for getting drug resistant TB which is very difficult to cure and makes you very ill.

There are five important things you must remember to tell your clinic sister or doctor before you start treatment:

1. **You have been treated for TB before -** The treatment for people taking TB drugs for the first time is not the same for people who have already been treated for TB. If you have taken TB drugs before, there is a chance that the TB bacteria in you body have changed and become resistant to those antibiotics. Your treatment will then be different to someone who is being treated for the first time. People who have had TB before usually have to take drugs for a much longer period than people who are being treated for TB for the first time.
2. **You are HIV-positive -** This will help you to be better cared for. If you are diagnosed with TB and don't know your HIV status, you should ask for an HIV test. If you are HIV-positive you should receive cotrimoxazole and have a CD4 test to see if you need ARV's.
3. **You are pregnant -** Tell your doctor if you might be pregnant since some TB drugs can damage unborn babies. The drug Streptomycin can cause deafness in unborn babies.
4. **You are taking oral contraceptives or the birth control pill -** The TB drugs interfere with contraceptives so your doctor may need to adjust the contraceptives while you are taking your TB drugs.
5. **If you are breast feeding –** TB drugs are compatible with breast feeding, and women can safely continue to breast feed. The baby may need to be given INH prophylaxis for 6 months, and the BCG may need to be delayed.

Preparing for treatment

Taking TB drugs is not easy. TB treatment is long and the drugs have side effects that may make you want to stop taking your treatment. If you do not complete your TB treatment, you risk you own life and the lives of people around you. Here are some things you should know to help you to prepare for treatment:

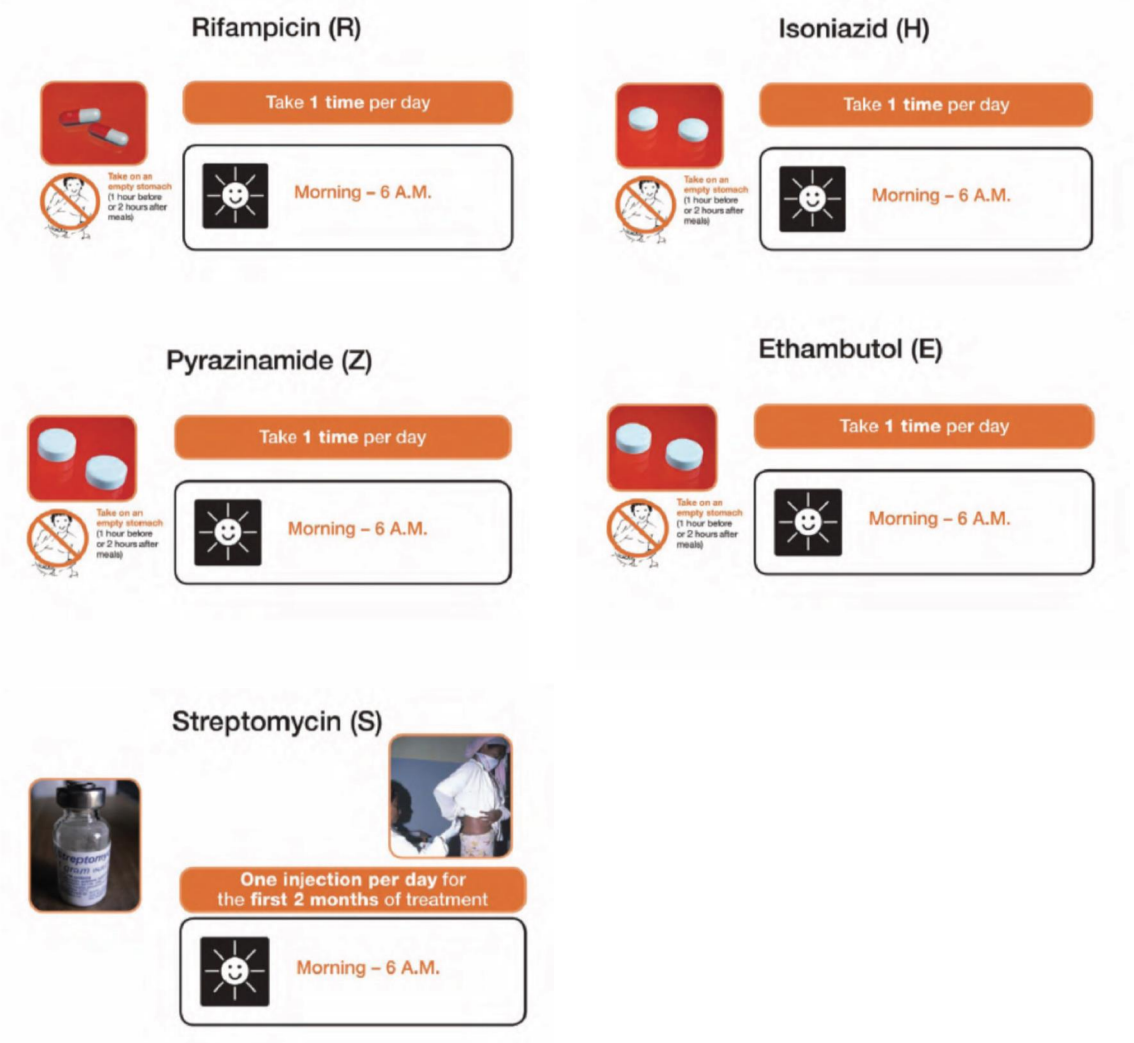
- **Side effects -** All of the TB drugs have side effects. Some side effects, like nausea, are only minor while others, like peripheral neuropathy and hepatitis, can make you very uncomfortable. It is important that you tell your healthcare worker how you are feeling. Sometimes there are other drugs you can take to make the side effects go away.
- **Drug interactions -** If you are taking other medications, like ARV's, they may interact with TB drugs to stop working or to produce more side effects. Again, tell your healthcare worker how you are feeling and make sure he or she knows about all of the medications you are taking, including traditional medicines.
- **Staying healthy -** Like all drugs, TB antibiotics can put a lot of stress on your body. It is important that you do your best to stay healthy. This means eating healthy foods like fruits and vegetables with lots of proteins and vitamins.
- **Alcohol and street drugs -** It is very important that you DO NOT drink alcohol while taking TB drugs. Drinking alcohol while taking TB drugs can make you develop hepatitis and cause liver failure. Street drugs make it difficult to take treatment because when you are high you may forget to take your treatment or just not care.
- **Traditional medicine -** If you start to have symptoms of TB, the decision to consult a traditional healer is your own, but you should also consult a healthcare worker. Many people will talk with a traditional healer first and this often delays the process of diagnosis. The longer you take to be diagnosed by a healthcare worker, the sicker you will become and the more people you will infect.
- **Have support -** TB treatment can be difficult. If you are going to start treatment, talk to someone who has completed TB treatment. They can tell you what to expect and share their experiences. You should also try to find people who can support you through treatment. This is very important.
- **Prophylaxis for family members –** If you have been diagnosed with TB, people close to you like family members and especially children, must be tested for TB as well. All children under 5, and HIV positive people who do

not have active TB should be put on Isoniazid for 6 months to prevent them from getting TB.

TB treatment

The drugs used, and the length of treatment depends on whether the person is being treated for the first time or not, and if they have drug resistant TB.
The minimum length of treatment is **6 months**.

The following drugs are used to treat TB:



There is also a combination tablet called **Rifafour**, which contains Rifampicin, INH, Pyrazinamide and Ethambutol. It is much easier for patients as it is one tablet taken once a day.

Patients need to be monitored during treatment to make sure that they are responding to the TB treatment.

- Sputum is retested after 2 months, 5 months and sometimes 7 months of treatment.
- If the symptoms do not improve, or the repeat sputum smears are positive, cultures will be needed to check for drug resistant TB.

Minor side effects of TB treatment are nausea and abdominal pain, joint pain and burning pain in the feet.
Patients should be warned that Rifampicin causes the urine to become bright orange.
More serious side effects are:

- severe skin rashes
- dizziness
- vomiting
- deafness
- jaundice
- confusion

The Importance of Adherence to Treatment

What is adherence?

Adherence is a word that we are very familiar with from HIV!
It means taking your drugs exactly as they are prescribed:

- taking all doses
- taking treatment regularly
- finishing the full course of treatment

Why do people stop taking treatment?

- They feel better and think they do not need the treatment any longer.
- They are experiencing side effects.
- They cannot get to the clinic to collect their treatment.
- They move away to another area to stay or work and there is no clinic nearby.
- TB treatment is very long. It can be difficult to remain on treatment for many months.
- If they are using alcohol or street drugs, it is difficult to stick to TB treatment.

What happens when people stop taking their TB medicines?
When you do not take your medicines properly, then the TB in your body may become resistant to the medicines. This can make you very ill, and make the TB very difficult to treat.

You may be contagious and be a danger to the people around you.
If you are taking TB treatment, adherence is the best way to protect yourself and the people around you.

Support for patients on TB treatment, and their families, is very important. Mentor mothers can help by providing emotional support, encouragement and giving information when needed.

SESSION 19: Drug Resistant TB (MDR & XDR)

Time required: 45 minutes

Purpose

- The purpose of this session is for MM's to learn how drug resistant TB comes about and about its diagnosis and treatment.

Objectives

- At the end of this session, MM will:
  - Know the two kinds of drug resistant TB.
  - Understand how a person gets drug resistant TB.
  - Understand the critical importance of identifying and treating MDR and XDR correctly.

Materials

- PowerPoint slides
- Board/flipchart and paper
- Markers

Lecture/Discussion: MDR and XDR 45 minutes

LECTURE CONTENT: Drug Resistant TB (MDR & XDR)

What is drug-resistant TB?

Drug resistant tuberculosis means that some of the strongest TB drugs cannot fight the TB bacteria in your body. Drug resistant tuberculosis is a very serious problem in South Africa. It is one of the major reasons TB is such a crisis in this country. We must understand drug-resistant TB so we can get control of this problem and prevent it from becoming worse.

Why does drug resistance happen?

TB becomes resistant to treatment if people do not adhere to their treatment, or if the incorrect treatment is given. As long as poor adherence continues, the problem of drug resistance will only get worse. There is treatment for drug-resistant TB, but this treatment is long and very expensive, which again makes adherence difficult. **Treatment for drug resistant TB is not always successful.**

Forms of drug-resistant TB

There are two forms of drug-resistant TB, Multi-Drug Resistant TB (MDR-TB) and Extensively Drug Resistant TB (XDR-TB). Both are a serious problem in South Africa.

MDR-TB: MDR-TB is a form of TB bacteria that is resistant to the two strongest anti-TB drugs – Isoniazid and Rifampicin. MDR-TB is very difficult to treat.

XDR-TB: XDR-TB is a form of TB bacteria that is resistant to Isoniazid, Rifampicin, **and** other antibiotics used to treat MDR TB. This means that XDR-TB is TB bacteria that cannot be treated with the most powerful first line and second line TB antibiotics. This leaves very few options for effective treatment.

How common is MDR-TB?

In South Africa there are about 15,400 new cases of MDR-TB every year.

How do you get drug resistant -TB?

There are two ways of getting DR-TB.

1. Primary resistance

Just like regular TB, DR-TB gets into the air when someone sick with DR-TB coughs or sneezes and releases droplets filled with DR-TB. When you inhale air filled with DR-TB particles, the bacteria enter your body and you become infected with DR-TB.

2. Acquired or secondary resistance

Acquired resistance occurs when TB drugs are not taken properly, and the TB bacteria in your body mutate and become drug-resistant. Acquired resistance is the result of poor adherence.

Signs and symptoms of DR-TB

DR-TB and regular TB have the same symptoms mentioned above. This makes it difficult for healthcare workers to tell the difference between TB and DR-TB, but there are some other reasons to consider DR-TB.
If you have symptoms of TB, you should suspect MDR-TB if you:

- Have been around someone with DR-TB;
- Have been treated for TB before and did not take your treatment properly;
- Taking regular treatment for first time TB and do not start to feel better after one month;
- Taking first-line treatment and do not become smear-negative after two to three months

Diagnosing MDR-TB and XDR-TB

DR-TB is diagnosed by culture tests or the GeneXpert test. Culture tests take anywhere from 6-16 weeks to give results. This is a very long time, especially if you have a weak immune system. GeneXpert takes 2 days, but is not available in all areas yet.
If you have any of the reasons to suspect drug resistant TB you should tell your healthcare worker right away.

Curing MDR is very difficult

MDR can be cured, but the treatment regimen is very long and very expensive. Treating MDR-TB costs 25 times the amount it costs to treat regular TB. Treating MDR-TB requires several drugs that are less effective than the first line medication and much more toxic, which means there are more side effects. The regimen used to treat MDR-TB is called the second line regimen. Ideally, all patients with MDR-TB should be admitted to hospital for the intensive phase of treatment.

Treating MDR

Adhering to treatment is essential! Not adhering to the regimen means:

- More sickness and death;
- More people getting MDR-TB;
- Lots of money spent on expensive antibiotics and tests;
- XDR and more resistant TB

Treating XDR-TB is very difficult

XDR-TB can be cured in up to 30% of cases. That means **7 out of 10 cases cannot be cured**. The WHO reports that countries with good TB control programmes have been able to cure six out of every ten XDR-TB cases. But six out of ten is not ten out of ten, which means that even good TB programmes are not always successful. This is because XDR is almost impossible to cure in places with lots of HIV and little resources. There is no standard treatment regimen for XDR-TB. How XDR is treated depends on which TB antibiotics the TB bacteria in your body are resistant to. This means if you suspect XDR-TB, drug susceptibility tests need to be done right away. Whether treatment works depends on:

- The antibiotics the TB is resistant to;
- If you are HIV-positive;
- The severity of the disease

XDR-TB is very difficult to cure in people who are HIV-positive.

Isolation

If you have XDR-TB, you are carrying a deadly disease that is transmitted through the air and is basically not treatable. This makes you a very serious danger to yourself and your community. To prevent you from spreading XDR-TB to your community it is likely that your clinic or TB hospital will isolate you or put you in quarantine. You will probably be kept in hospital for at least 6 months. While in quarantine the hospital will be able to monitor your treatment and hopefully stop you from spreading XDR-TB to anyone else.

SESSION 20: TB in Home Visits

Time required: 1 hour

Purpose

- The purpose of this session is to prepare MM for how TB is to be handled in home visit situations.

Objectives

- At the end of this session MM will:
  - Know how to approach TB during home visits.
  - Know what to say to mothers depending on the different circumstances of the household, and on how much the mother being visited knows or does not know about TB.

Materials

- Powerpoint slides
- Board/flipchart and paper
- Markers
- Philani Mentor Mother Training DVD

Discussion: TB in Home Visits — 20 minutes

TB IN HOME VISITS

Ask if the pregnant mother or anyone else in the household is on TB treatment.

<u>If the mother is on TB treatment</u>

- Find out if she has told the doctor or sister at the TB clinic that she is pregnant to make sure the treatment she is taking does not hurt her baby.
- Ask about side effects.
- Discuss importance of adherence and encourage the mother.
- If the treatment will continue after the birth of the child discuss feeding options, and explain that the baby may need INH prophylaxis.
- Ask if she has tested for HIV, and encourage her to do so if she hasn't.

<u>If someone else in the household is on TB treatment</u>,

- Find out if the mother and other family members (especially children) have been tested for TB and put onto prophylactic TB treatment.

<u>If the mother is HIV positive and has not tested for TB</u>

- Encourage her to do so, especially if her CD4 count is low.

<u>If the mother is HIV positive and on TB treatment</u>,

- Find out how much the mother knows about the relationship between HIV and TB and fill in any gaps in knowledge.
- Ask about CD4 counts and plans about ARV treatment.
- Explain interaction between TB drugs and ARV's.

<u>If no one in the household is on TB treatment</u>

- Find out what the mother knows about TB, ask if she or anyone else in the household has symptoms of TB like cough, weight loss, night sweats etc., and refer for TB screening if necessary.

DVD Session: TB in Home Visits — 20 minutes

The trainers will guide this session.

Role Plays: Tuberculosis 20 minutes

Scenarios

Role Play 1

MM: You are doing a follow-up visit to a mother who is in early pregnancy. She also has TB and is on treatment at the clinic. She is very worried about her 4 year old child who is sick. When you enter the home, you see the sick child, who looks thin and small.

Dunyiswa: You are 3 months pregnant. You have also been diagnosed with TB recently, and have started TB treatment at the clinic. The treatment was started before you knew you were pregnant.
You are also worried about your 4 year old child who is sick. He has been coughing for 2 weeks, and is very sweaty and hot at night. He has no appetite.

Role Play 2

MM: In this role play, you want to discuss TB with a mother. (She does not have TB.) Find out how much she knows about TB. Talk to her about the symptoms of TB; how to protect children from getting TB; and the importance of taking treatment correctly, and what happens if people do not take their TB treatment.

Nwabisa: After visiting for a while, your mentor mother starts a discussion about TB. You know about TB because you sister's husband had TB a few years ago. You remember that he had a bad cough that wouldn't go away; night sweats; and he lost a lot of weight. He was ill for a long time before he got treatment. But, he eventually got better. You know he was cured because he had to test his sputum when the treatment was finished, to make sure that the TB was gone.

SECTION I
LABOUR AND DELIVERY

SESSION 21: The Process of Labour and Delivery

Time required: 30 minutes

Purpose

- The purpose of this session is to explain the process of normal labour. This will help the MM in identifying danger signs during labour and delivery and assisting the mother to get urgent care.

Objectives

- At the end of the session the MM will be able to:
  - Explain how one knows when labour starts.
  - Explain in general terms what happens during labour and delivery.

Materials

- Illustrations of pregnancy and the birth process (MM Manuals)
- Video

Presentation and discussion: Labour and delivery 20 minutes

Three Stages of Labour

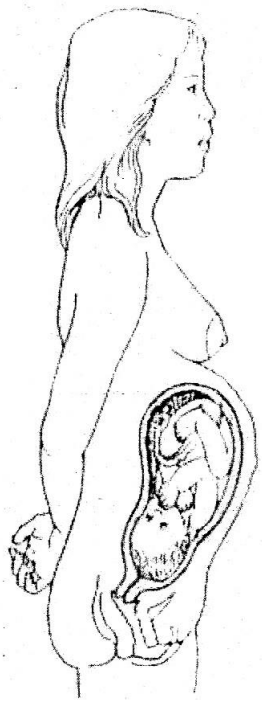
1st Stage: Starts from the beginning of regular pains until the mouth of the womb is fully open. This happens inside the mother's body and cannot be seen.
The bag of waters also breaks. The fluid is usually clear but may be yellow or green or red. *This first part of labour usually lasts about 8 to 12 hours*.

2nd Stage: Contractions push the baby out of the womb, resulting in the delivery of the baby. *This second part of labour usually lasts about 1 hour*.

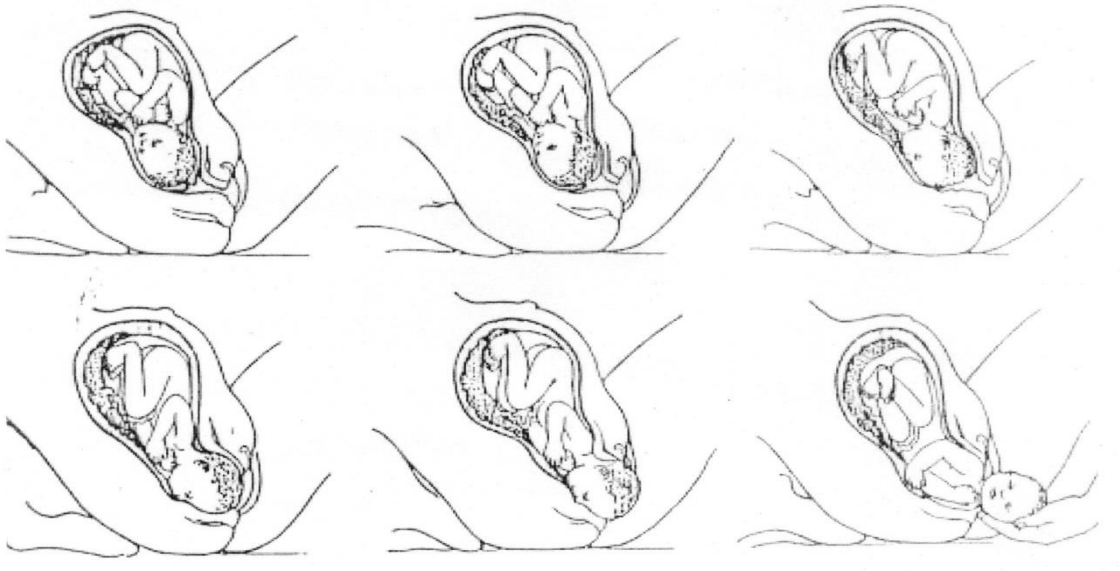
3rd Stage: The contractions cause the placenta to peel off. This is called delivery of the placenta. *This third part of labour usually lasts about 20 to 30 minutes.*

Illustrations of Pregnancy and the Birth Process
From *The Childbirth Picture Book* by Fran Hosken and Marca Williams, Women's International Network News

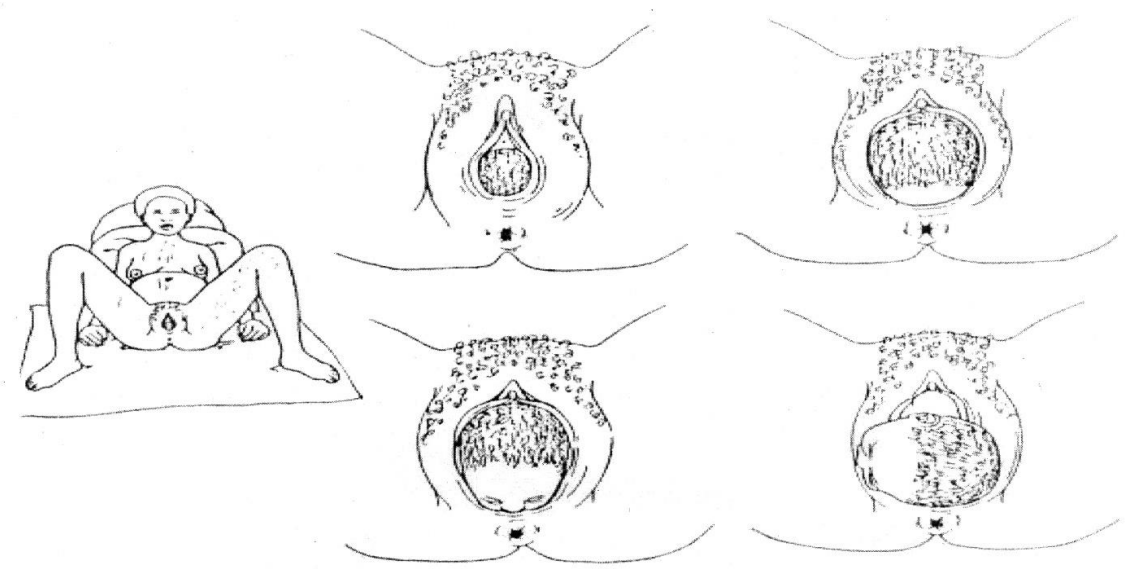
Pregnant Woman Full Term



Process of delivery



How the baby delivers in normal (head) position



For the mother

- 2 large pack of sanitary towels
- 1 roll of toilet paper
- 1 face cloth
- Toothbrush
- Toothpaste
- 1 towel
- 1 bar of soap
- 3 to 4 pairs of panties
- Something to eat and drink
- Pajama's
- Something to eat and drink
- Maternity Case Record
- ARV medication (if HIV positive)

For the baby

- 1 pack of disposable nappies
- 1 face cloth
- 1 bar of baby soap
- 2 baby blankets
- Baby clothes
- Cotton wool

Discussion: Immediate care of a newborn — 5 minutes

If the baby is breathing normally, give the baby to the mother immediately. Put the baby on the mothers' bare chest (skin to skin) and wrap them both in a blanket to keep warm. Ideally breastfeeding should start within the first 30 minutes after delivery. Mother and baby should not be separated from each other unless there is a medical reason. This is known as "rooming in".

Presentation and discussion: Danger signs in labour — 5 minutes

For the mother:

- Excessive bleeding
- Fits or convulsions
- Prolonged Labour
- Retained Placenta
- Baby's hand, foot or cord come out before the head

For the baby:

- Does not breathe or cry at delivery (or weak cry)
- Born very small

SECTION J
INFANT FEEDING

SESSION 22: Your Own Beliefs about Feeding

Time required: 1 hour

Purpose

- The purpose of this session is for MM's to explore their own knowledge and beliefs about breastfeeding and the way that they communicate with others about the issue.

Objectives

- At the end of this session MM's will:
  - Understand their own beliefs about infant feeding.
  - Be able to relate their own beliefs to broader community traditions and beliefs.
  - Be able to openly speak about their own beliefs about infant feeding.
  - Be willing and open to hear the facts about infant feeding so that they can save newborn lives.

Material

- MM manuals

Individual Reflection: Your beliefs about breastfeeding 30 minutes

- Before you can assist women to exclusively breastfeed you need to examine your own beliefs about breastfeeding and address your own concerns.
- Listen to the mother and learn about her concerns before you try to help her.
- A mother will only exclusively breastfeed is she has the confidence to do so and if she believes that this is the right thing to do.

Exclusive breastfeeding

Exclusive breastfeeding means that the baby is fed only breast milk – either directly from the breast or expressed breast milk.
Exclusive breastfeeding is recommended during the first 6 months of life.

Medicine, multivitamin drops or syrup prescribed by a nurse or doctor is allowed. Sugar salt solution given for diarrhoea is allowed.

The baby does not receive:

- water
- other drinks (e.g. juice, tea)
- solid or semi-solid foods
- traditional medicines
- remedies bought at the pharmacy without a prescription from the doctor or nurse.

Exclusive breastfeeding is better than mixed feeding, as it reduces the rate of infections in the baby.

You will learn more about how HIV-negative and HIV-positive women should feed their babies later in this chapter.

Brainstorming activity: Beliefs about breastfeeding 30 minutes

The trainers will guide this session.

SESSION 23: Communication Skills and Counselling to Support Appropriate and Safe Infant and Young Child Feeding

Time required: 2 hours 30 minutes

Purpose

- The purpose of this session is to familiarise the participants with the listening, learning and confidence building skills that can be used to support appropriate and safe infant feeding.

Objectives

- At the end of this session MM's will be able to:
  - Understand the counselling skills that should be used to support women.
  - Use these skills to counsel women so that they feed their children appropriately and safely.

Material

- MM manuals

Key points to remember during this session:

- Good communication and counselling skills are essential to build a mother's confidence.
- Listen to the mother and learn about her concerns before you try to help her.
- A mother will only exclusively breastfeed if she has the confidence to do so and if she believes that this is the right thing to do.
- Counselling and support for a woman's infant feeding choice is one of a MM's main responsibilities.

Activity: Your communication skills 30 minutes

The trainers will guide this session.

Are you married? **Yes/No**

Have you ever been married? **Yes/No**

Do you have a partner? **Yes/No**

What is your main activity during the day?

How many times have you been pregnant?

How many live children have you given birth to?

How many of your children are alive today?

How do you want to feed your baby during the next 4-6 weeks?

Are you planning to give any other liquids (such as tea, water, juice or gripe water to your baby?) **Yes/No**

During pregnancy did you ever discuss with anyone at the clinic what the best way for you to feed your baby is? **Yes/No**

Have you ever been tested for HIV? **Yes/No**

Have you ever discussed your HIV status with anyone? **Yes/No**

What is the main source of water that you use for drinking?

How long does it take you to go to your nearest hospital? **? hours**

Have you given your baby any breast milk since he/she was born? **Yes/No**

In the past 4 days have you given the baby any other liquids? **Yes/No**
What liquids did you give him/her?

Discussion: Communication skills 30 minutes

The trainers will guide the discussion.

Discussion: Counselling 25 minutes

Counselling means more than advising.
Counselling is a helping relationship. When you counsel a mother, you

- listen to her,
- help her to understand the choices that she has to make,
- help her to decide what to do, and
- help her to develop confidence to carry out her decisions.

Counselling is helping people identify the small steps they can take to change their behaviour.

- As a Mentor Mother you should NOT make a decision for a woman, or push her towards a particular course of action.
- As a Mentor Mother you need to accept that a woman may find it difficult to implement her feeding decision. She may have many concerns and may need to discuss issues with other family members. You will need to support and assist women through this process.

IMPORTANT: Remember that as a Mentor Mother you cannot take away all a woman's worries, and you are not responsible for her decisions. You are supporting her to implement her decision.

The principles of counselling must always be observed during your visits.
- Confidentiality,
- Acceptance of the mother,
- Individualisation of her circumstance,
- Non-judgmental attitude,
- Control of your own involvement

Role-play: Counselling and Communication skills 40 minutes

Scenario 1:

Mother: You are 24 years old. This is your first baby. He is 1 month old. You are HIV negative and have been breastfeeding your baby. You are worried that your baby is crying too much. Your mother-in-law says that the baby is hungry and that you should start giving him some weak porridge. You are confused and want to speak to the Mentor Mother about this. You are upset and start crying.

Mentor Mother: This is your first day at work, so you are a little nervous and don't make eye contact. The mother sits opposite you. There is a table in between the 2 of you. You are surprised when she starts crying. You sit still, or move backwards. Half way through the session your cellphone rings, you answer it and then rush to leave the house.

- Helpful non-verbal communication:
  - Keep your head level
  - Use appropriate eye contact
  - Pay attention
  - Remove barriers (e.g. a table between you and the mother)
  - Take time
  - Touch appropriately
- Ask open questions
- Use responses and gestures, which show interest

(e.g. nod, smile, say "Aha" or "Mmm")

- Reflect back what the mother says
- Empathise – show that you understand how she feels
- Avoid judging words

REMEMBER: A mother will only exclusively breastfeed is she has the confidence to do so and if she believes that this is the right thing to do. The counselling and support you give will build the mother's confidence.

Building confidence and giving support

- Accept what a mother thinks and feels
- Recognise and praise what a mother and baby are doing right
- Give practical help
- Give a little, relevant information
- Use simple language
- Make one or two suggestions, not commands

Scenario 2:

Mentor mother:
Replay the same role play, but this time sit, next to the mother. Try to use the counselling skills you have learnt. Show the mother affection when she starts crying. When you cell phone rings you switch it off and continue listening to the mothers concerns. Ask if the mother would like you to speak with her and her mother-in-law.

Activity: Practising Counselling Skills 1 hour

1. **Open ended questions**

Questions 1-4 are “closed” which means that it is easy to answer 'yes' or 'no'. Rewrite a new 'open' question, which requires the mother to tell you more.

'Closed question'	'Open question'
Do you breastfeed your baby?	How are you feeding you baby?
To answer:	
1. Does your baby sleep with you?	
2. Are you often away from your baby?	
3. Does Sara eat porridge?	
4. Do you give fruit to your child often?	

2. Sometimes it is helpful to ‘**reflect back**’ what a mother has said. It may encourage her to explain further. Look at the following statements. Statements 1-3 are some things that mothers might tell you. Underneath are three responses. Choose the response that 'reflects back' what the statement says. For statement 4, make up your own response which 'reflects back' what the mother says.

Example:
My mother says that I don't have enough milk.
a) Do you think you have enough milk?
b) Why don’t you have enough milk?
c) She says that you have a low milk supply?

Minentle does not like to eat thick porridge.
a) Minentle does not seem to enjoy thick porridge?
b) What foods have you tried?
c) It is good to give Minentle thick foods as he is over six months old.

He doesn't seem to want to suckle from me.
a) Has he had any bottle feeds?
b) How long has he been refusing?
c) He seems to be refusing to suckle?

I tried feeding him a bottle, but he spat it out.
a) Why did you try using a bottle?
b) He refused to suck from a bottle?
c) Have you tried to use a cup?

My husband says our baby is old enough to stop breastfeeding now.

3. Statements 1-4 are things that mothers might say. Underneath the statements are three responses that you might make. Underline the words in the mother's statement which shows something about how she feels. Choose the response that is most **empathetic.**

For stories 5 and 6 underline the feeling words, then make up your own empathising response.

Empathising – to show that you understand how she feels.

Example:
My baby wants to feed so often at night that I am <u>exhausted</u>.
a. How many times does he feed altogether?
b. Does he wake up every night?
c. You are really tired with the night feeding.

Jabu has not been eating well for the past week. I am very worried about him.
a. You are anxious because Jabu is not eating?
b. What did Jabu eat yesterday?
c. Children often have times when they do not eat well.

My breast milk looks so thin – I am afraid it is not good.
a. That is the foremilk – it always looks rather watery.
b. You are worried about how your breast milk looks?
c. Well, how much does the baby weigh?

I feel there is no milk in my breasts, and my baby is a day old already.
a. You are upset because your breast milk has not come in yet.
b. Has he started suckling yet?
c. It always takes a few days for breast milk to come in.

I am anxious that if I breastfeed I will pass HIV on to my baby.
a. I can see you are worried about breastfeeding your baby.
b. Would you like me to explain to you how the HIV virus is passed from mothers to babies?
c. What have you heard about other options for feeding your baby?

Andiswa brings Sinovuyo to see you. He is nine months old. Andiswa is worried. She says, “Sinovuyo is still breastfeeding and I feed him three meals a day, but I am so upset, he still looks so thin”.

What would you say to Andiswa to empathise with how she feels?

You visit with Abongile. She is pregnant with her first baby and has found out that she has HIV. She says, “I am so frightened that my mother-in-law might find out”.

What would you say to Abongile to empathise with how she feels?

4. **Using non-judgemental words**

Sometimes, we use words which can make a mother feel that we are judging her. All the words in this table can be "judging words".

JUDGING WORDS			
Well	Normal	Enough	Problem
Good Bad Badly	Correct Proper Right Wrong	Adequate Inadequate Satisfied Plenty of Sufficient	Fail Failure Succeed Success

Fill in the table below. Look at the 'judging word' and find a similar word in your language. Then, try to rewrite the question in a non-judging way.

USING AND AVOIDING JUDGING WORDS			
English	Local language	Judging question	Non-judging question
Well		Doe she suckle well?	
Normal		Are his stools normal?	
Enough		Is he gaining enough weight?	
Problem		Do you have any problems breastfeeding?	

SESSION 24: The Importance of Breastfeeding and the Composition of Breast milk

Time required: 2 hours

Purpose

- The purpose of this session is for participants to understand the importance of breastfeeding and the composition of breast milk.

Objectives

- At the end of this session MM's will:
  - Understand the importance of breastfeeding.
  - Know the composition of breast milk.
  - Understand the risks of not breastfeeding.

Material

- PowerPoint slides
- MM manuals

- Breast milk alone has all that a baby needs to grow during the first 6 months of life.
- Breast milk protects a baby against infection.
- Exclusive breastfeeding has many more benefits than mixed feeding or formula feeding.

LECTURE CONTENT: Breastfeeding 2 hours

Why is breastfeeding important?
Write down the responses.

Exclusive breastfeeding has been identified as the single most effective way of saving the lives of young children in developing countries.

Write the word BREASTFEEDING vertically on a flip chart. Ask participants to use each letter to think of an **advantage of breastfeeding**.

e.g.
B – best for baby
R – reduces illness
E – easy to digest
A - antibodies
S - saves lives
T – temperature is right
F - free
E - emotional bonding
E – environmentally friendly
D – delays pregnancy
I – iron and vitamins
N - nutrients
G – good growth of baby

There are many advantages to breastfeeding:

- Breast milk provides ideal nutrition for the baby.
- Breastfeeding contains antibodies that protect against many infections.
- Breastfeeding provides closeness and contact between the mother and her baby that helps psychological development.
- Breast milk is always available! It is convenient and requires no preparation.

- Breastfeeding is free. The family will not have to spend money on formula milk and fuel, leaving money to buy food for other members of the family.

Advantages of breastfeeding for the mother:

- Early initiation of breastfeeding (soon after delivery) reduces post-delivery bleeding.
- Helps the womb to return to pre-pregnancy position.
- Helps to the mother lose the pregnancy weight.
- Breastfeeding delays the return of mothers' fertility helping to space the next pregnancy.
- She is less likely to become anaemic after childbirth.
- She is less likely to develop cancer of the ovary, uterus and breast.
- She also has a lower risk of developing high blood pressure, diabetes and heart disease.

Breast milk is called a "**living fluid**". Ask participants what they think this means. Explain that the composition of breast milk is not always the same.
It varies:

- according to the age of the baby
- from the beginning to the end of a feed
- between feeds and at different times of the day.
- when the mother is exposed to infections (antibodies are made and protect the baby)
- if the weather is hot, the breast milk will contain more water for the baby's needs.

Breast milk has all that a baby needs to grow and develop during the first 6 months of life.

Breast milk contains:

Fat	Provides energy for growth. Needed for a baby's growing brain and eyes, and for healthy blood vessels
Protein	Building blocks for growth. Human protein is very easy for babies to digest. Anti-infective proteins help to protect a baby against infection.
Lactose	A sugar that provides energy for growth.
Lipase	Helps digest fat (not present in animal milks or formula). The fat in breast milk is more completely digested and better used by a baby's body than the fat in cow's milk or formula.
Vitamins	Contains plenty of vitamin A, B and C.
Iron	Helps the blood carry oxygen. More easily absorbed in breast milk. Baby is protected from iron deficiency anaemia until at least 6 months of age.

Formula milks are made from a variety of products, including animal milks (such as cow's milk), soybean, and vegetable oils. They are less perfect for babies and do not contain certain important substances found in breast milk.

How breast milk protects babies against infections?

- Breast milk is not just a food for babies. It is a living fluid. It protects babies against infections.
- For the first year or so of life, a baby's immune system is not fully developed, and cannot fight infections so a baby needs to be protected by his mother.
- Breast milk contains anti-infective proteins, which help to protect a baby against infection. Breast milk also contains antibodies against infections, which the mother has had in the past.
- Research has shown that breast milk protects against **diarrhoea, ear infections, meningitis and chest infections**.
- The protective effect of exclusive breastfeeding is decreased when other fluids/ feeds are added to the baby's diet.

- Artificial feeds (formula milk) do not contain living substances (antibodies and anti-infective proteins) and so provides much less protection against infection.
- A baby should not be separated from his mother when she has an infection or when the baby is sick, because her breast milk protects him against the infection.

What colostrum is?

- Colostrum is the special breast milk that women produce in the first few days after delivery.
- It is thick and yellowish in colour
- Colostrum contains more protein than later milk.

Read the following 3 statements about colostrum. Ask participants their responses to these statements, and allow 5 minutes for discussion.

1. Colostrum is the best part of the mother's milk
2. Colostrum is not good for the baby and should be discarded
3. Colostrum is the same as milk that comes later on.

Ask participants what the **common beliefs about colostrum in their community are?**

- Colostrum is very good for the baby. It should not be thrown away.
- Colostrum is the baby's first immunisation.
- Colostrum contains more antibodies and anti-infective proteins than mature milk.
- Colostrum has a mild cleansing effect. It helps to clear the baby's gut of meconium (the first rather dark stools). This helps to prevent jaundice (yellowness).
- Colostrum contains substances called growth factors, which help a baby's immature intestine to develop after birth. This helps to prevent the baby from developing allergies and intolerance to other foods.
- Colostrum is rich in vitamin A which helps to reduce the severity of any infections the baby might have.
- Colostrum is ready in the breasts when a baby is born. It is all that babies need before the mature milk comes in.

Babies should not be given any drinks or foods before they start breastfeeding.

After a few days, colostrum changes into mature milk. There is a larger amount of milk, and the breasts feel full, hard and heavy. Some people call this the milk `coming in'.

Mature milk

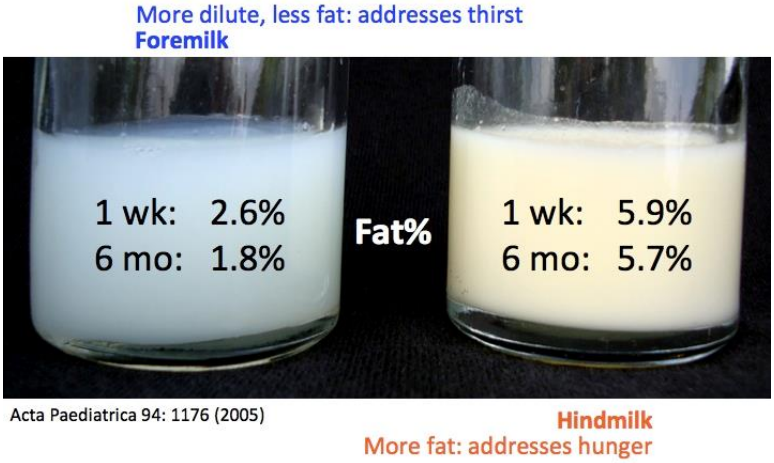
There are two types of mature milk: **foremilk** and **hindmilk.**

Foremilk:

- bluish milk that is produced early in a feed
- produced in larger amounts
- provides plenty of protein, lactose, and other nutrients.
- contains all the water that the baby needs. Babies do not need other drinks of water before they are 6 months old, even in a hot climate. If they satisfy their thirst on water supplements, they may take less breast milk.

Hindmilk:

- the whiter milk that is produced later in a feed
- contains more fat than foremilk which makes it looks whiter
- provides more energy and makes the baby full.



It is important not to take a baby off a breast too quickly. He should be allowed to continue until he has had all that he wants, so that he gets plenty of fat-rich hindmilk.

Mothers sometimes worry that their milk is `too thin'. This is because foremilk is clear or bluish in colour. It is important for a baby to have both foremilk and hindmilk to get a complete `meal' and all the water that he needs.

What are the disadvantages of artificial feeding?

Disadvantages of artificial feeding:

- A baby who does not receive any breast milk has a higher risk of becoming ill with diarrhoea, respiratory, ear, and other infections.
- Diarrhoea may become persistent if babies are intolerant of animal milk.
- He is also more likely to develop allergic conditions such as eczema and asthma.
- A baby receiving formula milk (no breast milk at all) is more likely to die from infections and malnutrition than a breastfed baby.
- He may become malnourished, because he gets too few feeds, or because the feeds are not measured correctly.
- He is more likely to suffer from vitamin A deficiency.
- The risk of some chronic diseases in the child, such as diabetes, is also increased.
- Formula fed babies have a higher risk of obesity in later life.
- Bottle feeding may interfere with bonding.
- There is a lot of work involved in washing and sterilising bottles, and preparing bottles.
- Formula is expensive.

SESSION 25: Helping a Mother Position and Attach her Baby for Breastfeeding

Time required: 1 hour and 15 minutes

Purpose

- The purpose of this session is to give participants the skills so that they can help a mother position and attach the baby for breastfeeding.

Objectives

- At the end of this session MM's should be able to:
  - Help a mother position herself as she puts the baby to the breast.
  - Help a woman to attach her baby correctly to the breast.
  - Identify poor attachment.

Material

- PowerPoint slides
- MM manuals

Lecture/Discussion: Positioning a baby for breastfeeding

30 minutes

- Always observe a mother breastfeeding before you try to help her position and attach her baby.
- Take time to see what she does so that you can understand her situation clearly.
- Good positioning ensures that the mother is comfortable and the baby breastfeeds well. Breast milk has all that a baby needs to grow and develop during the first 6 months of life.

Many mothers and babies are able to breastfeed easily. But some need help. There are some things that a mother and baby have to learn:

- A mother has to learn how to position her baby, so that he can attach well.
- A baby has to learn how to take the breast into his mouth to suckle effectively.

Different positions that can be used for breastfeeding

There are many different positions that the mother can use when breastfeeding. In any position, it is important for:

- the baby to take enough breast tissue into his mouth so that he can suckle effectively.
- the mother to be comfortable, with her back supported. If she is sitting up, it is helpful to have pillows supporting her arm, so that she does not lean forward.

Look at the pictures below so that you learn about some of these positions.

a) Cradle position

b) Cross-cradle position

c) Football or underarm position

d) Lying down position

- The football position is useful for mothers who have a forceful flow of milk; and mothers who have twins.

- The Football and lying down positions are both useful for mothers who have had a Caesarian delivery, as it removes pressure from the wound.

How to help a mother to position her baby

Greet the mother and ask how breastfeeding is going.
Ask the mother to show you how she breastfeeds.
Assess a breastfeed.
Explain what might help, and ask if she would like you to show her.
Make sure that she is comfortable and relaxed.
Sit yourself down in a comfortable position.
Explain how to position her baby, and show her if necessary.
The four key points of positioning are to hold the baby:

- head and body straight; facing the mother's breast
- his nose facing her nipple
- his body close to her body (tummy to tummy)
- his whole body supported, not just his neck and shoulders

Lecture/Discussion: Positioning a baby for breastfeeding
30 minutes

When a baby is well attached, he removes breast milk easily, and it is called effective suckling.

There are three main reflexes which happen automatically without the baby having to learn them:

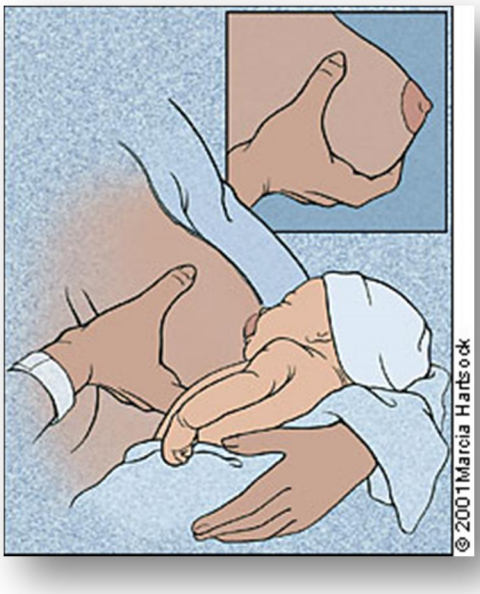
Rooting reflex	When something touches a baby's lips or cheek, he opens his mouth and may turn his head to find it. He puts his tongue down and forward.
Sucking reflex	When something touches a baby's palate, he starts to suck.
Swallowing reflex	When his mouth fills with milk, he swallows.

Offering the breast

Show her how to support her breast (C-hold):

- her fingers against her chest wall below her breast
- her first finger supporting the breast
- her thumb above

Her fingers should not be too near the nipple.



Explain or show her how to help the baby to attach:

- touch her baby's lips with her nipple
- wait until her baby's mouth is wide open
- move her baby quickly onto her breast,
- aim his lower lip below the nipple

Notice how she responds and ask her how her baby's suckling feels.

Look for signs of good attachment.

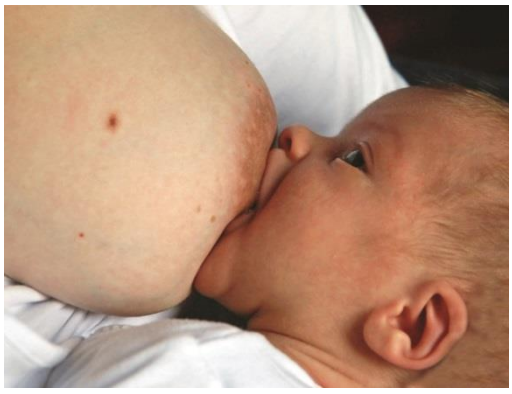
Attaching baby to the breast

- Good attachment prevents sore nipples or cracked nipples and increases milk production.
- It is important for the baby to be well attached to the breast for effective suckling to take place.

Mentor mothers need to be able to identify good and poor attachment when helping mothers to successfully initiate and sustain exclusive breastfeeding.

Rooting reflex – baby opens mouth wide

Attachment: What you see from the outside



Picture 1: Good attachment

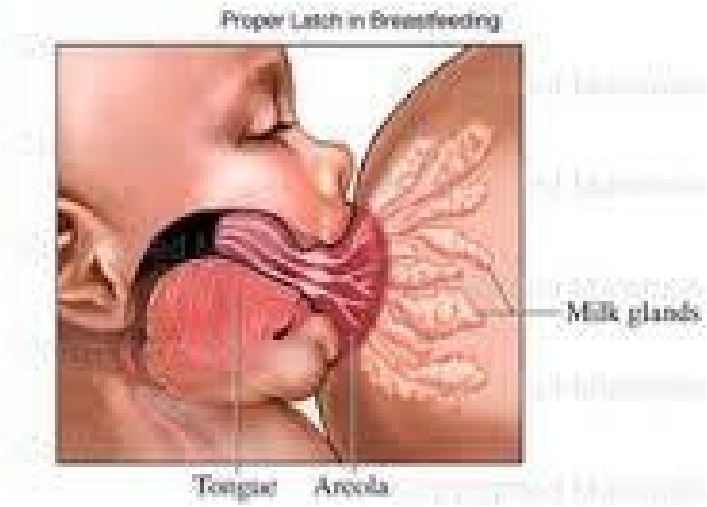
Picture 2: Poor attachment

What differences do you see between pictures 1 and 2?

Picture 1	**Picture 2**
The baby's chin touches the breast.	The baby's chin does not touch the breast.
His mouth is wide open.	His mouth is not wide open, and it points forwards.
His lower lip is turned outwards.	His lower lip is not turned outwards.
You can see more of the areola above his mouth and less below. This shows that he is reaching with his tongue under the milk ducts to press out the milk.	You can see the same amount of areola above and below his mouth, which shows that he is not reaching the milk ducts.

Make sure that participants understand and see the differences between pictures 1 and 2.

Attachment: What happens on the inside



The baby has the nipple well inside his mouth.

Show that the milk ducts are situated under the areola (they collect milk from the milk glands). The baby presses the milk ducts with his tongue, to release the milk.

If a baby is well attached, you also notice effective suckling – that is, slow deep sucks, sometimes pausing; and you may hear swallowing.

Always assess and observe a breastfeed, especially on a newborn baby, to observe attachment.

Poor attachment

- Can make it seem as though a mother is not producing enough milk. In other words she has an apparent poor milk supply. Then, if the situation continues, her breasts may really make less milk.
- Can cause sore or cracked nipples.

Common mistakes that arise when breastfeeding

Holding the baby incorrectly	• too high (sitting with knees too high) • too low (with the baby unsupported, so mother has to lean forward) • too far to one side (putting a small baby too far out in the 'crook' of the arm, instead of the forearm)
Offering the breast incorrectly	• holding the breast with fingers and thumb too close to the areola; • pinching the nipple or areola between your thumb and fingers, and trying to push the nipple into the baby's mouth; • holding the breast in the 'scissors' or 'cigarette' hold.
Holding the breast back from the baby's nose with a finger	• This is not necessary, and can pull the nipple out of the baby's mouth. A baby can breathe well without the breast being held back. • If the mother is worried that the baby is too close to the breast, she can push the baby's buttocks towards her to free the nose.

Practical tips:

- Always observe a mother breastfeeding before you try to help her and give help to a mother only if she has difficulties.
- If the baby is suckling effectively and the mother is comfortable, there is no need to change anything. Some mothers and babies are comfortable in positions that would make breastfeeding difficult.
- Help a mother position her own baby. It does not help if you can get a baby to suckle if the mother will not be able to do it herself.
- Be careful not to 'take over' from her and explain what you want her to do.
- If possible, demonstrate on your own body to show her what you mean.

Group discussion: What causes poor attachment 15 minutes

Why does the use of a feeding bottle cause poor attachment?

Answer:

What support does the mother need to latch a baby correctly? Why would a lack of skilled support cause poor attachment?

Answer:

SESSION 26: How to Assess a Breastfeed

Time required: 1 hour and 45 minutes

Purpose

- The purpose of this session is to teach participants how to effectively assess a breastfeed, and support a mother who is having problems breastfeeding.

Objectives

- At the end of this session MM's should be able to:
  - How to observe and assess a breastfeed.
  - How to assist a mother who is having difficulty breastfeeding.

Material

- PowerPoint slides
- MM manuals

Group discussion: How to Assess a Breastfeed 30 minutes

How to Assess a Breastfeed
(a) Observe the baby.
(b) Observe how baby responds.
(c) Observe how the mother puts her baby on her breast?
(d) Observe how the mother holds her breast during a feed?
(e) Does the baby look well attached to the breast?
(f) Is the baby suckling effectively?
(g) How does the breastfeed finish?
(h) Does the baby seem satisfied?
(i) What is the condition of the mother's breasts?

> If a mother feels good about breastfeeding, and if her baby is positioned so that he can suckle effectively, exclusive breastfeeding is likely to be successful.

(a) **Observe the baby**
Look at his general health, alertness and growth.
Look for signs of conditions which can interfere with breastfeeding such as:

- blocked nose
- difficulty breathing
- thrush
- jaundice
- dehydration
- tongue tie
- cleft lip or palate.

(b) **Observe how baby responds**

- If the baby is young: rooting for the breast when he is ready for a feed. He may turn his head from side to side, open his mouth, put his tongue down and forward, and reach for the breast.
- If the baby is older: turning and reaching for the breast with his hand.

Both these responses show that a baby wants to breastfeed.

- If the baby cries or pulls back or turns away from the mother, it shows that he does not want to breastfeed, and that there may be a problem with breastfeeding.

- Feeding outcomes:

Baby is calm during a feed and relaxed and content after a feed	getting breast milk appropriately
Baby is restless and slips off the breast or refuses to feed	not well attached not getting the breast milk mother may be tempted to give other foods or drinks to the baby

(c) **Observe how the mother puts her baby on her breast**

- Observe the position the mother is using to feed the baby. She should be comfortable and relaxed. Is her back supported? Does she need a pillow to support her arm? She should not be leaning forward.
- Is the baby well supported? The baby's nose should be opposite mother's nipple, and his body close to her body.

(d) **Observe how the mother holds her breast during a feed**

- The mother should support her whole breast with her hand against her whole chest wall (c-hold). This usually helps a baby to suckle effectively, especially if his mother has large breasts.

(e) **Does the baby look well attached to the breast?**

- The baby's chin touches the breast.
- His mouth is wide open.
- His lower lip is turned outwards.
- You can see more of the areola above his mouth and less below.

(f) **Is the baby suckling effectively?**

- The baby should be taking slow deep sucks, showing that he is getting breast milk. He is well attached to the breast, and suckling effectively.
- The baby is swallowing so that you can see or hear it. If a baby swallows, it means that he is getting breast milk.

(g) **How does the breastfeed finish?**

- Does the baby leave the breast by himself, feeling satisfied, or does the mother pull the baby off the breast?
- Always ask how breastfeeding feels to the mother. If she has discomfort or pain in her breasts, then her baby may not be well attached. If she is comfortable, then he is likely to be well attached.

(h) **Does the baby seem satisfied?**

- If a baby releases the breast himself, and looks satisfied and sleepy, this shows that he has had all that he wants from that side. He may or may not want the other side too.
- The exact length of time is not important. Feeds normally vary very much in length. But if breastfeeds are very long or very short, it may mean that there is a problem.
- In the first few days, or with a low-birth-weight baby, breastfeeds may be very long and this is normal.

(i) **What is the condition of the mother's breasts?**

- Breasts which are full before, and soft after a feed, show that the baby is removing breast milk.
- Breasts, which are very full or engorged all the time, show that the baby is probably not removing breast milk effectively.
- Looking at the condition of the nipples and the breast; red skin fissures may show that there is a problem.

Activity: Assessing correct position and attachment 45 minutes

What do you think of this baby's position and attachment?

Slide 25/1 Signs that you can see clearly are: • the baby is close to the breast, and facing it; • his mouth is quite wide open • his lower lip is turned outwards; • his chin is almost touching the breast; • his cheeks are round; • there is more areola above the baby's mouth than below it. **The baby is well attached to the breast.**	**Slide 25/2** Signs that you can see clearly are: • the baby's chin is not touching the breast; • his mouth is wide open and lower lip is turned outwards • There is more areola above than below the breast; • his cheeks are pulled in – although this may be because he is a low birth weight baby. **This baby is well attached.**
Slide 25/3 Signs that you can see clearly are: • the baby is not close to the breast and his body is not close to the breast; • his chin is not touching the breast • his mouth is not wide open, his lips point forward; • there is as much or more areola below the baby's mouth as above it. **The baby is poorly attached.**	**Slide 25/4** Signs that you can see clearly are: • the baby is facing the breast • his head and body are straight • his chin is touching the breast • his mouth is quite wide open • his lower lip is turned in and not outwards • his cheeks are round • there is more areola above the baby's mouth than below it . **This baby is not well attached.**

Slide 25/5 The signs that you can see are: • the baby is close to the breast, although his neck may be twisted; • his chin is not touching the breast • his mouth is not wide open • his lower lip is turned outwards • his cheeks look round • there is more areola below the baby's mouth than above it. **This baby's attachment can be improved.**	**Slide 25/6** The signs that you can see are: • the baby is close to the breast and facing it • however his body is twisted • his lower lip is turned inward • the mother is holding the breast with a scissor grip • the mother's back is not well supported • the mother is not supporting the baby's bottom **The baby is not well attached and the mother is poorly positioned.**
Slide 25/7 Signs you can see are: • the baby is facing the mother • his body is well supported • his chin is touching the breast • his mouth appears to be wide open • difficult to say if his lower lip is turned outwards • there is more areola above than below the baby **This baby is well attached.**	

Role-play: Positioning baby for breastfeeding 30 minutes

Scenario 1:
Mother: You sit comfortably and relaxed, and act being happy and pleased with your baby. You hold baby close, facing your breast, and support his whole body. Look at your baby, and fondle or touch him lovingly. You support your breast with your fingers against your chest wall below your breast, and your thumb above, away from the nipple.

Scenario 2:
Mother: You sit uncomfortably, and act being sad and not interested in your baby. You hold your baby loosely, and not close, with his neck twisted, and you do not support his whole body. You do not look at him or fondle him, but shake or prod him a few times to make him go on breastfeeding. You use a scissor grip to hold her breast.

SESSION 27: Breast Conditions Related to Breastfeeding

Time required: 1 hour and 30 minutes

Purpose

- The purpose of this session is to teach participants about breast conditions, and which mothers need to be referred to the clinic.

Objectives

- At the end of this session participants should be able to:
  - Identify common breast conditions.
  - Give appropriate advice for conditions that can be managed at home.
  - Know when to refer a mother to the clinic for more serous breast conditions.

Material

- PowerPoint slides
- MM manual

Discussion: Breast Conditions 1 hour

There are several common breast conditions, which sometimes cause difficulties with breastfeeding.

1. Full or Engorged breasts
Full breast:
A few days after delivery when her milk has “come in” a mother’s breasts may feel hot and heavy and hard but her milk flows well. This is normal fullness. Sometimes full breasts feel quite lumpy.

The only treatment that she needs is for her baby to breastfeed frequently, to remove the milk.

The heaviness, hardness, or lumpiness decreases after a feed, and the breasts feel softer and more comfortable. In a few days, her breasts will adjust to the baby's needs, and they will feel less full.

The following advice can be given to the mother and will help in reducing the pain:

- Inserting cold cabbage leaves into the bra
- Wearing a bra to support the breasts
- Apply warm and then cold cloths to the breasts
- Let the baby drink as much as possible
- Massaging the breasts gently to stimulate milk flow

Engorgement:
Engorgement means that the breasts are overfull, partly with milk, and partly with increased tissue fluid and blood, which interferes with the flow of milk.

Signs and symptoms:

- Breast is shiny and red, and filled with milk
- breasts feel painful
- milk does not flow well
- the nipple is flat, because the skin is stretched tight (when a nipple is stretched tight and flat like this, it is difficult for a baby to attach to it, and to remove the milk)
- often affects both breasts

Sometimes when breasts are engorged, the skin looks red, and the woman has a fever. This may make you think that she has mastitis. However, the fever usually settles in 24 hours.

It is important to be clear about the difference between full and engorged breasts.

Full breasts	**Engorged breasts**
Hot Heavy Hard Milk is flowing No fever	Painful Swollen Tight, especially the nipple Shiny May look red Milk is NOT flowing Fever

The causes of engorgement are:

- plenty of milk;
- delayed start to breastfeeding;
- poor attachment, so breast milk is not removed effectively;
- reducing the feeding time
- restricting the length of breastfeeds.

How to prevent engorgement:

- let the baby start breastfeeding soon after delivery;
- make sure that the baby is well attached to the breast;
- encourage unrestricted breastfeeding.

How to treat breast engorgement:

- **It is essential to remove milk from the breast**.
- If milk is not removed, mastitis may develop, an abscess may form, and breast milk production will decrease.
- Do not advise a mother to “rest her breast”.
- If the baby is able to suckle, he should feed frequently. This is the best way to remove milk. Help the mother to position her baby, so that he attaches well. Then he suckles effectively, and does not damage the nipple.
- If the baby is not able to suckle, help his mother to express her milk. She may be able to express by hand or she may need to use a breast pump, or a warm bottle. (See session on `Expressing breast milk').

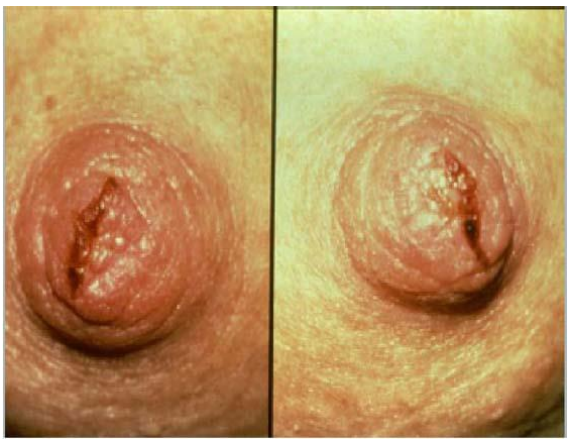
Sometimes it is only necessary to express a little milk to make the breast soft enough for the baby to suckle.

Taking a warm bath or shower, helps the breasts to release milk.

- After a feed, put a cold compress on her breasts. This may help to reduce oedema.
- Build the mother's confidence. Explain that she will soon be able to breastfeed comfortably.

2. Sore or cracked nipples

The most significant cause of sore or cracked nipples is due to **incorrect positioning and latching of the baby at the breast**.



First look for a cause:

- Observe the baby breastfeeding, and check for signs of poor attachment.
- Examine the breasts: look for signs of Candida infection (thrush), engorgement or fissures.

Treatment:

- Explain that the soreness is temporary, and that soon breastfeeding will be completely comfortable.
- Help her to improve her baby's attachment on the unaffected breast.

Often this is all that is necessary.

- She does not need to rest her breast. She should express the breast milk and cup feed or discard the milk if there is a lot of blood coming out during expressing. She should not bleed from the nipple if the technique of expressing breast milk is good.
- Help her to reduce engorgement if necessary.

- Consider referral for treatment if the skin of the nipple and areola is red, shiny, or flaky; or if there is itchiness, deep pain, or if the soreness persists.

If an HIV+ mother has a sore on the nipple or cracked nipples, and the baby suckles from that breast, there may be a higher risk of transmitting HIV to the baby. It is better for the mother to express the breast milk and feed the baby using a cup. If there is blood in the milk, it is better to discard the milk.

Advise the mother:

- to rub a little expressed breast milk over the nipple and areola with her finger. This promotes healing.
- not to wash her breasts more than once a day, and not to use soap, or rub hard with a towel. Breasts do not need to be washed before or after feeds. Washing removes natural oils from the skin, and makes soreness more likely.
- not to use medicated lotions and ointments, because these can irritate the skin, and there is no evidence that they are helpful.

3. Candida infection (Thrush)

Candida infections often follow the use of antibiotics to treat mastitis, or other infections.

Symptoms include:

- burning or stinging, which continues after a feed
- pain which shoots deep into the breast. A mother may say that it feels as though needles are being driven into her breast.
- skin may look red, shiny and flaky.
- the nipple and areola may lose some of their pigmentation or look normal

Suspect Candida if sore nipples persist, even when the baby's attachment is good. **Check the baby for thrush**. He may have white patches inside his cheeks or on his tongue, or he may have a rash on his bottom.

Refer the mother and baby to the clinic for treatment.

Advise the mother to stop using pacifiers (dummies); help her to stop using teats, and nipple shields. If these are used, they should be boiled for 20 minutes daily

4. Mastitis

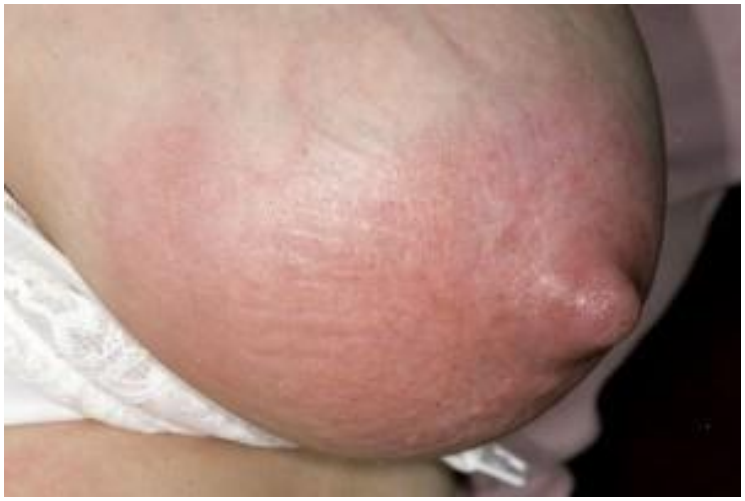
Mastitis is an infection of the breast tissue.

It is caused by:

- poor drainage of all or part of a breast due to:

- infrequent breastfeeds
- ineffective suckling due to poor attachment
- blocked milk duct
- pressure from tight clothes, usually a bra, especially if she wears it at night; or from lying on the breast, which can block one of the ducts
- pressure of the mother's fingers, which can block milk flow during a breastfeed.
- the lower part of a large breast draining poorly, because of the way in which the breast hangs.

- cracked nipple, which allows infection to enter the breast tissue.
- trauma to the breast which damages breast tissue, for example, a sudden blow, or an accidental kick by an older child.



Symptoms of mastitis:

- Severe pain and fever
- Mother feels sick.
- Part of the breast is swollen and hard and the overlying skin is red.

Mastitis is often confused with engorgement; however engorgement affects the whole breast, and often both breasts. Engorgement is not usually associated with a fever.

Treatment:

- Many **mothers with mastitis need antibiotics**, therefore, refer a mother to the clinic or health centre for treatment.
- Express breast milk frequently and discard the expressed breast milk. It is necessary to express the milk. If the milk stays in the breast, an abscess is more likely.
- Gently massage the affected breast while her baby is suckling from the unaffected one. This helps to remove milk from different parts of the affected breast more equally. Show her how to massage over the blocked area, and over the duct, which leads from the blocked area, right down to the nipple. This helps to remove the block from the duct. She may notice that a plug of thick material comes out with her milk.
- Apply compresses. Warmth is comfortable for some mothers while others prefer cold compresses to reduce swelling.
- Support the breasts well to make her more comfortable. (However, do not bind the breasts tightly, as this may increase her discomfort.)
- Advise her to rest and to get help at home with her duties. Talk to her family if possible about sharing her work. Resting with her baby is a good way to increase the frequency of breastfeeds.
- Relieve pain. Raw cabbage leaves, placed directly on the breast can reduce pain and swelling.
- Usually, blocked duct or mastitis improves within a day when drainage to that part of the breast improves. Start breastfeeding the baby from this breast once it has improved.

5. Breast abscess

A breast abscess is caused by a bacterial infection, which causes pus to collect in the breast tissue. It can follow on from mastitis, especially if is not treated promptly. It can also develop if the mother has cracked nipples.

Symptoms of a breast abscess:

- Pain, redness and swelling in an area of the breast
- Fever

Treatment:

- Refer the mother immediately to clinic or hospital.
- Mother will need antibiotics, and surgery to drain the pus from the breast.
- Advise the mother to stop breast feeding from the affected breast, and to express milk.

Breast conditions such as sore or cracked nipples, mastitis and breast abscesses may increase the risk of HIV transmission through breast milk.

If you see a mother with the following features, refer her to the clinic for treatment:

- Nipples with a deep crack
- Bleeding nipples
- Nipples oozing pus or bleeding
- Breast lump
- Painful breast with fever

Role play: Breast conditions when breastfeeding 30 minutes

The trainers will guide the session.

Scenario 1:
The mother has cracked nipples

Scenario 2:
The mother has hot, heavy, hard breasts but no fever. The milk flows well

Scenario 3:
The mother has painful, swollen breasts that are tight – especially at the nipple and shiny. One of the breasts looks a little red. Milk is not flowing well. The mother does not have a fever.

SESSION 28: How Milk is Produced and Released by the Breast and Expressing Breast Milk

Time required: 70 minutes

Purpose

- To familiarise participants with how breast milk is produced and released by the breast, and how to express breast milk.

Objectives

- At the end of this session MM's will:
  - Know how milk is produced and released.
  - Know when and why expressing breast milk is useful.
  - Be able to help a mother to express breast milk.

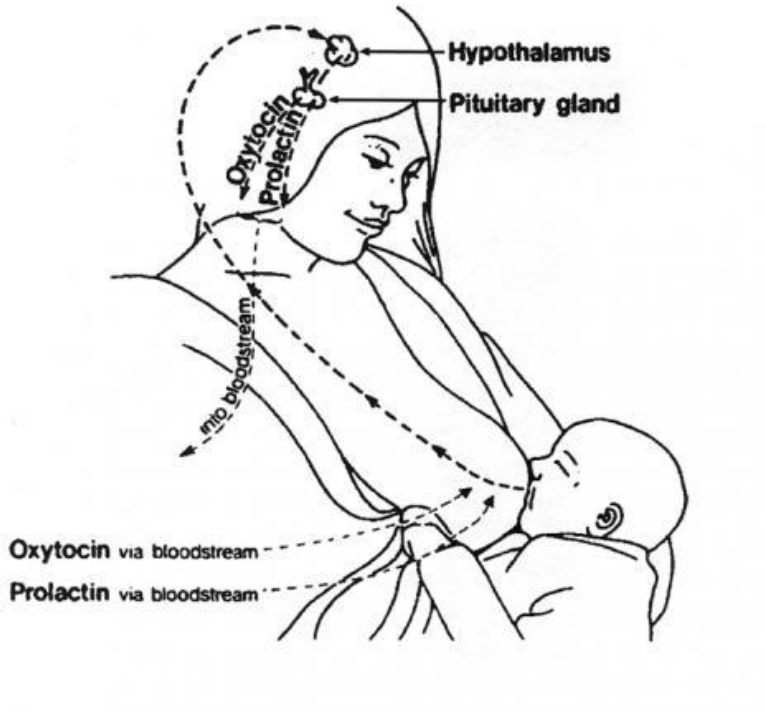
Material

- Balloons for each participant.

Discussion: Milk Production and Release — 10 minutes

- The more a baby suckles the more milk is produced.
- The baby and the feelings of the mother control milk production and release.

Sucking or other stimulation of the breast sends nerve impulses to the brain, causing the release of two hormones: **prolactin** and **oxytocin**.



Prolactin causes the production of milk.

Oxytocin causes the "let-down" reflex, which releases milk at the start of a feed.

Discussion: Expressing Breast Milk 30 minutes

Expressing breast milk is useful:

- when the mother has to go to work or has to go out for the day
- to relieve engorgement
- to relieve blocked duct or milk stasis
- when feeding a baby as he learns cup feeding
- when feeding a baby while he learns to suckle from an inverted nipple
- when feeding a baby who has difficulty in co-ordinating suckling
- when feeding a baby who `refuses', while he learns to enjoy breastfeeding
- when feeding a low-birth-weight baby who cannot breastfeed
- when feeding a sick baby, who cannot suckle enough
- to keep up the supply of breast milk when a mother or baby is ill
- to prevent leaking when a mother is away from her baby
- to help a baby to attach to a full breast
- to prevent the nipple and areola from becoming dry or sore

It is important that the oxytocin reflex works before milk expression to make sure the milk flows from the mother's breasts.

Ask participants if they know **how to stimulate the oxytocin reflex**, to help mothers to express breast milk.

Help the mother psychologically:

- Build her confidence
- Try to reduce any sources of pain or anxiety
- Help her to have good thoughts and feelings about the baby

Help or advise her to:

- Hold her baby with skin-to-skin contact if possible. She can hold her baby on her lap while she expresses. If this is not possible, she can look at the baby. If this is not possible, sometimes even looking at a photograph of her baby helps.
- Take a warm soothing drink (not coffee).
- Warm her breasts. For example, she can apply a warm compress, or warm water, or have a warm shower.
- Stimulate her nipples. She can gently pull or roll her nipples with her fingers.

- Massage or stroke her breasts lightly. Some women find that it helps if they stroke the breast gently with finger tips or with a comb, or gently roll their closed fist over the breast towards the nipple.

Expressing breast milk by hand

- Hand expression is the most useful way to express milk. It needs no appliance, so a woman can do it anywhere, at any time.
- It is easy to hand express when the breasts are soft. It is more difficult when the breasts are engorged and tender. So teach a mother how to express her milk in the first or second day after delivery. Do not wait until the third day, when her breasts are full.
- Choose a cup, glass, jug or jar with a wide mouth.
- Wash the cup in soap and water and pour boiling water into the cup, and leave it for a few minutes. Boiling water will kill most of the germs. When ready to express milk, pour the water out of the cup.
- Teach a mother to do this herself. Do not express her milk for her. Touch her only to show her what to do. Be gentle.
- Before starting, the mother should wash her hands thoroughly.
- She should sit or stand comfortably, and hold the container near her breast.

A woman should express her own breast milk. The breasts are easily hurt if another person tries. If you are showing a woman how to express, show her on your own body as much as possible, while she copies you. If you need to touch her to show her exactly where to press her breast, be very gentle.

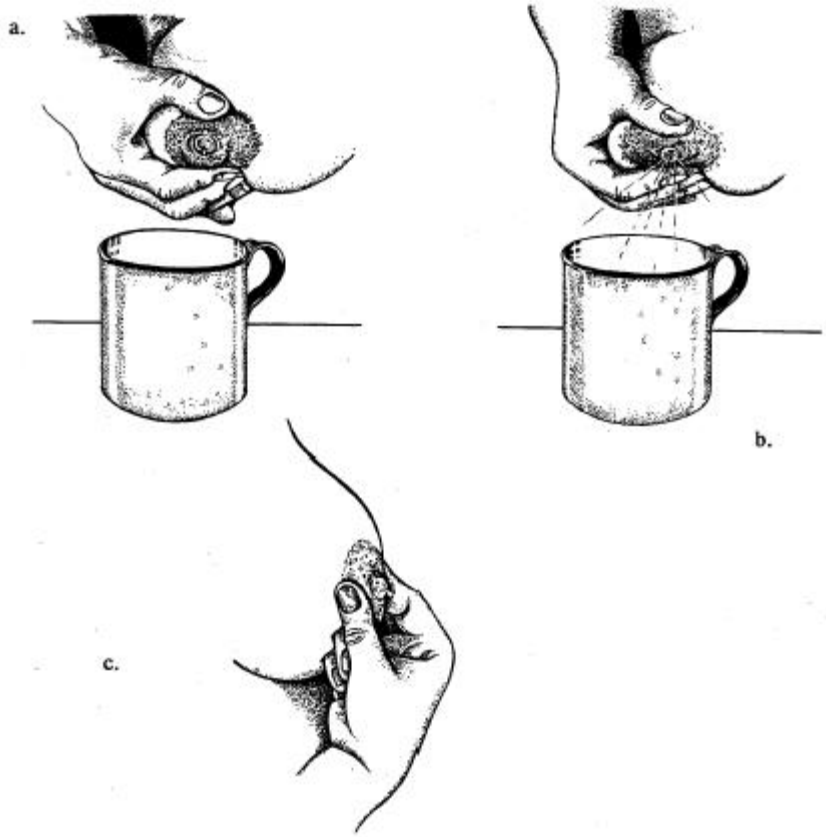
Activity: Expressing breast milk with balloon 30 minutes

1.Blow up a balloon.

2. Put her thumb on her breast above the nipple and areola, and her first finger on the breast below the nipple and areola, (opposite the thumb). She supports the breast with her other fingers.

3. Press her thumb and first finger slightly inwards towards the chest wall. She should avoid pressing too far because that can block the milk ducts.

4. Press her breast behind the nipple and areola between her finger and thumb. She must press on the milk ducts beneath the areola. Sometimes in a lactating breast it is possible to feel the ducts. They are like pods or peanuts. If she can feel them, she can press on them.



5. Press and release, press and release.

a) Place finger and thumb each side of the areola and press inwards towards the chest wall.
b) Press behind the nipple and areola between your finger and thumb
c) Press from the sides to empty all segments.

Tips:

- This should not hurt - if it hurts, the technique is wrong.
- At first no milk may come, but after pressing a few times, milk starts to drip out. It may flow in streams if the oxytocin reflex is active.
- Press the areola in the same way from the sides, to make sure that milk is expressed from all segments of the breast.
- Avoid rubbing or sliding her fingers along the skin. The movement of the fingers should be more like rolling.
- Avoid squeezing the nipple itself. Pressing or pulling the nipple cannot express the milk. It is the same as the baby sucking only the nipple.
- Express one breast for at least 3-5 minutes until the flow slows; then express the other side; and then repeat both sides. She can use either hand for either breast, and change when they tire.
- To express breast milk adequately takes 20 - 30 minutes, especially in the first few days when only a little milk may be produced. It is important not to try to express in a shorter time.

How often should a mother express her breast milk?

It depends on the reason for expressing the milk, but usually as often as the baby would breastfeed.

- *To establish lactation, to feed a low-birth-weight (LBW) or sick newborn:* She should start to express milk on the first day, within six hours of delivery if possible. She may only express a few drops of colostrum at first, but it helps breast milk production to begin, in the same way that a baby suckling soon after delivery helps breast milk production to begin.

She should express as much as she can as often as her baby would breastfeed. This should be at least every 3 hours, including during the night. If she expresses only a few times, or if there are long intervals between expressing, she may not be able to produce enough milk.

- *To keep up her milk supply to feed a sick baby:* She should express at least every 3 hours.
- *To build up her milk supply, if it seems to be decreasing after a few weeks:* Express very often for a few days (every hour), and at least every 3 hours during the night.

- *To leave milk for a baby while she is out at work:* Express as much as possible before she goes to work, and also while at work to help keep up her supply.

- *To relieve symptoms, such as engorgement, or leaking at work:* Express only as much as is necessary.

SESSION 29: Practising Exclusive Breastfeeding

Time required: 2 hours and 20 minutes

Purpose

- This session aims to discuss common concerns and difficulties with exclusive breastfeeding and how these can be addressed.

Objectives

- At the end of this session MM's will be able to:
  - Understand common concerns about exclusive breastfeeding which they are likely to encounter in their work.
  - Know how to address these common concerns.

Material

- MM manuals
- Philani Mentor Mother Training DVD

Exclusive breastfeeding should begin within the first half an hour of birth and should continue on demand – whenever the baby wants to feed, during the day and night – for the first 6 months of life.

Activity: Exclusive Breastfeeding — 1 hour and 15 minutes

The trainers will guide this session.

Common concerns and beliefs / Difficulties with Exclusive Breastfeeding	**Your responses to address women's fears / concerns**
1. Breast milk alone is not enough for the baby's growth.	Breast milk alone contains all the nutrients the baby needs for the first 6 months of life: protein, fatty acids, lactose, vitamins, iron and other minerals. These nutrients in breast milk are easily digestible. Breast milk alone is enough for baby's growth. The baby does not need additional foods or fluids.
2. Breast milk alone is not enough to protect a baby from illness and infection.	
3. Babies need traditional medicines to keep them well.	
4. A mother does not produce enough milk for a growing child.	
5. A young baby with diarrhoea needs traditional medicine to clean the stomach and stop diarrhoea	

Common concerns and beliefs / Difficulties with Exclusive Breastfeeding	**Your responses to address women's fears / concerns**
6. The first milk, colostrum, produced by the mother is bad and should be thrown away.	
7. A baby who cries is not getting enough milk and needs other fluids.	
8. A fat baby is a healthy baby.	
9. Babies need water in the 1st 6 months, especially to quench thirst.	
10. A breastfeeding baby needs enemas to prevent constipation.	
11. Sore nipples are caused because a baby sucks too long.	
12. Breastfeeding spoils a woman's breasts and her shape.	

Common concerns and beliefs / Difficulties with Exclusive Breastfeeding	**Your responses to address women's fears / concerns**
13. Women with small breasts cannot breastfeed	
14.	
15.	
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21.	

Common concerns and beliefs / Difficulties with Exclusive Breastfeeding	Your responses to address women's fears / concerns
22.	
23.	
24.	

Activity: Breastfeeding scenarios 25 minutes

In a large group discuss the following scenarios and what advice can be given to each mother:

Scenario 1:
Maria and Zinhle are sitting together under the tree. Maria's baby, Themba is 4 months and 3 days old. Zinhle's baby Thabo is 4 months and one week old. Maria is exclusively breastfeeding Themba. Zinhle feeds Thabo some breast milk and some formula milk. The average weight of a 4-month old baby is 6.5kg. Themba weighs 6.6kg and Thabo weighs 8kg. Maria thinks that her baby is not fat enough.

Answer:

Scenario 2:
Zandile is HIV positive. She has a 1 month old baby, Toby. Zandile was counselled about her HIV status, and she has disclosed to her boyfriend and her mother. She does not meet all the AFASS criteria and is thus exclusively breastfeeding Toby.

However when Toby is 3 months Zandile has to go back to work. She will not be able to take Toby with her and does not know how she will breastfeed him. What advice would you give her?

Answer:

DVD Session: Breastfeeding **40 minutes**

The trainers will guide this session.

SESSION 30: Infant Feeding for HIV Positive Women who meet AFASS Criteria and have chosen not to Breastfeed.

Time required: 2 hours

Purpose

- This session teaches participants about avoiding all breastfeeding amongst HIV-positive women who meet the AFASS criteria.

Objectives

- At the end of this session MM's will understand:
  - The AFASS criteria.
  - Why HIV positive women who meet the AFASS criteria should give their babies only formula milk for the first 6 months of life, and should not breastfeed.
  - How to address mothers and family's concerns around exclusive formula feeding.

Material

- PowerPoint slides
- Flipchart Board / flipchart and paper
- Markers

Discussion: Breastfeeding and HIV 30 minutes

HIV can be transmitted during pregnancy, labour and delivery and through breastfeeding. Thus HIV positive women should receive antiretroviral treatment to prevent transmission during pregnancy, labour and delivery and should consider not breastfeeding.

Slide 1:
Of **100 HIV positive women**:

- approximately **30** will transmit HIV to their babies if they do not receive antiretroviral therapy
- **21** women will transmit HIV during pregnancy, labour and delivery
- **9** women will transmit HIV during breastfeeding, (if fed for more than 6 months).
- **70** babies born to HIV positive women will not be infected with HIV.

Slide 2:
In the presence of antiretrovirals:

- approximately **2-5%** of women will transmit HIV to their babies
- **3%** during pregnancy, labour and delivery, and
- **2%** through mixed breastfeeding for more than 6 months.

If women exclusively breastfeed their babies for 6 months then the risk of transmission through breastfeeding is reduced.

Note that in the presence of ARV's and exclusive breastfeeding approximately 98% of babies born to HIV positive women will not be infected with HIV.

Participants may want to colour this into the diagrams below.

The **AFASS** criteria assist with the feeding choice in HIV positive women:

Acceptable	The mother sees no reason why her feeding choice would have any negative social or cultural outcomes or lead to stigma and discrimination.
Feasible	The mother (or family) has adequate time, knowledge, skills and other resources to prepare and feed the baby, and the support to cope with family, community and social pressures.
Affordable	The mother and family can buy the product and everything needed to prepare the feeding option.
Sustainable	Availability of a continuous and uninterrupted supply and dependable system of distribution for all ingredients and commodities needed to safely implement the feeding option, for as long as the baby needs it.
Safe	Formula milk would be correctly and hygienically prepared by clean hands, using clean, safe water and clean utensils. Nutritionally adequate quantities of formula milk would regularly be available. Clean water and fuel would be regularly available. Formula milk would be fed preferably with cups rather than bottles.

If HIV-positive women meet the AFASS criteria they can choose to avoid breastfeeding. If they avoid breastfeeding they should exclusively formula feed for the first 6 months of life.

Exclusive formula feeding means that the baby receives only formula milk and no other foods or fluids. (No water, glucose water, tea, porridge, fruit, vegetables, traditional medicines by mouth or over-the-counter medicine by mouth.)

Discussion: Feeding by HIV positive mothers 30 minutes

1. Discuss the following questions in pairs:

- **Have you seen or heard about mothers giving their babies under the age of 6 months food and other things to taste from their cups and plates?**
- **Have you seen or heard about mothers who avoid breastfeeding their babies but who give them the breast for comfort and not for feeding?**
- **What do you know about breastfeeding and HIV?**
- **Do you know any HIV positive women with babies? How do they feed their babies, or how do you think they feed their babies?**
- **How do you think HIV positive women should feed their babies?**
- **Why do you think that HIV positive women should choose between exclusive breastfeeding and exclusive formula feeding?**
- **What is mixed feeding? Why do we say that HIV positive women should avoid all mixed feeding?**
- **What is meant by avoiding all breastfeeding? What milk can babies drink if they avoid all breastfeeding? If babies avoid all breastfeeding should they receive sugar water? Tea? Porridge? Cereal? Vegetables? Fruit?**
- **What do you understand by the words acceptable and feasible and affordable and sustainable and safe (We call this the AFASS criteria)? Why are these important?**
- **Why do you think HIV-positive women should avoid breastfeeding only if they meet the AFASS criteria?**
- **Why do you think HIV positive women should stop breastfeeding at 6 months (if they meet the AFASS criteria)?**

HIV positive women need to choose between exclusive breastfeeding and exclusive formula feeding.

HIV positive women should avoid mixed feeding (feeding both breast milk and formula milk) as it increases the risk of HIV transmission to the baby.

HIV-positive women who avoid breastfeeding often feed their babies formula milk and other solids, including cereals, fruit and vegetable from as early as 3 weeks of life. All mixed feeding should be avoided.

If avoiding breastfeeding at all times is acceptable, feasible, affordable, sustainable and safe then HIV-positive women should avoid all breastfeeding.

'At all times' means even at night and even when the partner, mother or mother-in-law is around. For their own health, babies who avoid all breastfeeding should be fed only formula milk for 6 months. No cereal, vegetables, tea, juice, fruit or glucose water.

If avoiding all breastfeeding at all times, is not acceptable, feasible, affordable, sustainable and safe then HIV-positive women should exclusively breastfeed for 6 months.

Breastfeeding can be stopped at 6 months if avoiding breastfeeding has become acceptable and feasible and affordable and sustainable and safe.

At 6 months, if AFASS criteria are not met, mothers should continue to breastfeed as well as giving complementary foods. They need to have regular follow-up at the clinic. As soon as AFASS criteria are met all breastfeeding should stop.

HIV positive babies can be breastfed for at least 2 years.

Discussion: Feeding by HIV negative mothers 20 minutes

Feeding by HIV negative women or women of unknown HIV status:

HIV negative women or women of unknown HIV status should exclusively breastfeed for the first 6 months and continue breastfeeding thereafter for at least 2 years.

Breastfeeding mothers who become HIV positive while breastfeeding are at a high risk of transmitting HIV to their infants.

HIV negative women must be tested again for HIV at the 6 week infant visit, and every 3 months after this, if they are breastfeeding.

Activity: Concerns and Difficulties with Formula Feeding 40 minutes

1. On the left hand side of the table are concerns or difficulties or traditional beliefs that may prevent exclusive formula feeding. Think of more concerns, and add these to the blank spaces provided.

2. Discuss these statements as a large group. On the right hand side of the table fill in words, statements or responses that you can think of to address these beliefs, concerns or traditions.

Common concerns and beliefs / Difficulties with Exclusive Formula feeding	**Facts and simple relevant information**
1. Formula milk alone is not enough for the baby's growth.	Formula milk has been especially made for babies. Although it is not exactly like breast milk it contains all that a baby needs for the first 6 months of life if the mother cannot breastfeed
2. Babies need traditional medicines to keep them well.	
3. A young baby with diarrhoea needs traditional medicine to clean the stomach and stop diarrhoea	
4. A baby who cries is not getting enough milk and needs other fluids or cereal or porridge	
5. A fat baby is a healthy baby.	

Common concerns and beliefs / Difficulties with Exclusive Formula feeding	**Facts and simple relevant information**
6. Babies need water in the 1st 6 months, especially to quench thirst.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	

Common concerns and beliefs / Difficulties with Exclusive Formula feeding	**Facts and simple relevant information**
15.	
16.	
17.	
18.	
19.	
20.	

SESSION 31: Safe Formula Feeding

Time required: 2 hours

Purpose

- The purpose of this session is to teach participants how to support HIV-positive women who meet the AFASS criteria and have chosen not to breastfeed.

Objectives

- At the end of this session MM's will understand:
  - Be able to safely prepare formula milk.
  - Be able to advise a mother on how to feed formula milk using a cup.

Material

- Tin of the common formula milk that mothers use
- Utensils
- Water
- Cup
- Bottle
- Cleaning brush
- Kettle to boil water
- Measuring jug
- Teaspoon
- Permanent marker pen

Formula milk should be prepared hygienically using clean utensils and clean water to prevent illnesses such as diarrhoea.

It is important to mix the correct amount of formula powder and water together. If the milk is too weak (has too much water) the baby will not grow properly. If the milk is too strong the baby will not be able to digest it properly.

Babies should receive the recommended amount of formula milk at regular intervals so that they grow.

Formula milk should be fed using a cup rather than a bottle because cups are easier to clean and have been associated with fewer illnesses compared to bottles.

If exclusively formula fed babies become ill with diarrhoea they should be given oral rehydration fluid after the first loose stool and frequently thereafter (small amounts every 15 – 30 minutes).

Discussion: Formula Feeding — 1 hour and 10 minutes

1. **How often should a baby be fed with formula?**

Babies need frequent feeding, about 8 or more times a day (24 hours) during the first 2 months. This means feeding a baby every 3 hours, day and night. Babies need frequent feeding because their stomachs are small.
Formula milk can be reduced after 2 months to about 6 times a day.

Babies who are very small, and babies less than 2 months old, need night feeds. Some babies wake for a feed. Other babies may need to be awakened for a feed.

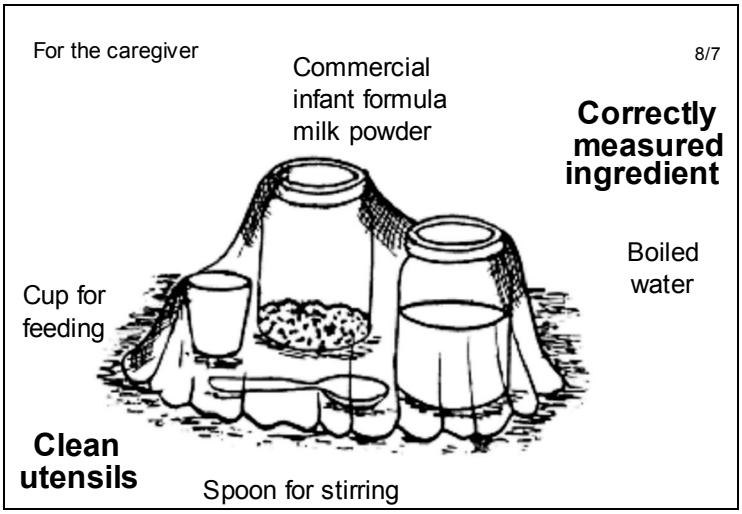
Approximate amount of formula needed per day:

Age in months	Weight in kilos	Approx. amount of formula per 24 hours	Approx. number of feeds*
1	3	450 - 600 ml	8 x 75 ml
2	4	600 - 800 ml	7 x 100 ml
3	5	750 ml	6 x 125 ml
4		900 ml	6 x 150 ml
5	6	1050 ml	6 x 175 ml
6		1200 ml	6 x 200 ml

*Includes rounding up or down for ease of measurement

2. A baby who is not breastfed is at increased risk of illness for two reasons:
   - Formula milk may be contaminated with bacteria that can cause infection.
   - The baby lacks the protection provided by the breast milk.

3. Safe preparation of formula feeds requires:
   - Clean hands
   - Clean utensils
   - Safe water
   - Safe storage



Always wash hands

- after using the toilet, after cleaning the baby's bottom, after disposing of children's stools; and after washing nappies and soiled cloths;
- after handling foods which may be contaminated (e.g. raw meat and poultry products) and after touching animals;
- before preparing or serving food,
- before eating, and before feeding children.

It is important to wash your hands thoroughly

- with soap or ash;
- with plenty of clean running or poured water;
- front, back, between the fingers, under the nails.

Let your hands dry in the air or dry them with a clean cloth. It is best not to dry them on your clothing or a shared towel.

Where should you prepare formula feeds? What do you need?
How do you clean bottles, teats and cups?

You need to keep both the utensils that you use, and the surface on which you prepare feeds, as clean as possible.

- Use a clean table or mat, that you can clean each time you use it.
- Wash utensils with cold water immediately after use to remove milk before it dries, and then wash with hot water and soap. If you can, use a soft brush to reach all the corners.
- Teats need to be turned inside out and scrubbed using salt or abrasive. They should then be boiled or soaked to sterilise.
- Keep utensils covered to keep off insects and dust until you use them.
- Use a clean cup to give any drink to a baby.

Utensils needed for bottle feeding are:

- Bottles and Teats
- Cups
- Bottle brush
- Pot for boiling bottle or non-metallic container for soaking the bottle in bleach.

What are the common ways of sterilising bottles in informal settlements?
How often do mothers usually sterilise bottles?
What common infection do babies get if the teats are not sterilised?

Bottles and teats are more difficult to clean than cups.
At least once a day they should be sterilized. This takes more time, attention and fuel.

How to sterilise bottles and teats:
a) **Boil bottles**:
Bring water to the boil in a large pot. There should be enough water to cover the bottles. Add bottles and teats and boil for 5 minutes. Remove bottles and teats and place on a clean dishcloth and allow to air dry.

b) **Soak in bleach**:
Fill a container with water. Add bleach (1 capful to 5 litres water). Allow bottles and teats to soak for 1 hour. Remove and rinse in previously boiled water. Air dry on a clean dishcloth. Make a new solution of bleach every day.

What kind of water should be used to prepare formula milk?
How do you prepare safe water for formula feeds?

Safe water is especially important for babies.
Preparing safe water:

- Bring the water to a rolling boil briefly before use. This will kill most harmful germs. (A rolling boil is when the surface of the water is moving vigorously. It only has to "roll" for a second or two.)
- Put the boiled water in a clean, covered container and allow to cool. The best kind of container has a narrow top, and a tap through which the water comes out. This prevents people dipping cups and hands into the water, which can make it dirty.
- If the water has been stored for more than a day, re-boil it before use.

How should a mother store formula milk?
How long can prepared formula milk be left standing for?
What should be done with left over milk? Should it be used for the next feed?

- Commercial baby formula powder must be kept dry to prevent growth of germs, especially in humid conditions.
- If a mother does not have a refrigerator, she must make feeds freshly each time.
- When a feed has been prepared with formula, it should be used within one hour, like fresh milk. If a baby does not finish the feed, she should give it to an older child or use in cooking.
- If a mother has a refrigerator, all the formula for one day can be made at one time and stored in the refrigerator in a sterilized container with a tight lid. For each feed, some of the formula is poured into a feeding cup.
- Some families keep hot water in a thermos flask. This is safe for water. But it is NOT safe to keep warm milk or formula in a thermos flask. Bacteria grow when milk is kept warm.

Discuss with the mother or other caregiver how the household routine works - whether the mother cooks once or twice a day, whether she can prepare feeds many times a day, how often she goes to market and what facilities she has for storage. Help her to find ways of preparing the baby's food in a clean and safe way.

4. Correct measurements for preparing formula milk.

Ask participants to answer the following questions and write down their answers on a flip chart:

What utensils and equipment do you need to prepare formula milk?
What can be used to measure the water?
What can be used to measure the formula powder?
Is it important to follow the instructions on the tin? Why?
Why should we not mix more powder with water?
Why should we not mix less powder with the water if we are running out of formula?

a) Measuring water

It is important to show the caregiver the amounts to use according to the age of the baby at the time. Show her new amounts as the baby gets older and takes more at each feed.

If a mother does not have a bottle or measuring jug marked with amounts, how can she measure the water?

A mother can use any container from home to measure water. You can mark the container for her so that she is able to measure the correct amount of water. The container should be:

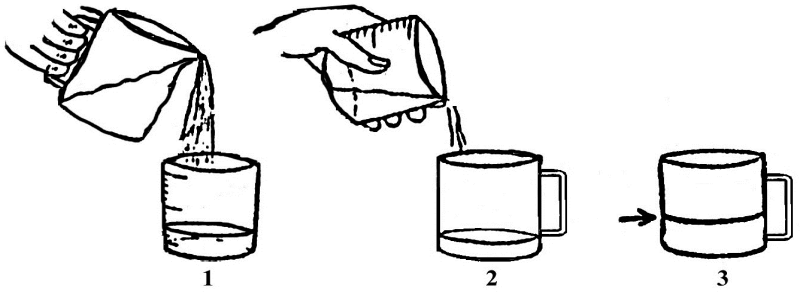
- easily available
- easy to clean and sterilize
- see-through
- able to be marked with paint, permanent marker, or by scratching a line on it; or used as a measure simply by filling it to the top.

Before a mother can use a container as a measure you need to mark the amount on the container, or show her how full it needs to be to measure the amount that she has to use.

You can measure the correct amount of water using your measuring jug. Pour the water into the mother's measure, and make a mark at the level it reaches.

For example: If you are making formula milk for a 3 month old baby:
1. Check how much milk the baby needs for every feed. *(125ml)*
2. Put water into your measure, to reach the 125 ml mark.
3. Pour the 125 ml water from your measure into the mother's container.
4. Help the mother to mark the level that the water reaches. For the measure to be accurate, the line should be thin and straight, not thick or sloped.

Figure 1 Mark a measure



b) Measuring formula milk powder

- Commercial baby formula does not need the addition of sugar or micronutrients. They are already mixed into the milk powder. Thus all you have to measure is the formula powder.
- Usually commercial baby formula comes with a special measure (called a scoop) in the tin of powder. This should be used only for that brand of baby formula) Different brands may have different size measures.

- Scoops always have to be levelled. Use a clean knife or the handle of a spoon. Do not use heaped scoops.

Commercial baby formula recipe:

(LOCAL BRAND) needs:
125 ml water + level scoops of commercial baby formula powder to make 125 ml formula feed.

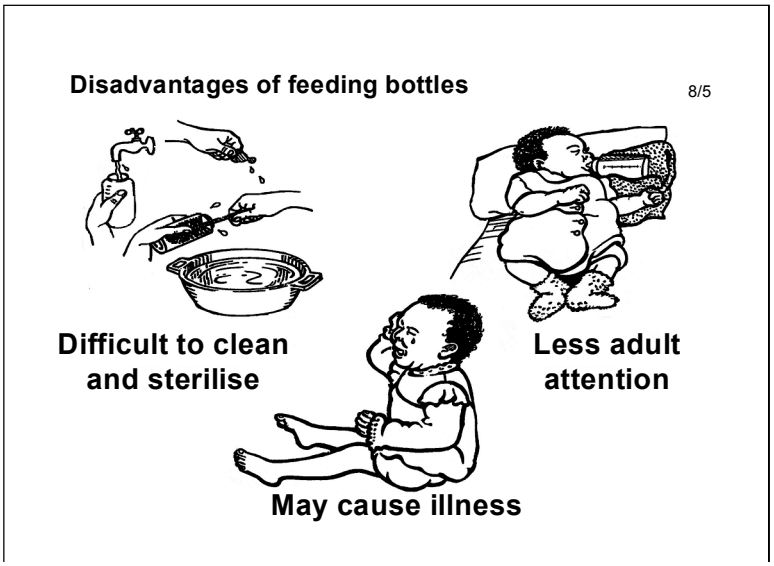
Example 1: To make **Infacare** use 1 scoop for every 25 ml of water.
Thus, to prepare 125 ml of milk you will add 5 scoops to 125 ml water.

Example 2: To make **Pre-Nan** use 1 scoop for every 30 ml water.
Thus, to prepare 120 ml of milk you will add 4 scoops to 120 ml water.

5. Cup feeding a young baby

Why are cups recommended for feeding babies instead of bottles?
What are some of the disadvantages of bottle feeding?
Can a newborn baby be fed from a cup?

Disadvantages of bottle feeding:

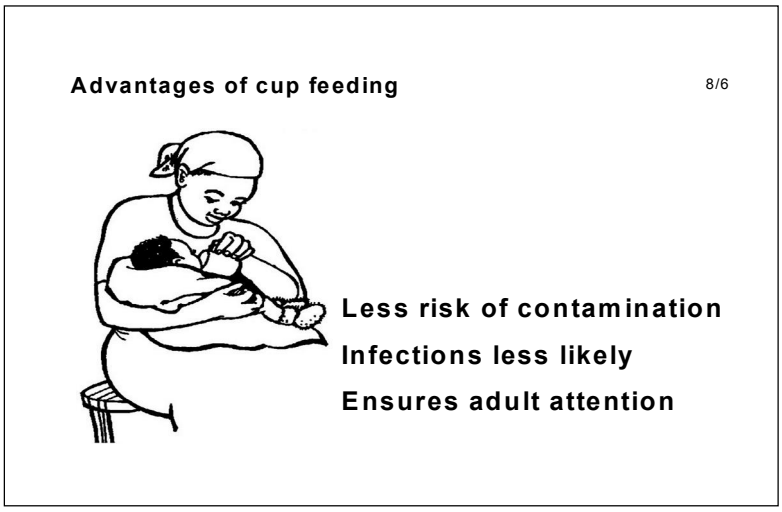


- Bottles are difficult to clean, and easily contaminated with harmful bacteria, particularly if milk is left in a bottle for long periods allowing bacteria time to breed.
- Bottles and contaminated milk can make babies ill with diarrhoea.
- Ear infections are more common with bottle-feeding.
- Bottle-feeding is associated with tooth decay, leading to pain as well as later eating difficulties.
- A bottle may be propped for a baby to feed itself, or given to a young sibling to feed the baby, so the baby has less adult attention and social contact.

Mothers may consider use of a bottle easier for themselves because it can be carried around, propped for the baby or given by a sibling. You may need to explain to a mother that these advantages to them are actually disadvantages to the baby.

What are the advantages of cup feeding a young baby?

- Cups are easily available in every household.
- Cups are easy to clean so the risk of contamination is less than with bottles.
- Cup feeding is associated with less risk of diarrhoea, ear infections and tooth decay.
- A cup cannot be propped up beside the baby. The caregiver has to hold the baby and pay attention. This ensures social contact during feeding and adult attention if the baby is having any difficulties.
- A cup does not need to be boiled, in the way that a bottle does. To clean a cup, wash it and scrub it in hot soapy water each time it is used. If possible, dip the cup into boiling water, or pour boiling water over it just before use, but this is not essential. An open, smooth surfaced cup is easiest to clean. Avoid tight spouts, lids, or rough surfaces where milk could stick and allow bacteria to grow.
- Small and preterm babies can be cup fed, as well as older babies.
- Spoon-feeding is acceptable. However it is slow for large amounts of milk. There is a risk that a caregiver may become tired and stop giving the feed before the baby has taken enough milk.



How do you cup feed a baby?

- Hold the baby closely, sitting upright or semi-upright on your lap.
- Hold the small cup of milk to the baby's lips; it just touches the lower lip.
- Tip the cup so that the milk just reaches the baby's lips.
- The cup rests lightly on the baby's lower lip, and the edges of the cup touch the outer part of the baby's upper lip.
- The baby becomes alert, and opens his mouth and eyes.
- A low birth weight (LBW) baby starts to take the milk into his mouth with his tongue.
- A full term or older baby sucks the milk, spilling some of it.
- DO NOT POUR the milk into the baby's mouth. Just hold the cup to his lips and let him take the milk himself.
- When the baby has had enough, he closes his mouth and will not take any more. If he has not taken the calculated amount, he may take more next time, or you may need to feed him more often.
- Measure his intake over 24 hours - not just at each feed.

If mothers are not used to cup feeding, they need information about it, and they need to see babies feeding by cup. The method needs to be taught in a way that gives them confidence to do it themselves.

Discussion: Preparing formula milk 30 minutes

Now that you have discussed the way to prepare formula milk and the requirements for safe formula feeding, you will be divided into groups of 4-5 people. Each group should practice preparing formula milk for a baby aged 1 week or 2 weeks or 4 weeks or 5 weeks.

Each group must measure the water and formula milk powder according to the requirements of each baby. One member of the group can read the instructions on the tin so that the group is guided by the recommendations.

Discussion: Comforting a baby who is not breastfeeding 20 minutes

Babies who are not breastfed are at risk of not getting enough attention, so a special effort needs to be made.

Mothers and other family members may expect to put a crying baby to the breast to comfort him. If a mother is HIV-positive and not breastfeeding, she will need to find other ways of comforting her baby.

Babies often cry because they are lonely and need someone to give them attention, not only because they are hungry. So they can be comforted in other ways than by suckling.

What are other ways of comforting a baby?
Massage, swaddling, carrying, rocking, singing or talking to the baby, and sleeping with the baby can all help to comfort him or her.

Sucking is very comforting to a baby. He can suck on his mother's forearm or her clean finger. This also ensures that he has contact with his mother.

If pacifiers (dummies) are used commonly or if participants mention them as a way to comfort babies, make these points:

- A pacifier does not make a good substitute for contact with another person.
- A baby who needs comfort or attention needs contact with another person, not to be left alone with a pacifier in his mouth.

- Pacifiers can carry infection and can increase the risk of a child having diarrhoea, respiratory illnesses, and thrush.
- Dipping a pacifier in honey or sugar can cause dental problems. Honey has also been associated with outbreaks of botulism in babies, causing a number of deaths.

SESSION 32: Teaching Formula Feeding to Mothers

Time required: 1 hour

Purpose

- The purpose of this session is to teach participants how to teach formula milk preparation to HIV positive women who meet the AFASS criteria and have chosen not to breastfeed.

Objectives

- At the end of this session MM's should be able to teach a mother how to safely formula feed.

Material

- PowerPoint slides
- Flipchart Board / flipchart and paper
- Markers

Role play: Teaching a mother to prepare a formula feed 45 minutes

Telling a woman how to prepare a feed or letting her watch you prepare a feed is not enough. You need to give her supportive teaching, and gently supervise her preparing one or more feeds herself, to ensure that she can do it adequately.

The trainer and a Mentor Mother or volunteer will perform these role-plays. There are two role-plays, demonstrating two ways of teaching a mother to prepare a feed.

Demonstration 1:
The mother sits uncomfortably on a stool or chair on one side of the table, and the health worker stands on the other side of the table facing the mother.

Mrs L is HIV-positive and following counselling she decided not to breastfeed. Her baby was born last night. A Mentor Mother is teaching Mrs L how to prepare the feeds.

MM: Gives Mrs L a sheet of written instructions	Now Mrs L, if you are paying attention, I will show you how to prepare your baby's feed properly. It is all written down on this paper, so that you will remember what to do. Now, first make sure that everything is clean including your hands. Do you always wash your hands with soap and hot water before handling the baby's food?
Mrs L:	(meekly) Yes, ma'am.

MM: Puts the utensils on a clean cloth on the table Very quickly measure using measuring cup and unexplained measures	Good. Well now, collect all the things you need - milk, water, pot, spoon, and cup. Make sure that the place you put them on is clean. You can put them on a clean cloth like this. Measure the ingredients like this. Make sure you use warm previously boiled water. You must use the quantities that are written down on the label. Don't add too much water or too much milk powder or you will make your baby ill. You can understand the instructions on the tin, can't you?
Mrs L:	(Meekly) Yes, ma'am.
MM: If possible show a hot plate or way of heating that the mother would not have at home	(Mentor Mother measures and mix the feed.) Now, you mix the milk well and let it cool. You leave it to cool and then feed your baby using a cup, the way you saw the nurse do it at the earlier feed. Don't use a bottle. It is too difficult to clean and will make your baby ill.
Mrs L:	(Meekly) Yes, ma'am.
MM:	Now you should be able to prepare the feeds properly. Take your baby to the health centre next week so that the nurse there can check that he is putting on weight and that you are feeding him properly and doing everything right.
Mrs L:	(Meekly) Yes, ma'am.

Demonstration 2:

Mrs M is HIV-positive and following Counselling she decided not to breastfeed. Her baby was born last night. A Mentor Mother is helping Mrs M to learn how to prepare the feeds herself.

MM:	Good morning Mrs M. What a lovely baby you have. Would you like to sit down while we talk?
Mrs M: (sits)	Thank you.
MM: (also sits)	When we talked before the baby was born, you decided to use baby formula for feeding your baby. How do you feel about that decision now?
Mrs M:	Yes, that is what I think would be best, because I discussed it with my husband.
MM:	Fine. You saw the nurse prepare the baby's feed when you were in the hospital. Would you like me to go through it again, to see if you can remember it all?
Mrs M:	Yes please – I am not sure about how much milk powder to mix.
MM:	OK – it is a bit complicated, so let's do it step by step. *(MM Gives Mrs M paper with written instructions and pictures.)* The instructions are also written on this paper, with some pictures, to help you remember when you go home. We'll look at the paper later. You remember that we talked about using a jar to measure the water, and the scoop to measure the formula powder. Were you able to bring a jar with you?
Mrs M:	Yes, here it is…
MM:	Very good. We will mark the jar so that you can use it for measuring. Let's do that. This is my measure, with the right amount of water in it. I will put the water into your measuring jar. You see where it comes to? Let us mark that on your jar, like this. Is it all right for me to make a mark? It should stay there, and not come off. *(Marks cup with permanent marker or cuts with a knife.)*
Mrs M:	Yes, I can keep that jar to use as a measure.

MM:	Now you can use your jar to measure the right amount of water. *(MM tips water out of mother's cup.)* Now please fill the jar with water to the line, to show me. *(Mrs M fills jar to the line.)* Good. That's just right – now we can start to make the feed. Now, to start, you need to make sure everything is clean. How will you do this?
Mrs M:	I will have a clean place to prepare the feed *(spreads a cloth)*, a clean pot, cup, spoon and my measuring jar and clean hands *(washes her hands)*.
MM:	Good. Clean hands, clean utensils and a clean place are important. What will you do then?
Mrs M:	I will need to measure the milk powder. How will I do that?
MM:	There's a scoop provided with each tin. You need to use that scoop all the time.
Mrs M:	So I put in ….. scoops of milk powder to water that measures to this level (…ml). *(Measures according to the instructions on the label and puts into the cup.)* Then I mix well.
MM:	*(Shows mother a piece of paper with directions.)* You are using your measuring jar well, but can we go over it again? Let us look at the pictures and the instructions on the label *(they look at the label together)*.
Mrs M:	Oh yes. That's important – I must get that right. *(She reads the instructions again)*
MM:	Very good – you are correct and you have measured very well! Let's practise measuring the powder again.
Mrs M:	Like this? *(Shows a levelled scoop and puts back in tin)*
MM:	Yes, that's right. While the milk is cooling, tell me about how you found cup feeding your baby this morning.
Mrs M:	Well, it was a little difficult. Some of the milk ran out of his mouth and that bothered me. Then he didn't finish all the feed.
MM:	Yes, it can be a little difficult the first time. You are both learning how to do it. And they do take different amounts at different feeds. When your baby is ready to feed, we will do it together.
Mrs M:	Thank you. Then I can ask if I don't understand.

MM:	Ask anytime that you want to. You will be able to prepare feeds and cup feed your baby well very soon.

Activity: When to teach preparation of formula milk 15 minutes

The trainers will guide the session.

SESSION 33: Common Baby Feeding Difficulties

Time required: 1 hour and 30 minutes

Purpose

- The purpose of this session is to teach participants how to help mothers with common feeding difficulties.

Objectives

- At the end of this session MM's will understand the common causes of feeding difficulties and what can be done to help mothers overcome them.

Material

- PowerPoint slides
- Flipchart Board / flipchart and paper
- Markers
- Copies of the RtHB

Discussion: Common Infant Feeding Difficulties

1 hour and 15 minutes

Common baby feeding difficulties:

- Refusal to feed
- Not getting enough milk
- Crying

1. Refusal to feed

Ask participants **why they think a baby may refuse to feed**.

Reason for refusal	**Explanation**
Illness	The baby may attach to the breast, but suckles less than before. A formula fed baby may take a very small amount of feed than is recommended.
Pain	• Pressure on a bruise from forceps or vacuum extraction. The baby may cry and fight as his mother tries to feed him. • Blocked Nose • Sore mouth (Candida infection (thrush), an older baby teething). The baby suckles a few times, and then stops and cries.
Sedation	A baby may be sleepy because of: • drugs that his mother was given during labour; • drugs that she is taking for psychiatric treatment
Difficulty with the feeding technique	Sometimes feeding has become unpleasant or frustrating for a baby.
Has a change upset the baby?	Babies have strong feelings and if they are upset they may refuse to feed. They may not cry but simply refuse to suckle/feed. This is the commonest when a baby is aged 3-12 months. He suddenly refuses several feeds. This behaviour is sometimes called a 'nursing strike'. • Separation from his mother when she starts a job • A new carer, or too many carers • A change in the family routine (moving house, visiting relatives) • A change in his mothers smell, (different soap or different food)

	• Illness of his mother or a breast infection

If there is difficulty with the feeding technique, look for possible causes:

- Feeding from a bottle or sucking on a pacifier (dummy).
- Not getting much milk because of poor attachment or engorgement, or poor cup feeding technique.
- Pressure on the baby's head by his mother or a helper positioning him roughly with poor technique. The pressure makes him want to fight.
- His mother holding or shaking the breast, or shaking the baby, which interferes with attachment. If formula feeding, the mother may shake the cup.
- Restriction of feeds, for example feeding only at certain time.
- Too much milk coming too fast due to oversupply. For breastfeeding babies, the baby may suckle for a minute and then come off choking or crying when the ejection reflex starts. This may happen several times during a feed. The mother may notice milk spraying out as he comes off the breast.
- For cup fed babies, mothers who have not mastered the cup feeding technique tend to pour the milk into the baby's mouth.
- Early difficulty co-ordinating suckling. (Some babies take longer than others to learn to suckle effectively).
- Refusal of one breast only: Sometimes a baby refuses one breast but not the other. This is because the problem affects one side more than the other.

Is it apparent or real refusal?

Sometimes a baby behaves in a way, which makes his mother thinks that he is refusing to feed. However he is not really refusing.

- When a newborn baby is rooting, he moves his head from side to side as if he is saying 'no'. However this is normal behaviour.
- Between 4 and 8 months of age babies are easily distracted for example when they hear a noise. They may suddenly stop feeding. It is a sign that they are alert.

What can you do to help?

a) Treat or remove the cause if possible:

Cause	Intervention
Illness	Refer the baby to the clinic for treatment.
Pain	• help the mother to find a way to hold the baby without pressing on a painful place • treat thrush with gentian violet or nystatin • for a blocked nose suggest saline drops or breast milk to clear it; and short feeds, more often than usual for a few days.
Sedation	If the mother is on regular medication, try to find an alternative.
Feeding Technique	Look for problems with positioning, latching and cup feeding, and assist mother as appropriate.
Oversupply of milk: Poor attachment Poor cup feeding Giving both breasts at every feed Too much milk	This happens when too much milk comes too fast, for both cup and breastfed babies. • For breastfed babies, if a baby suckles ineffectively, he may feed frequently, or for a long time, and stimulate the breast so that it produces more milk than he needs. Assist mother to improve attachment. • Help mother to improve cup feeding technique. • Oversupply may result if a mother tries to make her baby feed from both breasts at each feed, when he does not need to. Suggest that she lets the baby suckle from only one breast at each feed. Let the baby continue at that breast until he finishes by himself, so that he gets plenty of fat enriched hind-milk. At the next feed give him the other breast. • For breastfeeding mothers, suggest she express some milk before a feed; lie on her back to feed (if milk flows upwards it is slower); or hold her breast with the scissor hold to slow the flow.
Changes which upset a baby	Discuss the need to reduce separation and changes if possible. Suggest that she stops using a new soap, perfume or food.
Apparent refusal	• Explain to her that rooting is normal. If breastfeeding, she can hold her baby at her breast to explore her

	nipple. Help her to hold baby closer, so that it is easier for him to attach. • If there is a distraction, suggest that she try to feed the baby somewhere quieter for a while. The problem usually passes.

b) Help the mother and baby to enjoy feeding again

This is difficult and can be hard work. You cannot force a baby to feed. The mother needs help to feel happy with her baby and to enjoy feeding. They have to learn to enjoy close contact again. She needs you to build her confidence, and to give her support.

Tips to help the mother to do these things:

Keep her baby close to her all the time.

- She should care for her baby herself as much of the time as possible.
- Ask grandmothers and other helpers to help in other ways, such as doing the housework, and caring for older children.
- She should hold her baby often, and give plenty of skin-to-skin contact at times other than feeding times. She should sleep with him next to her.
- If the mother is employed, she should take leave from her employment.
- It may help if you discuss the situation with the baby's father, grandparents, and other helpful people.

For a breastfed baby, offer breast whenever the baby is willing to suckle.

- She should not hurry to feed again, but offer her breast if her baby does show an interest.
- He may be more willing to suckle when he is sleepy or after a cup feed, than when he is very hungry.
- She can offer her breast in different positions.
- If she feels her ejection reflex working, she can offer her breast then.

For a formula fed baby, make a small amount of feed and offer a freshly made formula feed more frequently.

She can express her breast milk and feed it to her baby from a cup, until he is able to breastfeed again.

She should avoid shaking the breast or the cup if formula feeding.
She should avoid pressing the back of the baby's head.

2. Not enough milk

- One of the commonest reasons for mixed feeding is that the mother thinks that she does not have enough milk.

- Many breastfeeding mothers think that they do not have enough milk. However, almost all mothers can produce enough breast milk for one or even two babies. They can almost all produce more than their baby needs.

- Sometimes a baby does not get enough breast milk. This is usually because he is not suckling enough or not suckling effectively. It is rarely because his mother cannot produce enough.

- It is more important to think not about how much milk a baby is getting, but rather about how much the mother can produce.

- Mothers using formula may experience the problem of not enough milk for different reasons as well, and they may also think that their babies are not getting enough milk.

A useful rule of thumb is this: in the first six months of life a baby should gain at least 600 grams in weight each month.

> **Note:** It is normal for a newborn to loose weight in the first week of life. A baby usually regains their birth weight at 10 days of age.

If a baby is not growing well, he may be ill, or he may not be getting enough food. A breastfed or formula fed baby may not be getting enough milk.

Only two signs reliably show that a baby is not getting enough milk. These are:

a) Poor weight gain:

- Less than 600g a month
- Less than birth weight after 2 weeks
- The baby does not follow his/her growth lines on the growth chart.

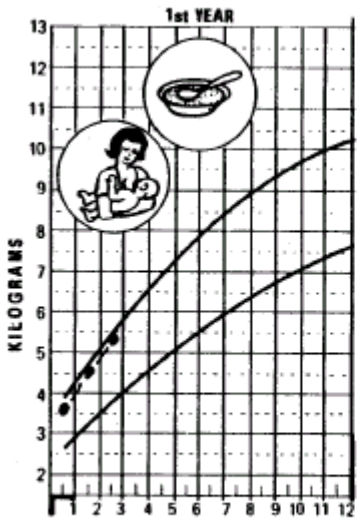
b) Passing small amounts of concentrated urine (yellow and strong smelling), less than 6 times a day.

If the baby is gaining enough weight he is getting enough milk.

If no weight record is available you cannot get an immediate answer.

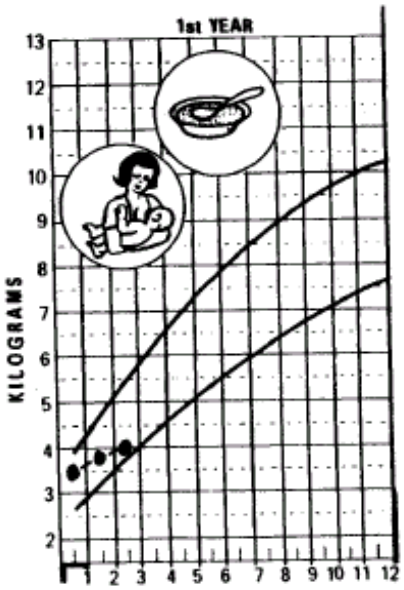
The following examples illustrate how growth charts can be used to determine whether a baby is getting enough milk.
Use the slides to illustrate the examples:

Example 1:



The baby is growing well.

Example 2:



This baby is not growing well. His weight is not increasing according to a recommended line. In fact he is dropping from one line to another. The mother should practice EBF on demand, at least 8 times per 24 hours.

Reasons why a baby may not get enough milk

Ask participants **what they think are the causes of a poor milk supply in breastfeeding women.**
Write their ideas on a flip chart.
The following are **misconceptions** about the causes of poor milk supply. If these come up be ready to answer participants' questions if they have difficulty in believing that these are not important reasons.

Factors that do not affect the breast milk supply:

- Age of mother
- Sexual intercourse
- Menstruation
- Disapproval of relatives and neighbours
- Returning to a job (if baby continues to suckle often)
- Age of baby
- Caesarean section
- Preterm delivery
- Many children
- Simple ordinary diet

Reasons for a baby not getting enough milk:
Common:

- Feeding factors
- Psychological factors (mother)

Uncommon:

- Physical problems (mother)
- Physical problems (baby)

Explanations on the reasons why a baby may not get enough milk will help you when counselling mothers in different situations.

a) Feeding factors

Reason for not enough milk	Explanation
Delayed start to breastfeeding	If a baby does not start to breastfeed in the first day, his mother's breast milk may take longer to come in and he may take longer to start gaining weight.
Short feeds	• Breastfeeds may be too short or hurried so that the baby does not get enough fat rich hindmilk. Sometimes a mother takes her baby off her breasts after only a minute or two. This may be because the baby pauses and his mother decides that he has finished. Or she may be in a hurry or she may believe that her baby should stop in order to suckle from the other breast. • Sometimes a baby stops suckling too quickly for example if he is too hot because he is wrapped in too many clothes.
Poor preparation of the feeds	A mother may be mixing the formula incorrectly for the following reasons: • Does not know how to prepare the feed correctly. • Believes the baby will grow faster if she puts more formula powder. • She dilutes the formula, as she wants to use the formula for a longer duration than stipulated. • Uses the formula for other household purposes, for example, feeding the siblings.
Infrequent feeds	• Breastfeeding less than 8 times a day in particularly the first 4 weeks is a common reason why a baby does not get enough milk. • For a formula fed baby, feeding less than 7 times a day during the first two months, and less than 5 times per day thereafter may lead to baby not getting enough milk. • Sometimes a mother does not respond to her baby when he cries or she may miss feeds because she is too busy or at work. Some babies are content and do not show that they are hungry often enough. In this case a mother should not wait for her baby to

	demand but should wake him to feed every 3 hours at least.
No night feeds	If a mother stops night feeds before her baby is ready, her milk supply may decrease, or, if mother does not wake up to formula feed the baby at night, the day feeds may not be enough.
Poor feeding technique	If a baby suckles ineffectively he may not get enough milk, or if mother does not learn the cup feeding technique the baby may not get enough formula.
Complementary Feeding	Giving the baby other solids or drinks including plain water, in place of exclusive breastfeeding or exclusive formula, reduces the amount of milk that the baby may take.
Bottles and pacifiers (dummies)	• A baby who feeds from a bottle or who sucks on a pacifier may suckle less at the breast so the breast milk supply decreases. • If formula fed, such a baby may not be fed as frequently, as he is given a pacifier instead of a feed.

b) Psychological factors relating to the mother

Psychological factor	Explanation
Lack of confidence	Mothers who are very young or who lack support from family and friends often lack confidence. Mothers may lose confidence because their baby's behaviour worries them. Lack of confidence may lead a mother to give unnecessary supplements, thus failing to sustain her exclusive baby feeding choice.
Worry and stress	• If a breastfeeding mother is worried, stressed or in pain, her oxytocin reflex may temporarily not work well, and she will produce less milk. • If a formula feeding mother is worried or stressed, she may not have time to feed the baby as frequently.
Rejection of the baby and tiredness	In these situations a mother may have difficulty in responding to her baby. She may not hold him close enough to attach well; she may feed infrequently or for a short time. She may give her baby a pacifier when he cries instead of feeding him.

c) Physical condition of the mother

- Medication

Contraceptive pills, which contain estrogens, may reduce the secretion of breast milk. Progesterone only pills and Depo-Provera are preferred as they do not reduce the breast milk supply. Diuretics may reduce the breast milk supply.

- Pregnancy

If a mother becomes pregnant again she may notice a decrease in her breast milk supply.

- Severe malnutrition

Severely malnourished women may produce less milk. However, a woman who is mildly or moderately undernourished continues to produce milk at the expense of her own tissues, provided her baby suckles often enough. Malnourished breastfeeding women can be referred for nutritional supplementation while breastfeeding.

- Alcohol and smoking

Alcohol and cigarettes can reduce the amount of breast milk that a baby takes.

- Retained piece of placenta

This is RARE. A small piece of placenta remains in the uterus and makes hormones, which prevent milk production. The woman bleeds more than usual after delivery her uterus does not decrease in size and the milk does not come in.

- Poor breast development:

This is VERY RARE. Occasionally a woman's breasts do not develop and increase in size during pregnancy and she does not produce much milk. If the mother noticed an increase in the size of her breasts during pregnancy then poor breast development is not her problem. It is not necessary to ask about this routinely. Ask only if there is a problem.

d) Physical condition of the baby

- Illness

A baby who is ill and unable to suckle or suck well enough does not get enough milk.

- Abnormality

A baby who has congenital problem such as a heart abnormality may fail to gain weight. This is partly because he takes less milk and partly because of other effects of the condition. Babies with a deformity such as a cleft palate, or with a neurological problem or mental handicap often have difficulty in suckling/sucking well especially in the first few weeks.

Helping a mother whose baby is not getting enough milk

Look for a cause

Listen and learn	Psychological factors - how mother feels, fears and anxieties.
Take a history	Feeding factors. Complementary feeds. Medication – contraceptive pill, diuretics.
Assess a feed	Baby's position during feeding, feeding technique, bonding or rejection.
Examine the baby	Illness or abnormality; growth
Examine the mother	Her nutrition and health
Examine her breasts if breastfeeding	Any breast conditions
Observe the feeding utensils	Cleanliness. Size of teats.

Build confidence and give support: Help the mother to give her baby more milk and to believe that she can manage

Accept	Her ideas about her worries. Her feelings about feeding and her baby.
Praise (as appropriate)	She is still feeding exclusively. Her breasts are good for making milk if breastfeeding exclusively.
Give practical Help	Improve baby's breast feeding technique. A mother who is using formula may need to show how she is preparing the feeds. Provide supportive teaching to correct her difficulties.
Give relevant information	Explain the baby's milk requirements. Explain how the baby can get more milk – increase frequency of feeds.
Use simple language and suggest (as appropriate)	Feed more often, longer at night, stop using bottles or pacifiers (use cup if necessary).
	Stop other feeds and drinks (if baby less than 6 months old). Ideas to reduce stress and anxiety. Offer to talk to family if necessary.

Help with less common causes:

Baby's condition	If ill or abnormal, treat or refer.
Mother's condition	If taking estrogen pills or diuretic, help a breastfeeding mother to change and get a suitable method or treatment. Help as appropriate with other conditions.

Follow up:
See daily then weekly until baby gaining weight and mother confident.
It may take 3-7 days for the baby to gain weight after birth.

Helping a mother who thinks that she does not have enough breastmilk

Understand her situation

Listen and learn	To understand why she lacks confidence. Empathise.
Take history	To learn about pressures from other people.
Assess a feed	To check the feeding technique.
Examine mother	Breast size may cause lack of confidence (if breastfeeding).

Build confidence and give support

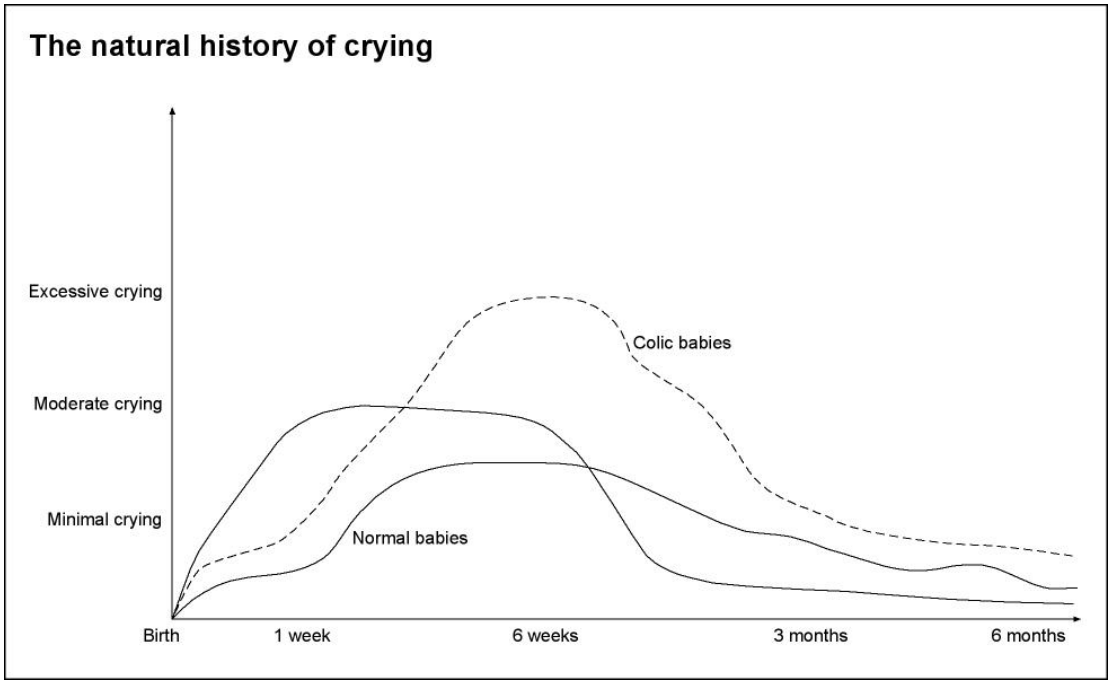
Accept	Her ideas and feelings about her milk.
Praise (as appropriate)	Baby growing well – getting all the milk he needs. Good points about her feeding technique. Good points about baby's development.
Give practical help	Improve feeding technique if necessary.
Give relevant information	Correct mistaken ideas, do not sound critical. Explain about babies' normal behaviour. Explain how breastfeeding works (if breastfeeding). (What you say depends on her worries.)
Use simple language and suggest	Ideas for coping with tiredness. Offer to talk to her family if necessary.

3. Crying

- A common reason why a mother may think that the baby is not having enough milk is that she, or her family, thinks that the baby is 'crying too much'.
- Many mothers start mixed feeding because of their baby's crying. This puts the baby at higher risk of HIV if mother is HIV positive and breastfeeding, and at higher risk of diarrhoea and respiratory infections irrespective of the feeding option. Sometimes a baby cries more when complementary feeds are introduced too early.
- A baby who cries a lot can affect the relationship between itself and its mother, and cause tension among other members of the family. An important way to help a feeding mother is to counsel her about her baby's crying.

Natural history of crying

The main way that babies communicate what they want and need and like is by crying. Some babies cry a little, others a lot. ALL babies cry quite a lot, especially in the first few weeks.



Approximately 40% of babies will cry as is indicated by the bottom line in the graph. These babies do cry a reasonable amount in the beginning but they start

to decrease the amount of crying slowly after 6 weeks. 30% of babies will cry a little more than that in the first 6 weeks of life, but these babies are still healthy and normal. Approximately 30% of all babies have colic their crying builds to being excessive in the first 6 weeks, and then continues at a high level until about 3 months of age, after which it slowly tapers off.

Why do babies cry?

Hunger

- Most common cause of crying in a young baby.
- During a growth spurt a baby may seem very hungry for a few days, possibly because he is growing faster than before. He demands to be fed very often. This is commonest at the ages of about 2 weeks, 6 weeks and 3 months, but can occur at other times.

Discomfort

- Wet or soiled nappy.
- Clothes that irritate the baby's skin.
- Being too hot or too cold.
- Being undressed.
- Tired.

Pain or Illness

- If the baby has an illness or infection, they may cry more than usual.
- Gastro-oesophageal reflux (where milk and fluids from the stomach are regurgitated up into the mouth) is also a common problem in babies. This may cause significant pain in babies. These babies may also vomit after feeds, and fail to gain weight.

Lack of physical contact

- Some babies cry more than others and they need to be held and carried more. In communities where mothers carry their babies with them, crying is less common than in communities where mothers like to put their babies down or where they put them to sleep in separate cots.

Colic

- Some babies cry a lot without one of the above causes. Sometimes the crying has a clear pattern. The baby cries continuously at certain times of day, often in the evening. He may pull up his legs as if he has abdominal pain. He may appear to want to suckle but it is very difficult to comfort

him. Babies who cry in this way may have a very active gut or wind but the cause is not clear. This is called colic. Colicky babies usually grow well and the crying usually becomes less after the baby is 3 months old.

Mother's food

- Sometimes a mother notices that her baby is upset when she eats a particular food. This is because substances from the food pass into her milk. It can happen with any food and there are no special foods to advise mothers to avoid, unless she notices a problem.
- Babies can become allergic to the protein in some foods in their mother's diet. Cow's milk, soy, egg and peanuts can all cause this problem.
- Babies on exclusive formula may be allergic to animal protein in the milk being used. Mother may need to consider changing to other milks such as soy milk.
- Caffeine in coffee, tea and colas can pass into breast milk and upset a baby. If a mother smokes cigarettes, or takes other drugs, her baby is more likely to cry than other babies. If someone else in the family smokes, that also can affect the baby.

What can you do to help a mother whose baby cries a lot

Helping with a baby who cries a lot

<u>Identify causes</u>

Listen and learn	Help mother to talk about feelings (guilt, anger, self blame). Pressures from family and others. Empathise.
Take a history	Learn about babies feeding and behaviour. Learn about mother's diet, coffee, smoking, drugs.
Assess a feed	Position during feds, time spent per feed, and amount per feed (if cup or formula fed).
Examine baby	Illness or pain (treat or refer as appropriate). Check growth.

Build confidence and give support

Accept	Mothers ideas about the cause of crying. Her feelings about baby and his behaviour.
Praise *(as appropriate)*	Her baby is growing well and is not sick.
Give relevant information	Milk provides all the baby's needs. Her baby is fine, not naughty or bad. Baby has real need for comfort. Crying will decrease when baby is 3-4 months old, if due to colic. Medicines for colic not recommended. Mixed feeding may be harmful to the baby. Comfort suckling on hand if formula feeding. Pacifiers can help, but must be kept clean.
Suggest *(as appropriate)*	Reduce coffee and tea Avoid smoking before or during breastfeeds. Stop milk, eggs, soya, peanuts if allergy suspected. (One week trial, if mothers diet adequate)
Practical Help	Assist with breastfeeding, cup feeding technique or formula feeding as needed. Show mother and others how to hold and carry baby with close contact, gentle movement, and gentle abdominal pressure. Offer to discuss situation with family if necessary. Discuss and show ways of comforting a baby who is not breastfeeding.

Different ways to hold and carry a colic baby

SESSION 34: Counselling Practice - Applying Counselling Skills to Different Infant Feeding Situations

Time required: 2 hours

Purpose

- This session allows participants to consolidate and practice their counselling skills and everything they have learnt during their training on feeding.

Objectives

- At the end of this session MM's should feel confident in applying the counselling and communication skills they have learned to various feeding situations.

Material

- PowerPoint slides
- Flipchart Board / flipchart and paper
- Markers

Role plays: Counselling on Infant Feeding 2 hours

Scenarios:

Role play 1: Mother lives with her mother-in-law. Mother-in law wants her to give her baby porridge. Baby is 3 weeks old. Mother feels that she does not have enough breast milk.

Role play 2: Mother lives with her mother. Mother does not know her HIV status. Baby is crying too much. Mother has just had a caesarean section. Baby is 3 days old. Grandmother wants mother to give her baby formula milk.

Role play 3: Mother lives with her partner. He believes that breastfeeding is good. Mother is HIV positive but the partner refuses to believe her. The baby is 1 week old. Mother meets all the AFASS criteria. She wants to avoid all breastfeeding.

Role play 4: Mother lives with her sister. Mother does not know her HIV status. Baby is 3 weeks old. Mother's sister believes that baby needs glucose water to prevent constipation.

SESSION 35: Counselling Practice with Mothers and Babies - Applying Counselling Skills to Real Life

Time required: 2 hours

Purpose

- The purpose of this session is to allow trainees the opportunity to practice all the counselling skills that they have learnt, with volunteer mothers and babies, so as to give them a chance to simulate the working environments they will be encountering.

Objectives

- At the end of this session MM's will:
  - Understand how it feels to interact with mothers and babies in reality.
  - Have an idea of which areas of the interaction they did well, and the areas in which they need to focus more attention.

Material

- None

Role plays: Counselling with mothers and babies 2 hours

The trainers will guide this session.

SECTION K
MOTHER AND BABY CARE

SESSION 36: Introduction to Neonatal Care - The Importance of Community Home-based Care for Mothers and Newborns

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.

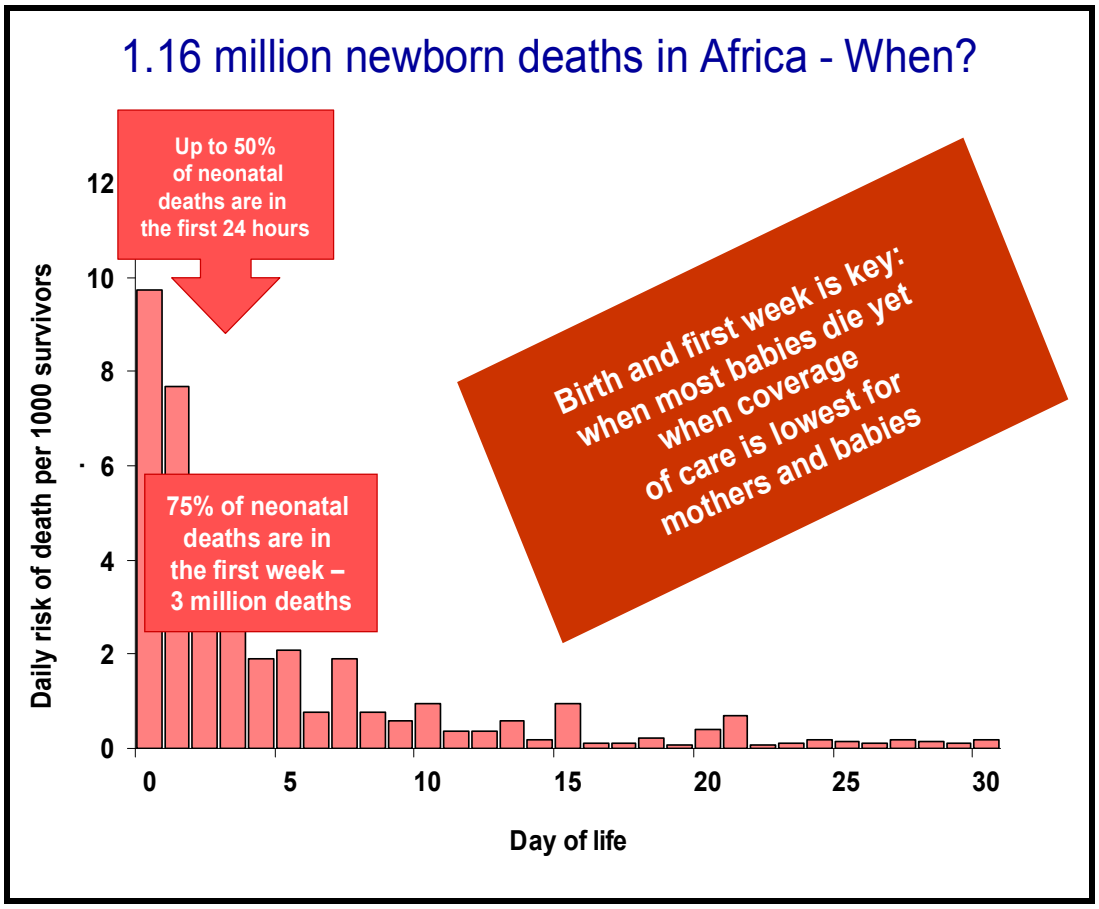
Objectives

- At the end of the session the MM will be able to:
  - Explain why the delivery and the first month after delivery are important for the health of mothers and babies.
  - Describe, in general terms, the intervention in the neonatal period of the MM that will improve the health of mothers and newborns.

Materials

- Board/flip chart and paper
- Markers
- Glass jar
- Rice to fill the glass jar

Discussion: Introduction to the Neonatal Period 10 minutes



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

The important thing to think about 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.

Causes of neonatal deaths

- **Prematurity** (most common cause)
- Complications from the birth (birth trauma, asphyxia)
- Infections
- Neonatal tetanus
- Congenital abnormalities (rare)

MM's can play an important role in helping mothers to:

- establish good feeding practices from birth

- keeping the baby warm
- preventing infections like tetanus and diarrhoea

Story and discussion: Importance of care for mothers and newborns 10 minutes

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.

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

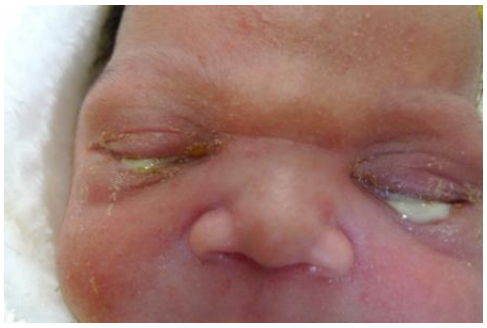
- At the end of the session the MM will:
  - Know to refer babies with eye infections for antibiotic treatment.
  - Know how to provide umbilical cord care.
  - Know how to prevent and care for skin (nappy) rash.

Materials

- PowerPoint slides

Discussion: Eve Care 10 minutes

1. Babies can get bacterial eye infections. Some of these infections can occur if the mother had a vaginal infection (even without symptoms) during pregnancy.



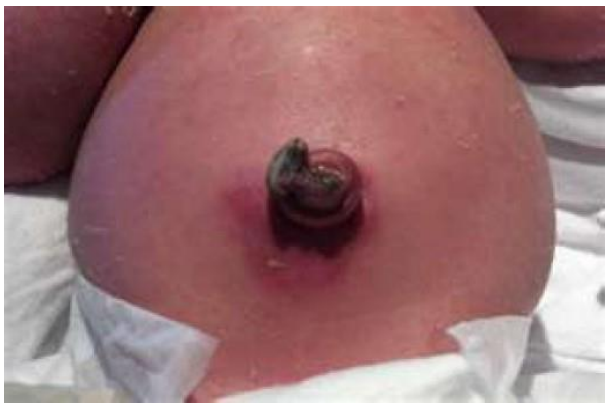
2. If MM's see that a baby has an eye infection, they need to refer them immediately to the clinic to get antibiotic ointment.

3. Advise the mother to gently clean the discharge from the eyes with clean water and cotton wool.

Discussion: Umbilical Cord Care 10 minutes

1. Remember, the most important thing is to keep the cord stump clean and dry. It is also important to fold the nappy below the umbilical cord, so that urine or stools do not contaminate the cord.

2. **Traditional medicines or dung applied to the cord can be extremely dangerous for the baby.** Neonatal tetanus is caused by a bacteria found in the soil, that can infect the cord if it is not properly cleaned. It causes severe muscle spasms, and death in many cases.



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 oozing pus, or smells, or the skin around the umbilicus is red refer the baby to the health centre.

Discussion: Skin Care (nappy rash) 10 minutes

Keep baby clean and dry; if not too cold, expose rash to the air and sunlight for some minutes during the day. If not improved, use zinc ointment (e.g. Fissan paste) - put on after every nappy change 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:
  - Determine if a baby is 'high-risk'
  - Define low birth weight (LBW) and explain the risks.
  - Explain the immediate care of the LBW baby after delivery.
  - Explain the skin-to-skin or Kangaroo Mother Care (KMC) method, and when and how it is used.

Materials

- Video: Caring for the Small Baby – Positioning Skin-to-Skin and KMC

Discussion: Low Birth weight & High Risk Babies 10 minutes

High risk newborn babies that are:

- Low birth weight (LBW)
- born early (premature)
- If baby and mother have a breastfeeding problem on the first day

LBW infants*:* Weight less than 2500 grams or 2.5 kg.

Prematurity is defined*: Baby* born before 38 weeks of pregnancy.

Most babies born too early are LBW but some babies at full gestation are also LBW. Being LBW at full gestation means that the baby did not grow well during pregnancy, and can be caused by a mother who:

- Is short and is underweight
- Does not eat enough food and/or eats food that is not nutritious during pregnancy
- Has an illness such as TB, HIV
- Is anaemic (weak blood)
- Works too hard during pregnancy.

Risks a LBW baby faces:
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)
- Very small babies are at risk of bleeding in the head and of death.

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 of dying is 1 out of 100.
- If the baby weighs between 2.0 to 2.5 kg, the risk is 10 out of 100.
- If the baby weighs less than 2.0 kg, the risk is 36 out of 100.
- If the baby is born early, the risk is 36 out of 100.

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

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

Discussion: Care of a LBW baby 20 minutes

Immediate care is needed for the LBW baby should include:

- Keep room even warmer than usual.
- Dry baby immediately after delivery.
- Put skin-to-skin with mother, and cover.
- 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.
- 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 need to feed more often, **every 2 hours**. This means that if the baby is sleeping, the mother should wake the baby for a feed. This should be done until the baby gains some weight and is stronger.

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

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.

Content box: Kangaroo Mother Care (KMC) method

Kangaroo Mother Care (KMC) method

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.
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).
Any member of the family can keep the baby this way to help relieve the mother from time to time.

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 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 suckle a little.
• Once the baby can suckle, he should be put on the breast frequently to stimulate milk production. Continue feeding with cup 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 richer in nutrients than standard formula milk.

Video: Caring for a LBW Baby – Skin to Skin and KMC 10 minutes

The trainers will guide this session.

SESSION 39: Identifying Danger Signs and using Referral Notes during Postnatal Visits

Time required: 2 hours and 15 minutes

Purpose

- To develop the ability to identify danger signs and make referrals during home visits during the early postnatal period.

Objectives

- At the end of the session the MM will be able to:
  - Use the below information to screen newborns and mothers for danger signs during postnatal home visits.
  - 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

- Board/flipchart paper and paper
- Markers
- Referral Notes
- Model Role Play Script— Identifying danger signs during Postnatal Home Visit
- Community Resource Guides

Discussion: Danger signs in mothers and newborns after delivery
75 minutes

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.

Since you have already learned about danger signs in pregnant women and during delivery, we will now focus on screening mothers after delivery and on newborns.

Use this information during every postnatal home visit (after delivery) to screen for problems in mothers and newborns. If a problem exists, refer the mother or newborn, or if the problem is not serious, provide health education advice and management.

A. Danger signs in mothers after delivery (postpartum)

- **Excessive vaginal bleeding**
- **High fever**
- **Headache and/or convulsions**
- **Breast problems**

Excessive vaginal bleeding - Danger of death - Refer immediately

Ask and observe:	What to do:	In the meantime:
• 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).	• 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.	• 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.

High fever - Danger of death - Refer immediately

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 and Observe:	What to do:
• Ask if the mother feels hot or feverish. • If she has a fever then refer. • Ask if the mother has a foul-smelling discharge. • If the mother has a foul-smelling discharge, she must go to a health facility immediately	• Refer to the hospital immediately

Headache and/or convulsions – Danger - Refer immediately

Ask and Observe:	What to do:
• High blood pressure in pregnancy can continue in the time after delivery, and the mother can still be at risk of having fits. • Ask if the mother has severe headaches, vomiting, abdominal pain or fits.	• If the mother has headaches as well as one of the above symptoms, then refer immediately to hospital. • If the mother is still on medication for high blood pressure, check that she has taken her medicines.

<u>Breast problems</u> - Problem to mother and baby - Counsel/Refer
The problems can include: feeling she "doesn't have enough milk", engorgement, cracked nipples, difficulty with latching on, and breast infections.

Ask and Observe:	What to do:	No problems with breast feeding:
• Observe if the baby is suckling well. • Observe if she has engorgement, cracked nipples, etc. • Note if the baby is low birth weight.	• Observe a breastfeed. • Weigh baby and assess weight gain • Counsel the mother on how to resolve the problem. • Observe if she can practise what you have counselled her about. If the problem has not improved in a day or two, refer to the health facility.	• Praise and reassure mother. • Continue with health education.

B. Danger signs for the newborn

- **Not able to feed**
- **Drowsy and can't wake up**
- **Too cold or feverish**
- **Rapid, laboured breathing (60 respirations or more/ minute)**
- **Umbilical discharge with redness extending to surrounding skin**
- **Convulsions**
- **Eyes with pus**
- **Baby born early/very small**

<u>Not able to feed or drowsy and can't wake up</u> - Danger of death - Refer immediately

Ask and Observe:	What to do:
• 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.	• 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.

Too cold or feverish - Danger of death - Refer immediately

Ask and Observe:	What to do:
• Ask the mother and observe if the baby feels colder or hotter than normal.	• Refer to hospital immediately.

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

Ask and Observe:	What to do:
• 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.	• A rate of 60 or more breaths per minute could be a sign of pneumonia. • Refer immediately.

Umbilical discharge with redness - Danger of death - Refer immediately

Ask and observe	What to do:
• Observe if navel is red or has pus. • The MM could ask and if the mother says the navel is fine, she should still observe.	• If only with pus around umbilicus, this is a sign of local infection. • Refer for treatment as it could worsen and become life threatening.

Convulsions - Danger of death - Refer immediately

Ask and Observe:	What to do:
• Ask the mother if baby has had any fits.	• If the child has had fits the child should be referred for investigation. If the child is fitting, refer immediately.

Eyes with pus – Danger - Refer for treatment or treat if trained

Ask and Observe:	What to do:
• Observe if the baby has pus in its eyes. This can be a sign of local eye infection.	• Refer for treatment or treat if trained, and observe next day. • If not improved, refer.

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

Ask and observe:	What to do:
• Observe and weigh baby. Assess growth progress since birth and observe feeding.	• Start Kangaroo/skin-to-skin (KMC). • If baby in distress, then refer immediately. • If not, assist with feeding if needed and encourage KMC.

Activity: Use of Referral Notes **15 minutes**

The trainers will guide this session.

Facilitator Model Role Play: Screening for Danger Signs 30 minutes

Model Role Play Script: Screening for danger signs

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

MM: Andiswa, 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?

ANDISWA: 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?

ANDISWA: 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 are positive chest indrawings on breathing.)*
Andiswa, the baby is very sick. The baby is breathing fast, has 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.

ANDISWA: Can I make a meal for the family first?

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

SESSION 40: Sequencing of Postnatal Home Visits

Time required: 1 hour and 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:
  - Explain when she will visit each mother and newborn during the postnatal period.
  - Explain when she will use the referral note.
  - Explain the sequencing of tasks during each visit.

Materials

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

Presentation: Postnatal Home Visits 20 minutes

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.

If a mother has two or more of the following risk factors, she will receive two extra visits before birth and two extra visits after birth.
Risk factors for mothers:

- HIV
- TB
- alcohol use in pregnancy
- previous LBW baby

Discussion: Hand washing 5 minutes

CORRECT HAND WASHING

• 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 with soap 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 hands, 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
30 minutes

Postnatal Home Visit Outlines

After Birth - *Each mother will receive a minimum of six postnatal visits (at 2 days, 1 week, 2 weeks, 4 weeks, 2 months, and 6 months). An additional two visits will be made for mothers and/or child with two or more risk factors.*

1st visit - 2 days

Topics: Child health, Infant feeding, Hygiene, Protection of child, Mother care and Danger signs

Visit outline:

Child

- Observe child and check for danger signs: breathing, temperature, alertness, eyes, umbilicus.
- Discuss danger signs and what to do.
- Weigh child and plot on road to health card and in folder.
- Observe breast feeding, or mixing of formula and cleaning of bottle.
- Discuss cord care, and general hygiene.
- Observe if baby is warm and protected.
- Observe mother practicing Kangaroo Care and discuss special frequent feeding routine for LBW babies if indicated.
- Check if baby received Nevirapine if necessary.

Mother

- Check for danger signs: vaginal bleeding, temperature or other signs of infection, breast engorgement or mastitis.
- Assess mother's general condition - exhaustion, depression, support.
- Advise about good routines.
- Explain when you will return for the next visit.

2nd visit - 1 week

Topics: Child health, Infant feeding, Growth monitoring, Protection of child, Mother care, TB, HIV, Danger signs and Alcohol

Visit outline:

Child

- Observe child and check for danger signs: breathing, temperature, alertness, eyes, umbilicus.
- Observe feeding routines, and assist if needed.
- Weigh baby and plot on road to health card and in folder, inform mother and discuss implications of weight gain or loss.
- Check on effectiveness of Kangaroo Care and special frequent feeding routine of LBW baby.
- Check if baby is getting Nevirapine, if necessary.

Mother

- Check for danger signs: vaginal bleeding, temperature or other signs of infection, breast engorgement or mastitis.
- Assess mother's coping ability, sleep, hygiene, depression, support.
- Observe whether the mother is bonding well with her baby. Encourage her to hold her baby a lot, and smile and talk to her baby.
- 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 TB and ARV treatment if applicable.
- If HIV negative, educate about how to stay negative.
- Explain when you will return for the next visit.

3rd visit - 2 weeks

Topics: Child health, Infant feeding, Growth monitoring, Protection of child, Mother care, TB, HIV, Alcohol and Danger signs

Visit outline:

Child

- Observe child for danger signs: breathing, temperature, alertness, eyes.
- Again discuss danger signs and what to do.
- Observe feeding routines.
- Weigh baby and plot on road to health card and in folder, inform mother and discuss implications of weight gain or loss.
- Check on effectiveness of Kangaroo Care and special frequent feeding routine for LBW baby.
- Discuss good hygiene in order to protect child from infections.
- Check that baby is receiving Nevirapine, if necessary.
- Check the baby's development: Baby should look at the mother's face, especially when she is feeding the baby. Encourage the mother to have close physical contact with her baby, to make eye contact with the baby, and to talk to the baby as she goes about the activities of her day

Mother

- Check for danger signs: vaginal bleeding, temperature, breast problems.
- Assess mother's coping ability, sleep, hygiene, depression, support.
- Check on continuation of TB and ARV treatment and consumption of alcohol as indicated. Counsel if necessary.
- If HIV negative, educate about how to stay negative.
- Discuss mother's plan for the day. .
- Discuss the child support grant and process of application.
- Explain when you will return for the next visit.

4th visit - 4 weeks

Topics: General child health, Infant feeding, Growth monitoring, Protection of child, Mother care, TB, HIV, Alcohol, Danger signs, Immunisations

Visit outline:

Child

- Observe child and check for danger signs: breathing, temperature, alertness, hydration, eyes.
- Observe feeding routines.
- Weigh baby and plot on road to health card and in folder, inform mother and discuss implications of weight gain or loss.
- Check on effectiveness of Kangaroo Care and special frequent feeding routine for LBW baby.
- Observe hygiene routines.
- Check on the baby's development: Baby should have good eye contact with the mother; baby should respond to loud noises. For emotional development of the baby encourage close bonding with the mother. Babies are interested in brightly coloured objects – hang up objects with string, or make a simple mobile.

Mother

- Check for danger signs.
- Assess mother's coping ability, sleep, hygiene, depression, support.
- Check on TB, ARV treatment and alcohol consumption if indicated. Counsel if necessary.
- If HIV negative, educate about how to stay negative.
- Discuss mother's plan for the day.
- Promote attendance at clinic at 6 weeks, for mother to have access to family planning, repeat HIV testing; and baby to receive immunisations. Babies of HIV+ women will be given cotrimoxazole and have PCR test for HIV.
- Give mother referral letter for HIV test of child, if applicable.
- Discuss the child support grant and process of application.
- Explain when you will return for the next visit.

5th visit - 2 months

Topics: General child health, Infant feeding, Growth monitoring, Protection of child, Mother care, TB, HIV, Alcohol, Danger signs, Immunisations
Visit outline:

Child

- Observe child and check for danger signs: breathing, temperature, alertness, hydration.
- Observe feeding routines.
- Weigh baby and plot on road to health card and in folder, inform mother and discuss implications of weight gain or loss.
- Discuss introduction of solids and stress the importance of only introducing solids at 6 months.
- Check on effectiveness of Kangaroo Care and of special frequent feeding routine for LBW baby. Discuss how to protect child from infections.
- Observe hygiene routines.
- Check baby's development: baby should be smiling, and may be making some sounds. The baby will have much stronger neck muscles now, and should have good control of the head. Encourage continued close physical contact, and communication with the baby. Having interesting objects to look at, is good for babies of this age, and will encourage them to start reaching for them as their movements become more co-ordinated.
- Refer babies who are floppy; have stiff arms and legs; don't move one side of the body well; unable to make good eye contact; poor sucking; or are not smiling

Mother

- Assess mother's coping ability, sleep, hygiene, depression, support.
- Check on TB, ARV treatment and alcohol consumption if indicated. Counsel if necessary.
- If HIV negative, educate about how to stay negative.
- Discuss mother's plan for the day.
- Check that clinic visit happened at 6 weeks, that immunizations were done and that HIV testing was done and results known, and cotrimoxazole was given if relevant. Advice about family planning.
- Discuss the child support grant and process of application.
- Explain when you will return for the next visit.

6th visit - 6 months

Topics: General child health, Infant feeding, Growth monitoring, Protection of child, Mother care, TB, HIV, Alcohol, Danger signs, Immunisations

Visit Outline:

Child

- Check for danger signs: breathing, temperature, alertness and hydration.
- Observe feeding routines. Weigh baby and plot on road to health card/booklet and in folder. Inform mother and discuss consequences of weight gain/loss.
- Discuss introduction of solids, frequent feeding of solids, importance of balanced diet and continuation of breast feeding for two years and beyond.
- Check that immunisations have been done, HIV results are known and appropriate action has been taken regarding treatment for child.
- Discuss how to protect child from infections. Observe hygiene routines.
- Discuss how to make home safe for a child as the child grows and starts moving around.
- Check on baby's development according to guidelines on the road to health booklet. Encourage the mother to give the baby a selection of interesting objects to play with (e.g. put some beans or lentils into a plastic bottle for the baby to shake) Talk to the baby, and encourage the baby to explore his/her surroundings. If possible, encourage the mother to show her child books and pictures, and read or tell stories to the child.
- Refer babies who are floppy; not able to use both hands; do not respond to sounds; have a squint; or respond poorly to people.

Mother

- Assess mother's coping ability, sleep, hygiene, depression, support.
- Check on TB, ARV treatment and alcohol consumption as indicated. Counsel if necessary.
- If HIV negative, educate about how to stay negative.
- Check on family planning.
- Explain when you will return for the next visit.

Extra Postnatal Visits 7 and 8

*A mother who has two or more of the following risk factors: HIV, TB, excessive alcohol intake, or a LBW baby will receive two extra postnatal visits at **3** and **4** months respectively.*

7th visit (3 months)

Topics: Child health, Infant feeding, Growth monitoring, Protection of child, Mother care, TB, HIV, Alcohol, Danger signs and Immunisations
Visit outline:

Child

- Observe child and check for danger signs: breathing, temperature, alertness and hydration.
- Observe feeding routines. Weigh baby and plot on road to health card and in folder, inform mother and discuss consequences of weight gain/loss. Stress importance of only introducing solids at 6 months.
- Check on effectiveness of KMC and frequent feeding routine for LBW baby.
- Discuss how to protect child from infections. Observe hygiene routines.
- Check that immunisations and HIV testing of child has been done and cotrimoxazole was given if applicable.
- Check on baby's development
- Refer babies who are floppy; not able to use both hands; do not respond to sounds; have a squint; or respond poorly to caregivers.

Mother

- Assess mother's coping ability, sleep, hygiene, depression, support.
- Check on mother's TB, ARV treatment and alcohol consumption if applicable. Counsel if necessary.
- Discuss mother's plan for the day.
- Explain when you will return for the next visit.

8th visit (4 months)

Topics: Child health, Infant feeding, Growth monitoring, Protection of child, Mother care, TB, HIV, Alcohol, Danger signs and Immunisations

Visit outline:

Child

- Observe child and check for danger signs: breathing, temperature, alertness, hydration.
- Observe feeding routines. Weigh baby and plot on road to health card and in folder, inform mother and discuss implications of weight gain or loss. Stress importance of only introducing solids at 6 months.
- Check on effectiveness of kangaroo care and special frequent feeding routine for LBW baby.
- Discuss how to protect child from infections. Observe hygiene routines.
- Check that child has had relevant immunisations, and that HIV testing was done and cotrimoxazole was given if applicable.
- Check baby's development: Baby will be able to roll over, and starts to pull up with his/her arms. Baby will try to grab things, but will not always succeed! Encourage mother to continue with close contact with the child, and talk to the child in interesting ways.

Mother

- Assess mother's coping ability, sleep, hygiene, depression, support self care.
- Check on TB, ARV treatment for mother and child and alcohol consumption if relevant. Counsel if necessary.
- Discuss mother's plan for the day.
- Advise about family planning.

SESSION 41: Practise 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

- Board/flipchart and paper
- Markers
- Field guide
- Referral Note

Role plays: Postnatal home visits — 60 minutes

Scenarios for role plays:

Scenario 1

First visit on Day 2

Mentor Mother

- 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.

Nokwanda

- Your first baby was born yesterday at the clinic (MOU). You are well, and the baby is doing well. You are breastfeeding. You are HIV negative. You drank alcohol during pregnancy, but were able to reduce your drinking after discussions with your mentor mother.

Second visit on Day 7:

Mentor mother

- The baby feels hot.

Nokwanda

- You are doing well.

Scenario 2

First visit on Day 2:

Mentor Mother

- 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.

Khanyisa

- You have a healthy baby boy, delivered 2 days ago. You are bottle feeding your baby. You have been bleeding heavily since delivery. You are HIV positive and are taking your ARV's.

Second visit on Day 7:

- Khanyisa was kept in hospital for 2 days for postpartum bleeding. She is now back at home. Mother and baby are fine.

Scenario 3:

First visit on day 2:

Mentor Mother

- Nyameka gave birth to her seventh baby at the clinic. She returned home on Day 2, and you are visiting her that same day. Both mother and baby are fine.

Nyameka

- Your seventh baby was born yesterday at the clinic. You have come home today. You and your baby are well. You are bottlefeeding your baby.

Scenario 4:

Second visit on day 7.

Mentor Mother

- Zimkitha gave birth to her first baby, and you are visiting a week after the delivery. She is having problems breastfeeding her baby. He is not latching well, and you notice that she has cracked nipples. When you weight the baby, you find that he has not gained much weight in the last 5 days. His weight is 3 kg. When you check the baby, you find that his hydration is normal, he has no fever, and is alert.

Zimkitha

- You have a baby boy, born one week ago. This is your first baby. He is not breastfeeding well, and your nipples are becoming cracked and sore. He is crying a lot. You are worried, and think it may be better to change to bottle feeding.

SECTION L
POSTNATAL DEPRESSION

SESSION 42: 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.
  - Understand that at times treatment may be required.
  - MM's will learn how to help mothers with postnatal depression and identify when to refer mothers for additional support.

Materials

- Powerpoint slides
- Board/flipchart and paper
- Markers
- Folders

Discussion: Postnatal Depression 45 minutes

The trainers will guide this session.

LECTURE CONTENT: Postnatal depression

Please note information for this section has been taken from: Perinatal Mental Health Project. 2013. Maternal Mental Health: A Handbook for Health Workers 3rd Edition. UCT, Rondebosch, South Africa.

Pregnancy, and the postnatal period, is often a distressing time for many women. For example, in South Africa, almost half of all pregnant women living in poor communities experience depression. Depression within the months leading up to birth is just as common as postnatal depression. Mental illness during pregnancy can have serious and long lasting consequences. For example, it is associated with poor foetal growth and premature delivery. Children with mothers who experience mental illness are more likely to be abused, perform poorly in school and develop mental illnesses themselves. It is therefore an important aspect of health for mentor mothers to focus on.

Risk factors for mental illness include:

- Poverty,
- Violence and abuse
- Rape,
- HIV/Aids
- Refugee status
- Substance abuse

All such factors are prevalent in the areas in which we work and hence, it is important to monitor the psychological health of every mother within our programme.

Baby Blues:
Emotional changes are common during pregnancy and in the first few weeks following the birth of a baby. New mothers are prone to feeling:

- irritable
- sad
- anxious

- restless
- lonely
- impatient

Mothers may experience mood swings and cry a lot, for no apparent reason. These symptoms are very common in the first 2 weeks following the birth of the baby and are a result of the hormonal changes in one's body related to breastfeeding, the exhaustion experienced after delivery, and adjusting to motherhood. Sometimes, as a result of these feelings, new mothers may miss appointments, ignore advice or not take responsibility, they may be rude or even aggressive and it is important to remember that often these actions are a result of the mother's state of mind. If symptoms do not disappear within 2 weeks, then the mother may be experiencing depression.

Postnatal Depression:

Postnatal depression is an illness, like diabetes or heart disease. It is characterised by a low mood and other symptoms lasting 2-4 weeks. It can be treated with therapy, support networks and medicines such as antidepressants. The symptoms of postnatal depression include:

- Often feeling sad or down, almost on a daily basis
- Frequent crying or tearfulness
- Feeling restless, irritable or anxious
- Feeling of hopelessness
- Loss of interest or pleasure in life. It's hard for you to see the funny or good side of life and you experience a lack of joy in life
- Loss of appetite and weight loss or alternatively, increased appetite and weight gain
- 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"
- Feeling like life isn't worth living
- Showing little interest in your baby and finding it difficult to bond with your baby
- You sometimes lose your sense of time - you can't tell the difference between ten minutes and two hours
- Finding it hard to focus, remember things or make decisions

- Feeling constantly worried or anxious
- Experiencing mood swings
- Withdrawing from family and friends
- Experiencing a loss of sex drive
- Having thoughts of harming oneself or one's baby.

If a mother is experiencing **five or more** of these symptoms for 2 weeks or longer and one of these symptoms is either sadness or loss of interest then it is likely that she may be depressed.

Sometimes postnatal depression will go away with time but often people with postnatal depression need medication and/ or support to get better.

A mentor mother needs to be able to tell which women are experiencing the 'normal' symptoms of pregnancy and which women need help for their emotional
well-being. Below are some useful tips for picking up mental distress
and mental illness:

- Does the mother often talk about a range of different physical symptoms,
- such as aches and pains?
- Is she showing signs of false labour? This may be a sign of underlying
- distress.
- A woman's body language and behaviour can often show that she is 'sad' or 'worried'. For example:
    - Is she taking care of her appearance?
    - What is her facial expression like? Does she look sad or distressed?
    - What does her voice sound like? Does she sound distressed?
    - Does she avoid eye-contact?
    - What is her posture like? Does she seem low or dejected?

Another sign could be that the mother is talking about many other problems
in her life, and not just her health. These can include:

- Work issues
- Problems with relationships
- Problems with her other children

The interaction between the mother and the baby can give you clues about
her emotional state. The mother could be experiencing mental distress if:

- Breastfeeding is difficult, especially if the difficulty is related to low self-esteem, hopelessness or excessive worrying

- The mother does not play or communicate with her child
- The mother shows hostility to the child
- The mother's interaction with her baby is either remote or intrusive
- The mother repeatedly describes the baby as 'irritable', 'fussy' or
- 'colicky'

How can you help women with mental health problems?

Aside from referring mothers to specific organisations, you can help support mothers in other ways. Women who are distressed or suffer from a mental health problem need someone who can listen, guide them and provide information. They can feel isolated and vulnerable and need to be encouraged to make social connections to form support systems. They require different types of treatment and care, depending on the severity or level of their distress. Information can empower women and help them to feel in control of their situation. Listening skills and empathy, however, are also vital tools to help mothers in distress.

Having someone to talk to, even for a short time, has real and positive effects for women. Listening to the mother and showing empathy is one of the most important things you can do for her.

SECTION M
CHILD HEALTH

SESSION 43: Social Factors in Child Health

Time required: 30 minutes

Purpose

- The purpose of this session is to create awareness about the risk factors in peri-urban and rural areas which create challenges for child and infant health, as well as to ensure that all MM are aware what the child grant is, who can apply for it, and how to do so.

Objectives

- At the end of this session MM will know:
  - What characteristics of informal settlements make it harder to protect children from ill health.
  - Who is eligible to access a child support grant and how one applies for the grant.

Material

- PowerPoint slides

Discussion: The Socio-Economic context of the Child Health 15 minutes

The trainers will guide this session.

Discussion: Child Support Grants 15 minutes

The Child Support Grant - FAQ

What is the child support grant?
A child support grant is money paid to the primary care giver of a child to provide for the child's basic needs.

How much is the child support grant? R310 per month

Who is eligible to apply for the child support grant?

- The primary care giver (parent, grandparent or a child over 16 heading a family) of the child or children concerned.
- A child or children under the age of 18.
- The child and care giver must be South African Citizens or permanent residents and must be living in the country at the time of application.
- You may not apply for support for more than six children if you are not the biological parent
- You may not earn more than R2900 per month

If approved, how does a person get the money every month?

A grant is payable by:

- cash at a specific pay point on a particular day
- electronic deposit into your bank account
- post bank account
- institution (e.g. children's home)

How do I apply?

- Apply at the social security office (SASSA) nearest to where you live.
- If you are too old or sick to travel to the office, ask someone to request a home visit on your behalf. The person must bring a letter from you or a doctor's note explaining why you cannot visit the office. A home visit may also be arranged.
- If you are working, show proof of your recent income (e.g. pay slip) or make a sworn statement at a police station.
- If you are married, show proof of your wife or husband's income (e.g. pay slip if they are working) or make a sworn statement.
- Show a copy of your discharge certificate if you were retrenched or fired from your previous work.
- If you are unemployed, make an affidavit at the police station to prove that you do not have an income.
- If you are not the parent of the child, and you are taking care of him or her, make an affidavit at the police station to prove that you have permission from the parents to take care of the child.
- Complete your application form in the presence of an officer from the department.
- Submit the form together with your ID and the child's or children's birth certificate.
- After submitting the application you will be given a receipt, keep it as proof of your application.
- Please note that only the beneficiary or a SASSA official can complete the application form. The beneficiary's fingerprints will be needed to complete the application form. You can, however, appoint a procurator to receive the grant on your behalf.

How long will my application take to be approved?

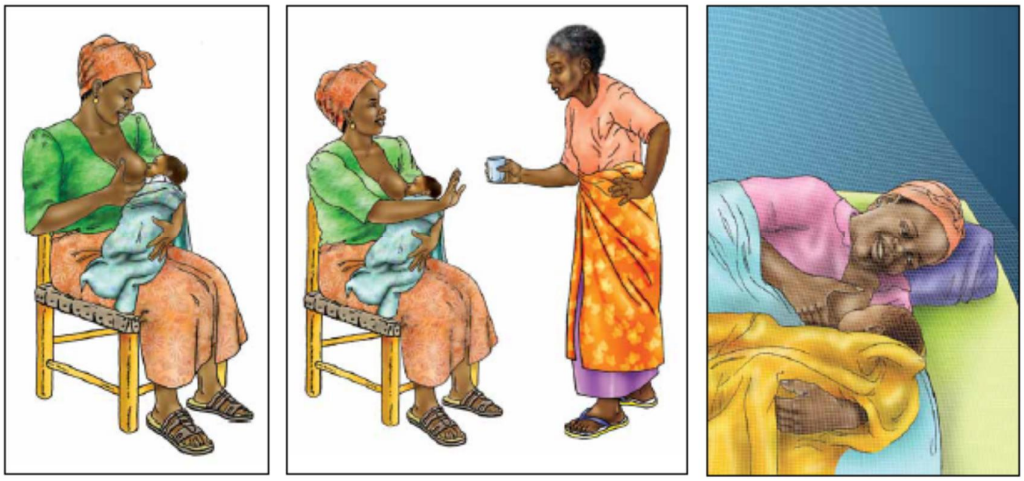
- It may take up to three month to process your application.
- The social security office will inform you in writing whether or not your application was successful.
- If your grant is approved, you will be paid from the you applied.

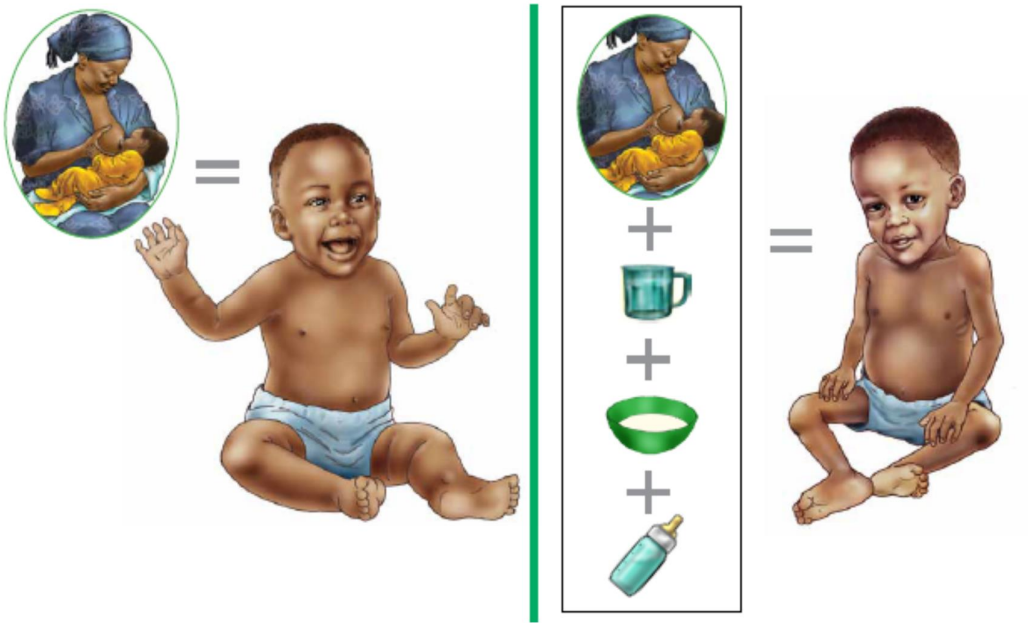
Lecture: Feeding young children 45 minutes

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

Babies 0 – 6 months of age:

- Exclusive breastfeeding or exclusive formula feeding.





Children 6 – 12 months of age:

- After six months a variety of healthy foods are added to the breast milk. This is called complementary feeding.
- It is important for children to continue to drink breast milk or formula milk up until 2 years and beyond.
- At 6 months the breast milk no longer provides the iron the baby needs therefore **iron rich foods** needs to be added to the diet. Egg yellow and pureed chicken livers may be added to porridge.
- The change from exclusive breast feeding to family foods usually covers the period from 6 to 18-24 months of age. It is a very vulnerable period if the food does not have enough nutrients and energy for the baby to stay healthy, or if the baby is not fed often enough. It is the time when malnutrition starts in many infants, and leads to the very high number of children under five years of age in the world who have malnutrition.

- It is also a time when a child is at risk for catching illness because there is a possibility that the food they are given is unhygienic and therefore can pass germs to the baby.

Introducing solid foods:

- It is best to start introducing solids to a baby with small amounts of foods at a time. Children have small stomachs, and can only eat a small amount at a time.
- Give food 2-3 times a day from 6-8 months, and increase to 3-4 times a day from 9-11 months.
- Start with protecting foods (**fruit, vegetables) and energy foods (mielie meal or oats porridge)**.
- Mash the food so that it is easy for the child to chew and swallow.
- Later introduce building foods like chicken, fish, egg yolks, beans and lentils.
- From 8 months the baby can be given some 'finger foods' e.g. banana.
- Advise the mother to use iodised salt for cooking, as it provides iodine needed in the diet.
- Advise the mother on hygienic food preparation, e.g. washing hands, washing fruit and vegetables before cooking, and clean surfaces.

Food practices to avoid:

- Do not add sugar to the baby's milk or food.
- Do not add honey or syrup to the baby's food before the baby is 1 year old.
- Do not add spices or extra salt to the baby's food. Use salt sparingly when cooking.
- Do not give the baby coffee, tea or creamers.

Feeding children 1 – 2 years old:

- From 1 year, give food first and then milk afterwards.
- 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, it is important to feed them often throughout the day.
- 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) and **vegetables** (beans, carrots, peas, broccolli) to the baby's porridge or samp.
- A baby can have 2-4 cups of full cream milk from 1 year. Too much cow's milk can cause iron deficiency, and can also fill the child so that they don't want to eat other foods.
- Give children a healthy snack between meals, e.g. fruit, yoghurt, a slice of bread with peanut butter.
- Egg whites and peanut butter can be introduced after 1 year.

Foods to avoid:

Discourage foods such as potato chips, ice-cream, fizzy drinks, sweets and chocolates.

- Avoid eating food with too much salt, as this can cause high blood pressure.
- Avoid eating a lot of sugary foods, as these destroy the teeth and decrease the appetite for healthier foods.
- Avoid oily and fatty foods. They can cause children to become obese and lead to health problems.

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, yoghurt, a slice of bread with butter and peanut butter).

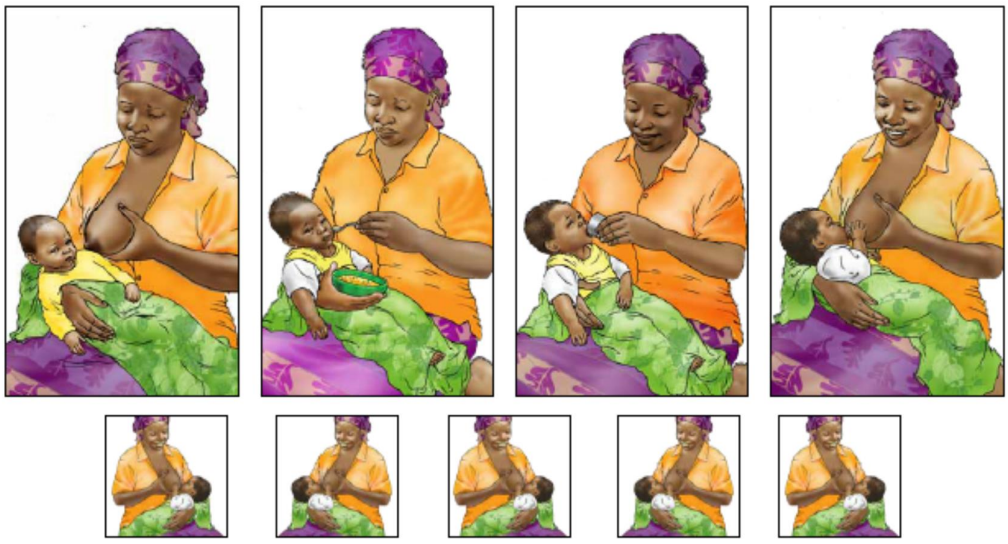
Tips on feeding a child with a poor appetite

- Feed small, frequent and favourite meals.
- Give snacks in between meals.
- Give milk rather than other fluids except in diarrhoea.
- Give foods with high energy content e.g. bread with peanut butter.
- Actively encourage the child to eat.
- Give the child food like.
- Check that the child is not filling up with sweets or chips.

Feeding a sick child

- Breastfeeding more often helps a child not to loose as much weight, and gives the child comfort.
- Be patient and encourage the child to eat as the child may not feel like eating because of their illness.
- Give the child food they like eating.
- Give small amounts often throughout the day.
- Give the child an extra meal every day for 2 weeks, once they are better, to catch up the weight they have lost

Sick baby more than 6 months



Health Promotion Messages in the Road to Health Booklet (RtHB)

On pages 10, 11 and 12of the RtHB, you will find standardised health promotion messages for children from birth to 60 months. This is a good resource to use during discussions with mothers about what and how to feed their children.

HEALTH PROMOTION MESSAGES

Up to 6 months

Feeding:

- Breastfeed *exclusively* (give infant only breast milk and no other liquids or solids, not even water, with exception of drops or syrup consisting of vitamins, mineral supplements or medication;
- Breastfeed as often as the child wants, day and night;
- Feed at least 8 to 12 times in 24 hours;
- When away from the child leave expressed breast milk to feed with a cup;
- Avoid using bottles or artificial teats (dummies) as this may interfere with suckling, be difficult to clean and may carry germs than can make your baby sick.

Why is exclusive breastfeeding important?

- Other foods or fluids may damage a young baby's gut and make it easy for infections (including HIV) to get into the baby's body.;
- Decreases the risk of diarrhoea;
- It decreases risk of respiratory infections;
- It decreases risk of allergies;

If you have chosen to formula feed your baby, discuss safe preparation and use of formula with the health care worker

HEALTH PROMOTION MESSAGES

6 - 12 months

Feeding:

For all children start complementary foods at 6 months

- Continue breastfeeding;
- Always breastfeed first before giving complementary foods;
- Start giving 2—3 teaspoons of soft porridge and begin to introduce vegetables and then fruit. Give mashed dried beans and locally available animal foods daily to supplement the iron in the breastmilk. Examples include egg (yolk), minced meat, fish, chicken/chicken livers, mopani worms;
- Gradually increase the amount and frequency of feeds.
- Children between 6—8 months should have two meals a day. By 12 months this should have increased to 5 meals per day, whilst frequent breastfeeding continues;
- Offer your baby safe, clean water regularly;
- If the baby is not breastfed, give formula or at least 2 cups of full cream cow's milk (cow's milk can be given from 9 months of age);

Feeding: 12 months up to 5 years

- If the child is breastfed, continue breastfeeding as often as the child wants until the child is 2 years and beyond;
- If not breastfeeding, give at least 2 cups of full cream milk, which could be maas, every day;
- Encourage children to eat a variety of foods;
- Feed your children five small meals a day;
- Make starchy foods the basis of a child's main meals;
- Children need plenty of vegetables and fruit every day;
- Children can eat chicken, fish, eggs, beans, soya or peanut butter every day;
- Give foods rich in iron and vitamins A and C;

Iron-rich foods: Liver, kidney, dark green leafy vegetables, egg yolk, dry beans, fortified cereal;
Remember that tea interferes with the absorption of iron. Iron is best absorbed in the presence of vitamin C;
Vitamin A-rich foods: Liver, dark green leafy vegetables, mango, paw paw, yellow sweet potato, full cream milk;
Vitamin C-rich foods: Citrus fruit (oranges, naartjies), guavas, tomatoes;

- If children have sweets, treats or drinks, offer small amounts with meals;
- Offer clean, safe water regularly;
- Encourage children to be active every day.

Activity: Plan a Day's Menu for a 1 year Old Child **30 minutes**

The trainers will guide this session.

SESSION 44: Growth Monitoring and Malnutrition

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

Material

- Copies of Road to Health Booklet growth charts (boys and girls)
- Scale
- Pencils and erasers
- Board / flipchart and paper
- Markers
- Coloured pens/pencils

Group Work: Malnutrition — 15 minutes

The trainers will guide this session.

Discussion: Growth Monitoring and Malnutrition — 45 minutes

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
- Mid-upper arm 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 (microcephaly) can be caused by malnutrition, foetal alcohol syndrome, infections and congenital disorders. If a baby's head is very large, it can signal hydrocephalus which means that there is too much fluid around the brain.
- **Mid-upper arm circumference** is a good indicator of wasting in children and can be helpful to assess acute malnutrition. A special measure is used for children from 6 months to 5 years of age.

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.

Why do we need to weigh children frequently?
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 loose 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.
It is important that a child grows along a curve on the growth chart. If they are gaining weight slowly, their weight may drop off the growth curve onto a lower curve. This is called **growth faltering.**

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**
- **eating the wrong food** which is not nutritious enough
- **ill** - illness prevents the body from utilising the nutrients a child is eating

Types of malnutrition
Children can be classified as having **moderate acute malnutrition (MAM) or severe acute malnutrition (SAM)**, depending on where their weight falls on the growth chart. Severely malnourished children are at high risk of illness and death.
Malnutrition that exists over a long period of time causes a child to be not only underweight, but also stunted (low height for age).
One in five South African children are stunted.

When assessing malnourished children you may see the following clinical diseases:

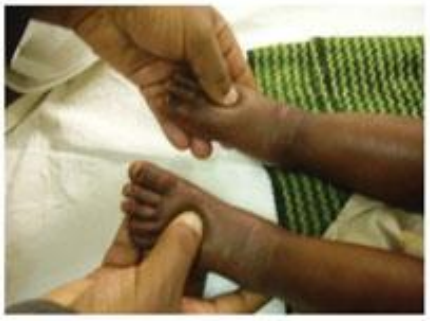
1) <u>Kwashiorkor</u>

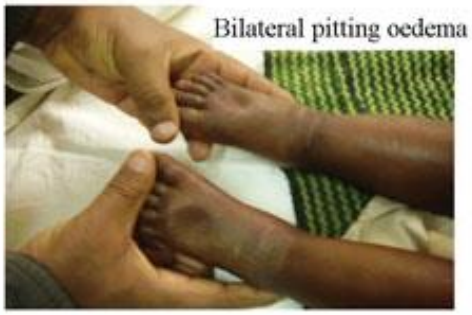
Kwashiorkor is caused by a lack of protein.
It can be seen in children who eat a lot of starch, but not enough protein.
It is often precipitated by illnesses such as TB, measles or gastroenteritis.

Fig. 30. A child with kwashiorkor

Signs of kwashiorkor are:

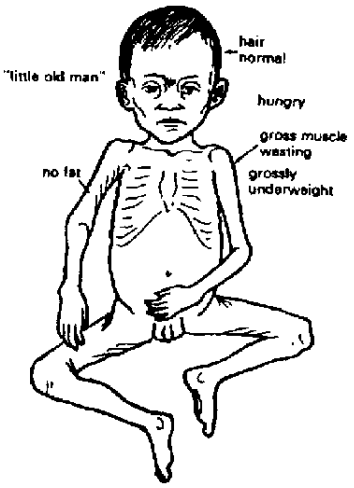
- Sparse, reddish hair
- skin rashes
- swelling of legs and face
- anaemia (pale)
- sores at corners of mouth
- apathy and irritability





To test for oedema, press your thumb firmly into the child's foot or lower leg. If the child has oedema, a dent will be left when you remove your finger.

2. Marasmus



Marasmus occurs when there is severe nutritional deprivation.
These children are severely stunted and wasted, and have very thin arms and legs.
There is loss of all subcutaneous fat.
Marasmic children are usually weak and lethargic.

What are the effects of malnutrition?

Poor nutrition in the first 2 years of life (especially stunting) leads to **irreversible damage**. Malnourished children become short adults; do less well at school; earn less as adults; and their children have lower birthweights.

Undernutrition causes the brain not to grow and develop properly. Malnourished children are lethargic and tired, and thus tend to have poor motor development and will not explore their environment, which further impacts on their development.
Better nutrition improves cognition (thinking ability) and schooling and ultimately adult earnings.

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 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 programme** 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 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. Adding a teaspoon of oil or margarine into the food every day, is a good way of adding to the energy content of the food.
- Check that the child has been **dewormed and has received Vitamin A**.

Practical Session: Growth Charts — 3 hours

The Road to Health Booklets use graphs with Z-scores. Z scores measure how much a particular weight differs from the norm (or average). So they are helpful in telling us how much more or less a child's weight is compared to the average.

If we were to plot the weights of all the children in South Africa 95 out of 100 would fall between Z+2 and Z-2 (this is called 2 standard deviations above and below average weight), and this is considered normal weight for age.
99 out of 100 of all children in South Africa would fall between Z-3 and Z+3.

We use Z-2 as the cut off line for normal weight – so that:

A child with a weight **below Z-2** would be **underweight for age**.

If the weight is **between Z-2 and Z-3** the child is **moderately underweight.**

If the weight **is below Z-3** the child is **severely underweight.**

Similarly, if the weight is **above Z+2**, the child would be **overweight for age**.

The older Road to Health Card uses percentile charts (children born before 2011 will have these charts). Percentiles tell you the percentage of children that have a particular weight at a particular age. For example a child whose weight falls on the 40th percentile means that 40% of healthy children of the same age will weigh the same or less than that child.

A child with a weight **below the 3rd centile** is considered **underweight for age.**

A child with a weight **above the 97th centile** is considered **overweight for age.**

For example:
A child whose weight falls on the 3rd percentile means that only 3% of normal children at the same age as that child weigh the same or less than that child.

A child whose weight falls on the 50th percentile means that 50% of children in the same age category weigh the same or less than that child. This is an average weight.

A child whose weight falls on the Z-2 line is 2 standard deviations from the average weight – in other words, significantly less than the average weight for that age.)

Practical Session: Growth Chart Plotting

1. Thandi is 4 years and 4 months old. She weighs 14kg.
2. Bongani has turned 2 years old. He weighs 12kg.
3. Nokwanda is 3 months old. She weighs 4 kg.
4. Nosipho is 8 months old. She weighs 7.5kg.
5. Nandipha is 16 months old. She weighs 9kg.
6. Bulelwa is 5 months old. She weighs 4.5kg.
7. Thebo is 1 week old. He weighs 2.2kg.
8. Sandile is 10 months old. He weighs 8.5kg.
9. Yanga is 12 months old. He weighs 6.5kg.
10. Zukiswa is 12 months old. She weighs 10kg.
11. Lindelwa is 5 months old. She weighs 8kg.
12. Luvo is 4 years old. He weighs 15kg.
13. Ntombizodwa is 3 years and 7 months old. She weighs 11kg.
14. Loyiso is 15 months old. He weighs 13.5kg.

15. Nomonde is 2 years and 2 months old. She weighs 9kg.

16. Nyameka is 8 months old. She weighs 4kg.

17. Khanyisa is 22 months old. She weighs 11kg.

18. Nosiswe is 18 months old. She weighs 8kg.

19. Zodwa is 4 years and 3 months old. She weighs 11.5kg.

20. Sive is 4 months old. She weighs 4kg.

Practical Session: Calculating Age

Calculating age using the date of birth of a child is a very important skill. Explain to the trainees how to calculate the age using the child's date of birth. Ask them to work out the ages of the children born on these days.

1. 17 October 2012, 11 kg, girl

2. 26 July 2014, 2.2 kg, boy

3. 8 March 2013, 8 kg, girl

4. 30 May 2011,

5. 14 September 2010, 14 kg, boy

6. 2 April 2012, 9kg, boy

7. 21 January 2014, 4kg, girl

8. 19 August 2013, 6.5kg, boy

Plotting the weight of premature babies

When plotting the weight of premature babies, it is important to first work out the **corrected age** of the baby.

Look at page 5 of the RtHB and check the **gestational age** of the baby. This will tell you whether the baby was born at term (38 or more weeks of pregnancy), or whether the baby was premature.

Work out how many weeks premature the baby is:
40 weeks – gestational age = no. of weeks born early
e.g. A baby born at 32 weeks gestation, is 40 – 32 = 8 weeks premature.
Now, subtract this from the current age:

Current age – no. of weeks premature = corrected age
e.g. A baby that is 3 months old, born 8 weeks prematurely would have a corrected age of 3 months – 8 weeks = 1 month.

Plotting exercises with premature babies:

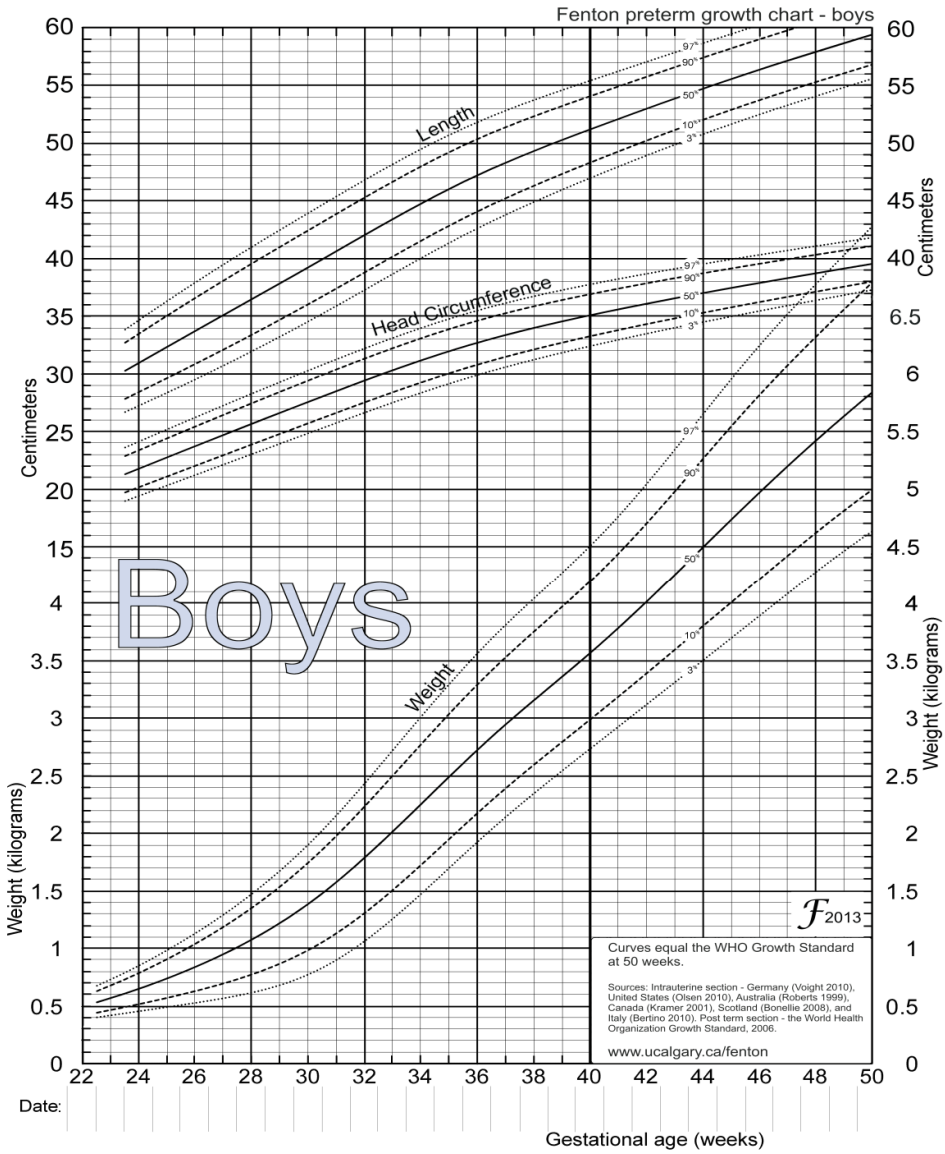
1. Sive is 4 months old, but was born at 32 weeks of pregnancy. She weighs 4kg.

2. Thandi is 8 months old and weighs 6kg. She was a premature baby, born at 34 weeks gestation.

3. Indiphile is 6 weeks old. He was born at 35 weeks gestation. He weighs 2.8kg.

4. Andile is 8 weeks old and weighs 2kg. He was a premature baby, born at 30 weeks gestation

The Fenton Premature Growth charts are very useful for plotting the weight of premature babies, up to the age of 10 weeks. After 10 weeks, you can continue plotting on the normal growth charts.



Practical Session: Case Studies

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.

Case 1
Nosiswe is 2 months old. She weighs 5kgs.

Interpretation:

Case 2
Bongani is 2 years old. He weighs 8.5kg.

Interpretation:

Case 3
Loyiso is 6 months old. He weighs 3.5kgs.

Interpretation:

Role Play: Underweight for Age Babies — 20 minutes

MM: You are coming to visit a grandmother who is caring for her 7 month old grand-daughter, Sisipho. The granny is upset when you arrive. In this visit you need to find out what problems the baby has, and deal with these appropriately. You must also weigh the baby (she is 4,9 kg) and show the granny how to make a formula feed.

Grandmother: You are caring for your grand-daughter, Sisipho. She is not feeding well, and she sleeps all the time. She also has thrush in her mouth.
You are having a difficult time as your daughter passed away last month in Johannesburg. Now you have to look after her baby, and she is not well. You are feeding her formula milk mixed with Nestum porridge. You don't have

Practical Session: Height Charts — 30 minutes

Correct measurement of length:

- Remove caps, socks and shoes.
- Place child on a flat surface (table or bed) with their head against a wall.
- Make sure the body is straight and at a right angle from the wall.
- Position the head so that the baby is looking straight up at the ceiling.
- Gently pull the legs straight. You may need to push down the knees.
- Bend one foot upwards.
- Measure from the wall to the bottom of the heel with a tape measure.

Correct measurement of height:

- Remove caps, socks and shoes.
- Ask the child to stand straight up against a wall.
- Make sure their feet are together and heels are touching the wall.
- The child should look straight ahead.
- Place a book (or a stiff ruler) on top of the child's head.
- Measure from the book to the floor with a tape measure.

Interpreting height measurements:

- A child whose height is between Z-2 and Z+2 has a **normal height** for age.
- A child whose height is below Z-2 is **stunted**.
- A child whose height is below Z-3 is **severely stunted**

Practical Session: Plotting exercise

1. Anele is 10 months old. Her length is 70cm.
2. Bongani is 16 months old. His length is 83cm.
3. Lulama is 3 years and 5 months old. Her height is 87cm.
4. Mbali is 2 years and 8 months old. Her height is 90cm.
5. Nkosinathi has just turned 4 years old. His height is 89cm.
6. Likho is 3 years and 1 month old. Her height is 104cm.
7. Indiphile is 20 months old. His length is 82cm.
8. Sipho is 2 years and 3 months old. His height is 78cm.
9. Zodwa is 4 months old. Her length is 64cm.
10. Yanga is 4 years and 7 months old. His height is 98cm.

SESSION 45: Childhood Immunisations and Vitamin A

Time required: 15 minutes

Purpose

- The purpose of this session is to teach the importance and scheduling of standard childhood immunisations and Vitamin A supplementation.

Objectives

- At the end of this session, MM will:
  - At the end of this session MM will know which diseases children need to be immunized against and when each immunisation should occur.
  - MM will understand the benefits of giving Vitamin A, and when to give Vitamin A.

Material

- Road to Health Booklet
- Vitamin A capsules (100 IU and 200 IU)

Immunisation 15 minutes

The public health impact of immunisations:

- Immunisation 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.
- Immunisation has eradicated smallpox completely. Before, smallpox was responsible for many deaths, and the illness put tremendous strain on health care systems with limited resources.
- Polio has almost been eradicated as a result of immunisations.
- Only by educating mothers and families, will it be possible to increase the coverage of immunisations given to children. It is important to provide answers to people's concerns about the safety, quality and benefits of vaccines.

In South Africa there are immunisations for 11 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
- Rotavirus (causing diarrhoea)
- Pnuemococcal disease (pneumonia and meningitis)
- HPV (causing cervical cancer - given to Grade 4 school girls)

IMMUNISATIONS					6
Name and surname:			ID number:		
Age group	**Batch no.**	**Vaccine**	**Site**	**Date given dd/mm/yy**	**Signature**
Birth		BCG	Right arm		
		OPV0	Oral		
6 weeks		OPV1	Oral		
		RV1	Oral		
		DTaP-IPV-Hib1	Left thigh		
		Hep B1	Right thigh		
		PCV 1	Right thigh		
10 weeks		DTaP-IPV-Hib2	Left thigh		
		Hep B2	Right thigh		
14 weeks		DTaP-IPV-Hib3	Left thigh		
		Hep B3	Right thigh		
		PCV2	Right thigh		
		RV2	Oral		
9 months		Measles1	Left thigh		
		PCV3	Right thigh		
18 months		DTaP-IPV-Hib4	Left arm		
		Measles2	Right arm		
6 years		Td	Left arm		
12 years		Td	Left arm		

Vitamin A — 15 minutes

Why is vitamin A important?

- Vitamin A is especially needed for the eyes, bones, skin and growth.
- A deficiency of vitamin A causes eye and skin problems.
- Many poorly nourished children do not get enough vitamin A.
- Children who get sick with Measles and Diarrhoea are more likely to be very sick and die, if they do not have enough vitamin A.

Supplementing vitamin A

- Vitamin A is given every 6 months from birth until age 5.
- The capsule contains an oil, which is given by mouth.
- Before giving Vitamin A, you must check the RTHC to see when it was last given. Look on page 9 and on the growth chart (pages 14-15).
- **An overdose of Vitamin A can be harmful, so it is very important to check that it has not already been given.**

- When you have given vitamin A, you must write the date and sign in the blocks corresponding to the age of the child on page 9 of the RtHB or RtHC. You can also write on the growth chart (pages 14-15) corresponding to the age of the child when it was given.

Dose

Age	**Dose**
6 months	100 000 IU (grey capsule)
1-5 years	200 000IU (orange capsule)

VITAMIN A SUPPLEMENTATION 9

	At age	Date given dd/mm/yy	Signature	At age	Date given dd/mm/yy	Signature
200 000 IU Mother at delivery (not llater than 6 - 8 weeks)		/ /				
100 000 IU	6 mths	/ /				
200 000 IU every 6 months	12 mths	/ /		42 mths	/ /	
	18 mths	/ /		48 mths	/ /	
	24 mths	/ /		54 mths	/ /	
	30 mths	/ /		60 mths	/ /	
	36 mths	/ /				

ADDITIONAL DOSES:

For conditions such as measles, severe malnutrition, xerophthalmia and persistent diarrhoea. Omit if dose has been given in last month.
Measles and xeropthalmia: Give one dose daily for two consecutive days. Record the reason and dose given below.

Date	Dose given	Reason	Signature	Date	Dose given	Reason	Signature

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:
  - The causes and symptoms of gastroenteritis.
  - When treatment needs to be sought for gastroenteritis with severe diarrhoea.
  - How to mix a home made rehydration fluid and to use this to rehydrate dehydrated children.

Material

- Container of 1 litre
- Teaspoons
- Salt and sugar

Lecture/Discussion: Gastroenteritis 30 minutes

LECTURE CONTENT: Gastroenteritis

Gastroenteritis is an infection of the intestines caused by viruses, bacteria (germs) or parasites. It causes diarrhoea, vomiting, abdominal 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 cause 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?

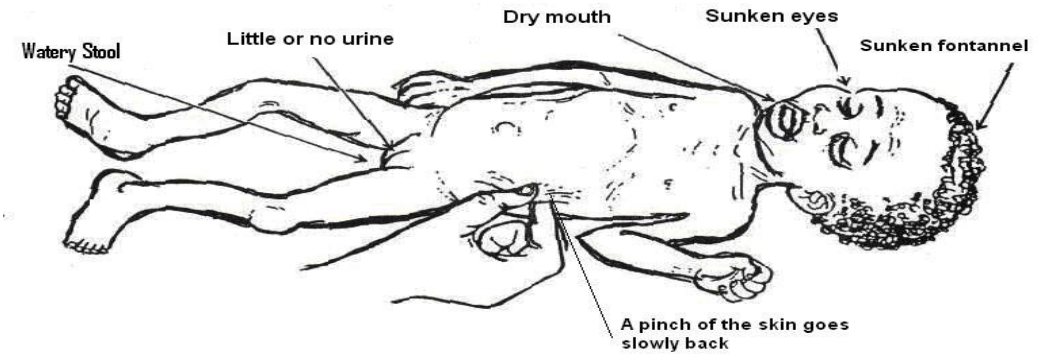
- Diarrhoea with or without vomiting
- Dehydration
- Headache, fever, chills, and
- Abdominal pain

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

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

Dehydration happens when the body looses 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 this is difficult to tell)
- Poor skin turgor (when fluid is lost from the skin, if it is pinched it remains pinched and doesn't flatten back into position)
- sunken eyes and sunken fontanelle
- Dry mouth
- Little or no urine or dark yellow urine
- Decreased tears
- Dizziness or light-headedness (children would not volunteer this information).

Causes of Gastroenteritis?

The bacteria and germs which cause gastroenteritis are found in **unclean water and food** which is not properly cleaned or well cooked, or is old. Bacteria is found in meats, chicken, eggs and un-pasteurised dairy products. 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

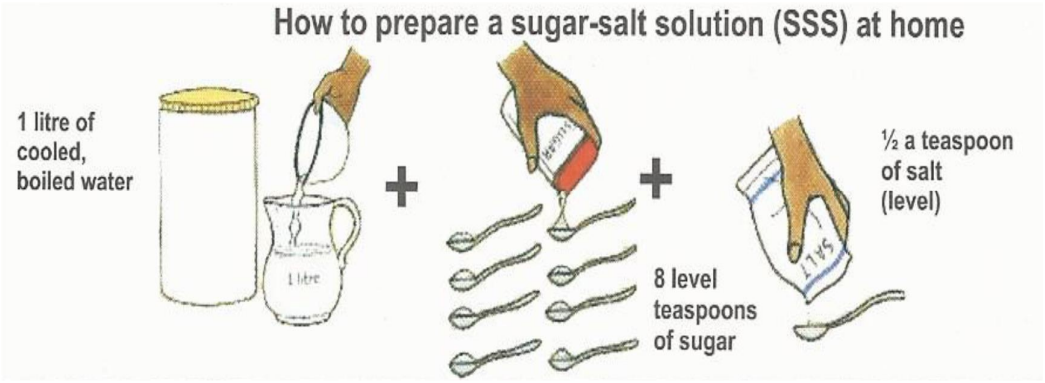
How can one protect children from the illness?

- 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 at once on home made **oral rehydration solution** at home. This is the most important treatment.
A simple and cheap, home made rehydration fluid can be made by mixing:



8 teaspoons of sugar and **½ teaspoon of salt** into **1 litre of boiled water**

- Give this solution after each loose stool, using frequent small sips from a cup (half a cup for children under 2 years and 1 cup for children 2-5 years).
- Small amounts should be given frequently (every 15-30 minutes) until the diarrhoea stops
- If the child vomits, wait for 10 minutes then continue with small amounts frequently.
- Continue to feed the child. However, if the child does not want to eat, just continue with the rehydration solution.
- 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 help immediately if the child has the following symptoms:

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

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, once they have recovered.

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

Practical session: Making Oral Rehydration Solution 15 minutes

The trainers will guide this session.

SESSION 47: Skin Problems: Scabies, Eczema, Thrush (Candida)

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:
  - Know how to identify Scabies, Eczema, and Thrush in young children (nappy rash was covered previously in neonatal care).
  - Be able to give advice to mothers about how to prevent skin problems, and when to refer children to the clinic for treatment.

Material

- Black board / paper flip chart
- Markers

LECTURE CONTENT: Thrush (Candida), Mouth Ulcers, Scabies and Eczema

1. Thrush

What is Thrush (Candida)?

Thrush is a fungal (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 can get thrush during delivery, when they pass through a vagina infected with yeast. Symptoms appear as oral thrush within seven to 10 days after birth. Thrush can also be caused by teats of bottles that are not properly sterilised.

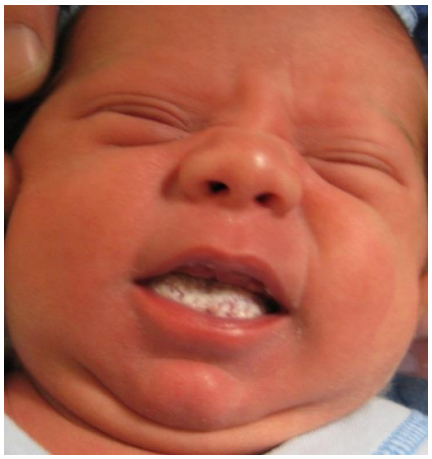
Thrush is a very common condition in patients with impaired immunity, especially in people living with AIDS.

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 anti-fungal medication only as prescribed by a doctor.
- Follow a healthy diet with lots of fruit and vegetables.

2. Mouth Ulcers (Apthous ulcers)

What are the symptoms of mouth ulcers?

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

Treatment of mouth ulcers

Mouth ulcers usually recover within 10 days without any treatment.

They can be very painful. Give the child Panado ½ hour before meals to make it easier for the child to eat. Feed the child soft foods that are easy to swallow. Give the child vitamins.

3. Scabies

What is Scabies?

Scabies is a skin rash caused by 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.

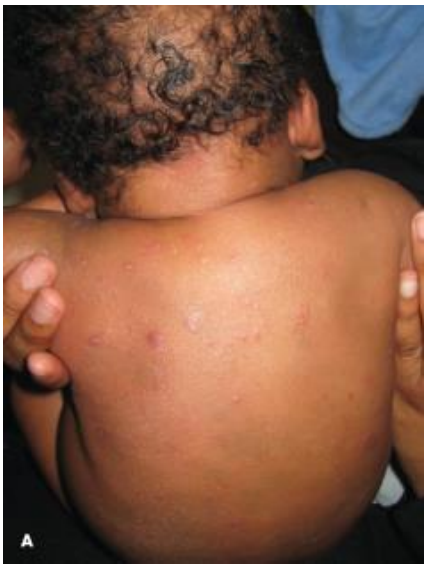
Is Scabies Contagious?

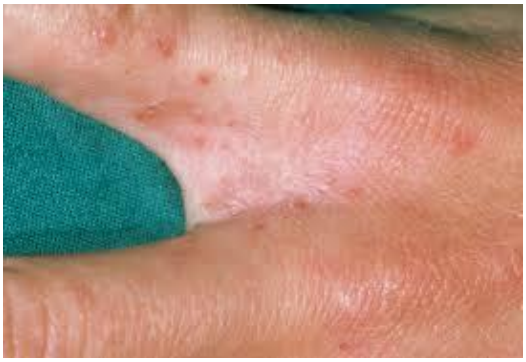
It is highly contagious and is easily passed on by close physical contact, sharing of clothes and sharing of bedding.

Symptoms of Scabies

- Itchy skin rash 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

- Scabies is treated with an ointment or soap 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.

4. Eczema

What is Eczema?

Eczema is inflammation or irritatation of the skin.

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.

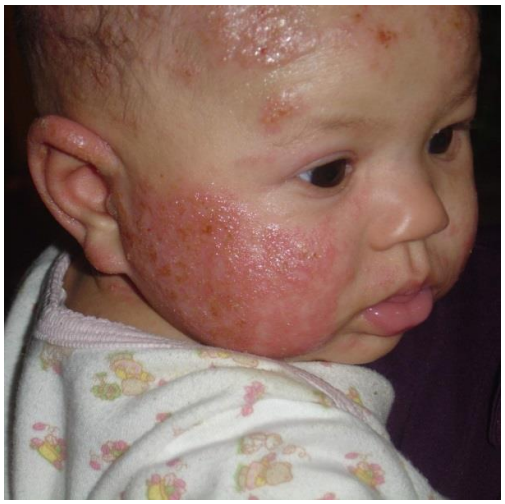
With the right treatment, eczema is manageable.

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.

Eczema can be worsened by:

- contact with rough or coarse materials
- exposure to heat or cold
- exposure to certain household products like soap or detergent
- contact with animals
- upper respiratory infections or colds
- stress

Treatment of Eczema

Moisturisers (aqueous cream) must be applied 2-3 times daily to the skin.

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.

Aqueous cream can be used as a soap when bathing.

Avoid creams with perfumes and colouring.

Children should try not to scratch the skin, as this can lead to infection.

Children with eczema should be referred to the clinic for treatment. There is no direct cure for eczema, but treatment will relieve and prevent itching.

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

Material

- Black board / paper flip chart
- Markers

Discussion: Common Respiratory Illnesses 30 minutes

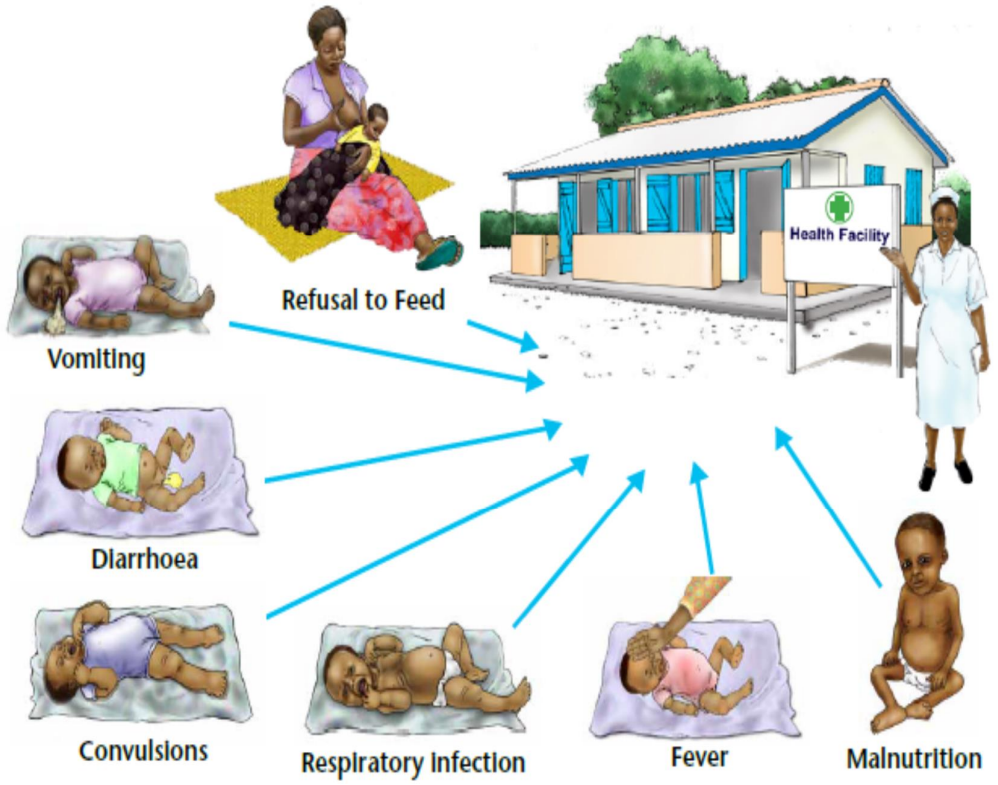
Respiratory illnesses such as TB, pneumonia and other respiratory infections, are responsible for many deaths in children and infants in Cape Town. Protecting children from respiratory illness can mean saving their lives and the lives of those around them.

Difference between upper and lower respiratory tract infections.
Answer:

- An upper respiratory tract infection is an infection of the nose, throat, or the trachea (upper airways). Common symptoms are a runny or blocked nose, a sore throat 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.

Signs of respiratory illness include the following:

- Nasal discharge which does not clear after a few days, or which changes from being watery to becoming thick and yellow or green
- Coughing for more than 1-2 weeks
- Wheezing (tight chest)
- Sore / inflamed 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


Refusal to Feed
Health Facility
Vomiting
Diarrhoea
Convulsions
Respiratory Infection
Fever
Malnutrition

SECTION N
ABUSE, NEGLECT AND VIOLENCE

SESSION 49: Identifying and Protecting Women and Children from 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 Cchild Abuse and Neglect as well as Intimate Partner Violence (IPV)

Objectives

- At the end of this session MM will be able to:
  - Know what signs are possible indicators of abuse, in both children and adults.
  - Understand what circumstances and social situations foster environments where there is less risk of child abuse occurring.
  - Know what to do in the event that they come across cases of child abuse during their work on this project.
  - Know what signs are possible indicators of IPV.
  - Know the different types of IPV
  - Know what to do in the event that they come across cases of IPV.

Materials

- PowerPoint slides
- Board/flipchart and paper
- Markers

Activity: Abuse or Not Abuse? 45 minutes

The trainers will guide this session.

Statements:

- A 12 year boy is slapped on the hand?
- A baby is shaken by its mother?
- A father sleeps in the same bed as his 12 year old daughter?
- A mother sleeps in the same bed as a 14 year old son with a disability?
- Parents walk around the house naked in front of the children?
- A mother tells her young son that she wishes he had never been born?
- A 12 year old boy forces a 7 year old girl to masturbate him?
- A man persuades a 10 year old into sexual acts by offering affection and money?
- A 13 year old boy is beaten with a belt for telling lies?
- A 14 year old girl is left on her own at home, for several hours every night, while her mother goes out to work?
- A 7 year old boy is sent out to sell sweets on the streets for 10 hours a day?
- A 10 year old girl is told to go out and not return home until she has enough money to buy food for supper?
- A 3 year old is tied to a post while her mother is making bricks by hand?
- A 13 year old boy is told he mustn't go to school for a few weeks but must rather look after his four siblings who are all under 4 years old as his mother must go to the Eastern Cape?
- A 7 year old girl witnesses her mother's boyfriend take 'tik' and abuse her mother.

Children's Rights in South Africa

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

Discussion: Identifying Signs of Abuse in Children — 45 minutes

LECTURE CONTENT: Recognising 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

A child may be a victim of physical abuse, neglect, sexual abuse, and/or emotional abuse. It is important to note 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
- Is aggressive or extremely withdrawn
- Is extremely compliant or emotionally withdrawn

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
- Often expresses difficulties in coping with the child
- Delays seeking medical attention for the child
- Appears unconcerned for the child’s wellbeing and shows little genuine affection towards the child.
- Has a history of abuse as a child

Signs of Neglect

Consider the possibility of neglect when the child:

- Appears lethargic and undemanding
- 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
- Has not attained significant developmental milestones within his/her age range
- 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
- Ignores the child's affectionate overtures
- Indicates that the child was unwanted/ continues to be unwanted
- Indicates that the child is hard to care for, describes the child as demanding

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 12
- Runs away
- Displays age-inappropriate sexual play with toys, others or self
- Displays unusual or excessive itching in the genital or anal area
- Contracts venereal diseases or a recurrent urinary tract infection
- 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
- Accuses the child of being sexually provocative

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
- Appears depressed, extremely withdrawn or aggressive
- Is overly compliant, too well-mannered, too neat and clean
- 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
- Constantly belittles or berates the child
- Withholds physical and verbal affection from the child

Discussion: Protective factors in preventing Child Abuse 45 minutes

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 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.

Discussion: What to do when you suspect child abuse 30 minutes

- Always make decisions that are in the best interest of the child (not the mother, or yourself or other parties involved)
- Start gathering information as soon as you suspect abuse. Document all information gathered and treat it as confidential.
- Speak to your supervisor and ask for advice. Together with your supervisor, decide how the situation should be managed. Consult the criteria of abuse to verify information before making any allegations. Decide whether there are reasonable grounds to suspect abuse and decide on which external role-players to involve in the process (external role players can include Department of Social Development, Child Protection Unit, SAPS, and NGO's such as Child Welfare, ChildLine, BADISA, ACVV, FAMSA etc.)
- As a mentor mother, you are obligated to report cases of abuse to social services, who in turn can refer cases to the police.
- Assure the mother or child you are dealing with, that you have the child's best interest at heart.
- Continue to visit the house and ask questions to try and get clarity on whether abuse is present.
- Remain objective at all times and do not allow personal matters, feelings or preconceptions to cloud your judgement.
- Avoid negative remarks or looks. These reactions are likely to increase the parent's anger and make matters worse.
- Remember that the reporting and investigation of child abuse must be done in such a way that the safety of the child is ensured at all times.

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.

Case Scenarios: Dealing with Child Abuse & Neglect — 45 minutes

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, you notice that her child is outside the house by herself. She is wearing only a small dress, and it is clear she has not washed for a few days. You can see she has diarrhoea, and is very weak.

You go inside and ask Zukiswa what is wrong with the child and for how long she has been ill. 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 2:

You are visiting Thandiwe and her children. Thandiwe is a mother to three children aged one, three and nine years old. Thandiwe has been seen by you for almost two years now as she is HIV positive. She cares for her children deeply and they are growing well and have all been born HIV negative. They have recently returned from being in the Eastern Cape for three months.

Thandiwe tells you that her nine year old daughter has been acting strangely lately and seems to be in a lot of pain when she sits down and has started wetting her bed at night. She no longer wants to eat and she seems quiet and withdrawn.

Thandiwe tells you that when she was in the Eastern Cape she was worried because her daughter seemed very scared of her uncle and would try and run away when he came back to the house.

Thandiwe also told you that she took her daughter to the clinic the last week and was told her daughter has a urinary tract infection.

Discussion: Intimate Partner Violence — 45 minutes

One of the most common forms of violence against women is that performed by a husband or intimate male partner.

IPV is a serious, preventable public health problem that affects millions of people. The term "intimate partner violence" is any act of aggression, psychological abuse, forced intercourse and various controlling behaviours such as isolating a person from family and friends and can include restricting access to help or information

Physical violence is the intentional use of physical force which may lead to death, disability, injury, or harm and includes:

- Scratching
- Pushing
- Throwing
- Grabbing
- Biting
- Choking
- Shaking
- Slapping
- Punching
- Burning
- Use of a weapon
- Use of restraints

Sexual violence is divided into three categories:

- 1. Use of **physical force** to compel a person to engage in a sexual act against his or her will, whether or not the act is completed;
- 2. **Attempted or completed sex act** involving a person who is unable to say no because of:
  - Illness
  - Disability
  - Alcohol or other drugs
  - Intimidation or pressure
- 3. **Abusive sexual contact** is the threat of physical or sexual violence with the use of words, gestures, or weapons to communicate the intent to cause death, disability, injury, or physical harm.

Psychological/emotional violence can include:

- Humiliating the victim
- Controlling what the victim can and cannot do
- Withholding information from the victim
- Deliberately doing something to make the victim feel diminished or embarrassed
- Isolating the victim from friends and family
- Denying the victim access to money or other basic resources

Stalking generally refers to "harassing or threatening behavior such as:

- Following a person
- Appearing at a person's home or place of business
- Making harassing phone calls
- Leaving written messages or objects
- Vandalising a person's property

Consequences of IPV

Violence by an intimate partner has been linked to many immediate and long-term health outcomes including:

- physical injury
- gastrointestinal disorders
- chronic pain syndromes
- depression and suicidal behaviour
- reproductive health and can lead to unwanted pregnancy, premature labour and birth, as well as sexually transmitted diseases and
- HIV/AIDS.

On average, victims of partner violence experience more surgeries and visits to doctors and hospital than those without a history of abuse.

Intimate partner violence can affect a woman's earnings, job performance and her ability to keep a job.

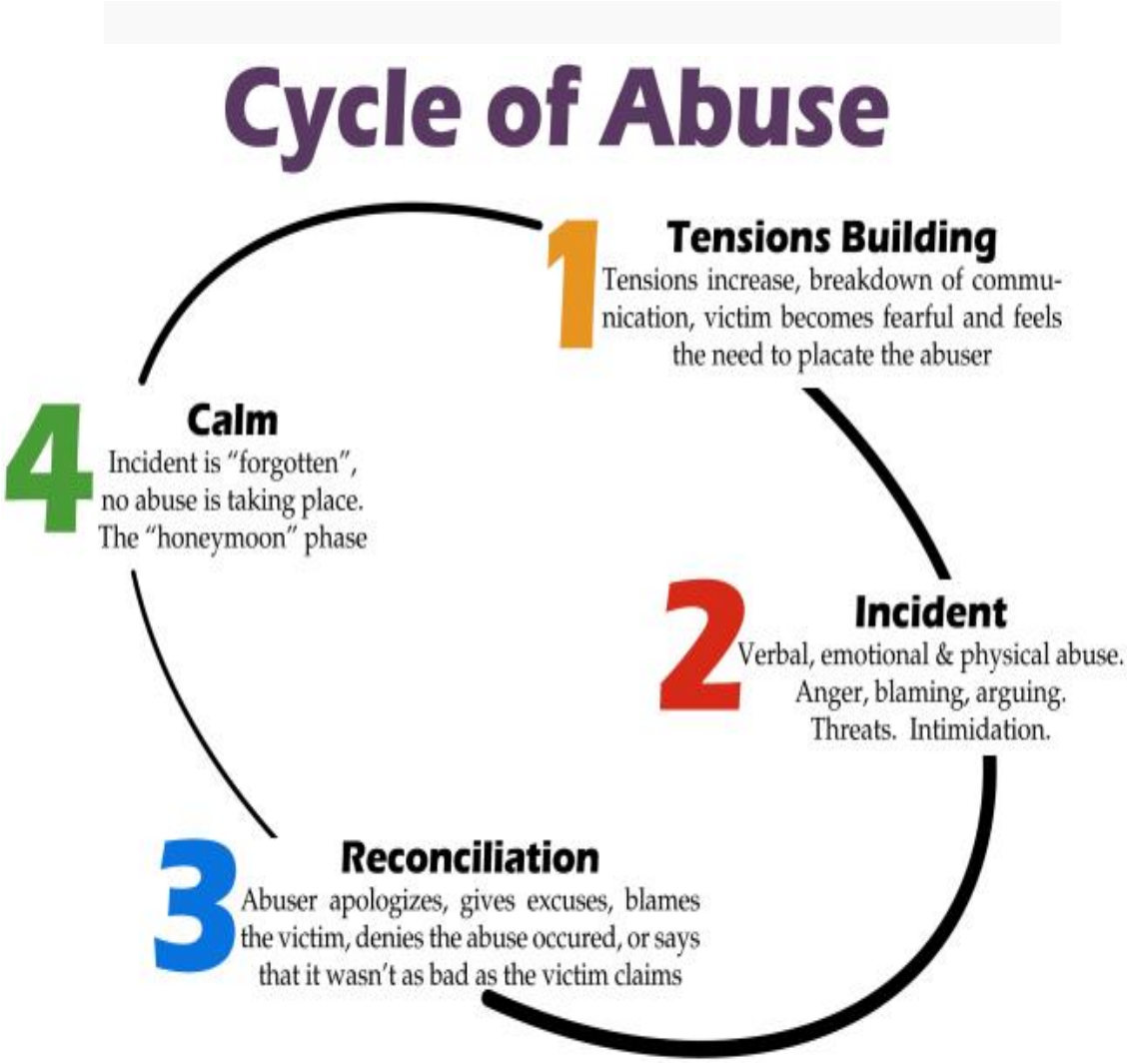
Did you know?
THERE IS A LINK BETWEEN IPV AND CHILD ABUSE AND NEGLECT

Health behaviour consequences

Women with a history of IPV are more likely to engage in behaviour that puts them at further health risks and can include:

Risky sexual behaviour	Using harmful substances	Unhealthy eating habits
• Unprotected sex • Sex at a young age • Unhealthy partners • Multiple sex partners • Trading sex for food, money or other items	• Smoking cigarettes • Alcohol and drug abuse	• Fasting • Vomiting • Overeating

The Cycle of Abuse



Risk factors

A combination of factors contribute to the risk of becoming a victim or perpetrator of IPV. Understanding these factors can help you identify opportunities for prevention

Individual factors	Relationship factors	Community factors
• Low self esteem • Low income • Low education • Young in age • Depression • History of abuse • Unemployment • Having few friends and being isolated from people • Emotional dependance and insecurity	• Relationship conflicts, fights or tension • Instability - divorce or seperation • Economic stress • Unhealthy family relationships and stress • Dominant partner	• Poverty • Overcrowding • Weak community sanctions against IPV • Traditional gender norms (women should stay at home and men work to support the family and make all the decisions)

Prevention strategies

IPV is a serious problem that has lasting harmful effects on individuals, families, and communities. The goal for IPV prevention is to stop it from happening in the first place. Referring women to crisis centres where they can receive individual counselling, job training and assistance in dealing with social services and legal matters. Refer to the community resource page for information on specific programmes and centres. Prevention efforts should include the promotion of healthy, respectful, nonviolent relationships.

Discussion: Dealing with Grief — 30 minutes

The trainers will guide this session.

SECTION O
SELF CARE

SESSION 50: 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:
  - Be able to recognise the warning signs of burnout in themselves and /or others.
  - Be aware of their thoughts, feelings, and behaviours during periods of stress.
  - Recognise their somatic warning signs.
  - Have an understanding of the importance of balancing work, health, family, friends and spiritual aspects of their lives.
  - Understand the importance of supportive relationships within the Mentor Mother group.
  - Know what they can do for themselves if feeling over-whelmed by their work.
  - Know what to expect from Philani in terms of support and supervision.
  - Know how to manage their stress on a day to day basis.

Material

- Board/flipchart and paper
- Markers
- Ball of wool
- Paper for participants to write on
- CD player and music

Discussion: The Roadmap to Self Care — 20 minutes

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

Discussion: Introduction to Self Care — 45 minutes

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.

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?

C = Connection

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

D = Day to Day Management of Stress

1. Referring to the previous exercise, point out that sometimes people drop the ball because the work is feeling too much; it is over-whelming, 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.

Conclusion

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).

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

SECTION P
THE FIELD GUIDE AND PROCESS OF HOME VISITING

SESSION 51: 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

- Field Guide

The Field Guide: Practical Session 2 hours

The trainers will guide this session.

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 book at the clinic 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. Bulelwa 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 Q
POST TEST AND CONCLUSION

SESSION 52: 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:
  - Complete the Post-test satisfactorily.
  - Competently carry out newly learned skills.
  - Mix a bottle of formula milk correctly.
  - Make an oral rehydration solution correctly.
  - Weigh a child correctly, calculate the child's age and plot the weight on the RtHB.
  - Interpret the weight

Materials

- Salt
- Sugar
- Water
- Measuring cup, bowl or jug to mix rehydration solution
- Formula feed
- Baby bottle
- Post-test Handout
- Answers to Post-test (trainer only)

Practical Session — 90 minutes

The trainers will guide this session.

Assessment: Post-test — 90 minutes

The trainers will guide this session.

SECTION R
ROLE PLAY ASSESSMENTS

SESSION 53: 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

- Video recorder
- MM need to have their field guides with them
- Doll

Preparation

- A member / several members of the training team 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. The trainees will conduct a home visit role play with someone 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 trainer.