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

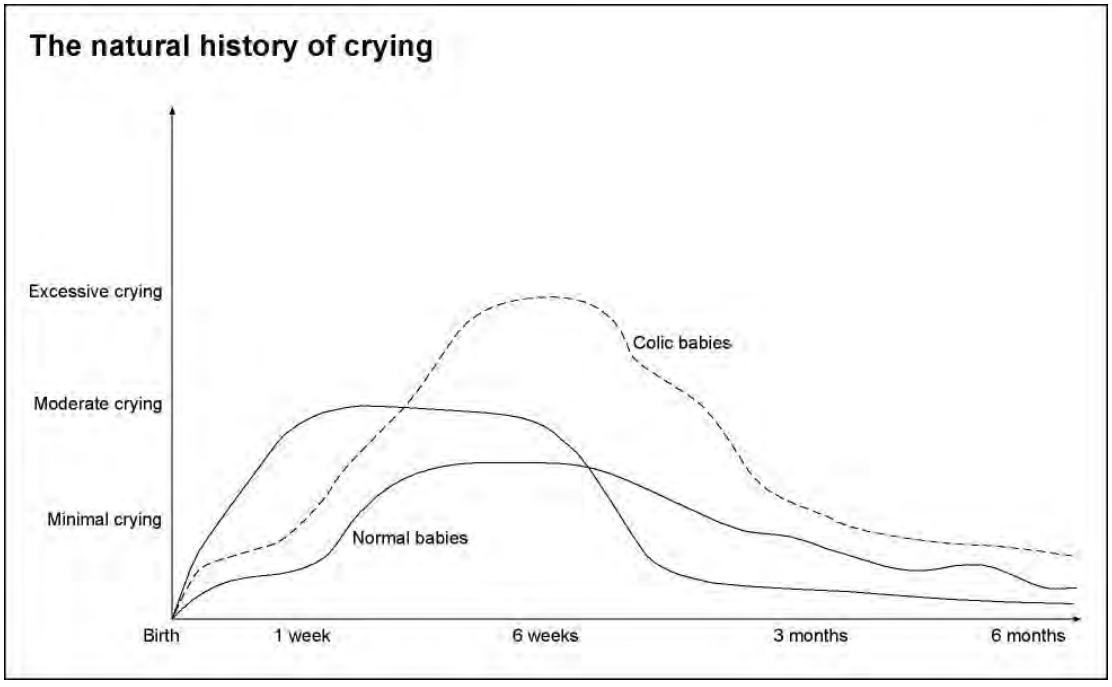
Accept	Her ideas and feelings about her milk.
Praise (as appropriate)	Baby growing well – getting all the milk he needs. Good points about her feeding technique. Good points about baby's development.
Give practical help	Improve feeding technique if necessary.
Give relevant information	Correct mistaken 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.

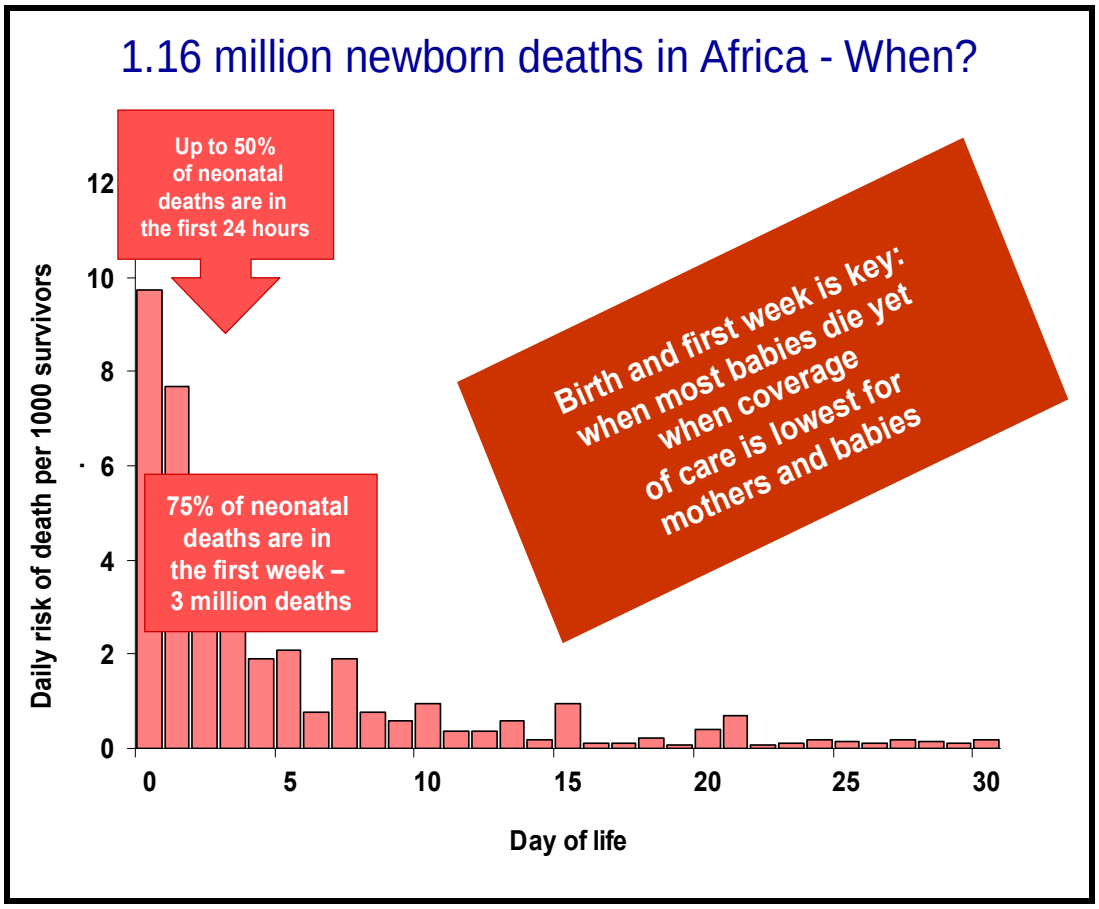
Objectives

- 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

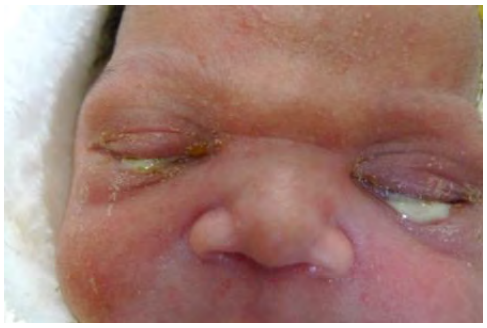
- At the end of the session the MM will:
  - Know to refer babies with eye infections for antibiotic treatment.
  - Know how to provide umbilical cord care.
  - Know how to prevent and care for skin (nappy) rash.

Materials

- PowerPoint slides

Discussion: Eye 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.



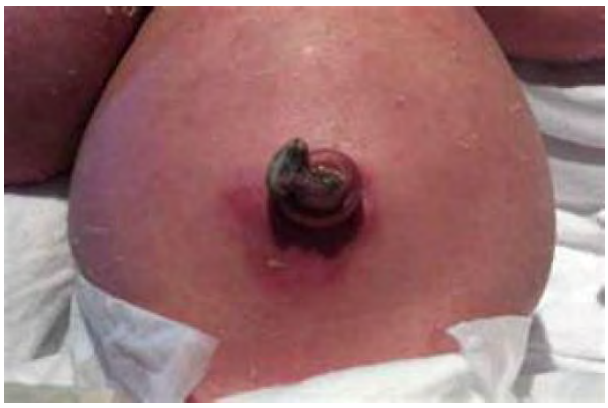
2. If MM's see that a baby has an eye infection, they need to refer them immediately to the clinic to get antibiotic ointment.

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.

Breast problems - 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?

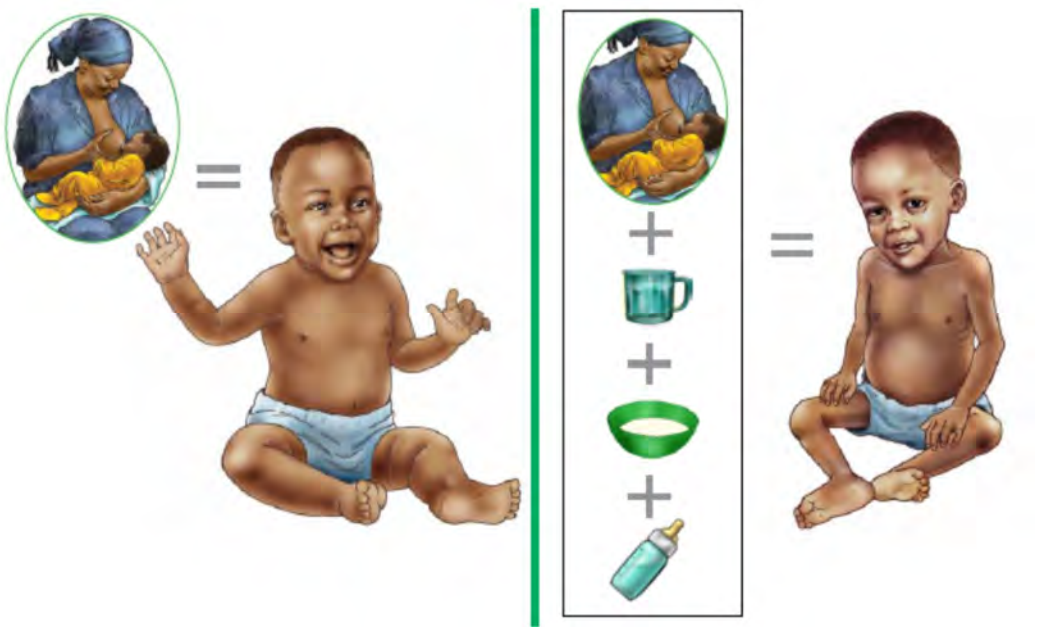
- It may take up to three month to process your application.
- The social security office will inform you in writing whether or not your application was successful.
- If your grant is approved, you will be paid from the you applied.

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).

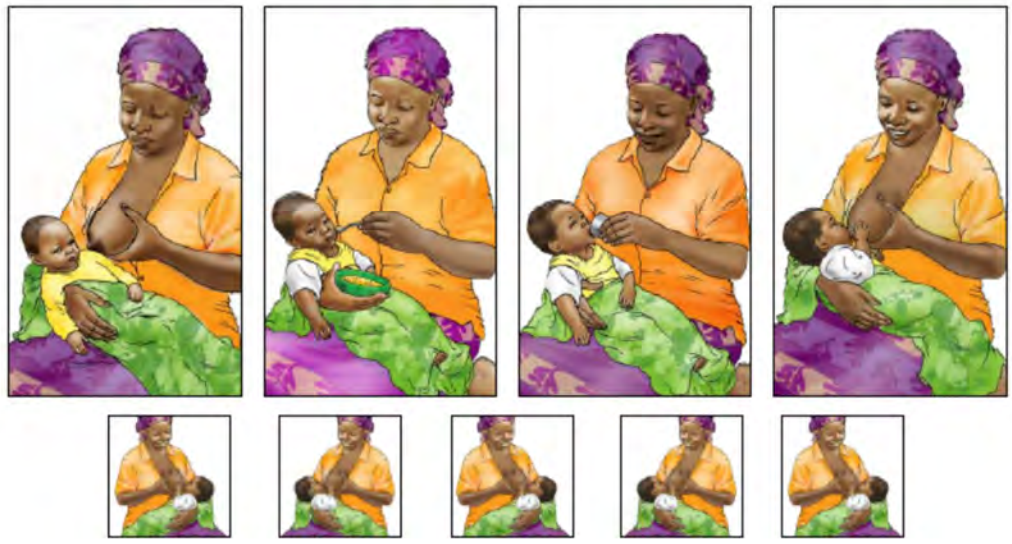
Tips on feeding a child with a poor appetite

- 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:

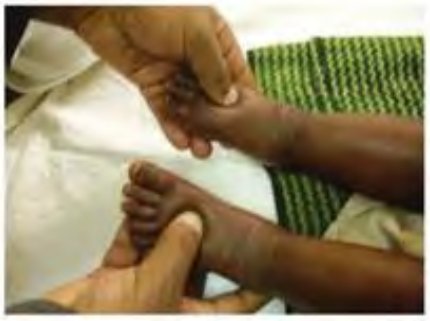
1) <u>Kwashiorkor</u>

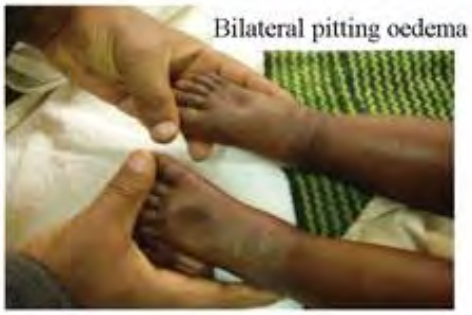
Kwashiorkor is caused by a lack of protein.
It can be seen in children who eat a lot of starch, but not enough protein.
It is often precipitated by illnesses such as TB, measles or gastroenteritis.

Fig. 30. A child with kwashiorkor

Signs of kwashiorkor are:

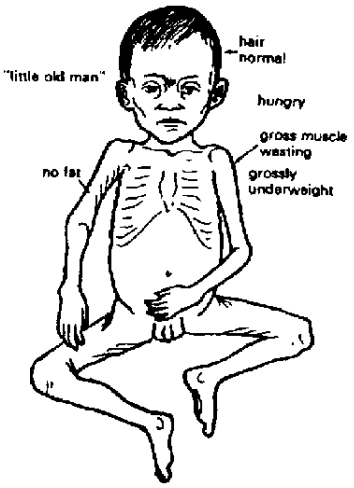
- Sparse, reddish hair
- skin rashes
- swelling of legs and face
- anaemia (pale)
- sores at corners of mouth
- apathy and irritability





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:

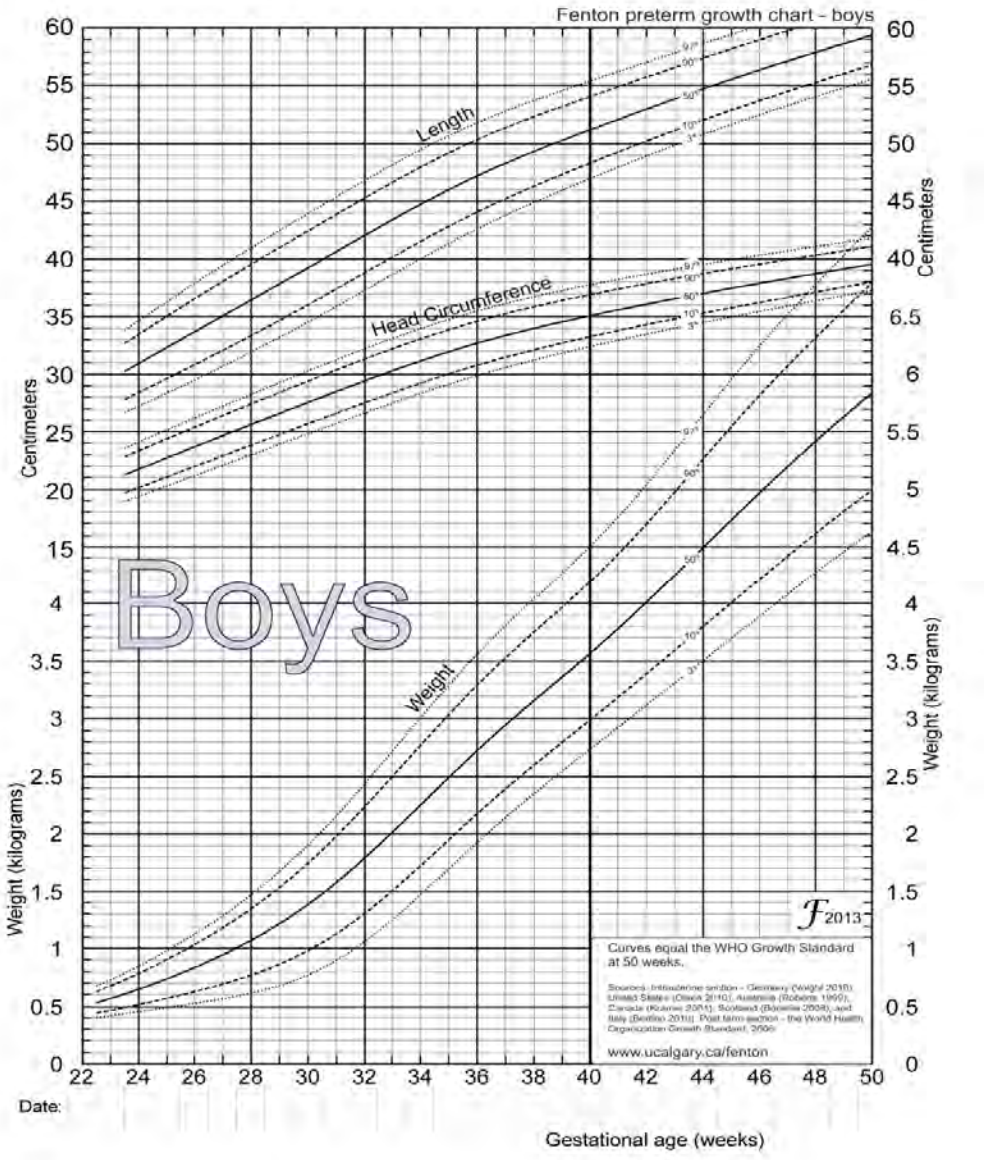
1. Sive is 4 months old, but was born at 32 weeks of pregnancy. She weighs 4kg.

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.

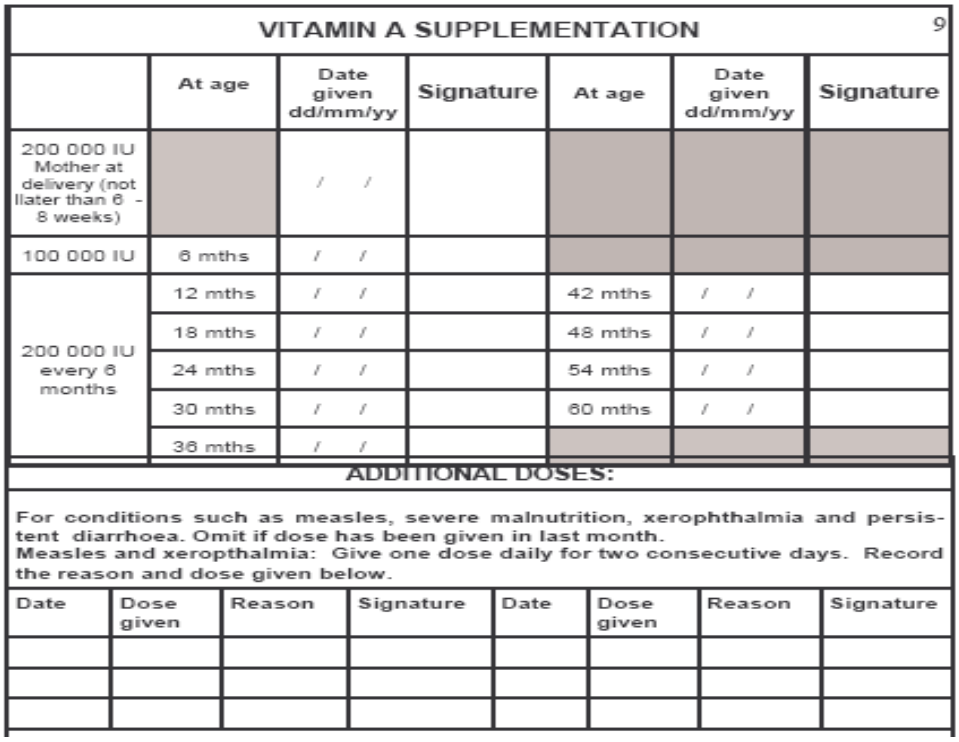
Supplementing vitamin A

- 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?

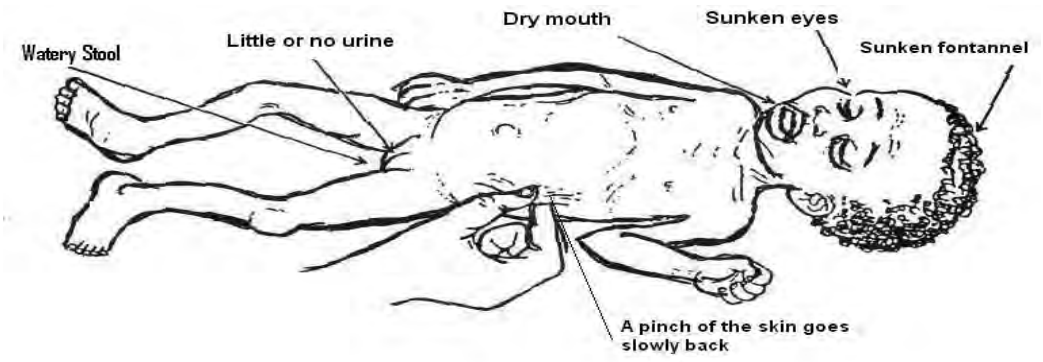
- Diarrhoea with or without vomiting
- Dehydration
- Headache, fever, chills, and
- Abdominal pain

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

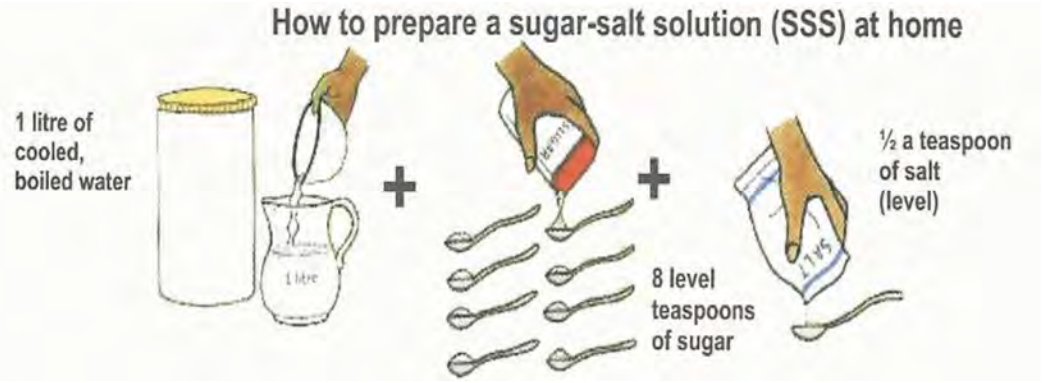
How can one protect children from the illness?

- 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.

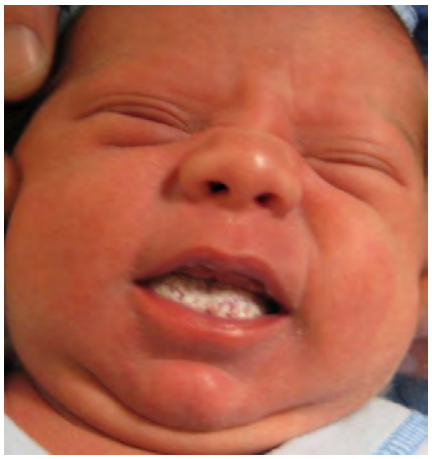
Thrush is a very common condition in patients with impaired immunity, especially in people living with AIDS.

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

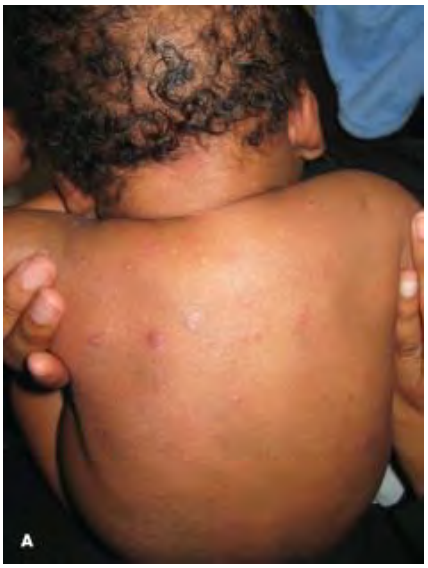
Treatment of mouth ulcers
Mouth ulcers usually recover within 10 days without any treatment.
They can be very painful. Give the child Panado ½ hour before meals to make it easier for the child to eat. Feed the child soft foods that are easy to swallow. Give the child vitamins.

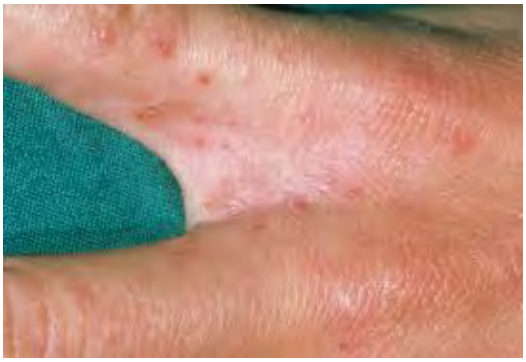
3. Scabies
What is Scabies?
Scabies is a skin rash caused by mites that burrow into the skin. The mites lay eggs under the skin which hatch and cause an itchy allergic reaction. The disease often affects areas of skin folds, especially in the groin, fingers, toes, wrists and underarms.

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.

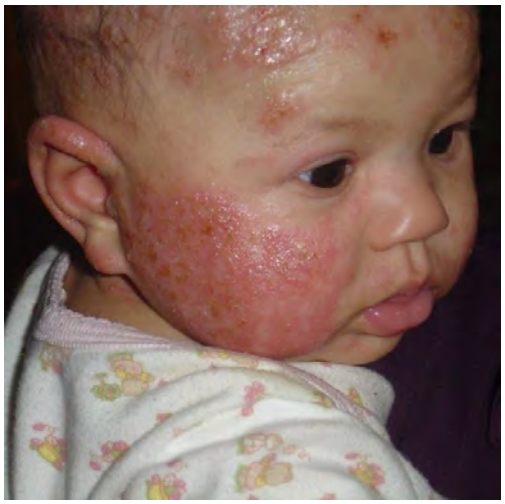
With the right treatment, eczema is manageable.

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

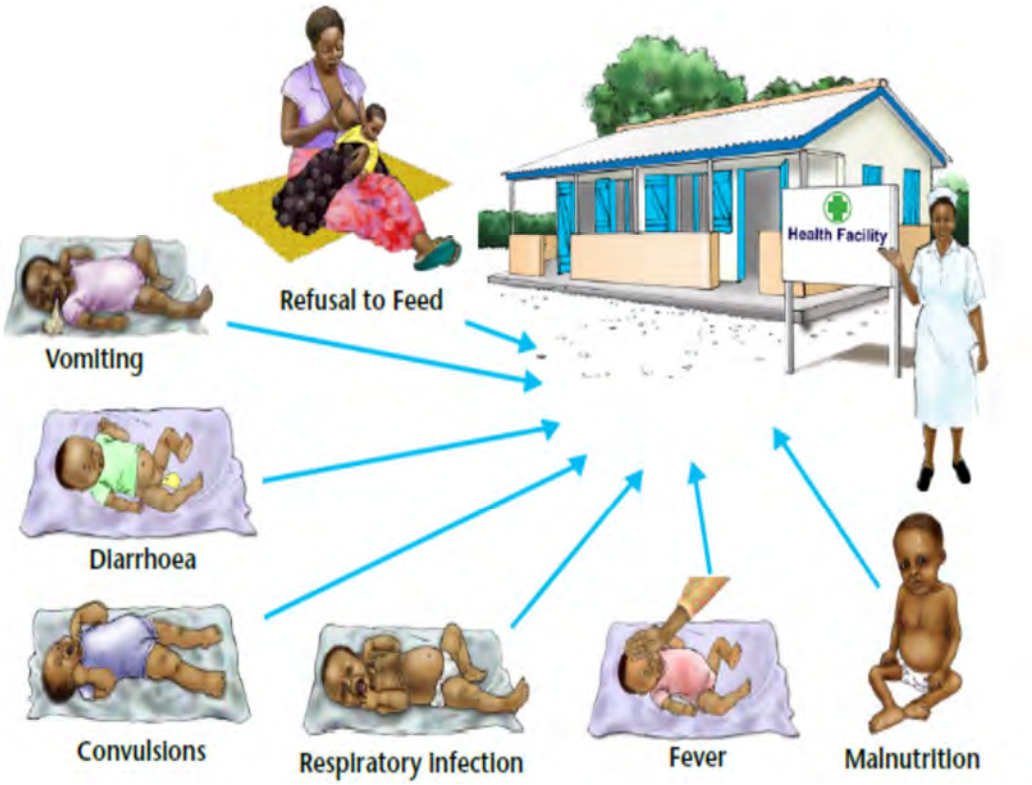
Respiratory illnesses such as TB, pneumonia and other respiratory infections, are responsible for many deaths in children and infants in Cape Town. Protecting children from respiratory illness can mean saving their lives and the lives of those around them.

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.

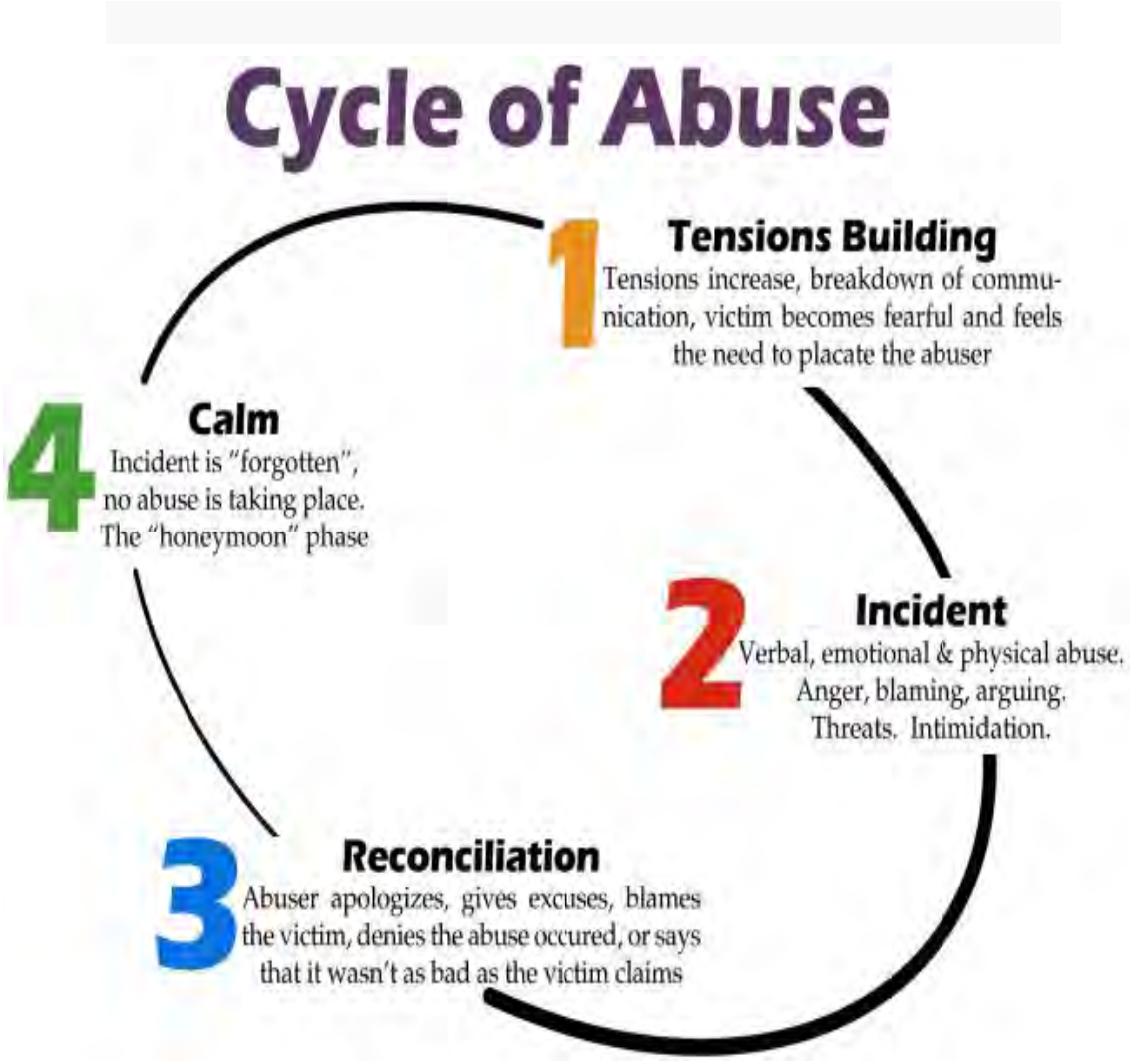
Did you know?
THERE IS A LINK BETWEEN IPV AND CHILD ABUSE AND NEGLECT

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.