Module 3
Maternal Child and Women's Health

AIM OF THE LESSON

Lesson 3.1 aims to share information about family planning choices.

Learning Outcomes

By the end of this lesson learners should be able to:

- Explain family planning and the benefits to the person, family and community
- Explain the different methods of family planning

Lesson Contents

- Benefits of family planning
- Family planning methods

References

1. National Department of Health. The Primary Health Care Package for South Africa – a set of norms and standards. South Africa. 2000
2. USAID, Johns Hopkins & WHO. Family Planning – Global Handbook for Providers. 2006
3. National Department of Health. Guideline on Reproductive Health. South Africa. 2009
4. National Department of Health. The South African Antiretroviral Treatment Guidelines. 2013
5. National Department of Health. National Contraception Clinical Guidelines. 2012

Your role as a CCG

Your role as a CCG is to explain to clients about the importance of family planning and to discuss with them the family planning methods that are available.

1. What is family planning?

It is important for a woman to be able to plan when and how many babies she would like to have. This is called family planning, and there are different ways to do this. These ways are described below.

This is the responsibility of both partners in the relationship. It is important that both the man and the woman have the correct information so that they can make the best choice for their family.

Benefits of family planning

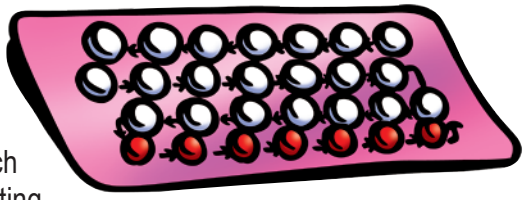
- If a woman can plan when she wants to fall pregnant she will lower the chances of having unwanted pregnancies and pregnancies that are dangerous for the mother and the baby
- If the mother has a disease that could make pregnancy dangerous and she decides to have a baby then it is important that she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

2. Methods of family planning

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

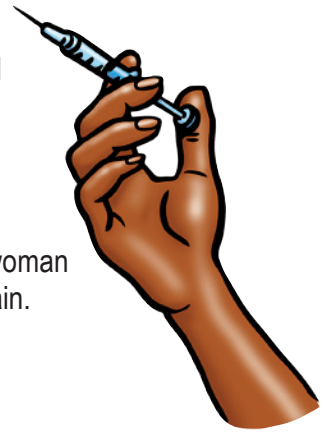
a. Temporary Methods

The pill



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

The injection

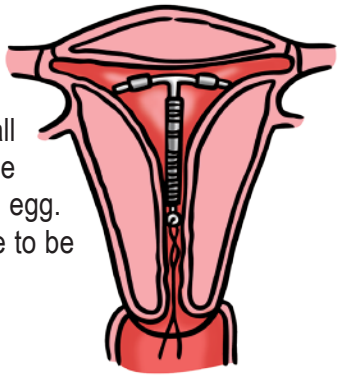


This is a hormone injection that is given every three months. It works very well but when a woman chooses to fall pregnant it can take a few months for her body to start making fertile eggs again.

Copper Intra-Uterine Contraceptive Device (Cu IUCD)

This is a device that is made of plastic and copper inserted into the womb and prevents the fertilised egg from attaching to the wall of the womb. It is not a common method in South Africa and is only available at some clinics. It's also known as the loop.

Sub-Dermal implants



Sub-Dermal implants are placed just under the skin of the upper arm. It releases small amounts of one of the female hormones into the body. This results in stopping of the release of the egg from the ovary. It also stops sperm getting through to the womb to fertilise an egg. And finally, these devices make the lining of the womb thinner meaning that if an egg were to be fertilised, it would not be able to attach to the womb.

b. Barrier Methods

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

Condoms

Condoms are the most used barrier method. **They are also the only method that provides protection against HIV and other STIs as well** [see Lesson 4.10 on Prevention of HIV and STIs: The Role of Condoms].

c. Withdrawal Method

This is when the man withdraws the penis from the vagina before ejaculation. It is not a very good method to stop

pregnancy as some sperm can enter the vagina even before ejaculation. It also does not protect against STIs or HIV.

d. Permanent Methods

Surgery

The only way to provide permanent family planning is an operation. Both men and women can have an operation. Men can have an operation called a vasectomy (Blocks the sperm from moving into the penis during ejaculation).

Handy Hints

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

Women can have an operation called a tubal ligation (this means the fallopian tube is cut so that the egg does not reach the uterus.) This is a very good method of preventing pregnancy but it cannot easily be reversed if a couple later want to have a baby.

It is important to note that a woman cannot be forced to have a tubal ligation or a man a vasectomy.

The last type of family planning we will look at is called Emergency Contraception.

Emergency contraception is NOT a regular method of family planning. Emergency contraception can be used after no birth control was used during sex, or if the birth control method failed, such as if a condom broke. It can be used when:

- The woman has had consensual unprotected sex or her normal contraception has failed, e.g. a condom slipped or she missed her hormonal pill or injection
- She were raped and no contraceptive method was used

There are two types of safe and effective emergency contraception available in South Africa:

- Hormonal Emergency Contraceptive Pills (ECPs)
- Cu IUD

Both forms of emergency contraception should be used within 5 days of unprotected sex. Emergency contraception should only be used in emergencies. It is not intended for regular use.

Which contraceptive method is best for a person who is HIV-positive?

People with HIV, AIDS, STIs or those who are on anti-retroviral medicines (ARVs) can use most contraceptives safely.

Advantages and disadvantages of some methods are listed below:

- Condoms, non-penetrative sex and abstinence: these methods can prevent pregnancy and infection with HIV and STIs
- Oral contraceptives and injections: these methods can prevent pregnancy but cannot prevent infection with HIV and STIs. Women on ARV therapy should seek medical advice before using oral contraceptives and injections as some ARVs may reduce how well they work
- Intra-Uterine Contraceptive Device (IUCDs): this method can be used by an HIV-positive woman provided she is clinically well. It will prevent pregnancy but will not prevent infection with HIV and STIs

Group Discussion

Noluthando is a mother of three who lives in rural KZN. She is 45 years old. She would like to reconsider her family planning methods. Her daughter, Thabile is 18 years old and HIV-positive. Thabile does not want to have a baby until much later.

Discuss the following in groups:

1. What methods may be suitable for Noluthando considering her age and number of children?

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2. What methods may be suitable for Thabile considering her age, HIV status and decision to delay having children?

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AIM OF THE LESSON

Lesson 3.2 aims to share information about termination of pregnancy.

Learning Outcomes

By the end of this lesson learners should be able to:

- Explain termination of pregnancy (TOP) and when a woman qualifies for TOP

Lesson Contents

- Termination of pregnancy

References

1. Choice on Termination of Pregnancy Amendment Act (Act 1 of 2008)
2. Smith J; Bomela N; De Vos M; Nyawo M and Trueman K. Handbook for the management of HIV-positive women of reproductive age. Durban, South Africa: Health Systems Trust; 2011

Your role as a CCG

Your role as a CCG is to provide information about termination of pregnancy (TOP) to female clients and to share with them the criteria for TOP.

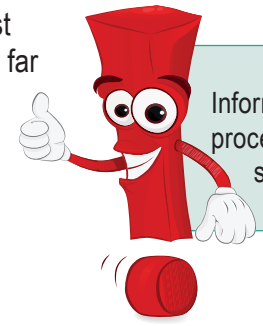
1. What is termination of pregnancy?

South Africa has passed a law that allows all women, including those that are HIV-positive to have a safe termination of pregnancy (TOP). This means if a woman finds out she is pregnant, she may ask for the pregnancy to be ended free of charge before it is time for the baby to be born. The woman needs to give informed consent. If her clinic does not perform TOP, they must refer her to the nearest clinic that does.

As deciding to have a TOP is a big step, the woman should talk to the social worker about any issues that she may be experiencing. Also, she may suffer some emotional distress after the procedure. If this happens the woman should be referred to the social worker for counselling.

2. When is a woman allowed to have a termination of pregnancy (TOP)?

There are some important points a woman must meet to have a TOP, and these depend on how far the pregnancy is when she goes to the clinic.



Handy Hints

Informed consent means the nurse has explained the procedure and all the risks involved and the woman has signed that she wants to have the procedure done.

Conditions for having a TOP

How far pregnant is she?	When she qualifies for a TOP?	Who can give informed consent?
Up to 12 weeks	On request of a pregnant woman (the woman must ask for a TOP)	Informed consent from the pregnant woman
13 to 20 weeks	• If having the baby could harm the woman's body or affect her mental state • If she cannot afford to have the baby because she does not have enough money or if having the baby would affect her relationships with her family and community • If the baby is not growing normally • If the pregnancy is a result of rape or incest (sex between close relatives)	Informed consent from the pregnant woman
After 20 weeks	If the pregnancy would: • be dangerous to the woman's life • affect the normal growth of the baby • cause a risk of the baby being hurt	Informed consent from the pregnant woman in consultation with two Medical Practitioners OR a Medical Practitioner AND a Midwife

Handy Hints

A woman may not be forced to have a termination of pregnancy because she is HIV-positive!

Group Discussion

Termination of pregnancy

1. When can a woman ask for a termination of pregnancy (TOP)?

2. How much does a termination of pregnancy (TOP) cost?

3. What does 'informed consent' mean?

4. Who has to give informed consent for a termination of pregnancy (TOP) if a woman is 13 – 20 weeks pregnant?

5. When can a woman be forced to have a termination of pregnancy (TOP)?

AIM OF THE LESSON

Lesson 3.3 aims to share information about antenatal care.

Learning Outcomes

By the end of this lesson learners should be able to:

- Show an understanding of how pregnancy occurs
- Show knowledge of the signs of pregnancy
- Show an understanding of the importance of antenatal care (ANC)
- Show an understanding of the schedule of antenatal care (ANC) visits to the clinic
- Show an understanding of the CCG home visit schedule and procedures
- Show knowledge on the topics of pregnancy related education
- Show an understanding of the specific issues with regard to teenage pregnancy

Lesson Contents

- Signs of pregnancy
- Antenatal care
- Schedule of antenatal visits
- Role of the CCG in antenatal care
- Pregnancy health education
- Teenage pregnancy

References

1. National Department of Health. Community Maternal, Neonatal, Child, Woman's Health Framework. South Africa. 2009
2. KwaZulu-Natal Department of Health. KZN Integrated Antenatal and Postnatal Care Manual. South Africa. 2009
3. Woods D.L, Theron G.B. Perinatal Education Programme Manual 1. South Africa. 2002
4. National Department of Health. Community-based Maternal, Neonatal, Children and Women's Health and Nutrition Interventions – Pocket Booklet for Community Health Workers. South Africa. 2009

Your role as a CCG

Your role as a CCG is to make sure that pregnant women book in early (before 14 weeks of pregnancy) for antenatal care; to make sure that your pregnant clients keep all their clinic visits and that all the healthcare workers recommendations are followed. You will need to refer the mother to the clinic as soon as possible if she is not feeling well.

1. What is antenatal care?

It is very important that a woman receives support during and after the pregnancy to help make sure that she and the baby stay healthy. Antenatal care (ANC) is the total care of the body and mind of the pregnant woman. This is done through check-ups at the clinic to help make sure that the mother is healthy and that her baby is growing normally. In addition, the mother will get information and advice about pregnancy, labour, childbirth and care of the newborn baby. It is very important that the mother goes to clinic as soon as she finds out she is pregnant. This should be within the first 14 weeks of her pregnancy. She should visit the clinic at least 5 times in her pregnancy.

Healthcare workers and family members need to work together to help the mother have a healthy pregnancy. The healthcare workers are also there to notice problems early so she can be treated as soon as possible.

Why is antenatal care important?

It is important because it makes sure that the mother and baby remain healthy during the pregnancy and up to when the baby is born. Also, antenatal care helps the mother prepare for the birth of her baby. ANC also helps to find any conditions that could put the life and/or the well-being of the mother or baby in danger, e.g. birth defects, diabetes, HIV, Sexually Transmitted Infections. This will allow her to be checked and treated for any STIs she may have and be given a PAP smear test. If she is HIV-positive, she will be prepared for and started on the right ARVs, depending on her CD4 cell count, to lower the chance of her baby getting HIV. CD4 cells are a type of white blood cell and they act like soldiers and defend the body against germs that make people sick. She will also be given information to help her understand why it is important that she feed her baby only breast milk for the first 6 months.

2. How does a woman become pregnant?

A woman becomes pregnant when a man's sperm enters the woman's vagina and then fertilises the egg to form the baby. Pregnancy can happen anytime after a girl begins menstruating until menopause occurs. It is important for a woman to plan when she wants to become pregnant [see Lesson 3.1 on Family Planning].

What are the signs of pregnancy?

Pregnant women will have some common signs that usually show or happen after four to six weeks of pregnancy, but they may not happen to all women.

- A missed period is the most common sign of pregnancy, especially if a woman's periods are usually regular
- Going to the toilet to urinate more often
- Sensitive or sore breasts or nipples
- Nausea and vomiting at any time of day (but usually in the morning) is common in the first three months
- Feeling tired, especially at the end of the day or late afternoon

Pregnancy Screening Tool

This screening tool will help the CCG determine if the client may be pregnant.

Pregnancy Screening Tool

	Y=Yes	N=No
1. When was the first day of your last normal menstrual period (Your normal period is the period you experience every month and this may be different from other women, e.g. the flow may be heavier, the number of days may be different).	DD MM	
2. Have you been having sex without using any form of contraceptive?	Y	N

Note:
If the answer to Question 1 indicates a missed period, the answer to Question 2 is 'YES', and the client has ONE of the following symptoms, then refer her to the clinic for a pregnancy test.

3. Are your breasts tender?	Y	N
4. Are you feeling nauseous?	Y	N
5. Do you feel tired all the time?	Y	N

Note to the CCG:

Read the following questions to your female clients.

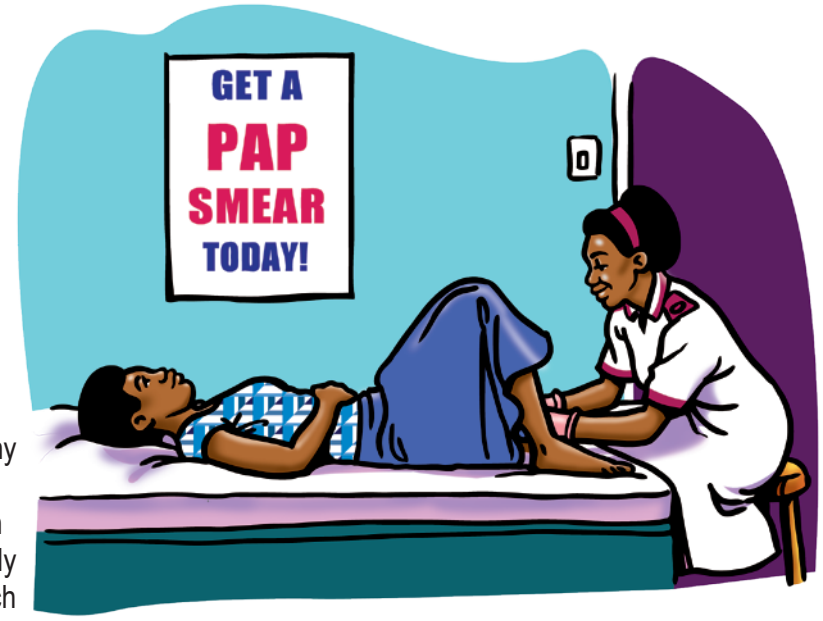
- Refer them to the clinic for a pregnancy test if the answer to Question 1 shows that they have missed a period and the answer to ANY of the other questions is 'Yes'

3. What does a healthy lifestyle mean in pregnancy?

When a woman is planning to fall pregnant the CCG can give the following advice to the woman to help ensure a healthy pregnancy:

- Eat a healthy diet with a lot of green leafy vegetables like spinach
- Stop smoking
- Stop drinking alcohol and taking other social drugs
- Do suitable exercises. Ask the healthcare workers at the clinic what type of exercises can be done
- Reduce or stop drinking coffee and fizzy drinks
- Ask the clinic to check if any medicines being taken could be harmful to the baby
- Have an HIV test, if the woman does not know her HIV status
- Examine breasts for lumps
- Go for a PAP smear

Healthy eating during pregnancy



It is very important for the growth of the baby that the mother eats a healthy diet.

If the mother does not eat healthy food, she may develop anaemia (the iron level of the blood is low) and this can lead to problems during labour, delivery and/or breastfeeding.

Pregnant women should:

- Eat three meals a day with healthy snacks, e.g. fruit in between
- Eat enough protein like chicken and fish
- Eat plenty of fresh vegetable especially green leafy vegetables like spinach which contain iron
- Drink 6 – 8 glasses of water per day
- Use very little salt
- Try and stop eating fast foods, fatty foods, very spicy foods and fried foods

Handy Hints

If a pregnant woman is planning to travel to a malaria area, she should talk to the healthcare workers at the clinic before she travels.

Handy Hints

The earlier a woman visits the clinic when she is pregnant the better.

4. When should a pregnant woman visit the clinic?

Clinic visits
1. Before 3 months (14 weeks)
2. 4 – 5 months (20 – 24 weeks)
3. 6 – 7 months (26 – 32 weeks)
4. 7 – 8 months (34 – 36 weeks)
5. 9 months (40 weeks)

In a normal pregnancy without any complications a woman should visit the clinic at least 5 times but it would be better if she visited more often. A woman should go to the clinic as soon as she misses her first period. If not after the first missed period, then after she misses a second period she must go to the clinic.

It is important to present at the clinic before 14 weeks (3 months) so that the mother gives both herself and her baby the best care and protection during pregnancy.

The number of times a mother needs to visit the clinic will also depend on the condition of the pregnancy to ensure the baby is growing well and complications can be avoided or risks reduced.

At the first visit the woman can expect the following:

- The nurse will take a history of the woman's health, family history and previous pregnancies
- The nurse will do a physical examination
- The nurse will check the woman's blood pressure
- The nurse will do some blood and urine tests
- The nurse will do a PAP smear test
- The nurse will ask questions to check if the woman may have TB
- The nurse will look for any signs of Sexually Transmitted Infections (STIs). STIs are diseases that are passed from one partner to another during sex [see Lesson 4.8 on STIs]
- The woman will get a Tetanus Toxoid injection
- The nurse will counsel the woman and offer an HIV test
- The woman will be given vitamins and folic acid tablets that are important to help keep her healthy during the pregnancy

5. What should the CCG do when visiting a household where a pregnant woman lives?

It is very important that at every visit the CCG checks that the woman has taken action on the advice of the previous visit.

1st visit	2nd visit	3rd visit	4th visit
Before 3 months	Between 4 and 5 months	Between 6 and 7 months	Between 7 and 8 months
Educate on: • Importance of booking early for ANC • Healthy eating in pregnancy • Exercise during pregnancy • Not drinking alcohol and not smoking • Importance of going to the clinic regularly • The right documents to take to the clinic • Getting vaccinated (immunised) for Tetanus • Taking vitamins and folic acid • Testing for HIV if she has not yet tested • How to stay HIV-negative if she is HIV-negative • How an HIV-positive woman can stop the virus from being passed onto the baby, including using a condom every time she has sex • Getting a CD4 cell count test if she is HIV-positive • Starting ARV therapy, if she is not taking ARVs • Explain the importance of being tested for TB and refer her for a test if necessary • Talk to her about anyone in her home having TB and if necessary, refer her to the clinic for follow up treatment • Discuss the importance of being tested for STIs and refer her to the clinic if necessary	• Make sure she has visited the clinic and is following any advice that the healthcare workers at the clinic have given her	• Make sure she has visited the clinic and is following any advice that the healthcare workers at the clinic have given her	• Make sure she has visited the clinic and is following any advice that the healthcare workers at the clinic have given her

1st visit	2nd visit	3rd visit	4th visit
Before 3 months	Between 4 and 5 months	Between 6 and 7 months	Between 7 and 8 months
• Explain the use of anti-retroviral (ARV) treatment, the importance of taking the ARVs as prescribed by the doctor during labour and birth and adherence counselling*	Educate on: • Healthy eating in pregnancy • Exercise during pregnancy • Not drinking alcohol and not smoking • Exclusive breastfeeding • Other feeding options, should the mother be unable to breastfeed • Importance of HIV testing for the mother and the baby • The family must know what danger signs to look out for during the pregnancy, e.g. bleeding, baby not moving • Disclosure of status if HIV-positive	Educate on: • Healthy eating in pregnancy • Exercise during pregnancy • Not drinking alcohol and not smoking • The family must know what danger signs to look out for during the pregnancy, e.g. bleeding, baby not moving • Exclusive breastfeeding • Other feeding options, should the mother be unable to breastfeed • Being ready for the birth (where to deliver, what to take with her to the hospital, who will look after the other children she may have) • Birth registration and the documents she will need • Importance of HIV testing for the mother and the baby • Talk to her about why the vaccinations for the baby are important	Educate on: • Healthy eating in pregnancy • Exercise during pregnancy • Not drinking alcohol and not smoking • Exclusive breastfeeding • Other feeding options, should the mother be unable to breastfeed • Being ready for the birth (where to deliver, what to take with her to the hospital) • Birth registration and the documents she will need • Importance of HIV testing for the mother and the baby
• The importance of exclusive breastfeeding, as well as other feeding options should the mother be unable to exclusively breastfeed	• Encourage the mother to take vitamins and her folic acid tablets	• Discuss transport arrangements for when the labour begins	• Encourage HIV-negative mothers to retest
• Explain the importance of telling her traditional healer that she is pregnant so that she will not receive any medicines from him that would be dangerous for her or the baby. The woman should also show the healthcare worker at the clinic any traditional medicines she may be taking	• Check if blood pressure and urine was tested and ask her to go back if it was not tested	• Check if blood pressure and urine was tested and ask her to go back if it was not tested	• Check if HIV-positive mothers have been started on ARVs and if they have had a CD4 count done

1st visit	2nd visit	3rd visit	4th visit
Before 3 months	Between 4 and 5 months	Between 6 and 7 months	Between 7 and 8 months
• If she is HIV-positive, explain the importance of her having her baby in a hospital, rather than at home	• Check if she had an HIV test when she went to the clinic and if she went back for the results. If she has not gone back, talk to her about the importance of knowing her HIV status for herself and her baby		• Talk to her about getting her partner to test for HIV, if he has not done so already
	• Check if she was tested for STIs		• Discuss the importance of being checked for STIs for herself and her partner
	• Ask her if she has made an appointment for her next ANC visit		• Make an arrangement to see the mother and her baby on the first day after she and the baby are discharged from the hospital
	• Refer her to a support group if HIV-positive		

**Adherence counselling is counselling by a healthcare worker that helps the client to continue taking their medicines as prescribed by the doctor.*

It is very important for CCGs to make these four visits to the households of pregnant women. The CCG must discuss the topics listed for each of the visits with the pregnant woman and her family.

6. Danger signs in pregnancy

There are some signs that the CCG should be aware of and educate their clients and families about:

- Client not gaining weight
- Is the woman pale and are her gums, inner eyelids and tongue whitish in colour
- Vomiting a lot causing dehydration. Dehydration is when the body does not have as much water and fluids as it should
- Putting on too much weight which can cause high blood pressure
- Unusual swelling of hands, face or legs
- Severe (bad) headaches
- Seizures (fits)
- Weakness, dizziness, fainting
- High fever
- Coughing a lot

- Sores, warts or blisters on or near the vagina
- Burning when passing urine
- Woman tired and out of breath
- Baby not moving
- Bleeding from the vagina
- Are there labour pains?
- Has the water broken early?
- If so, what colour is the water (e.g. yellow, green)?

If any of these signs are present the woman should go straight to the clinic to have a check-up.

7. Advice on illness during pregnancy

Anaemia

Anaemia happens when the blood does not have enough iron in it. This is dangerous as the iron in the blood carries oxygen to all parts of the body.

The common signs of anaemia are:

- Pale tongue and inner eyelids
- Feeling tired and weak
- Feeling out of breath and dizzy
- Heart beating fast
- Nausea (feel like vomiting)
- Constipation or diarrhoea

What to do for anaemia:

- Take iron tablets with food to reduce nausea
- Eat plenty of fresh vegetables, fruit and whole wheat products (e.g. whole wheat bread). Eat foods rich in iron such as meat, fish, eggs, milk and leafy green vegetables such as spinach and lettuce

Morning sickness

Some mothers feel nauseous and vomit early in the morning, and some feel nauseous all day.

What to do for morning sickness:

- Eat a dry biscuit, piece of bread, rice or porridge right after waking up in the morning
- It is better not to keep the stomach empty, so eat six small meals rather than three large meals a day
- Take liquids between meals and not with meals
- Don't eat spicy, fried or fatty foods

Heartburn

This is a burning feeling in the throat and chest. Heartburn happens more often later on in the pregnancy because as the baby grows, it presses on the mother's stomach.

What to do for heartburn:

- Eat small meals often
- Don't eat spicy, fried or fatty foods
- Drink milk if able to drink it without problems
- Don't drink fizzy drinks
- Do not lie down immediately after eating

Constipation

Some women suffer from constipation during pregnancy. This means that the stool becomes hard and it is difficult to go to the toilet.

What to do for constipation:

- Eat roughage like whole wheat and brown bread
- Drink at least 2 litres of water every day
- Eat lots of vegetables and fruits every day
- Do regular light exercises, e.g. fast walking every day
- It is very important that the mother NOT take laxatives or herbs which cause watery stools because this can cause dehydration

8. Signs of labour

There are some common signs that show that the baby is ready to be born.
These are:

- Her water breaks
- She has a discharge that has blood in it
- She starts to feel contractions that get worse over time
- She has a pain in her lower back that doesn't go away

If the mother has any of these signs, she must be taken to the hospital as soon as possible.

9. Teenage pregnancy

Teenagers who fall pregnant are cared for in the same way as any other pregnant woman. Teenagers can develop problems during pregnancy more easily, so they need to be watched very closely.

What to watch out for in teenage pregnancy:

- Teenagers may be scared of what their parents will say or do so they may try to hide the pregnancy. This means that they often do not go to the clinic for their check-ups and this is dangerous as they may have a problem that is not picked up. They should be encouraged to talk to their families for support

Group Discussion

Exercise 1

Some women take advice from the older women in the community during pregnancy. Sometimes this can have an effect on the pregnancy.

Divide into groups, discuss the following and give feedback to the class.

1. What are the positive cultural traditions that can affect a pregnancy?

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2. What are the negative cultural traditions that can affect a pregnancy?

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Group Discussion

Exercise 2

Thembi has just shared that she suspects she may be pregnant. She is 34 years old and it is her third pregnancy.

1. What signs might there be to see or ask about?

2. What advice should be given to her?

3. Thembi says she is suffering from morning sickness. What will help her?

4. How will Thembi and her family know when she is in labour?

AIM OF THE LESSON

Lesson 3.4 aims to share information about postnatal care.

Learning Outcomes

By the end of this lesson learners should be able to:

- Explain the importance of postnatal care
- Show how to successfully breastfeed a baby
- Show how to clean feeding bottles, teats and cups properly

Lesson Contents

- Postnatal care
- Breast feeding
- Infant feeding hygiene

References

1. King F.S. AMREF. Helping Mothers to Breastfeed Revised Edition. Kenya. 1992
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5. Lang S. Breastfeeding Special Care Babies. Edinburgh: Elsevier/BaillièreTindall. 2002
6. National Department of Health. PMTCT Training Guide: Module 4 – Session 2; Postnatal care and follow up of HIV-positive mothers, Page 6

Your role as a CCG

Your role as a CCG is to make sure that all clinic visits for the mother and baby are kept and that the mother and baby get the care that they need. You will need to refer the mother to the clinic as soon as possible if she or the baby is not feeling well.

1. What is postnatal care?

Postnatal care is the care that is given to a mother for the first six weeks after the baby is born. There are some important things to look out for to ensure that the mother and baby stay healthy after the birth. The CCG should visit the new mother at least four times in the first six months after delivery because the most problems that occur with mothers and babies happen in the first six months after birth.

The first visit should take place in the home as soon as possible after the baby is born. If the mother is discharged from hospital on the same day that the baby is born, the CCG should visit the mother on the same day to make sure that she and the baby are in good health.

2. What should the CCG do on these visits?

The mother

- Ask about bleeding and the amount and colour of the blood
- Ask about pain
- Talk to the mother about signs of infection (pain during urination, blood in the urine, vaginal discharge)
- Ask if she has a fever
- Talk to the mother about the importance of exclusive breastfeeding
- Ask about the breasts. Are they filling with milk? If not, check if the mother is latching the baby properly to allow for good flow of milk
- Educate the mother on the importance of personal hygiene, especially washing of the vagina [see Lesson 2.1 on the Human Body], and the wearing of a sanitary pad if the woman is still bleeding
- If the mother is lying in bed she should move her legs and feet and get up to walk regularly otherwise she may develop swollen and painful legs
- Ask about the mother's appetite. She should be eating a healthy diet [see Lesson 2.2 on Healthy Eating] and drinking plenty of water
- Advise the mother to rest when the baby is sleeping. She should get enough rest because it is important for making breast milk
- If the mother previously tested HIV-negative, refer her for another test
- If the mother is HIV-positive check that she is taking her ARVs
- If the mother is HIV-positive and not on ARVs, refer her to the clinic for ARVs and a TB test
- Refer the mother for a PAP smear test to check for cervical cancer
- Discuss different family planning methods which she could use
- Check that the mother knows that she must have a check-up at the clinic after six days, after six weeks, and after six months
- Advise the mother on the Tetanus Toxoid vaccination for herself

3. What care and support should the mother get after the baby is born?

It is very important that the mother gets the care and support to help her take care of herself and her baby.

One of the main ways of making sure that she stays healthy is by making sure that she gets care from the clinic at four very important visits [see Lesson 3.5 on Infant and Child Care]:

- Six hours after delivery
- Within six days of delivery
- Six weeks after delivery
- Six months after delivery

Schedule of clinic visits for the mother

The following table will show the services the mother should expect during these visits.

Six hours after delivery	Within six days of delivery	Six weeks after delivery	Six months after delivery
The mother and the baby should not be discharged before six hours after delivery	Visit the clinic within six days of delivery	Visit the clinic six weeks after delivery	Visit the clinic six months after delivery
Examinations that the mother will have			
You should be examined for: • Blood loss • Pain • Blood pressure • Pulse rate • Tears in your vagina	You should be examined for: • Low iron levels • Blood pressure • Signs of infection • Pain on caesarean (section) wound • Tenderness in the womb area • Breast complications • Vaginal discharge • Any infections in your urine	You should be examined for: • Low iron levels • Blood pressure • Signs of infection • Wounds and tears experienced during childbirth • Breast complications	
Support and Counselling			
Counselling on family planning methods	Receive counselling on family planning methods and you should be provided with the family planning method of your choice	You should continue to eat healthy foods; you can ask the nurse for more information on healthy eating	You should continue to eat healthy foods; you can ask the nurse for more information on healthy eating
She should be provided with support on exclusive breastfeeding	Receive further support on exclusive breastfeeding	Counselling on family planning methods and how to practice safer sex	Counselling on family planning methods and how to practice safer sex
Counselling on how to care for yourself after delivery	Given information on healthy eating	Receive cervical cancer screening	Receive support to introduce solid foods for the baby
If you are HIV-positive, guidance on how to give ARVs to your baby	Guidance on how to keep your baby well if your baby has diarrhoea	You will receive HCT, if you were HIV-negative when you were last tested for HIV	Ask to be screened for cervical cancer if you have not yet been screened

Six hours after delivery	Within six days of delivery	Six weeks after delivery	Six months after delivery
	If you are HIV-positive and not on ARVs, you will be started on ARVs	If you are HIV-positive and not on ARVs, you will be started on ARVs and screened for TB	You must ask for HCT, if you have not had a repeat HIV test
		If you are HIV-positive and you do not have TB, you will be given TB prevention medication (IPT)	Ask for a CD4 cell count test if you are HIV-positive and not had the CD4 cell count test
			Ask for TB screening if you have not yet been screened
			You will receive information on welfare grants that are available to mothers and caregivers

4. What are the danger signs for the mother?

Mother has:

- A high fever
- Heavy bleeding or smelly discharge
- Very pale skin
- Breasts are very swollen and painful

If the mother has any of the above she should go to the clinic as soon as possible.

5. What are the danger signs for the baby?

- Diarrhoea and vomiting
- High fever
- Change in skin colour (greyish, yellow, blue or darker than before)
- Not responding. This means that the baby does not move when touched or picked up. The baby does not turn the head to try and find the breast
- Swelling of the head

Important information on the baby:

- Check on how the mother is feeding the baby
- If the baby is suffering from diarrhoea, refer the baby to the clinic immediately and teach the mother how to prepare and feed the baby the oral rehydration solution [see Lesson 3.5 on Infant and Child Care] until the mother can get the baby to the clinic
- Teach the mother how to bath the baby and care for the cord [see Lesson 3.5 on Infant and Child Care]
- Check the baby's *Road-To-Health Book* and remind the mother of the vaccination schedule and refer to the clinic for vaccinations at 6, 10 and 14 weeks
- Check the baby's growth status using the malnutrition screening band for the arm and refer the baby to the clinic if the baby seems underdeveloped [see Lesson 3.5 on Infant and Child Care]

- Check the BCG vaccination site for signs of infection
- Educate the mother on the danger signs to watch out for
- Remind the mother about the clinic visits at 6 days, 6 weeks, and 6 months
- Encourage the mother to take the baby for the PCR test at 6 weeks if the mother is HIV-positive
- If the baby is HIV-negative, remind the mother to take the baby for another HIV test at 18 months
- If the baby is HIV-positive, ensure that the mother is giving the baby ARV medicine exactly as prescribed by the healthcare worker
- If the mother is HIV-positive and the baby is HIV-negative, ensure that the baby is being given co-trimoxazole as prescribed

Handy Hints

Breast is best.

6. What common problems can happen after birth?

g. Sore nipples

The mother's nipples may become sore or cracked from the baby suckling in the wrong position. While this is very painful for the mother, it also usually means that the baby is not getting enough milk.

- Help the mother to latch the baby onto the breast correctly. This should not be painful on the nipple
- The mother should only wash the breasts once a day with water. Soap can dry out the nipples and make the cracks worse
- Wait for the baby to stop suckling. If the baby is 'pulled' off the nipples this can make it worse. If the mother has to take the baby off the breast then the mother should slip her finger into the corner of the baby's mouth to release the suction
- The mother can rub breast milk onto the nipples after each feed. This will prevent further cracks

h. Painful full breasts

If the baby is not latching correctly or not emptying the breast at a feed, they may become very full and painful. The breast looks shiny and hard and the milk may have stopped flowing.

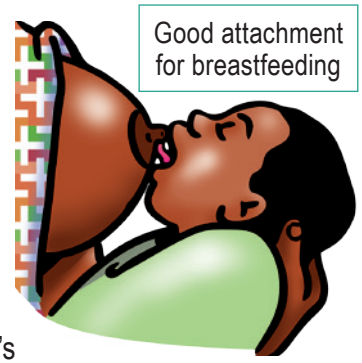
- Inserting cold cabbage leaves into the bra can help
- Wearing a bra to support the breasts helps with the pain
- The mother should apply warm and then cold cloths to the breasts
- Let the baby drink as much as possible
- Massaging the breasts gently to stimulate the milk flow

7. Infant feeding

In South Africa it is recommended that all mothers breastfeed exclusively for six months, whether or not they have HIV. **Exclusive breastfeeding** means feeding the baby only breast milk. The baby will not need other food or liquids. Whilst breastfeeding, the mother should not give her baby water, cooking oil, herbal teas, juice, porridge or any other liquids or foods. It is alright to give her baby medicine, as well as ARVs

that have been prescribed by a healthcare worker. No traditional herbs or medicines must be given to the baby either.

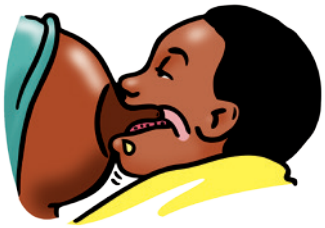
If the mother is unable to exclusively breastfeed the baby for six months, the mother should talk to the clinic staff about exclusive formula feeding for the baby. As with exclusive breastfeeding, it is important that the baby is not fed anything other than formula Milk. Medicines including ARVs provided by the clinic can be given.


Good attachment for breastfeeding

h. How to latch a baby correctly for successful breastfeeding?

Good attachment

- The baby's chin touches the breast
- The mouth is wide open
- The lips are curled outwards
- More of the areola (darker area around the nipple) is seen above the baby's mouth and less below
- This shows that the baby is reaching with their tongue under the nipple to press out the milk
- The baby is taking slow deep sucks
- Suckling should be comfortable and without pain


Good attachment for breastfeeding

Poor attachment

- The baby's chin does not touch the breast
- The baby's mouth is not wide open and the lower lip is not turned outwards
- The baby has not taken the mother's full nipple in their mouth but only the tip of the nipple


Poor attachment for breastfeeding

i. Positions for breastfeeding

There are several positions a mother can use for breastfeeding. The mother should try them all until a position is found that suits the mother and the baby.

j. Advantages of breastfeeding

- Breast milk has all the nutrition that a baby needs for the first six months
- Always available and sterile
- Breast milk helps protect the baby against diseases
- Exclusive breastfeeding lowers the risk of HIV transmission from mother to baby
- Helps to reduce the bleeding after delivery and for the womb to return to the normal size
- The holding of the baby close to the mother helps with bonding

8. What can the mother do if she is breastfeeding and can't be with the baby all the time?

The mother can express milk (squeeze milk out of the breasts) so that somebody else can feed the baby for her. It is important that this is done correctly so that the baby does not become sick.

i. How to clean a container for expressed breast milk?

Step 1
Explain to the mother that a cup, jug or jar with a wide mouth is needed. Explain that it is important to use a clean container to store the expressed milk so that the baby does not get sick from any germs in the container.

Step 2
Wash the cup in soap and clean water and rinse off all the soap.

Step 3
Pour boiling water into the container and leave it for a few minutes, then empty the container out. The boiling water will kill most of the germs.
Express milk into the empty container.

j. How to store breast milk?

The breast milk may be kept out of the fridge for 6 – 8 hours but if stored in the back of the fridge will last for 8 days. Remember to store the breast milk in a clean container with a tight lid.

k. How to express breast milk by hand?

Step 1
The woman must always wash her hands before expressing milk. The woman should sit or stand comfortably, with the container near her breast.

Step 2
The woman should put her thumb on her breast between the nipple and areola, and her forefinger on the breast, opposite the thumb. Support the breast with the other fingers. The woman should feel for small lumps on the edge of the areola with her forefinger and thumb.

Step 3
Press the breast behind the nipple and areola between the fingers and thumb. Press on the larger ducts beneath the areola. Sometimes when there is milk in the breast it is possible to feel the ducts. They are like pods, or peanuts. If the woman can feel them, she should press on them.

Step 4
Press and release, press and release. This should not hurt – if it hurts, the technique is wrong. At first no milk may come, but after pressing a few times milk starts to drip out.

Express one breast for at least 3 – 5 minutes until the flow slows; then express the other side; and then repeat both sides.

l. How to safely clean and sterilise cups?

Step 1
The caregiver should always wash their hands in soapy water before cleaning the baby's cups.

Step 2
To clean a cup, wash and scrub it in hot soapy water each time it is used. Rinse off all the soap. Dip the cup into boiling water, or pour boiling water over the cup just before using it.

Try not to use cups with rough surfaces where milk could stick and allow bacteria to grow.

m. Cleaning and sterilising bottles and teats

Step 1
The caregiver should always wash their hands in soapy water before cleaning the baby's bottles and teats.

Step 2
Bottles and teats are more difficult to clean than cups. A bottle and teat needs to be rinsed immediately after use with cold water, and then scrubbed inside with a bottle brush and hot soapy water. Rinse the soap off well. After washing the bottle and teat, it needs to be sterilised at least once a day.

Step 3
Boiling washed bottles and teats is one of the ways to sterilise them.

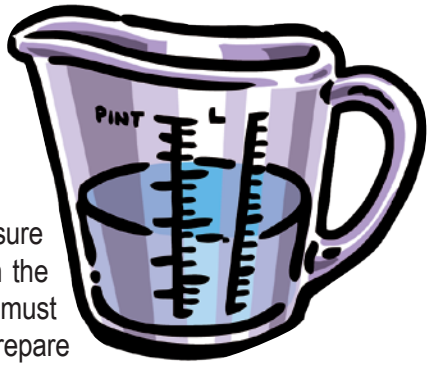
To do this:
Put the bottles into a pot of boiling water and let it boil for about 10 minutes. Do this at least once a day. It is best to do it at the end of the day.

And

Put the teats into a bowl and cover them with boiling water. Teats need to be turned inside out and scrubbed using salt or something rough. Let them stand for ten minutes.

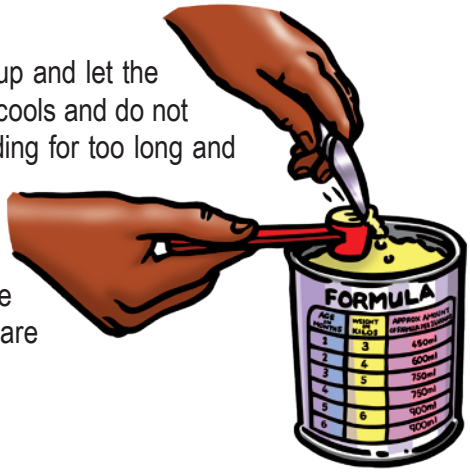
n. How to prepare formula safely?

Step 1
The caregiver should always wash their hands with soap and water before preparing the baby's formula.



Step 2
Always use a marked cup or glass to measure water and the scoop provided to measure the formula powder. It is important that the mother or caregiver reads the guide on the formula tin to find out how much water and powder to use. The mother or caregiver must strictly follow these instructions or ask her healthcare worker to show her how to prepare the baby's formula feed.

Bring water to the boil, pour the required amount of water into the measuring cup and let the water cool. Keep the water covered with a saucer (small plate or similar) while it cools and do not leave it to cool for more than 30 minutes. This will prevent the water from standing for too long and becoming contaminated with germs.



Measure the formula powder with the scoop provided and make sure that the scoops are level. Remember to follow the instructions on the container to see how much water and formula to use. It is very important that these instructions are carefully followed.

Step 3
Add the required scoops into the cup of cooled water. Stir well. Feed the baby using the cup and throw away any formula leftover from the feed. Once the baby has finished feeding, wash the cup and the utensils well.

Before feeding the baby, the caregiver should test the temperature of the milk by dropping a 'drop' on their forearm to make sure it is not too hot.

o. How to feed a baby with a cup?

To feed expressed breast milk by cup, the mother should:

Step 1
The mother/caregiver should always wash their hands with soap and water before feeding the baby.

Step 2
Wrap the baby in a blanket to prevent the baby's hands from knocking the cup and hold the baby closely. Support the baby's head and sit the baby upright or semi-upright in her lap.

Step 3
Hold the small cup to the baby's lips; the baby might start trying to suck.

Step 4
Hold the rim of the cup to the baby's upper lip and tip it slightly so that the milk just reaches the baby's mouth; the baby will then start lapping the milk with the tongue.
Keep the cup tilted and let the baby control the pace at which the milk is taken.

p. How to feed a baby with a spoon?

Spoon feeding is used when the baby is very small and has a low birth weight, or has breathing difficulties.

Step 1
The mother/caregiver should always wash their hands with soap and water before feeding the baby.

Step 2
Allow the baby to sip the milk from the spoon or very small amounts can be put into the baby's mouth using a spoon. It is important not to pour the milk from the spoon into the baby's mouth.

Role Play

Choose a group member who will play a pregnant woman unsure of what feeding option she will be using.

Discuss her concerns around infant feeding with her, keeping in mind the South African Government's policy about exclusive breastfeeding.

AIM OF THE LESSON

Lesson 3.5 aims to share information about infant and child care and development.

Learning Outcomes

By the end of this lesson learners should be able to:

- Show an understanding of how to take care of the newborn baby in the first month
  - Identify the danger signs for a newborn baby
  - Show how to bath a newborn baby
  - Show how to take care of the umbilical cord correctly
- Explain why babies have low birth weight
- Explain and demonstrate Kangaroo Mother Care
- Identify and give advice on common problems of the newborn and when to refer to the clinic
- Show how to read the growth monitoring chart in the *Road-To-Health Book* and recognise a child with poor growth
- Identify signs of malnutrition in children
- Explain some home treatments for sick children
- Explain the role of the CCG in Early Childhood Development (ECD)
- Explain the vaccination schedule and why it is important
- Explain what care the baby should receive from birth through to when the baby is six months old, other than at the monthly clinic check-ups
- Use the Child Health Screening Tool to identify actions that need to be taken by the mother and the CCG
- Discuss tips for parents to improve parenting skills

Lesson Contents

- Care of the newborn baby in the first month
- Danger signs for a newborn baby
- Bathing a newborn baby
- Umbilical cord care
- Low birth weight babies
- Kangaroo Mother Care
- Common problems of the newborn baby
- Growth monitoring in the *Road-To-Health Book (RTHB)*
- Malnutrition in children
- Home treatments for sick children
- Role of the CCG in Early Childhood Development (ECD)
- Vaccination schedule
- Care of the baby up to six months
- Child Health Screening Tool
- Parenting skills

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Your role as a CCG

Your role as a CCG is to make sure that the mother takes her baby to the clinic for all check-ups to monitor the baby's growth and development; as well as to get all the vaccinations. You will need to refer the mother to the clinic as soon as possible if the baby is not feeling well.

1. The first month after birth

The most important time for a baby is the first month after birth. This is when many babies die even though death can usually be prevented. The CCG can help prevent these deaths by educating the household on what danger signs to look for in newborn babies.

The CCG can use the checklist below to help with deciding if a baby is in any danger of serious illness. If the answer to any of the questions below falls in the coloured block on the checklist, the baby should be referred immediately to the nearest clinic.

Checklist: Danger signs in babies

	Y=Yes	N=No
1. Does the baby have a healthy cry?	Y	N
2. Is the baby breathing very fast or very slowly?	Y	N
3. Does the baby's skin have a yellowish colour?	Y	N
4. Has the baby been suckling and swallowing feeds well?	Y	N
5. Has the baby had any seizures (fits)?	Y	N
6. Does the baby feel hot or very cold when you touch the skin?	Y	N
7. Has the baby had a wet nappy today?	Y	N
8. Is there any discharge coming from the baby's eyes, or are the eyes swollen?	Y	N
9. Is the skin around the cord red and swollen?	Y	N
10. Has the baby had a dirty nappy today? Was the stool very hard or was it diarrhoea?	Y	N
11. Is the baby having difficulty in passing stools? (Does the baby cry a lot when trying to pass stools?)	Y	N

2. Bathing the newborn baby

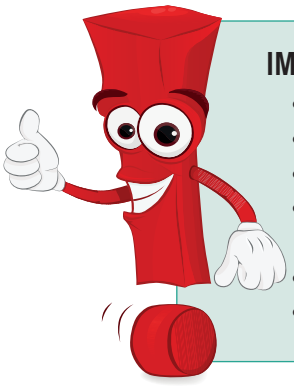
It is important for the CCG to show the new mother the best way to bath the baby. Other mothers will also appreciate being reminded.

The mother will need:

- A warm place with a flat surface
- A soft blanket or towel
- A sink or shallow plastic basin to hold the water
- A washcloth, an extra towel, cotton balls, mild baby soap, mild baby shampoo, a clean nappy and a change of clothes

Steps to bathing a baby

a. Keep baby warm during the bath. Only uncover the parts you are washing as babies get cold very easily
b. Lie the baby on his or her back on the towel or blanket
c. Wet washcloth, squeeze out extra water and wipe the baby's face, there is no need for soap
d. Use a damp cotton ball or clean cotton cloth to wipe each eyelid, from inside to outside corners
e. Wash carefully in the creases under arms, behind ears, around neck and in nappy area
f. Open the fists and wash between baby's fingers and toes
g. Remember to wash the vagina from front to back in girls to keep bacteria away from the vagina



Handy Hints

IMPORTANT:

- Keep the room warm, babies get cold easily
- Water should be warm to the touch, but not too hot
- Don't put the baby into a bath of water until the cord falls off. This will help prevent infection
- NEVER leave a baby alone in the bath – even for a few seconds. A baby can drown in just a little bit of water
- Don't forget to check the BCG vaccination site. Do not put anything on the site
- Babies wriggle around, be careful they do not fall

3. Caring for the cord

The cord area on a baby is like having a sore and can easily become infected if it is not looked after properly.

- The area around the cord should be cleaned every time the nappy is changed. Use cotton wool balls and surgical spirits. Do not clean the actual cord, just the area around it. Make sure to clean the whole area around the cord. Don't leave any dried blood on the tummy or around the cord
- Check for any swelling or redness around the stump as well as any smelly discharge
- Don't cover the cord as it will heal and dry faster if it is left outside of the clothes. This can be done by dressing the baby in clothing with a separate pants and top so that the cord is not covered. Make sure it is not covered by the nappy
- The mother should not try to remove the cord. It will fall off on its own. She should however clean the area for a few days after the cord has fallen off

Group Exercise

Activity 1

Show a member of the group how to bath a baby.

Activity 2

Show how to teach a mother to clean a cord.

4. What is a Low Birth Weight (LBW) baby?

If a baby weighs less than 2,5kg at birth or is born before 37 weeks of pregnancy, it is known as a Low Birth Weight (LBW) baby. These babies are more likely to develop problems.

e. What causes LBW babies?

- If a mother smokes or drinks alcohol during pregnancy
- Teenage pregnancy because the mother's body is not fully grown
- If the mother does not eat healthy food
- If the mother is sick, e.g. she has TB

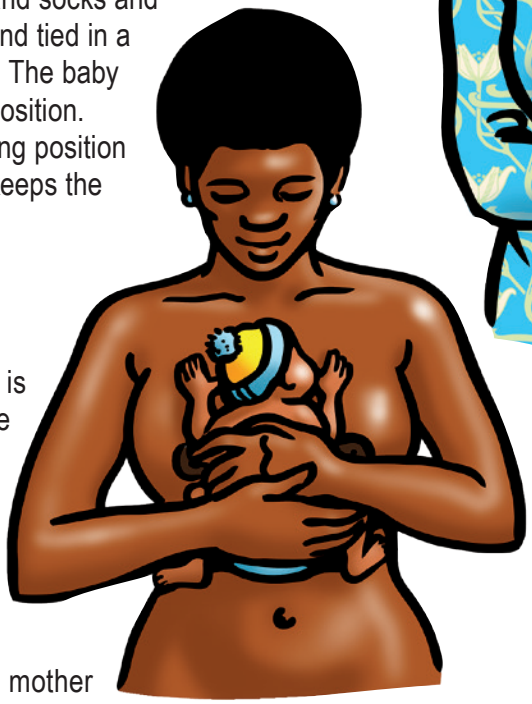
f. How can LBW babies be prevented?

- The mother must visit the clinic often during the pregnancy
- The mother must eat regular healthy meals during pregnancy
- The mother should not smoke cigarettes, drink alcohol or take drugs
- The mother must take the vitamins given by the clinic
- The mother must take her ARVs and TB treatment if she is on them

g. How should LBW babies be cared for?

The best way to manage LBW babies is by **Kangaroo Mother Care.** This method is used to keep the baby warm and it is also good for the bonding between mother and baby. The closeness gives the mother time to keep a watch over the baby and helps to control the baby's temperature and reduce the chances of the baby getting an infection. Any member of the family can assist the mother or can help her by also providing Kangaroo Mother Care to the baby.

The baby should wear only a nappy, hat and socks and must be put between her naked breasts and tied in a pouch or cloth around the mother's chest. The baby is carried all the time in this skin-to-skin position. The mother sleeps and rests in a half sitting position with pillows behind her back so that she keeps the baby close to her body at all times.



h. How should LBW babies be fed?

The best way to feed LBW babies is with exclusive breastfeeding. Exclusive breastfeeding means that the baby is fed only breast milk and is not given any other food or liquids (not even water), other than medicine, such as ARVs, that are given by healthcare workers at the clinic [see Lesson 3.4 on Postnatal Care]. If the baby can't suck properly the mother can use other options like expressing breast milk and feeding the baby with a cup or a spoon [see Lesson 3.4 on Postnatal Care]. These babies find it hard to drink as they are very weak and get tired easily. They may just go to sleep instead of drinking the full amount of milk. This baby needs special care and this includes giving them small amounts of milk often and taking them for more frequent visits to the clinic. If the CCG is at all concerned she should tell the mother to take the baby to see the healthcare workers at the clinic.

It is very important to check the growth of the baby. When visiting the household, the CCG must check the growth using the *Road-To-Health Book* and educate the mother on proper feeding of the baby. The *Road-To-Health Book* is a record of the growth and progress of the baby from birth onwards. It keeps a record of their vaccinations, weight and height.

9. What problems can happen to newborns?

j. The baby does not want to feed

When a baby refuses the breast, it can be very upsetting for the mother.

What to do:

- Check to see if the baby is sick (fever, diarrhoea or vomiting), and then refer to the clinic
- Calm the mother
- Watch the mother breastfeeding to see if she is doing it right [see Lesson 3.4 on Postnatal Care]. If the mother is also feeding the baby with a bottle containing breast milk the baby may be confused
- Encourage the mother to spend time bonding with the baby using the Kangaroo Mother Care method

k. The mother does not have enough milk

A mother sometimes thinks she does not have enough milk. She may have been told this by other women or she may be looking for a reason to change to formula feeding.

The CCG can find out the following:

- Why does the mother think she doesn't have enough milk? Is someone else telling her this?
- Does the mother feel confident about how to latch the baby properly?
- Is the mother breastfeeding correctly (watch how the mother feeds the baby)?
- Ask how often the baby has a wet nappy. A breastfed baby should have at least 6 wet nappies per day. If the baby has 6 wet nappies, the baby should be getting enough milk

l. The baby has a blocked nose

If the baby has a blocked nose, it can make it hard for the baby to drink and breathe at the same time. The mother can use a piece of paper towel or tissue to clean the baby's nose. She can roll it into a point and gently move it around in the nostril. She should clean both nostrils in this way. If the mucous is dry it helps to wet the tissue with clean water.

m. The baby cries a lot

Some babies just cry a lot. But it is important to check for any of the danger signs in the checklist at the beginning of this Lesson. If everything is fine, then advise the mother to carry and comfort the baby. If there are any problems, then refer the baby to the nearest clinic.

n. The baby is too small to breastfeed

If the baby is not yet suckling well and long enough, or is too small to suckle, do whatever works better for the mother:

- Let the mother express breast milk into baby's mouth
- Let the mother express breast milk and feed baby by cup or with a teaspoon [see Lesson 3.4 on Postnatal Care]

1. Name three causes of Low Birth Weight babies.

Exercise

2. Explain Kangaroo Mother Care and how to do it.

3. Name 3 common problems with newborns and what advice to give the mother.

6. What is growth monitoring?

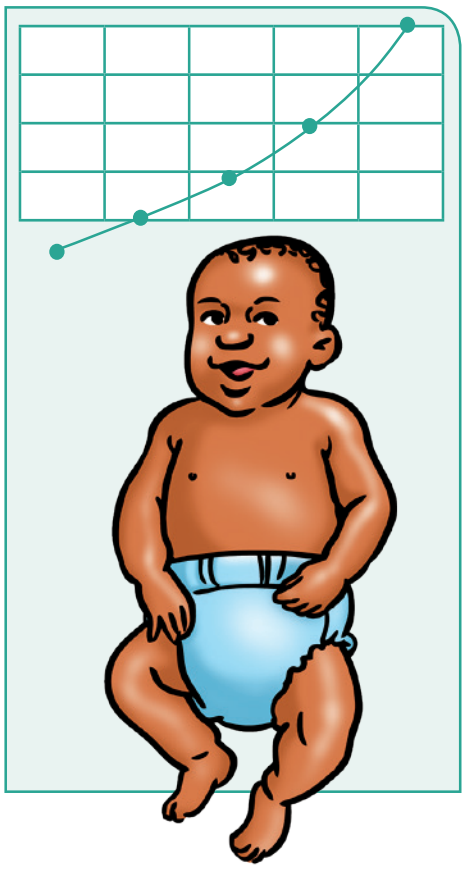
Growth monitoring is used to check if a child is growing well. The *Road-To-Health Book* is used to mark the weight to see if a child is growing well and according to what is expected.

The CCG can do the following:

- Weigh the child if a scale is available or use the Mid Upper Arm Circumference (MUAC) measurement to check on the growth of the child (see section on malnutrition further down in this Lesson)
- Explain to the mother what the graph on the *Road-To-Health Book* means
- If a child is found that is not growing well, refer them to the clinic
- Teach the mother how important it is to take the child to the clinic every month to be weighed

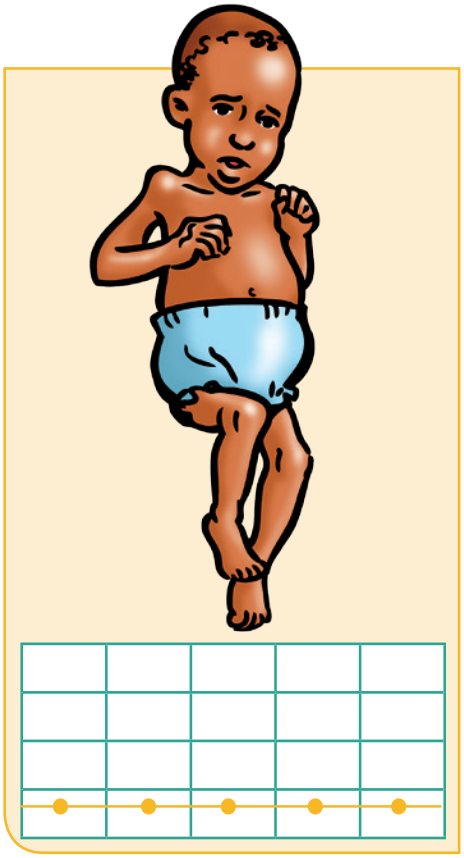
7. When is a child not growing well?

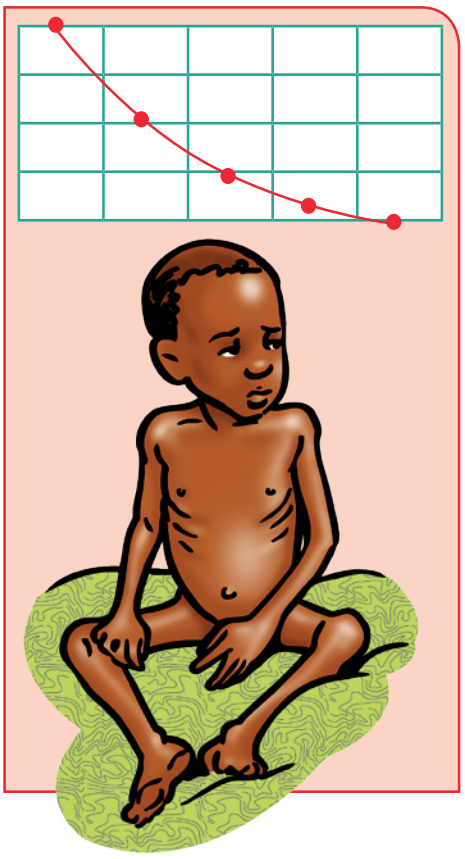
This is a child who weighs less than is expected or the child has not gained enough weight. This is shown by a flattening curve on the growth chart. This child should be visiting the clinic at least monthly.



GOOD: means child is growing well

DANGER: find out why and get advice





VERY DANGEROUS: may be very ill, needs extra care

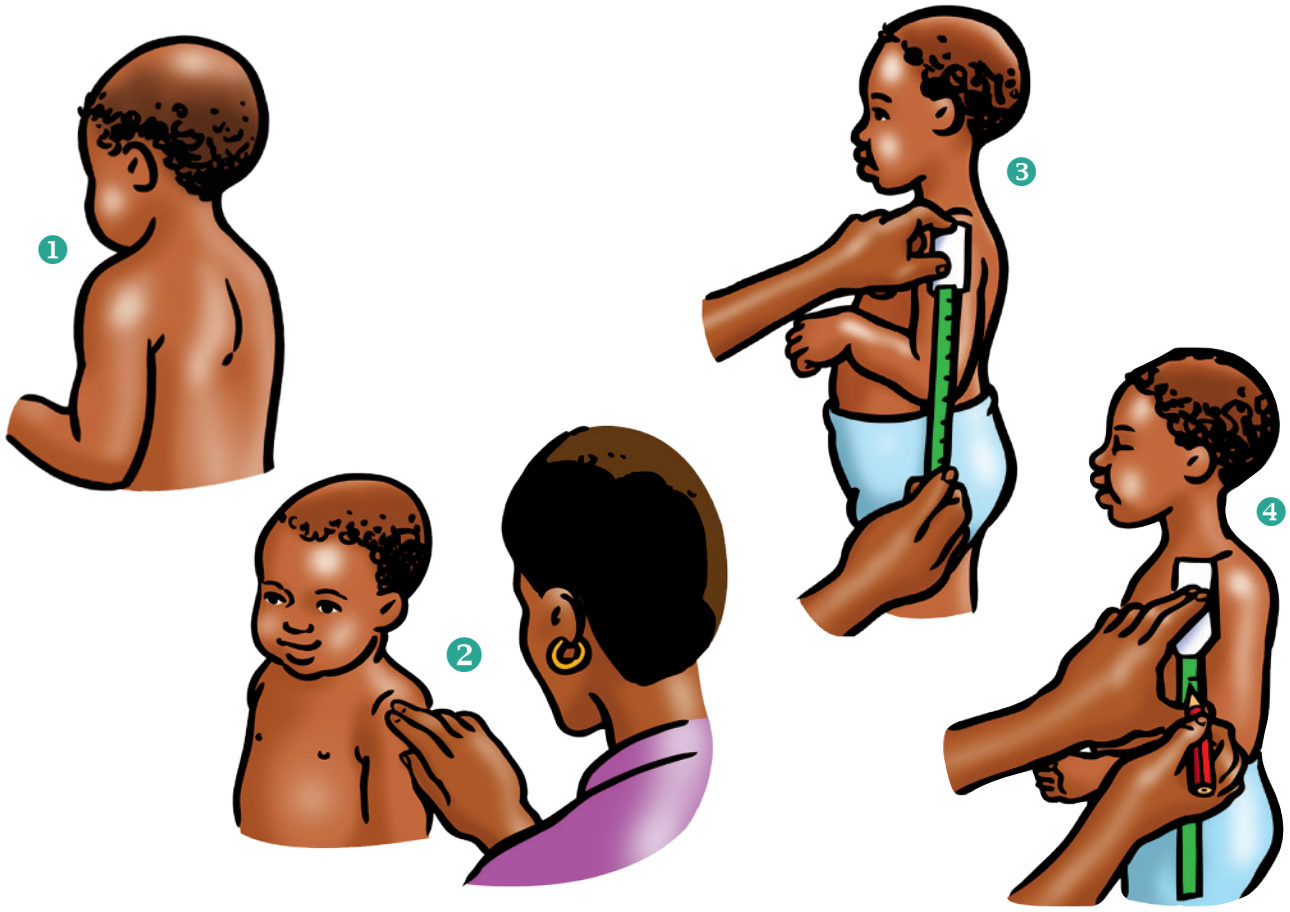
8. How can the CCG help in malnutrition?

- Recognise the signs of malnutrition (using the malnutrition screening tool) and refer children who may be suffering from malnutrition to the clinic
- Visit the home regularly to check on how the child is doing
- Educate the family on cooking and eating a healthy diet [see Lesson 2.2 on Healthy Eating]

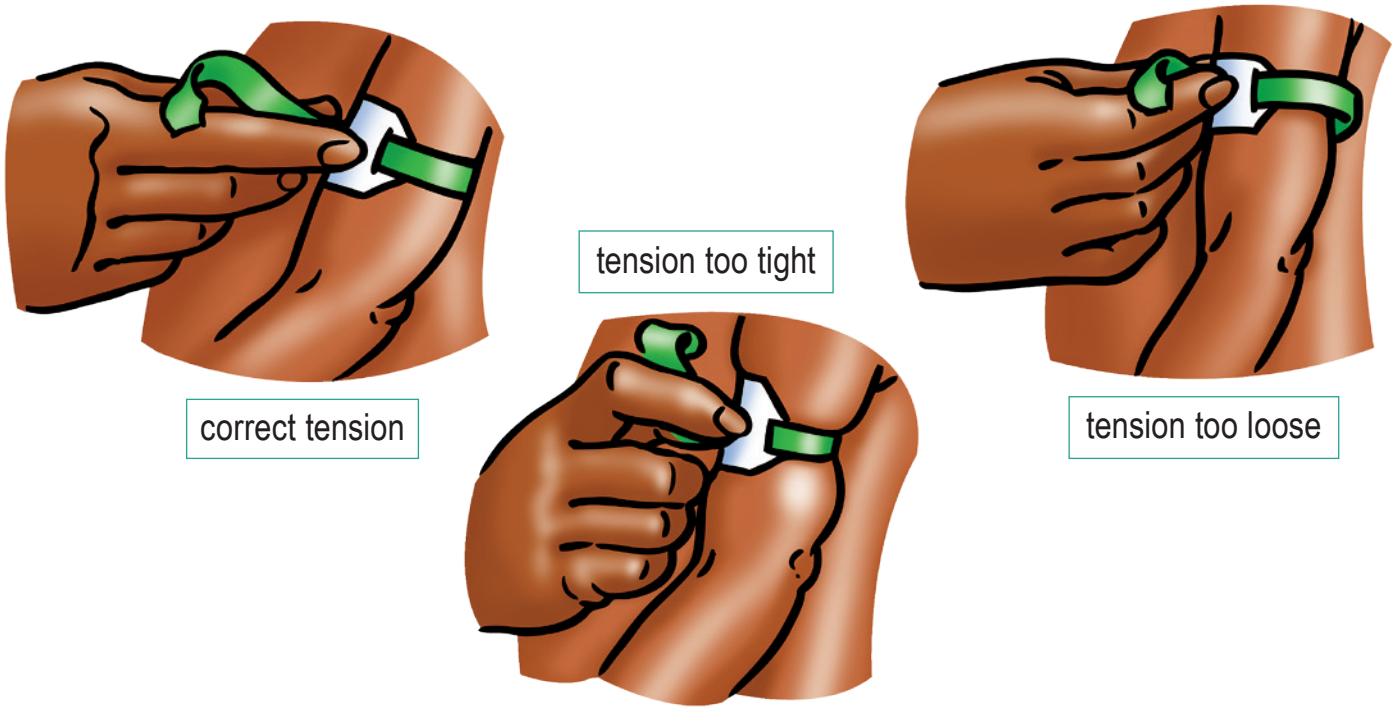
Malnutrition Screening Tool (The MUAC Measurement)

Step 1
Ask the mother how old her child is. If the child is between six months and five years, ask her permission to do a quick, safe and pain-free test on the child to see if the child is malnourished.

Step 2
Find the middle point of the child's upper left arm; this is between their shoulder and elbow.

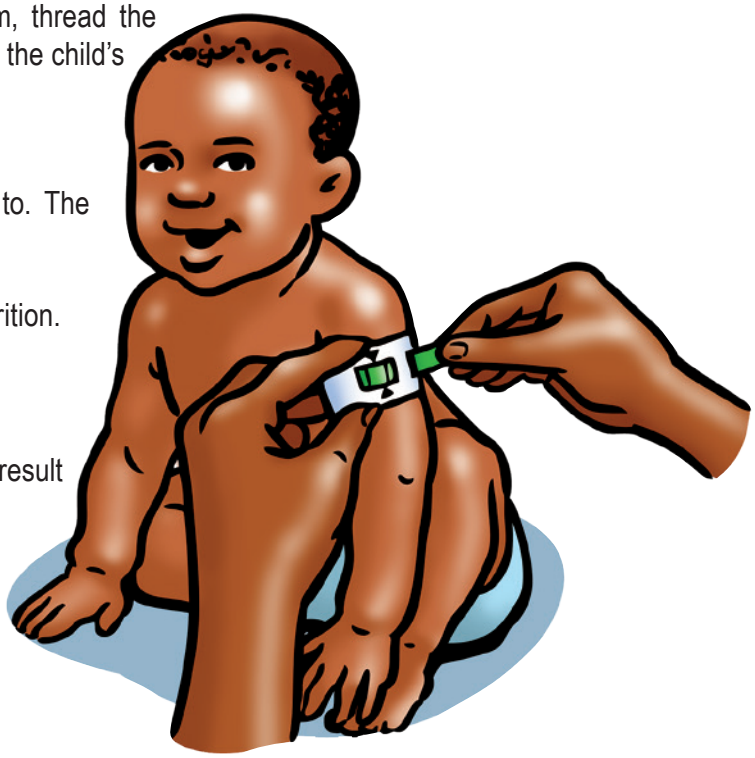


Step 3
Ask the child to relax their arm and let it hang at the side of their body. It is recommended to use a string instead of the MUAC tape to find the midpoint. Then take the coloured plastic strip and place it around the mid upper left arm of the child. Make sure that the strip is fitted properly around the arm. Do not pull the strip too tight to cause the skin to pull together, or too loose that the strip falls down.



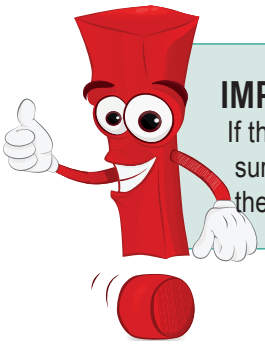
Step 4
Holding the white part of the strip on the child's arm, thread the narrow coloured strip through the small window around the child's arm until the strip fits the child's arm closely.

Step 5
Look at the colour that the two arrows are pointing to. The arrows will show red, yellow or green.
If it is green, the child is healthy.
If it is yellow, it means that the child is at risk of malnutrition.
If it is red, it means that the child is malnourished.



Step 6
Repeat steps four and five twice to make sure that the result is the same each time.

Step 7
If the child's result is either yellow or red after completing the tests, make sure the mother takes the child to the clinic as soon as possible, as the child is at risk of malnutrition or already malnourished.



Handy Hints

IMPORTANT:
If the test results show that the child is healthy and the CCG is not sure, always recommend that the mother or caregiver takes the child to a clinic for a healthcare worker to do a full test.

Role Play

Select a member of the group to be a mother and one to be a child. Explain to the group that the following is the situation they will be role playing:

When visiting the home, the CCG does a Mid Upper Arm Circumference (MUAC) measurement on the child.

Show how to do the MUAC measurement.

The CCG discovers the child falls into the yellow zone.

1. Discuss the importance of the mother taking the child to the clinic as soon as possible.

_____

_____

_____

2. Give advice on healthy eating.

_____

_____

_____

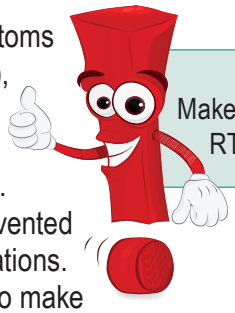
_____

3. The CCG must discuss with the mother that she will return to the household in two weeks time to conduct a follow up visit.

9. Common illnesses in children

Serious chest infections that start suddenly (e.g. pneumonia, diarrhoea and fever) are very common in children below the age of five years.

Pneumonia is an infection in one or both of the lungs. The symptoms include cough with phlegm (a thick spit that comes from the lungs), fever, and trouble breathing.



Handy Hints

Make sure that children get all their RTHB vaccinations.

Many children get sick and die from these illnesses or conditions. It is important to note that many of these conditions can be prevented by making sure that infants and children receive all their vaccinations. The CCG must check the child's *Road-To-Health Book (RTHB)* to make sure that the mother takes the child to the clinic so that the child can get all the RTHB vaccinations. This will help prevent the child from getting these conditions.

10. Home remedies for sick children

These remedies may be used for a short time until the mother or caregiver can get the child to the nearest clinic.

a. Fever

Fevers can be dangerous for children because they can cause fits.

- Use slightly warm water (not very warm) to sponge the child. This will bring down the fever
- Give Paracetamol (Panado) syrup as it says on the bottle
- Keep the child lightly covered but do not overheat
- Offer the child small amounts of liquid every 30 minutes
- If the child does not get better, take the child to the clinic immediately

b. Cough

Children sometimes get a cough and they do not always need a cough mixture.

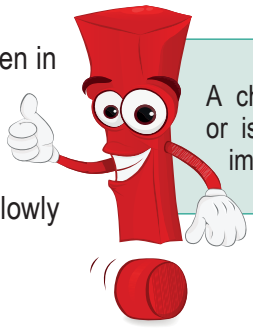
- Make the child a warm drink of tea with sugar or honey and lemon juice (if available)
- Breast milk soothes a cough if the child is still suckling. Clean the nose before feeding
- If the cough does not go away or if the child has a fever take the child to the clinic

c. Vomiting

It is important that a child who is vomiting does not become dehydrated. Vomiting can be a sign of a serious illness like meningitis.

Signs of dehydration:

- The soft spot on the top of the baby's head is sunken in
- Drinking quickly
- Sunken eyes
- Dry tongue/lips
- If the skin on the tummy is pinched, it returns very slowly back to normal



Handy Hints

A child who does not want to drink or is lethargic (tired) should be referred immediately to the nearest clinic.

d. Diarrhoea

- If the baby is breastfed, continue breastfeeding more often as long as the baby is not vomiting
- Give the baby a sugar and salt solution (ORS), which is described below

ORS
1 litre boiled water 8 teaspoons sugar ½ teaspoon salt
Mix well and give in small amounts every 30 minutes

If the child experiences any of the above symptoms, the home remedies should only be given to the child until the mother or caregiver can take the child to the clinic. If the child is on solids, give small frequent feeds e.g. soups.

11. What is Early Childhood Development (ECD)?

Children develop mentally as well as physically and as a result they start learning and performing more difficult tasks as they grow. The CCG has to know what is expected of children at each stage so that problems with development can be noted and referred to the clinic. The CCG must notice if the child is learning as they are growing.

Normal Childhood Development

It is very important that every visit the CCG checks that the mother has taken action on the advice of the previous visit.

	Normal Childhood Development		
	Seeing (Vision)	**Hearing and Speaking**	**Moving (Motor Development)**
Always ask	Can your child see?	Can your child hear and communicate as other children?	Does your child do the same things as other children of the same age?
 **14 weeks**	Baby follows close objects with eyes	Baby responds to sound by stopping sucking, blinking or turning	Child lifts head when held against shoulder
6 months 	Baby recognises familiar faces	Child turns head to look for sound	Child holds a toy in each hand
 **9 months**	Child's eyes focus on far objects Eyes move well together (no squint)	Child turns when called	Child sits and plays without support
18 months 	Child looks at small things and pictures	Child points to 3 simple objects Child uses at least 3 words other than names Child understands simple commands	Child walks well Child uses fingers to feed
 **3 years**	Sees small shapes clearly at 6 meters	Child speaks in simple 3 word sentences	Child runs well and climbs on things
5 – 6 years: school readiness 	A healthcare worker will use the Snellen E chart to check the child's eyesight	Speak full sentences and interact with children and adults	Hops on one foot Able to draw a stick person
REFER	Refer the child to the next level of care if child has not achieved the developmental milestone. Refer motor problem to Occupational Therapist/Physiotherapist and hearing and speech problem to Speech Therapist/Audiologist if you have the services at your facilities.		

12. How can a CCG assist with ECD?

When the CCG visits a home they should:

- Make sure that the mother regularly takes all children up to five years of age to the clinic to be weighed
  - 0 to 1 year: every month
  - 1 to 2 years: every two months
  - 2 to 5 years: every six months
- Assess the health of pre-school children and refer them to a clinic if necessary
- Measure the mid upper arm circumference and record it on the growth chart. Refer the child if the measurement is below what is expected
- Check the *Road-To-Health Book* to see if the child has missed any vaccinations and refer the child if vaccinations are overdue or have been missed
- Check if the child has received Vitamin A and refer to the clinic if necessary
- Check if the child has been de-wormed in the last six months and if not advise the mother to take the child to the clinic
- Check if the child has a birth certificate and if not refer the mother or the child's caregiver to the Department of Home Affairs

13. What is vaccination, and why is it important?

It is important that every child gets vaccinations to protect them against childhood diseases. If a child does not get vaccinated, they have a greater chance of becoming sick. Vaccination does not only protect the child, it also protects the whole community as the diseases prevented by the vaccinations are infectious.

CCGs need to check the RTHB regularly and remind the mother to take the child to the clinic to be vaccinated, as per the vaccination schedule (Refer to the *Road-To-Health Book* for the full vaccination schedule). If a child has missed any of the vaccinations, the mother must be told to take the child back to clinic to catch up on the missed vaccination. It is important that the child gets these vaccinations. Encourage the mother or the child's caregiver to take the child to the clinic as soon as possible.

The child can get side effects after being vaccinated. These side effects are generally mild and do not last for more than a day.

If the child develops a high fever, cries more than normal, sleeps a lot, starts to have fits, develops swelling of mouth, face, or throat, has problems breathing or gets a rash the child must be taken to the clinic as soon as possible.

VACCINATION SCHEDULE			
Age Group	**Vaccine**	**Disease**	**Side Effects**
At birth (first set of injections)	BCG	TB	Blisters
	OPV	Polio	Fever, vomiting, irritability
6 weeks (second set of injections)	OPV	Polio	Fever, vomiting, irritability
	RV	Diarrhoea	Fever, vomiting, irritability
	DTaP-IPV-Hib	Diphtheria, Tetanus, Whooping cough, Meningitis	Fever and irritability
	Hep B	Liver infection	Fever, vomiting, irritability
	PCV	Pneumonia	Fever and muscle pain
10 weeks (third set of injections)	DTaP-IPV-Hib	Diphtheria, Tetanus, Whooping cough, Meningitis	Fever and irritability
	Hep B	Liver infection	Fever, vomiting, irritability
14 weeks (fourth set of injections)	RV	Diarrhoea	Fever, vomiting, irritability
	DTaP-IPV-Hib	Diphtheria, Tetanus, Whooping cough, Meningitis	Fever and irritability
	Hep B	Liver infection	Fever, vomiting, irritability
	PCV	Pneumonia	Fever and muscle pain
9 months (fifth set of injections)	Measles	Measles	Fever
	PCV	Pneumonia	Fever and muscle pain
18 months (sixth set of injections)	DTaP-IPV-Hib	Diphtheria, Tetanus, Whooping cough, Meningitis	Fever and irritability
	Measles	Measles	Fever
6 years (seventh set of injections)	Td	Tetanus and Diphtheria	Fever, vomiting, irritability
12 years (eight set of injections)	Td	Tetanus and Diphtheria	Fever, vomiting, irritability

14. What services should the mother expect from the clinic during the first six months of the baby's life?

All mothers should take their babies to the clinic EVERY month for weighing but there are four very important visits for post-natal (after birth) care and they should not be missed:

- Six hours after delivery
- Within six days of delivery
- Six weeks after delivery
- Six months after delivery

The first visit takes place before the mother is discharged from the clinic within six hours of delivery.

It is still very important that the mother takes her baby to the clinic once a month up until the child is one year old, to make sure that the baby is growing and developing well.

Schedule of clinic visits for the baby

The following table shows what other care and support the baby will receive during these visits. These visits are in addition to the monthly visits for the baby to be weighed.

Six hours after delivery	Within six days	Six weeks after delivery	Six months after delivery
The mother and the baby should not be discharged before six hours after delivery The mother will receive education on exclusive breastfeeding	Take the baby to the clinic for a six day check-up	Take the baby to the clinic for the six week check-up	Take the baby to the clinic for the six month check-up
Examinations that the baby will have			
The baby should receive: • BCG vaccine • Polio vaccine • If mother is HIV-positive – the baby will receive ARVs and the mother will be given instructions on how to give the ARVs to the baby	The baby should be examined for: • Jaundice (baby's skin looks yellow) • Poor weight gain • Infection of the umbilical site (belly button) • Not passing stool • Diarrhoea • Poor feeding • Decreased sleepiness • Is the baby developing normally?	The baby should be examined for: • Jaundice (baby's skin looks yellow) • Poor weight gain • Infection of the umbilical site (belly button) • Not passing stool • Diarrhoea • Poor feeding • Decreased sleepiness • Is the baby developing normally?	The baby should be examined for: • Weight • Bowel movements • Nutrition • Is the baby developing normally?

Care and Support			
Encourage to breastfeed the baby for at least six months Babies of mothers who are HIV-positive will be given ARV medicine for the whole time she is breastfeeding The baby will continue to be given ARVs for one month after the mother stops breastfeeding The baby will then need to have another HIV PCR test	The healthcare provider should discuss the importance of vaccinating the baby and the *Road-To-Health Book* with the mother. The need for the mother to exclusively breastfeed the baby for at least six months will be reinforced	The baby should receive six-week vaccines and this must be written down in the *Road-To-Health Book*. The need for the mother to exclusively breastfeed the baby for at least six months will be reinforced	The healthcare providers will write down all the vaccines the baby has received in the *Road-To-Health Book*, including the vaccines the baby received at the 10 and 14 week clinic visits. The need for the mother to exclusively breastfeed the baby for at least six months will be reinforced
	The mother will be informed that she must bring the baby back to the clinic for a check-up and vaccines when the baby is six weeks old	If the mother is HIV-positive, she should be given further support on how to give ARVs to the baby	Further support and guidance on ways to prevent the baby from becoming dehydrated for babies with diarrhoea
	If the baby is on ARVs, the baby will be weighed and the medicines will be adjusted according to the baby's weight	If the mother is HIV-positive, the baby will be started on medicine to prevent getting infections	The mother will be informed that she needs to bring the baby back for a check-up and other vaccines when the baby is nine months old
		If the mother is HIV-positive: • The baby must have an HIV PCR test to check if the baby has HIV • The mother will be informed that she must go back to the clinic within one to two weeks later for the results of the baby's HIV PCR test • If the baby is HIV-positive, she must ensure that the baby is started on ARVs immediately • If the baby is HIV-negative, the mother must ensure that the baby has another HIV test after breastfeeding stops and again at 18 months	
		The mother will be informed that the baby will need to be brought back for a check-up and other vaccines, when the baby is 10 weeks old	

If there are children under 5 years of age in the household, the CCG can use this tool to screen the health of the child and advise the mother accordingly.

Child Health Screening Tool

Note to the CCG:
Please read the instructions for each question in this Child Health Screening Tool and screen all children between the ages of six weeks and five years.

Remember, if you tick any of the boxes linked to an action in the screening tool, you need to take all three of the following actions:

- Refer the mother/caregiver to the clinic with the child as soon as possible. Remind her to take the *Road-To-Health Book* with her
- Record the location of the household and the reason for the follow-up visit
- Return to the household within 2 weeks to follow-up and ensure that the child has been taken to the clinic. Continue to follow-up every two weeks until you confirm that the child was taken to the clinic

Handy Hints

Ask the mother/caregiver the following questions for all children in the household between 6 weeks and 5 years of age.

1. What is the child's age? ☐ **Years** ☐ **Months**

2. Vaccinations:

Ask to see the *Road-To-Health Book* and check which vaccinations the child has had.

→ Are all the child's vaccinations up to date?

- Yes
- No → **ACTION:** Remind the mother why childhood vaccinations are important and encourage her to take the child as soon as possible for any missing vaccinations.

3. Malnutrition:

Measure the mid-upper arm circumference of the child. (see activity on measuring mid-upper arm circumference in the section on malnutrition.)

→ What colour is the zone in the window of the measurement tape?

- Green
- Yellow → **ACTION:** If the mid-upper arm circumference of the child falls in the yellow or red zone, tell the mother that she must take the child to the clinic immediately.
- Red → **ACTION:** If the mid-upper arm circumference of the child falls in the yellow or red zone, tell the mother that she must take the child to the clinic immediately.

4. Other illnesses & danger signs:

Is the mother worried the child may not be WELL for ANY REASON?

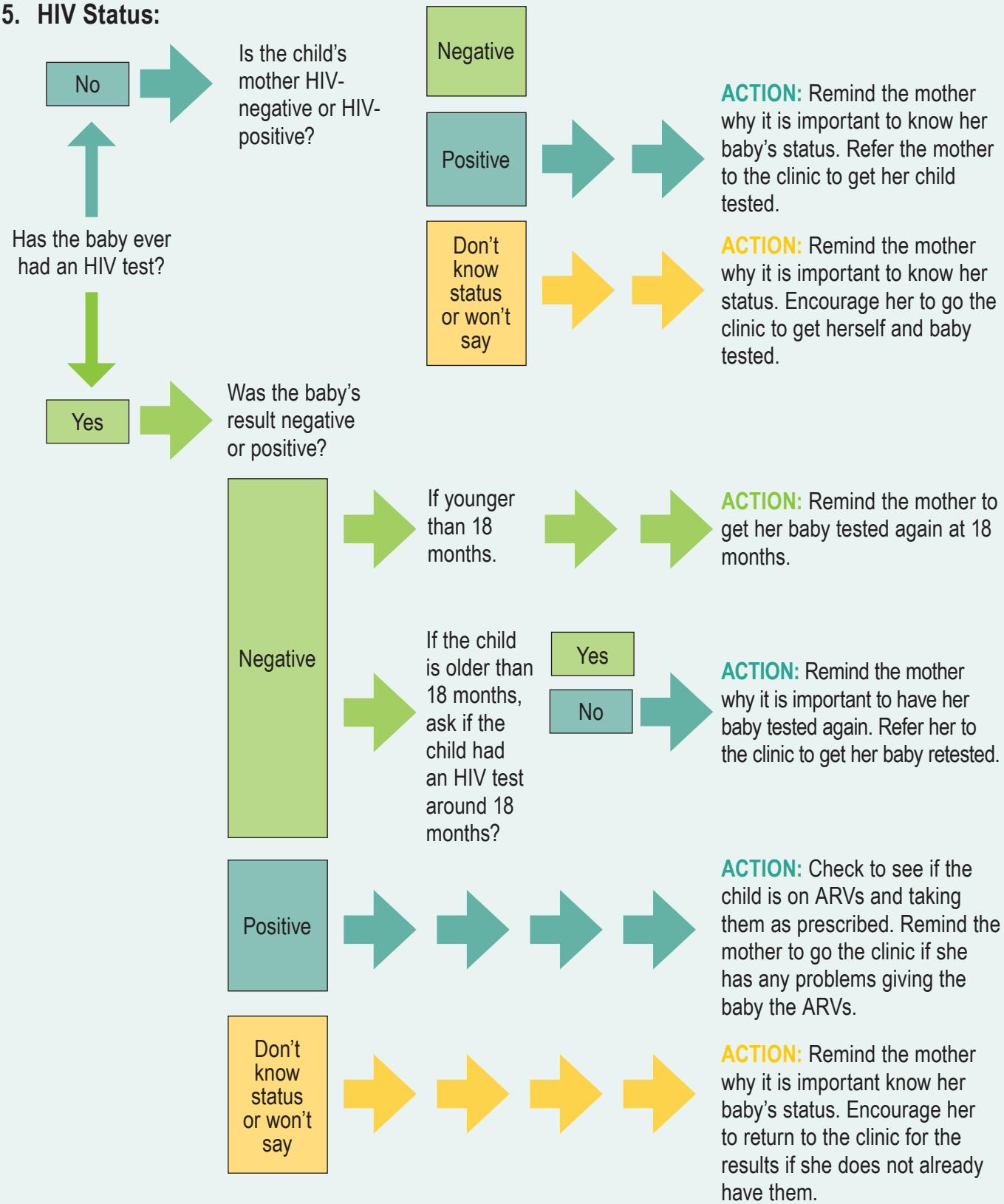
Yes → **ACTION:** If the mother is worried about the child FOR ANY REASON she should take the child to the clinic as soon as possible.

No

Has the child had any of the following signs of illness?: → **ACTION:** If the child has had any of these signs of illness encourage the mother to take the child to the clinic to be checked as soon as possible.

- Not able to drink or breastfeed ☐
- Baby does not have a healthy cry ☐
- The skin around the cord is red and swollen ☐
- Vomiting everything ☐
- Convulsions (seizure or fits) ☐
- Cough or difficulty breathing ☐
- Fast breathing or very slow breathing ☐
- Chest pulled in (child's ribs pull in as child breathes in) ☐
- Lethargic (tired) or unconscious ☐
- Skin has a yellowish colour ☐
- Diarrhoea ☐
- Fever or very cold to the touch ☐
- Did not have a wet nappy today ☐
- Did not pass a stool today ☐
- Stiff neck ☐
- Rash ☐
- Ear problem, pain or discharge ☐
- Eye infection/runny or red eyes ☐

5. HIV Status:


Has the baby ever had an HIV test?
No
Is the child's mother HIV-negative or HIV-positive?
Negative
Positive
ACTION: Remind the mother why it is important to know her baby's status. Refer the mother to the clinic to get her child tested.
Don't know status or won't say
ACTION: Remind the mother why it is important to know her status. Encourage her to go the clinic to get herself and baby tested.
Yes
Was the baby's result negative or positive?
Negative
If younger than 18 months.
ACTION: Remind the mother to get her baby tested again at 18 months.
If the child is older than 18 months, ask if the child had an HIV test around 18 months?
Yes
No
ACTION: Remind the mother why it is important to have her baby tested again. Refer her to the clinic to get her baby retested.
Positive
ACTION: Check to see if the child is on ARVs and taking them as prescribed. Remind the mother to go the clinic if she has any problems giving the baby the ARVs.
Don't know status or won't say
ACTION: Remind the mother why it is important know her baby's status. Encourage her to return to the clinic for the results if she does not already have them.

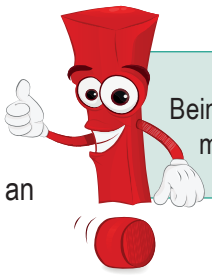
Role Play

Explain to the group that the following is the situation they will be role playing:

Divide into pairs. One person will play the role of the CCG and the other will play the role of the mother.

- The CCG is visiting a household that has a five month old baby
- The CCG must discuss the Child Health Screening Tool with the mother
- The CCG must encourage the mother to take the recommended actions

15. What are parenting skills?



Handy Hints

Being a parent is hard work but with many rewards.

Parenting is about how to raise children so that they become healthy adults; physically, emotionally and mentally. It is about supporting children, being a good person and leading a life that is an example to them. It is a job that takes time, love, patience and commitment.

16. How can the CCG help parents?

The CCG can give tips and advice on how to be a good parent:

- Children should be taught and encouraged to be independent:
  - Encourage children to dress themselves and help in the house by giving them small chores to do that they can manage at their age
  - This teaches them to speak with other family members and helps them have a positive attitude (think and act in a good way)

- Parents need to:
  - Make sure that the child attends all the clinic visits necessary for growth monitoring and for all vaccinations
  - Spend time with their children. This is one of the most important parts of being a parent. They should talk to them, read books together with them and answer the child's questions. Spending time with children means that they should not just watch TV with them
  - Show positive feelings and emotions to the children even when things are difficult. This helps them to learn how to cope with difficulties
  - Make sure the home is safe for the children so that they can explore and learn. Don't keep dangerous things around the house that could hurt the child [see Lesson 2.5 on Safety in the Home]

- Set rules and stick to them. All children need to know what they can and cannot do
- Help the children believe in themselves by encouraging them to do things like dressing themselves or tying their shoelaces
- Allow the children to make their own decisions for small things, e.g. which shoes to wear. This will help them to make bigger decisions themselves later in life
- Offer lots of praise and show pride and love in a positive way. This builds the self esteem of the children and makes them confident
- Protect the child from all types of abuse [see Lesson 5.8 on Domestic Violence and Lesson 5.10 on Child Abuse]
- Make sure the child knows that they can always speak to the parent about any problem that they have
- Not fight, argue or be abusive with each other in front of the child

17. Keeping children safe

The most important role of a parent is to keep the child safe and to protect the child. Some of the ways in which this can be done are:

- Take the child to the clinic for all the growth monitoring check-ups and RTHB visits
- Make sure that the child gets all the school health check-ups
- Take the child to the clinic quickly if they are not feeling well
- Take the necessary steps to protect the child if the child is living in or travelling to an area where there is malaria present [see Lesson 4.15 on Malaria]
- Talk to the child about not using smoking, using alcohol or drugs
- Discuss and look out for signs that the child is being bullied
- Talk to the child about why they should not talk to or accept sweets from strangers
- Talk to the child about sexual abuse and make sure they know that they must tell someone they trust if they are being touched in the wrong way
- Keep the home environment safe by keeping the electrical points covered; keeping matches, paraffin, medicines and other dangerous substances out of the reach of children
- Make sure that the child is properly secured in cars. Use the seat belts or car seats to keep the child safe
- Develop a plan. Set up a family emergency plan, such as a meeting place where everyone should gather if something unexpected happens in the family or community. It can help both parents and children feel safer

Exercise

1. What must the CCG check for when assessing ECD?

2. Explain what vaccination is and why it is important.

Group Exercise

In groups, discuss how parents can help to ensure that their children are physically and mentally healthy.

Module 3
Maternal Child and Women's Health

Case Study

Busi, a CCG, meets Gogo Mokoena at the community garden meeting. While attending the meeting Busi talks to everyone about how important it is for women who think they are pregnant to go to the clinic for a pregnancy test as soon as possible and that pregnant women must have proper care so that both the mother and the baby are healthy.

At the end of the meeting Gogo Mokoena tells Busi that she lives with her second son and daughter-in-law, Thandi, and their 2 young children aged 3 and 7. Also, her older son's teenage daughter lives with them. Gogo tells Busi that her daughter-in-law may be pregnant.

Case Study

Read the case study, divide into groups and discuss the questions for each visit.

1. What could Thandi have told Gogo that makes Gogo think that she may be pregnant?

_____

_____

_____

_____

2. On hearing this information from Gogo, what should Busi now plan to do?

_____

_____

_____

_____

Visit 1:
Busi finds Thandi and the younger child in the house. Thandi tells Busi that her husband is at work and that her older child and niece are at school.

Busi tells Thandi that she and Gogo Mokoena had talked at the meeting and that Gogo thought that Thandi may be pregnant. She asks Thandi for permission to talk to her about having a pregnancy test. Busi tells Thandi that she will ask her questions to see if she should go to the clinic for a pregnancy test.

1. What screening tool should Busi use to check if Thandi should go to the clinic for a pregnancy test?

_____

_____

_____

_____

Case Study

Thandi tells Busi that her last period was 5 weeks ago and that she is not on contraception.

2. Using the above screening tool and information, what should Busi tell Thandi to do? Give reasons for the answers.

Thandi tells Busi that things are hard financially and that she is worried that they may not be able to afford to care for the family if there is another child to care for.

3. What options does Thandi have? What would Thandi need to do to qualify?

4. Are there cultural considerations? If so, what are they and how could Busi help Thandi and her family overcome these?

5. Who else could Thandi talk to about this?

Case Study

Next, Busi talks to Thandi about the health of the two other children.

6. How would Busi know if the children are healthy and developing normally?

_____

_____

_____

7. What child services are available for Busi in the community?

_____

_____

_____

8. Show how Busi would use the Child Health Screening Tool with the younger child.

_____

_____

Busi asks to see the *Road-To-Health Book* for the older child as well. She notices that the child has not had the last set of vaccinations.

9. What should Busi tell the mother regarding this?

_____

_____

_____

10. When should Busi next follow up with the Mokoena family? Who should she follow up on and what does she need to follow up with each of them on?

_____

_____

_____

Case Study

Visit 2:
Busi goes back to the household. Thandi confirms that she did go to the clinic and that the healthcare workers at the clinic told her that she is 8 weeks pregnant. Also, Thandi has decided to keep the baby.

1. What would Busi have to check that Thandi did while she was at the clinic?

_____

_____

_____

2. How often should Thandi go to the clinic?

_____

_____

_____

3. What danger signs should the family look out for?

_____

_____

_____

_____

Thandi tells Busi that she is concerned that their niece may be sexually active. She asks Busi to talk to the niece about family planning.

4. What information about why family planning is good should Busi give to the niece?

_____

_____

_____

_____

Case Study

5. How should the niece decide on which family planning method to choose?

6. Is there any other information about teenage pregnancy that Busi should give the niece? If so, what would this information be?

7. When should Busi plan to visit the Mokoena household again? Who should she follow up with and what does she need to follow up with each of them on?

8. What should Busi's full schedule of visits to the Mokoena household be?

Case Study

9. What are the most important points that Busi would have discussed with the family during each of these visits?

_____

_____

_____

Next visit:
Busi stops by the Mokoena household again on the day that Thandi and baby are discharged from hospital. Busi wants to see how they are settling in. Thandi is concerned that the baby is not getting enough milk through breastfeeding. She is thinking about also feeding the baby formula milk.

1. What should Busi say to Thandi about why exclusive breastfeeding is good and what Thandi can do about her problem?

_____

_____

_____

2. What else could be preventing Thandi from wanting to breastfeed? How could Busi help her overcome this?

_____

_____

_____

_____

Busi asks Thandi to show her how the baby is latching on to the breast.

3. Describe what Busi should check to make sure that the baby is latching properly.

_____

_____

_____

_____

Case Study

4. How does Busi make sure that the mother and baby are doing well? What should she be checking for both of them?

5. What should she do if she think that there is a problem?

Next visit:
Busi comes by the next day to make sure that Thandi is able to latch the baby correctly. While there, Gogo Mokoena asks Busi to help them bathe the baby. They are also worried about how to clean the cord.

1. Describe what tips Busi can give Gogo and Thandi about bathing the baby.

2. How should they care for the cord to make sure that it does not become infected?

Case Study

Next visit:
Busi comes back to the Mokoena household one month later.

1. What should Busi check up on for the baby?

_____

_____

_____

_____

2. What information should Busi give her about the next clinic visit?

_____

_____

_____

_____

Thandi tells Busi that she is worried about how to continue with the breastfeeding once she goes back to work. She works too far away and cannot come home during the course of the day to breastfeed.

3. Describe what can be done to make sure that the baby is exclusively breastfed.

_____

_____

_____

4. How should the cups for storing the milk be sterilised?

_____

_____

_____

Case Study

5. Show how Busi can monitor the baby's growth to make sure that the baby is developing and growing well.

6. As a CCG working in this community, what are other points of discussion or services can you recommend to help the Mokoena family?

AIM OF THE LESSON

Lesson 3.6 aims to share information about Phila Mntwana and provide skills and other requirements needed for implementation in the Phila Mntwana Centres.

Learning Outcomes

By the end of this lesson learners should be able to (for children under 5 years of age):

- Provide comprehensive prevention and health promotion services at community level
- Provide community leaders and War Room members with a simple understanding of the health status of the children in the ward, so that corrective measures may be taken if necessary
- Monitor the nutritional and health status
- Identify and refer those with malnutrition, diarrhoea, TB and other health conditions as early as possible
- Identify and refer those who require other government services
- Understand the Reporting Tools for Phila Mntwana

Lesson Contents

- Overview of Phila Mntwana
- Setting up of the Phila Mntwana Centre
- Your Role as a CCG in the Phila Mntwana Centre
- Reporting Tools for Phila Mntwana
- IEC Pamphlets

References

1. Umgingindlovo Health District, Provincial Child Health and Operation Sukuma Sakhe. Phila Mntwana Implementation Toolkit. KwaZulu-Natal Province. 2013

Your role as a CCG

Your role as a CCG is to make sure that you monitor the baby's growth and development and understand and monitor the *Road-To-Health Book* to ensure that the baby is growing and developing normally. Also, you should be able to provide the correct health and preventive education information at the Phila Mntwana Centre to ensure that the mother/caregiver takes her baby to the clinic for all check-ups. Complete the Phila Mntwana Register and submit the reporting tools as required.

1. Overview of Phila Mntwana

a. The Need for Phila Mntwana

'Phila Mntwana' means 'the survival of the child'. Many children are dying of malnutrition, diarrhoea, TB and HIV-related conditions. Some of these children die at home and many more die in the hospitals. This is because the clinic or hospital is far away or the mother/caregiver delayed seeking immediate care because of lack of information. Phila Mntwana Centres have been introduced to help prevent death and illness in children under 5 years of age. The Phila Mntwana initiative is linked to War Rooms under Operation Sukuma Sakhe, the programme of Provincial Government. Community Caregivers will provide preventive and promotive services at Phila Mntwana Centres, assisted by mobile clinics and family health teams wherever possible. This will include immediate intervention and referral where required.

b. When will the Phila Mntwana Centres be open?

The Centres will be open on a daily basis (Monday to Friday) to offer preventative and promotive care to all children under 5 years of age even if they are well.

Handy Hints

Ask the mother/caregiver to bring their child, who is under 5 years of age, to the nearest Phila Mntwana Centre even if they are well.

c. What services are offered at the Centres?

Assessment of Nutritional Status in Children under 5 years

- The CCGs will conduct Mid Upper Arm Circumference (MUAC) measurements on all children 6 – 59 months. MUAC measurements will be taken monthly to detect acute malnutrition in children 6 – 59 months [Refer to Lesson 3.5, Section 6, 7 and 8 on Growth Monitoring]

Growth Monitoring

- Use the weight for age chart in the *Road-To-Health Book* (RTHB) to ensure that the child is growing according to their age. If the child does not have a *Road-To-Health Book*, refer the mother/caregiver to the clinic

Oral Rehydration

- If the child has diarrhoea, explain and demonstrate to the mother/caregiver how to prepare the Sugar-Salt-Solution (S-S-S)/Oral Rehydration Solution (ORS). This solution should be given to the child until the mother/caregiver can take the child to the clinic [Refer to Lesson 3.5 Section 10D Diarrhoea under Home Remedies for Sick Children]

Breastfeeding

- Promotion and education of exclusive breastfeeding to mothers [Refer to Lesson 3.4, Section 7 Infant Feeding]

Immunisation

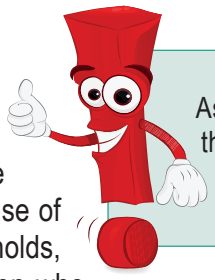
- Check the *Road-To-Health Book* and remind the mother/caregiver to take the child to the clinic to be vaccinated as per the Vaccination Schedule [Refer to Lesson 3.5, Section 13 What is Vaccination, and why it is important]

Wellness

- Provide Vitamin A supplementation to children who are between 12 – 59 months old and administer 6 monthly
- Check in the *Road-To-Health Book* if the child is due for deworming and refer if deworming is required
- Use the TB Screening Tool [See Module 4, Lesson 4.5 in Section 1 what is TB] to screen the mother/caregiver for TB and ask if anyone in the household has symptoms listed on the TB Screening Tool. Refer the mother/caregiver and those individuals with symptoms to the clinic
- Screen the child for TB using the Child Tuberculosis Screening Referral Slip [See Implementation Toolkit, Section D, Tuberculosis Screening] and refer if necessary. Screen the child should any household member or caregiver present with symptoms of TB
- Distribute Male and Female Condoms [Refer to Module 4, Lesson 10 Prevention of HIV and STIs: The Role of Condoms]
- Provider Initiated Counseling & Testing (PICT) Referral for children 18 months of age and older
- Educate mothers on the wellness management of their children
- All children visiting the Phila Mntwana Centre should have a *Road-To-Health Book* (RTHB)

Social Services

- Monitoring of ECD Centre enrolment for children 3–5 years
- Identification and referral of orphans and vulnerable children (This includes children that are at risk because of suspected abuse, children from child-headed households, children in need of removal or placement and children who show signs of neglect)
- Identification and referral of eligible children for child support grant
- Identification and referral of children with suspected/confirmed mental or physical disability



Handy Hints

Ask the mother/caregiver to bring the child's Road-To-Health Book to every visit to the Phila Mntwana Centre.

2. Setting up of the Phila Mntwana Centre

a. Where will the Phila Mntwana Centres be located?

The Phila Mntwana Centres will be based at a ward level, i.e. close to the communities. The location of the PHILA MNTWANA Centre will be decided by the local leadership in the War Room. The location will include, but not be limited to the following:

- War Rooms
- Early Childhood Development Centres (ECDs)
- Elderly Luncheon Clubs
- Any other location in the ward close to children under 5 years of age but far away from the clinic or War Room

Handy Hints

Make sure that each "PHILA MNTWANA CENTRE" is linked to a local/mobile clinic and the War Room (for those that are not located in the War Room).

b. Who provides services at the Phila Mntwana Centres?

- The CCGs will be responsible for providing services at the "PHILA MNTWANA CENTRE"
- The CCGs will rotate weekly to ensure that at all times services are provided. The CCG Supervisor/Community Health Facilitator will be responsible for staff rotation
- CCGs will be supported by the CCG Supervisor/Community Health Facilitator

c. Linkages to OSS War Room Team

- The "PHILA MNTWANA CENTRE" is an integral part of the War Room
- Data and information generated from the services needed and provided should form part of the health agenda during the War Room meetings
- The War Room Convener and the Local Ward Councillor should be provided with reports on the health status of the children in the community at monthly War Room meetings
- The wall charts should be updated and discussed at this level. These charts should guide what interventions are required

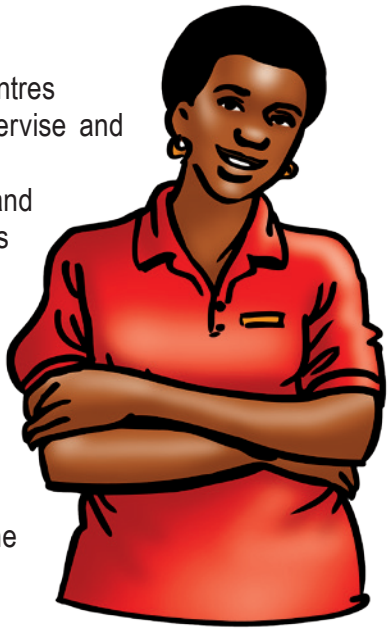
d. What resources are needed?

- Departmental referral representative contact list
- Tables
- Chairs
- Steel cupboards (storage of patient information)
- MUAC Tapes
- Non-stretchable string (50cm lengths, for measuring the mid-point of the upper arm)
- Vitamin A supplements (200 000 iu)
- Daily, weekly and monthly recording and reporting tools (tally sheets)
- Phila Mntwana Register (exercise book)
- Health education book (exercise book)
- Log book (exercise book)
- Growth Monitoring Desk Chart
- Sugar and Salt Solution/ORS sachets
- 1 Litre empty container (anything eg: 1 lt juice bottle, etc)
- Posters: Education posters for mothers as well as Phila Mntwana awareness posters giving information on

Phila Mntwana and services offered at Phila Mntwana Centres
- IEC pamphlets: Age specific pamphlets that educate mothers/caregivers on immunisation, HIV, feeding, developmental milestones and danger signs to be aware of, as well as specific pamphlets aimed at all ages on management of TB and diarrhoea in all age groups [See Section 4 (o): Relevant education offered]
- Administrative tools (All SOPs, training schedules, referral books, CCG recording and reporting tools)
- Baby weighing scales (where applicable)
- Condoms (male and female)
- Condocans
- Male and female dildos
- Disinfectant hand spray
- Stationery (pens, pencils, rulers, erasers, scissors, red, green and yellow markers; and materials for attaching markers in War Room)
- Consumables from clinic (toilet rolls, paper towels, soap, gloves, sample RTHBs)
- Fact Sheets
- Graphs
- Weekly and Monthly Summary Sheets

Depending on the location of the Phila Mntwana Centres, various structures have been tasked with the provision of resources, for example, if it is located at an Early Childhood Development Centre, it would be Department of Social Development and the Department of Education that will provide resources. For Phila Mntwana Centres located in the War Room, municipalities are responsible to provide resources, etc. The ultimate responsibility to ensure that the Phila Mntwana Centres are adequately resourced would be that of the CCG supervisor/Community Health Facilitator.

e. Who is involved in Phila Mntwana?

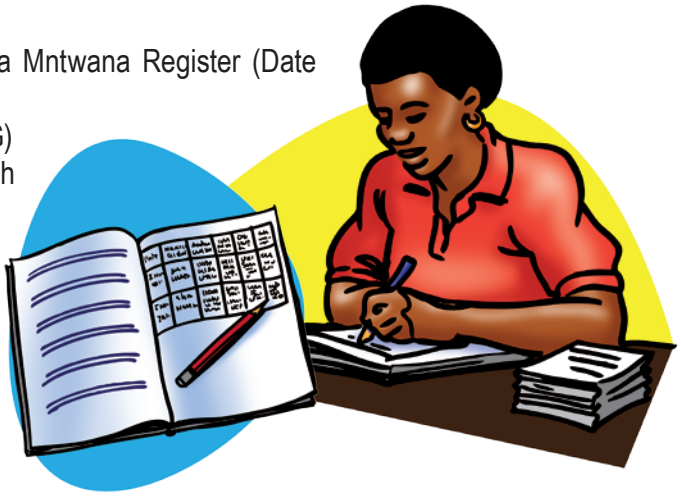


- CCGs will be responsible for providing services at the Phila Mntwana Centres
- CCG Supervisors and Community Health Facilitators (CHF's) will supervise and monitor the activities conducted by the CCGs
- Family Health Teams (FHTs) which include the Professional Nurse (PN) and Enrolled Nurse (EN) will support the CCGs in all Phila Mntwana activities wherever available
- The Operational Manager will oversee the functioning of the FHTs and work with CHFs and the War Room Health representative to plan interventions to address problems
- The War Room Task Team will convene weekly meetings and review reports from Phila Mntwana Centres, develop action plan for challenges and identified cases needing intervention
- At District level, there are various stakeholders that are involved in the management of Child Health. These include the following Portfolios:
  - The Maternal Child and Women's Health (MCWH) Coordinator
  - District Clinical Specialist Team (DCST)
  - The PHC Co-ordinator
  - The District Information Officer (DIO)
  - The Dietician
  - The District Outreach Team
  - The Phila Mntwana District Task Team

3. Your Role as a CCG in the Phila Mntwana Centre

a. Welcome the mother/caregiver and child to the Phila Mntwana Centre

- Record the date in the second column of the Phila Mntwana Register (Date (day/month/year)
- Write your initials in the third column (Initials of CCG)
- Record the child's name and surname in the fourth column
- Record the child's date of birth (day/month/year) in the fifth column
- Record the sex of the child (male/female) in the sixth column
- Record the mother's/caregiver's name and contact details in the seventh column of the Phila Mntwana Register



Phila Mntwana Register

District: ..... **Sub-district:** .....

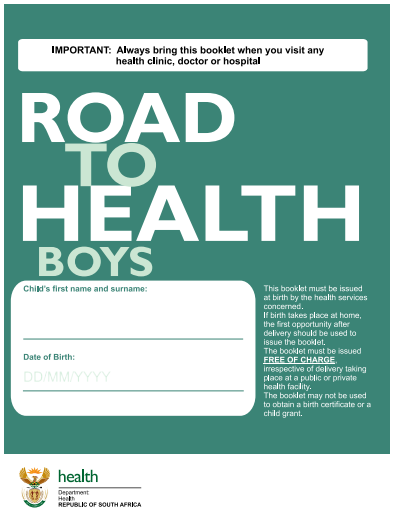
Ward no. : ..... **Name of CCG:**.....

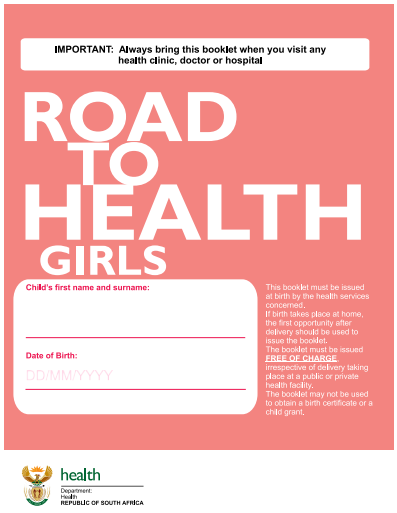
	Date (dd/mm/yy)	Initials of CCG	Name and Surname of Child (Fill in All Children)	Date of Birth (dd/mm/yy)	Sex (M/F)	Mother or Caregiver's Contact Details (Name and Isigodi and Cell Number)
1						
2						
3						
4						
5						

b. Review the Child's *Road-To-Health Book* (RTHB)

The *Road-To-Health Book*

All children are issued a *Road-To-Health Book* at birth or at the first contact with the healthcare system after birth. The RTHB is carried by the mother/caregiver, who should bring it to every health visit. Healthcare workers including CCGs should use the RTHB to help mothers/caregivers gain a better understanding of the child's health and healthcare needs. It is important, therefore, to explain, discuss and review information in the RTHB with mothers/caregivers.





The *Road-To-Health Book* is also an important tool to monitor high quality care of children and to record key information, including the following:

- Nutritional Status
- Growth and development
- Immunisations
- Vitamin A supplementation
- Deworming
- TB status
- PMTCT (Prevention of Mother-To-Child Transmission)
- HIV testing
- Visual and hearing screening
- Infant and young child feeding
- Records of hospital admissions and visit

Handy Hints

- Ask the mother/caregiver for the child's Road-To-Health Book (RTHB)
- Check that the Child's RTHB is up to date and that all essential demographic information on page 4 RTHB is completed
- If the Child under 5 years of age does not have a RTHB (e.g. if the RTHB is lost or was not issued by the clinic), refer the child to the nearest clinic
- Emphasise the importance of keeping the RTHB safe and bringing it to every clinic visit and Phila Mntwana visit

4

DETAILS OF CHILD AND FAMILY (To be completed at birth)	
Child's first name and surname: _____ _____	
Child's ID number: ☐☐☐☐☐☐☐☐☐☐☐☐☐	
Mother's ID number: ☐☐☐☐☐☐☐☐☐☐☐☐☐	
Date of birth / / dd mm yyyy	Name of facility where child was born:
Child's residential address:	
Mother's name:	Mother's birth date:
Father's name:	Who does the child live with?
How many children has the mother had (including this child?)	
Number born (including stillbirths) ☐	Reason(s) for death(s):
Number alive now ☐	Date information given: / / / dd mm yyyy
Child in need of special care (mark with X) (Complete at delivery or at first contact with health services)	
Is the baby a twin, triplet, etc? Yes ☐ No ☐	Does the mother need additional support to care for the child? (Specify) Yes ☐ No ☐
Any disability present (including birth defects?) (Specify) Yes ☐ No ☐	Other: (Specify)

ROAD TO HEALTH

Nutrition

For children between 6 months to 5 years, take their MUAC measurement according to the standard procedure as follows:

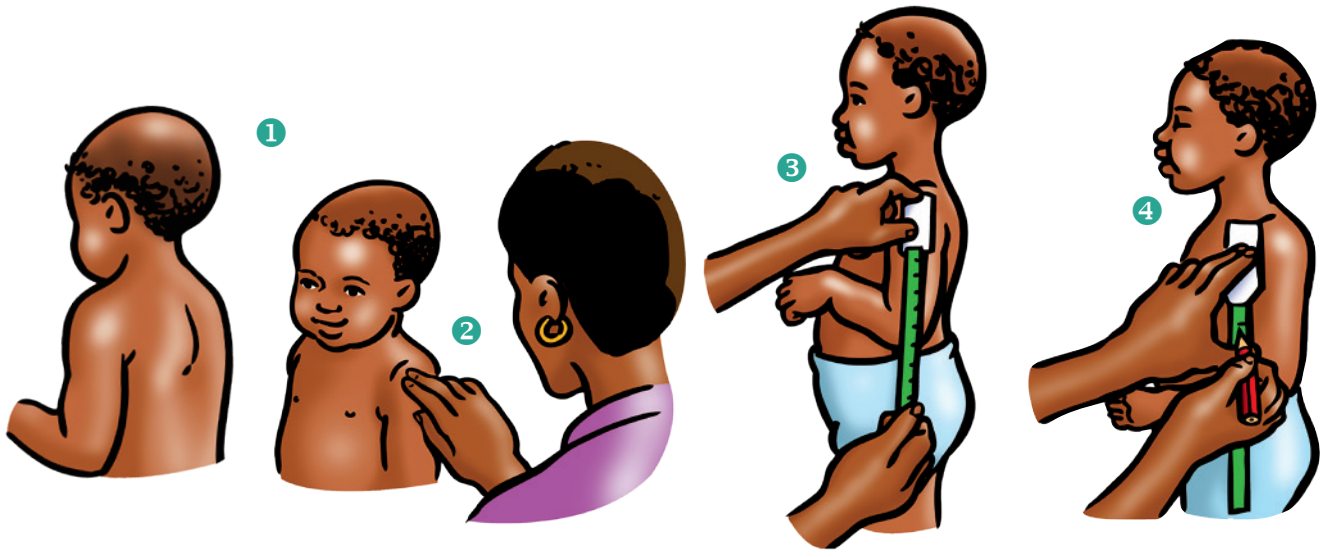
MUAC Tape Measure

For the simple three-color tape (red, yellow, green), slide the end through the first slit and then through the second slit. Read the colour that shows through the window at the point the two arrows indicate.

Simple three-colour MUAC Tape

How to measure MUAC?

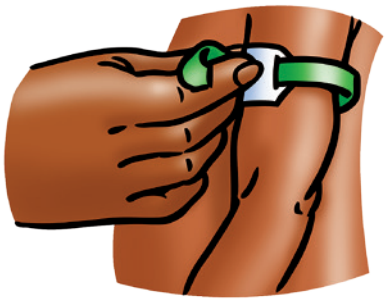
1. MUAC is always taken on the left arm
2. Find the middle point of the child's upper left arm; this is between their shoulder and elbow
3. Measure the length of the child's upper arm, between the bone at the top of the shoulder and the tip of the elbow (the child's arm should be bent)
4. Find the midpoint of the upper arm and mark it with a pen. It is recommended to use a string instead of the MUAC tape to find the midpoint



5. The child's arm should then be relaxed, falling alongside his/her body
6. Wrap the MUAC tape around the child's arm, such that it is in contact with the child's skin. It should neither be too tight nor too loose

correct tension

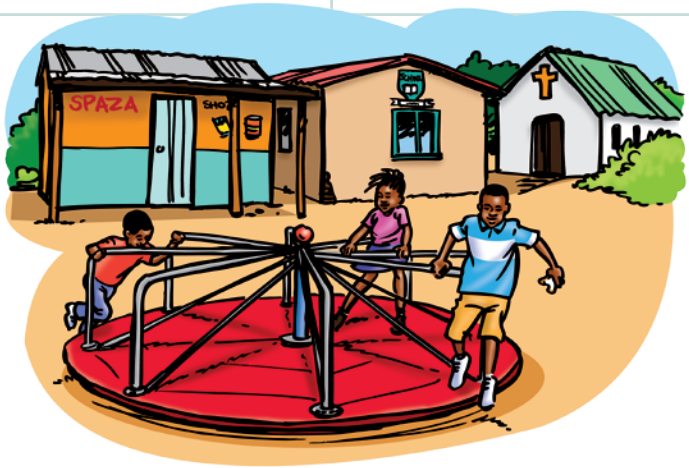
tension too tight



tension too loose

Interpretation of MUAC

A child who is growing well	A child who has Moderate Acute Malnutrition (MAM)	A child who has Severe Acute Malnutrition (SAM)
GOOD	**DANGER**	**VERY DANGEROUS**
If the child is found to have a MUAC of ≥ 12.5cm, praise the caregiver and tell her to carry on the good work. Ask "How are you feeding the child?" and perhaps advise if there is a problem related to nutrition.	If the child has a MUAC of between 11.5 and 12.4cm, the child has MAM. Refer the child to the local clinic with a CCG referral letter. Child should be taken to the clinic within 24 hours. Another referral letter should be written to DSD for investigation (e.g. poverty, unemployment, neglect etc.).	If the child has a MUAC of < 11.5cm, the child has SAM. Refer or take the child to the local clinic for immediate medical assessment and explain to the mother/caregiver why it is important. Another referral letter should be written to DSD for investigation (e.g. poverty, unemployment, neglect etc.).



- Record the MUAC status in the Phila Mntwana Register. If the child is in the green (not acutely malnourished) region, place a (✓) in the MUAC-Green column and praise the caregiver. If the child is in the yellow region (Moderate Acute Malnutrition-MAM), place an (X) in the MUAC-Yellow column. If the child is in the red region (Severe Acute Malnutrition-SAM), place an (X) in the MUAC-Red column. Place a (–) in the unused columns

District: ..... **Sub-district:** .....

Ward no. : ..... **Name of CCG:**.....

NUTRITION					CHILD HEALTH						SOCIAL SERVICES				OTHER REFERRALS					
MUAC Green	MUAC Yellow	MUAC RED	Vitamin A	Infant Feeding	Diarrhoea	Immunisation	TB Screening	18 months and older Provider Initiated Counselling and testing (PICT)	Deworming Screening	Developmental Screening	Birth Registration	Orphans and vulnarable children	Early childhood development centres	Child support grant	DOH	DSD	SASSA	Other Departments	Health Education	Tick Cases Closed, i.e. Intervention Provided

- Record the child's MUAC reading on page 19 in the RTHB

19

MID-UPPER ARM CIRCUMFERENCE (MUAC) (Every 3 months)							
Date of visit	MUAC	Date of visit	MUAC	Date of visit	MUAC	Date of visit	MUAC
< 11.5 cm indicates severe acute malnutrition (REFER urgently) ≥11.5 < 12.5 cm indicates moderate acute malnutrition (Manage as in IMCI guidelines)							

HOSPITAL ADMISSIONS				
Hospital name	Admission number	Date of admission dd/mm/yyyy	Date of discharge dd/mm/yyyy	Discharge diagnosis
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	

- Plot the child's MUAC status in the Ward MUAC Monthly and Quarterly Summary Graph. Fill in the coloured block that corresponds to the child's MUAC status (e.g. If the child is in the green region, fill in the green block). Follow the number sequence within each coloured block starting with block 1 on the bottom left and move across to the end of the row. When the first row is filled, move to the second row. One block should be filled in per child
- Refer the child to the health facility immediately if the child is in the red region or within 24 hours if the child is in the yellow region and/or the child has oedema of both feet also refer the child to DSD for further investigation

Ward MUAC Monthly & Quarterly Summary Graph

Year: .....

Municipality: ..... Ward No: ..... Number of children under 5 yrs in ward:

781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800
761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780
741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760
721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740
701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720
681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700
661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680
641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660
621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640
601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620
581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600
561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580
541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560
521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540
501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520
481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500
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441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460
421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440
401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420
381	382	833	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400
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221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240
201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220
181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200
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141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160
121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140
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61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80
41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60
21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40
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151	152	153	154	155
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136	137	138	139	140
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126	127	128	129	130
121	122	123	124	125
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106	107	108	109	110
101	102	103	104	105
96	97	98	99	100
91	92	93	94	95
86	87	88	89	90
81	82	83	84	85
76	77	78	79	80
71	72	73	74	75
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56	57	58	59	60
51	52	53	54	55
46	47	48	49	50
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1	2	3	4	5

118	119	120
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28	29	30
25	26	27
22	23	24
19	20	21
16	17	18
13	14	15
10	11	12
7	8	9
4	5	6
1	2	3

Month:

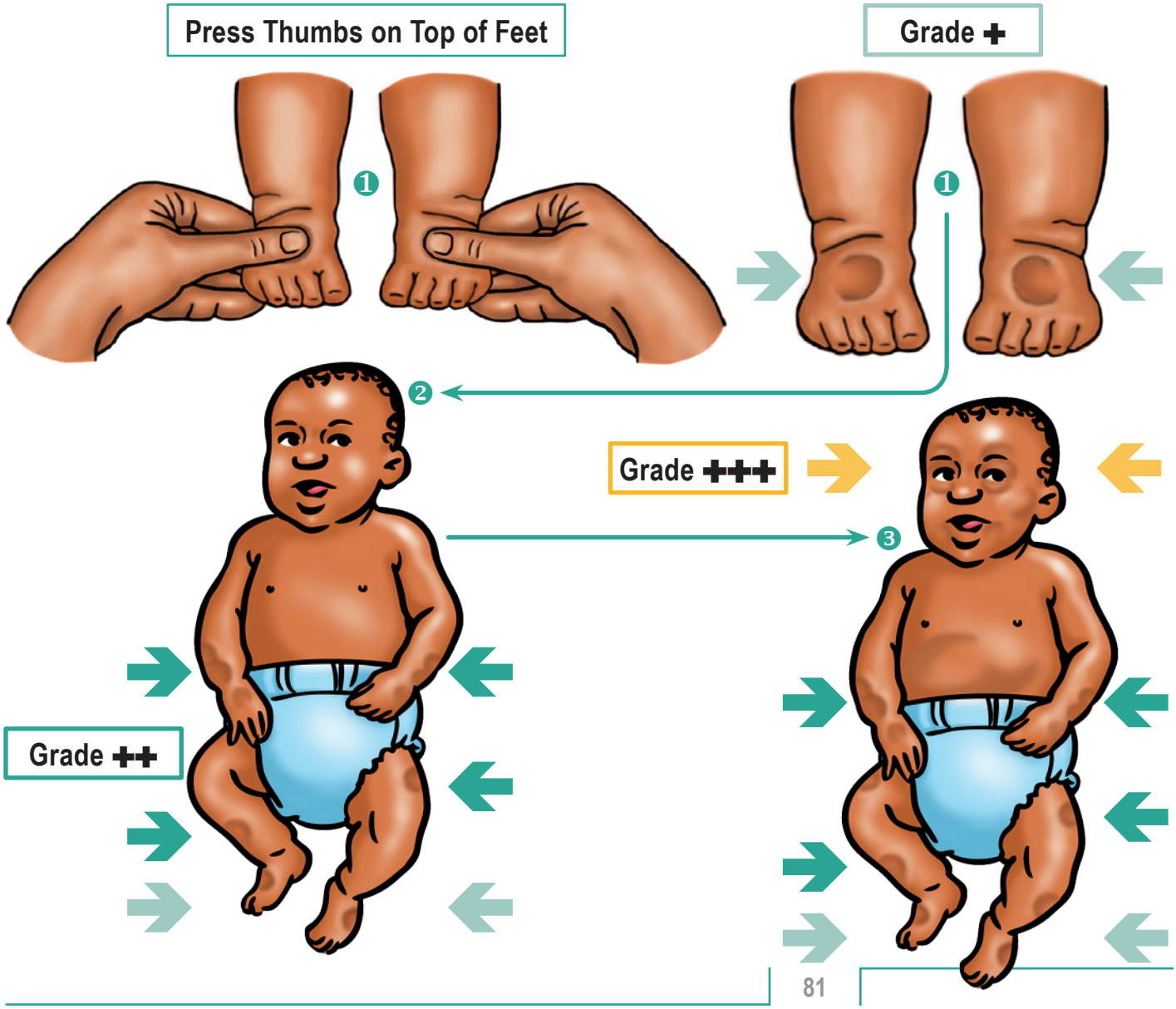
Not Acutely Malnourished – Growing Well	Moderate Acute Malnutrition	Severe Acute Malnutrition
MUAC ≥12.5cm	MUAC = 11.5 – 12.4cm	MUAC = <11.5cm OR Presence of Bilateral Pitting Oedema

Bilateral Pitting Oedema: Look and feel for oedema (swelling) in both feet

Checking for Bilateral pitting Oedema should be routinely done. Oedema on only one foot is not related to malnutrition. However if swelling is found on both feet, it may be related to Kwashiokor which is a form of acute malnutrition. Kwashiokor is the most common and widespread nutritional disorder in developing countries. It is a form of malnutrition caused by not getting enough protein in your diet. It is not characterised by typical wasting (thinness) that characterises Marasmus. Checking for Bilateral Oedema is therefore very important to detect Kwashiokor.

How to Check for Bilateral Pitting Oedema

Step ❶ Hold the child's feet and press your thumbs on top of both feet. Count to 3 and then lift your thumbs. If no pit shows or if a pit shows only on one foot, the child does not have bilateral pitting oedema. If a pit shows on both feet, go to Step ❷



❷ Continue the same test on the lower legs, hands and lower arms. If no pitting appears in these areas, then the child is said to have mild (grade**+**) bilateral pitting oedema. (Mild bilateral pitting oedema only shows on the feet.) If pitting appears in these areas, go to Step ❸

❸ Look for swelling in the face, especially around the eyes. If no swelling appears in the face, then the child is said to have moderate (grade++) bilateral pitting oedema. If swelling appears in the face, then the child is said to have severe (grade+++) bilateral pitting oedema

❹ If the child has oedema, have a second person repeat the test to confirm the results. Children with Bilateral Oedema should be referred urgently to the nearest clinic. If the child needs to be referred to a clinic, record that the child has bilateral pitting oedema in the Other Reasons for Referral Column in the Phila Mntwana Register.

c. Growth Monitoring

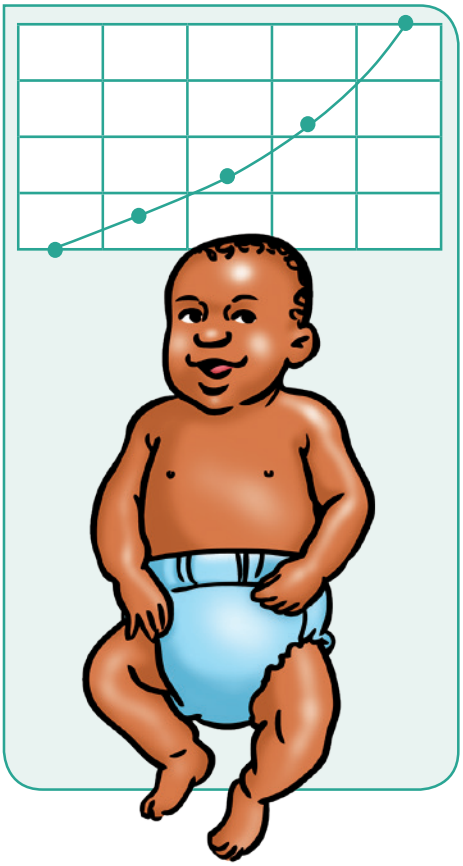
What is Growth Monitoring and Why is it Important?

Growth monitoring, is about checking whether a child is growing and developing as it should showing an increase in height, weight, and development. An adequate rate of growth is an indicator of good nutritional status in children; growth problems may indicate acute and/or chronic health problems. Growth monitoring provides an opportunity for the healthcare worker to intervene to prevent serious growth problems. Tracking the growth of a child is the easiest way to monitor the child's health status, and is a way of detecting malnutrition before it becomes severe. Healthy children grow very quickly in their first few years, and failure to grow is the first sign of malnutrition. Growth Monitoring can also be used to identify and refer other health problems in children under 5 years of age. This in turn will contribute to reducing the under 5 mortality rate (Millennium Development Goal no. 4).

1. Assess the growth of the child under 5 years using the weight-for-age chart. Nutritional status should be assessed using the length-for-age, and weight-for-length charts in the RTHB
2. Weight: If the child is under 1 year, they should be weighed monthly. If the child is between 1 – 2 years, they should be weighed every 2 months. If the child is between 2 – 5 years, they should be weighed every 6 months. If the child has not been weighed according to this schedule, refer the child to the health facility for a weight check
3. Length/height: The child's length/height should be measured by a nurse at the health facility every 6 months. If the child has not been measured according to this schedule, refer the child to the health facility for measuring
4. Weight for length/height: The child's weight for length/height should be assessed at every visit by the nurse at the health facility

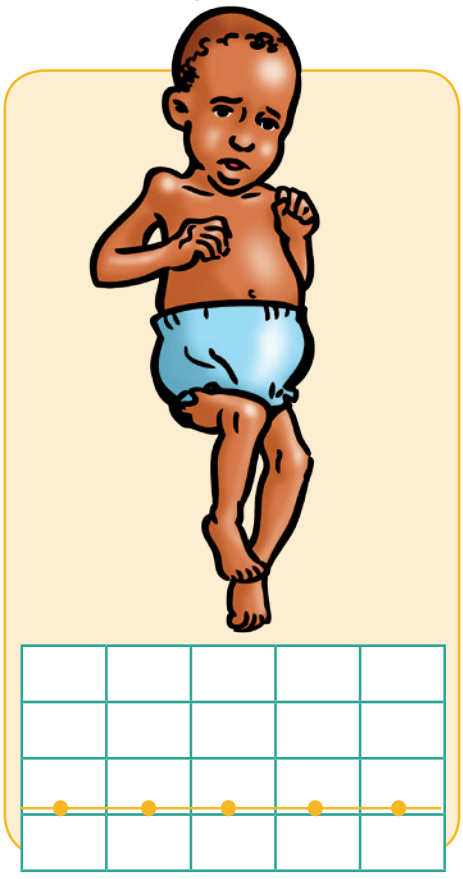
Handy Hints

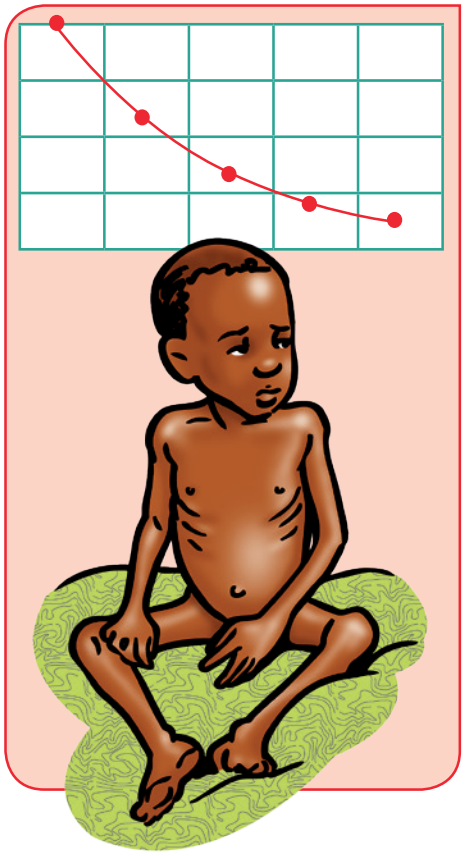
UNDERSTANDING THE GROWTH CHART:
When a child has not gained enough weight, it is shown by a flattening curve on the recorded growth chart, this child should be referred to the local clinic with a CCG referral letter within 24 hours. If a child weighs less than is expected or the child has a downward curve on the growth chart, write a referral letter for urgent and immediate referral to the nearest healthcare facility.



GOOD: means child is growing well

DANGER: find out why and get advice





VERY DANGEROUS: may be very ill, needs extra care

5. Refer the child to a clinic if these charts are not up-to-date or the child is:
   - Underweight for age (nutritional status assessment on weight-for-age chart)
   - Stunted (nutritional status assessment on length/height-for-age chart)
   - Wasted (nutritional status assessment on weight-for-length/height chart)
   - Not growing well (growth assessment on weight-for-age chart)

6. If the child is growing well, has all 3 charts up-to-date and has had all 3 charts measured according to the above-mentioned schedule, praise the mother/caregiver
7. If the child needs to be referred to a health facility, place an (X) in the DOH Column of the Phila Mntwana Register

NUTRITION					CHILD HEALTH						SOCIAL SERVICES				OTHER REFERRALS					
MUAC Green	MUAC Yellow	MUAC RED	Vitamin A	Infant Feeding	Diarrhoea	Immunisation	TB Screening	18 months and older Provider Initiated Counselling and testing (PICT)	Deworming Screening	Developmental Screening	Birth Registration	Orphans and vulnarable children	Early childhood development centres	Child support grant	DOH	DSD	SASSA	Other Departments	Health Education	Tick Cases Closed, i.e. Intervention Provided

Handy Hints

Training of CCGs to administer Vitamin A is on-going. Inform your Supervisor/CHF if you have not been trained.

d. Vitamin A supplementation

NB. CCGs that have not been trained must be referred for training by CCG Supervisors or CHFs prior to providing services at the Phila Mntwana Centres

- All children between 6 – 59 months need to be given an age specific Vitamin A dose every 6 months
- Check the child's RTHB on page 9 (see below). Check when the last Vitamin A dose was issued to the child
- If the child is 6 – 11 months, and Vitamin A was not previously given refer the child to the nearest health facility and place an (X) in the Vitamin A column of the Phila Mntwana Register
- If the child is 12 – 59 months and has missed their routine 6 monthly Vitamin A dose, give the child the appropriate dose of Vitamin A at the

Handy Hints

CCGs are not allowed to administer Vitamin A to children under the age of 12 months.

VITAMIN A SUPPLEMENTATION						
	At age	**Date given dd/mm/yy**	**Signature**	**At age**	**Date given dd/mm/yy**	**Signature**
200 000 IU Mother at delivery (not later 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 xerophthalmia: 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**

DEWORMING TREATMENT (Mebendazole or Albendazole)						
Dose	**At age**	**Date given dd/mm/yy**	**Signature**	**At age**	**Date given dd/mm/yy**	**Signature**
	12 mths	/ /		18 mths	/ /	
	24 mths	/ /		48 mths	/ /	
	30 mths	/ /		54 mths	/ /	
	36 mths	/ /		60 mths	/ /	
	42 mths	/ /				

Phila Mntwana Centre. Record the date that Vitamin A was issued to this child in the RTHB

- If you gave the child a dose of Vitamin A, place a (✓) in the Vitamin A column of the Phila Mntwana Register
- If the child did not require a Vitamin A dose, place a (-) in the Vitamin A column

NUTRITION					CHILD HEALTH						SOCIAL SERVICES				OTHER REFERRALS					
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e. Infant Feeding

- For children who are under 6 months of age, assess whether the child is being exclusively breastfed (no formula/solid food being given at all)
- Provide the mother/caregiver with the appropriate infant feeding messages according to the age of the child (refer to page 10 of RTHB or page 88 of the module)
- Refer the child with feeding difficulties to the nearest clinic and place an (X) in the Infant Feeding column of the Phila Mntwana Register
- If the child did not need to be referred, but the caregiver was counselled on feeding advice, place a (✓) in the Infant Feeding column of the Phila Mntwana Register

NUTRITION					CHILD HEALTH						SOCIAL SERVICES				OTHER REFERRALS					
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f. Diarrhoea

- Look for danger signs of Diarrhoea. Advise the mother/caregiver to take the child to the clinic IMMEDIATELY in the event of the child:

Being unable to drink anything
Vomiting everything
Having blood in his/her diarrhoea stool
Breathing very fast
Having sunken eyes or a very dry mouth
Being lethargic or unconscious

- Educate all mothers/caregivers on how to prepare and give the sugar-salt-solution (SSS)/oral rehydration solution (ORS) [see Module 3, Lesson 3.5 Section 10C Diarrhoea: Home remedies for sick children]
- Refer the sick child to the nearest health facility and place an (X) in the Diarrhoea column of the Phila Mntwana Register
- If the child screened negatively and did not require referral, place a (✓) in the diarrhoea column of the Phila Mntwana Register

NUTRITION					CHILD HEALTH						SOCIAL SERVICES				OTHER REFERRALS					
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Handy Hints

Look for signs of dehydration such as:

- soft spot on the top of the baby's head being sunken in
- baby drinking quickly
- baby has sunken eyes, dry tongue or lips
- the skin on the baby's tummy when pinched returns very slowly back to normal

10

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 that 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

Play: Provide ways for your child to see, hear, feel, and move.
Have colorful things to see and reach

Communicate: Look into your child's eyes and smile at him or her
Talk to your child and get a conversation going with sounds or gestures.

ROAD TO HEALTH

g. Immunisation

- Check the child's RTHB (page 6) to see if the immunisation schedules have been completed for a child of that age

6

IMMUNISATIONS					
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		

HEAD CIRCUMFERENCE AT 14 WEEKS AND AT 12 MONTHS

14 Weeks: _____ (Range: 38 - 43 cm) **12 Months:** _____ (Range: 43.5 - 48.5)

REFER if head circumference is outside range

ROAD TO HEALTH

- Educate the mother/caregiver on the immunisation schedule and remind her of the date given on page 2 of the RTHB by the health facility staff for the next immunisation.

ROAD TO HEALTH

WELL CHILD VISITS – RECORDING SHEET FOR CHILDREN LESS THAN 5 YEARS OLD

Record the following information for each visit on the spaces that are not shaded. Refer to the page numbers given in this booklet and complete the relevant section.						Remember to check the following. Tick if done, and record details on the relevant page					Date of next visit
Age	**Date**	**Growth (IMCI)** (page 14)	**PMTCT/ HIV status (IMCI)** (page 7&8)	**TB status (IMCI)**	**Feeding** (EBF/EFF/ mixed feeding for first 6 months)	Immunisations (page 6)	Vitamin A (page 9)	Deworming (page 9)	Development (page 13)	Oral Health (page 20)	
3 days											
6 wks											
10 wks											
14 wks											
4 mths											
5 mths											
6 mths											
7 mths											
8 mths											
9 mths											
10 mths											

2

- If the child's immunisations are not up-to-date and there is no mobile or Family Health Team (FHT) visiting the Phila Mntwana Centre, refer the child to the nearest health facility and place an (X) in the column for Immunisation of the Phila Mntwana Register
- If the child does not need to be referred, place a (✓) in the Immunisation Column of the Phila Mntwana Register

NUTRITION					CHILD HEALTH						SOCIAL SERVICES				OTHER REFERRALS					
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h. TB Screening

TB Screening Tool for Children

TB Screening Tool for Children

Read the following questions to all individuals in the household and refer them for TB testing at the clinic if you tick ANY ANSWER in the coloured blocks

	Y=Yes	N=No
1. Has the child been coughing or wheezing for more than 2 weeks?	Y	N
2. Has the child been losing weight or has there been unsatisfactory weight gain in the last three months?	Y	N
3. Does the child experience chest pains or shortness of breath?	Y	N
4. Has the child been in contact with someone who has TB (especially someone living in the same household or regularly spending time with the child)?	Y	N
5. Is the child tired and/or not as playful as usual?	Y	N
6. Has the child had a fever every day for 14 days or more?	Y	N

- If the mother/caregiver answers Yes to any of the TB screening questions, refer the child to the nearest clinic and place an (X) in the TB Screening Column of the Phila Mntwana Register
- If the mother/caregiver answered no to all questions, the child does not need to be referred, place a (✓) in the TB Screening Column of the Phila Mntwana Register

NUTRITION					CHILD HEALTH						SOCIAL SERVICES				OTHER REFERRALS					
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i. HIV Exposure

- Ask the mother about her own HIV status and also check the child's RTHB on page 7 to see if the PMTCT information is filled in
- If the mothers is HIV-positive, ask her if the child was tested at 6 weeks of age and after stopping breastfeeding. Check to see information is up-to-date on page 8 in the child's RTHB
- If the child was not tested for HIV or the RTHB is not up-to-date, refer the child to the health facility, place an (X) in the DOH Referral Column of the Phila Mntwana Register

NUTRITION					CHILD HEALTH						SOCIAL SERVICES				OTHER REFERRALS					
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j. Provider Initiated Counseling and Testing

- All children at 18 months of age or older should be offered PICT, regardless of the mother's HIV status
- If the child is 18 months of age or older and has never been offered PICT, refer the child to a health facility and place an (X) in the PICT Column of the Phila Mntwana Register
- If the child is 18 months of age or older and has previously been offered PICT, place a (✓) in the PICT Column of the Phila Mntwana Register

NUTRITION					CHILD HEALTH						SOCIAL SERVICES				OTHER REFERRALS					
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7

PMTCT/HIV INFORMATION			
Child's first name and surname: Child's ID Number:			
Fill in this section on discharge from Midwife Obstetric Unit (MOU) or obstetric ward or at first subsequent visit if not yet done			
Mother's latest HIV test result	Positive	Negative	To be done
When did mother have the test?	☐ Before pregnancy	☐ During pregnancy	☐ At delivery
Is the mother on life-long ART?	Yes	No	
If yes, duration of life-long ART at time of delivery	☐ < 4 weeks	☐ > 4 weeks	☐ Before pregnancy
Document ARVs the mother received:			
Did the mother receive infant feeding counseling?	Yes	No	
Decision about infant feeding	☐ Exclusive breast	☐ Exclusive formula	
Document Nevirapine given:			
All HIV exposed infants should receive Nevirapine for a minimum of 6 weeks			
Has the mother disclosed to anyone in the household?	Yes	No	
Has the mother's partner been tested?	Yes	No	
Remember to offer testing for all the mother's other children if not yet done **Offer a mother with unknown HIV status a rapid HIV test.** **If mother's HIV rapid test is positive, perform an HIV DNA PCR test on infant if ≥ 6/52**			

ROAD TO HEALTH

k. ART Support

- If the child is HIV-positive, ensure that the child is on ART and has been to the clinic in the past 4 weeks for a check-up and to collect medication
- If the child is HIV-positive and is not on ART or has not been to the clinic in the past 4 weeks, refer the child immediately to the health facility, place an (X) in the DOH Referral Column of the Phila Mntwana Register

NUTRITION					CHILD HEALTH						SOCIAL SERVICES				OTHER REFERRALS					
MUAC Green	MUAC Yellow	MUAC RED	Vitamin A	Infant Feeding	Diarrhoea	Immunisation	TB Screening	18 months and older Provider Initiated Counselling and testing (PICT)	Deworming Screening	Developmental Screening	Birth Registration	Orphans and vulnarable children	Early childhood development centres	Child support grant	DOH	DSD	SASSA	Other Departments	Health Education	Tick Cases Closed, i.e. Intervention Provided

l. Deworming Screening

- All children 1 – 5 years need deworming medication every 6 months
- Check the child's RTHB on page 9 to see whether deworming medication was issued to the child from age 1, for every 6 months

DEWORMING TREATMENT (Mebendazole or Albendazole)						
Dose	At age	Date given dd/mm/yy	Signature	At age	Date given dd/mm/yy	Signature
	12 mths	/ /		18 mths	/ /	
	24 mths	/ /		48 mths	/ /	
	30 mths	/ /		54 mths	/ /	
	36 mths	/ /		60 mths	/ /	
	42 mths	/ /				

- Refer the child to the health facility if deworming treatment is not up-to-date and place an (X) in the Deworming Screening Column of the Phila Mntwana Register
- If the child does not require referral, place a (✓) in the Deworming Screening Column of the Phila Mntwana Register

NUTRITION					CHILD HEALTH						SOCIAL SERVICES				OTHER REFERRALS					
MUAC Green	MUAC Yellow	MUAC RED	Vitamin A	Infant Feeding	Diarrhoea	Immunisation	TB Screening	18 months and older Provider Initiated Counselling and testing (PICT)	Deworming Screening	Developmental Screening	Birth Registration	Orphans and vulnarable children	Early childhood development centres	Child support grant	DOH	DSD	SASSA	Other Departments	Health Education	Tick Cases Closed, i.e. Intervention Provided

m. Developmental Screening

- Assess the child's RTHB on page 13 to check if developmental milestones were assessed according to age
- If the child's milestones were not assessed according to age, refer to the nearest health facility and place an (X) in the Developmental Screening Column of the Phila Mntwana Register
- If the child's milestones were assessed and no referral is necessary, place a (✓) in the Developmental Screening Column of the Phila Mntwana Register
- If physical or mental disability is evident or suspected, refer the the child to DSD for assessment and appropriate social intervention, (like Mental Health society/NACROD), blind and deaf society, etc) and place an (X) in Developmental Screening Column of the Phila Mntwana Register

NUTRITION					CHILD HEALTH						SOCIAL SERVICES				OTHER REFERRALS					
MUAC Green	MUAC Yellow	MUAC RED	Vitamin A	Infant Feeding	Diarrhoea	Immunisation	TB Screening	18 months and older Provider Initiated Counselling and testing (PICT)	Deworming Screening	Developmental Screening	Birth Registration	Orphans and vulnarable children	Early childhood development centres	Child support grant	DOH	DSD	SASSA	Other Departments	Health Education	Tick Cases Closed, i.e. Intervention Provided

DEVELOPMENTAL SCREENING			
	VISION AND ADAPTIVE	**HEARING AND COMMUNICATION**	**MOTOR DEVELOPMENT**
ALWAYS ASK	Can your child see?	Can your child hear and communicate as other children?	Does your child do the the same things as other children of the same age?
14 weeks	Baby follows close objects with eyes	Baby responds to sound by stopping sucking, blinking or turning	Child lifts head when held against shoulder 
6 months	Baby recognises familiar faces	Child turns head to look for sound	Child holds a toy in each hand 
9 months	Child's eyes focus on far objects Eyes move well together (No squint)	Child turns when called	Child sits and plays without support 
18 months	Child looks at small things and pictures	Child points to 3 simple objects Child uses at least 3 words other than names Child understands simple commands	Child walks well  Child uses fingers to feed
3 years	Sees small shapes clearly at 6 metres	Child speaks in simple 3 word sentences	Child runs well and climbs on things
5-6 years: School readiness	No problem with vision, use a Snellen E chart to check	Speaks in full sentences and interact with children and adults	Hops on one foot  Able to draw a stick person
REFER	**Refer the child to the next level of care if child has not achieved the developmental milestone. Refer motor problem to Occupational Therapist/Physiotherapist and hearing and speech problem to Speech therapist/Audiologist if you have the services at your facilities.**		

ROAD TO HEALTH

n. Birth Registration

- Ask the mother/caregiver if the child's birth has been registered with the Department of Home Affairs
- If the child's birth has not been registered, refer the mother/caregiver to Home Affairs and place an (X) in the Birth Registration Column of the Phila Mntwana Register
- If the child's birth has been registered, place a (✓) in the Birth Registration Column of the Phila Mntwana Register

NUTRITION					CHILD HEALTH						SOCIAL SERVICES				OTHER REFERRALS					
MUAC Green	MUAC Yellow	MUAC RED	Vitamin A	Infant Feeding	Diarrhoea	Immunisation	TB Screening	18 months and older Provider Initiated Counselling and testing (PICT)	Deworming Screening	Developmental Screening	Birth Registration	Orphans and vulnarable children	Early childhood development centres	Child support grant	DOH	DSD	SASSA	Other Departments	Health Education	Tick Cases Closed, i.e. Intervention Provided

o. Orphans and Vulnerable Children

- If the CCG suspects any type of abuse, neglect or thinks the mother/caregiver may be struggling to cope, refer the child to DSD and place an (X) in the Orphans and Vulnerable Children and DOH Column of the Phila Mntwana Registers
- If the child is living alone, without an adult caregiver or with an ill caregiver, refer the child to DSD and place an (X) in the Orphans and Vulnerable Children Column
- If the child has a disability and is not receiving appropriate care, refer the child to DOH and DSD and place an (X) in the Orphans and Vulnerable Children Column of the Phila Mntwana Register
- If no referral is necessary, place a (✓) in the Orphans and Vulnerable Children Column of the Phila Mntwana Register

NUTRITION					CHILD HEALTH						SOCIAL SERVICES				OTHER REFERRALS					
MUAC Green	MUAC Yellow	MUAC RED	Vitamin A	Infant Feeding	Diarrhoea	Immunisation	TB Screening	18 months and older Provider Initiated Counselling and testing (PICT)	Deworming Screening	Developmental Screening	Birth Registration	Orphans and vulnarable children	Early childhood development centres	Child support grant	DOH	DSD	SASSA	Other Departments	Health Education	Tick Cases Closed, i.e. Intervention Provided

p. Early Childhood Development Services

- If the child is between 3 – 5 years of age, ask the caregiver if the child goes to a creche, preschool or Early Childhood Development (ECD) centre
- If the child does not attend an Early Childhood Development Centre, encourage the mother/caregiver to enroll the child in an ECD service. Refer the child to DSD and place an (X) in the ECD Services Column of the Phila Mntwana Register
- If child attends regularly, place a (✓) in the ECD Services Column of the Phila Mntwana Register

NUTRITION					CHILD HEALTH						SOCIAL SERVICES				OTHER REFERRALS					
MUAC Green	MUAC Yellow	MUAC RED	Vitamin A	Infant Feeding	Diarrhoea	Immunisation	TB Screening	18 months and older Provider Initiated Counselling and testing (PICT)	Deworming Screening	Developmental Screening	Birth Registration	Orphans and vulnarable children	Early childhood development centres	Child support grant	DOH	DSD	SASSA	Other Departments	Health Education	Tick Cases Closed, i.e. Intervention Provided

q. Child Support Grant

- Ask the mother/caregiver if the child is getting a Child Support Grant
- If the child is not receiving a Child Support Grant, refer the child to SASSA and place an (X) in the Child Support Grant Column of the Phila Mntwana Register
- If the child is receiving a Child Support Grant, place a (✓) in the Child Support Grant Column of the Phila Mntwana Register

NUTRITION					CHILD HEALTH						SOCIAL SERVICES				OTHER REFERRALS					
MUAC Green	MUAC Yellow	MUAC RED	Vitamin A	Infant Feeding	Diarrhoea	Immunisation	TB Screening	18 months and older Provider Initiated Counselling and testing (PICT)	Deworming Screening	Developmental Screening	Birth Registration	Orphans and vulnarable children	Early childhood development centres	Child support grant	DOH	DSD	SASSA	Other Departments	Health Education	Tick Cases Closed, i.e. Intervention Provided

r. Other Reasons for Referral

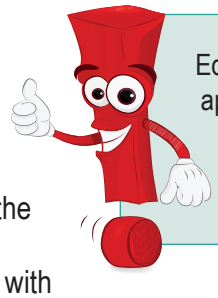
- If the child requires referral for any reason other than the above mentioned referrals, place an (X) in the appropriate "Other Referrals" Column (DOH, DSD, SASSA and Other Departments)
- The reasons a child is referred for other services may include:
  - Presence of danger signs or other health health conditions ➔ refer the child to the health facility and place an (X) in the DOH Column
  - Victim of crime such as rape ➔ refer the child to SAPS and place an (X) in the other Departments Column
  - Challenges with food security ➔ refer the child to DSD and SASSA and place an (X) in both DSD and SASSA Columns
  - If the child has been assessed and no other referrals are necessary, place a (✓) in all the Other Referrals Columns

NUTRITION					CHILD HEALTH						SOCIAL SERVICES				OTHER REFERRALS					
MUAC Green	MUAC Yellow	MUAC RED	Vitamin A	Infant Feeding	Diarrhoea	Immunisation	TB Screening	18 months and older Provider Initiated Counselling and testing (PICT)	Deworming Screening	Developmental Screening	Birth Registration	Orphans and vulnarable children	Early childhood development centres	Child support grant	DOH	DSD	SASSA	Other Departments	Health Education	Tick Cases Closed, i.e. Intervention Provided

s. Health Education

- Ensure that mothers/caregivers are given health and nutrition advice on all aspects of child wellness management available to the child
- Use the relevant age specific desk aids available to educate mothers/caregivers about caring for a child/baby at home. These are age specific pamphlets that educate mothers/caregivers in respect of all age groups ranging from 6 weeks to 5 years
- Pamphlets and Leaflets:
  - Caring for your Child: 6 Weeks
  - Caring for your Child: 10 Weeks
  - Caring for your Child: 14 Weeks
  - Caring for your Child: 6 Months
  - Caring for your Child: 9 Months
  - Caring for your Child: 12 Months
  - Caring for your Child: 18 Months
  - Caring for your Child: 2 Years
  - Caring for your Child: 3 Years
  - Caring for your Child: 4 Years
  - Caring for your Child: 5 Years
  - Caring for your Child: Managing Diarrhoea
  - Caring for your Child: When to be Concerned about TB
- Note, there are 2 of these pamphlets that apply to all age groups that will guide mothers/caregivers on how to manage Diarrhoea and TB in children
- All the IEC pamphlets provide information and education on the following in respect of each age group:
  - Immunisation
  - HIV
  - Feeding
  - Developmental Milestones
  - Next clinic visit
  - Danger Signs

- Give the mother/caregiver an age appropriate well-baby pamphlet to educate her on how to care for her child
- Remind the mother/caregiver that the child must be assessed monthly at either the Phila Mntwana Centre or the nearest health facility
- If the mother/caregiver is provided with health education, place a (✓) in the Health Education Column of the Phila Mntwana Register
- If unable to provide health education to mother/caregiver, place a (–) in the Health Education Column



Handy Hints

Educate the mother/caregiver using an age appropriate Caring for your Child pamphlet. In addition, give the mother/caregiver the Diarrhoea and TB pamphlets because they are relevant to all children that attend the Phila Mntwana Centre.

NUTRITION					CHILD HEALTH						SOCIAL SERVICES				OTHER REFERRALS					
MUAC Green	MUAC Yellow	MUAC RED	Vitamin A	Infant Feeding	Diarrhoea	Immunisation	TB Screening	18 months and older Provider Initiated Counselling and testing (PICT)	Deworming Screening	Developmental Screening	Birth Registration	Orphans and vulnarable children	Early childhood development centres	Child support grant	DOH	DSD	SASSA	Other Departments	Health Education	Tick Cases Closed, i.e. Intervention Provided

t. Case Closed and Intervention Provided

- Refer all children under 5 years with child health problems to the CCG allocated to the specific household and FHT Team for follow-up and Household Profiling
- CCGs to compile a list of all referrals to other departments for intervention and presentation to the OSS War Room Convener for further action
- Feedback should be given by each department to which referrals were made and the interventions provided should be recorded
- CCGs should visit the referral health facility weekly to collect the Phila Mntwana Referral Slips for children referred
- Place a (✓) in the Case Closed and Intervention Provided Column of the Phila Mntwana Register once the child has been taken to the facility to which they had been referred AND the necessary interventions have been provided For children who did not present at the clinic, follow-up on the cases by contacting the mother/ caregiver listed and the War Room for interventions from other departments to be closed
- Follow up on children who did not receive necessary interventions for which they had been referred

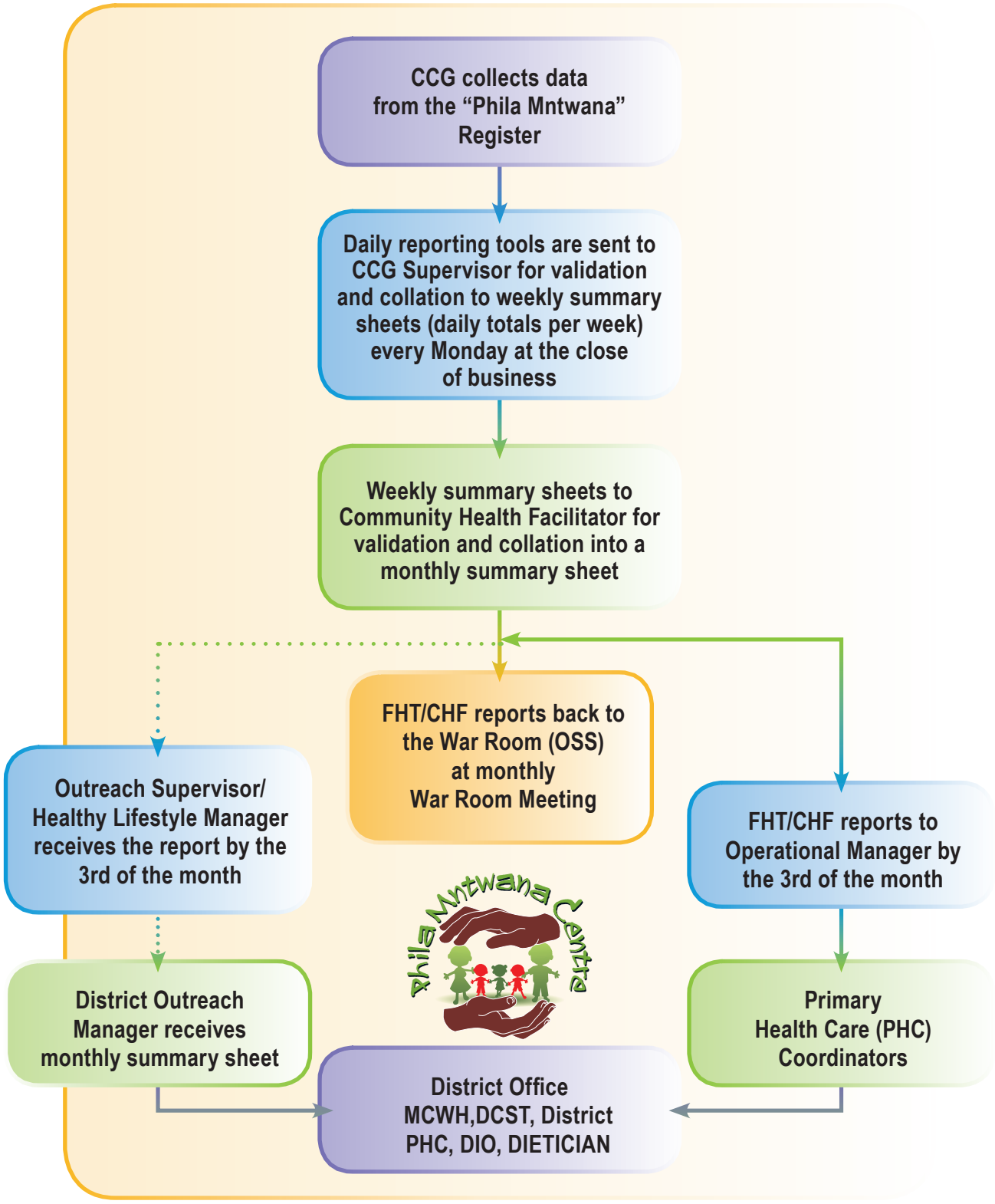
NUTRITION					CHILD HEALTH						SOCIAL SERVICES				OTHER REFERRALS					
MUAC Green	MUAC Yellow	MUAC RED	Vitamin A	Infant Feeding	Diarrhoea	Immunisation	TB Screening	18 months and older Provider Initiated Counselling and testing (PICT)	Deworming Screening	Developmental Screening	Birth Registration	Orphans and vulnarable children	Early childhood development centres	Child support grant	DOH	DSD	SASSA	Other Departments	Health Education	Tick Cases Closed, i.e. Intervention Provided

Data Recording and Reporting

- Ensure that all services rendered are recorded in the Phila Mntwana Register
- Fill in the Register correctly, making sure to place an (X) or (✓) as necessary
- Ensure that the CCG weekly and monthly summary sheets are completed and forwarded to the CHF and to the CDW in the War Room

Standard Operation Procedure for Data Flow (Phila Mntwana Centres)

The Data Flow Chart shows the reporting process and path that the data follows.



Group Discussion

Each group will be allocated 1 of the Phila Mntwana Reporting Tools to examine in greater detail. Answer the following questions, based on the CCG Reporting Tools,

1. What is this Tool for?

_____

_____

_____

2. Who fills out this Tool?

_____

_____

_____

3. Where does the information for filling out the Tool come from?

_____

_____

_____

4. Are there any Tools needed to complete the Phila Mntwana Register?

_____

_____

_____

5. When is this Phila Mntwana Register completed, and how often?

_____

_____

_____

CCG Reporting Tools

1. Phila Mntwana Register

The Phila Mntwana Register should be filled in carefully and as instructed.

							NUTRITION					CHILD HEALTH						SOCIAL SERVICES				OTHER REFERRALS					
	Date (dd/mm/yy)	Initials of CCG	Name and Surname of Child (Fill in All Children)	Date of Birth (dd/mm/yy)	Sex (M/F)	Mother or Caregiver's Contact Details (Name and Isigodi and Cell Number)	MUAC Green	MUAC Yellow	MUAC RED	Vitamin A	Infant Feeding	Diarrhoea	Immunisation	TB Screening	18 months and older Provider Initiated Counselling and testing (PICT)	Deworming Screening	Developmental Screening	Birth Registration	Orphans and vulnarable children	Early childhood development centres	Child support grant	DOH	DSD	SASSA	Other Departments	Health Education	Tick Cases Closed, i.e. Intervention Provided
1																											
2																											
3																											
4																											
5																											
Total Attended																											
Total Referred																											

2. Weekly Summary Sheet

This weekly summary sheet must be completed once a week, with regard to all of the children seen by the CCG during the week.

Weekly Summary Sheet

Health facility: ..... **Date:** ..... / .....

Data Elements	Number	Comment
Children Screened at Phila Mntwana Centre		
Total Children Monitored for Malnutrition (MUAC)		
Children with Green MUAC		
Children with Yellow MUAC (MAM)		
Children with Red MUAC (SAM)		
Children Given Vitamin A Supplementation		

3. Monthly Summary Sheet

This monthly summary sheet must be completed once a month, with regard to all of the children seen by the CCG during the month.

Monthly Summary Sheet

Health facility: ..... **Date:** ...../ .....

Data Elements	Number	Comment
Total Children Screened at Phila Mntwana Centre		
Children Monitored for Malnutrition (MUAC)		
Children with Green MUAC		
Children with Yellow MUAC (MAM)		
Children with Red MUAC (SAM)		
Children Given Vitamin A Supplementation		
Children Referred for Feeding Difficulties		
Children Referred for Diarrhoea		
Children Referred for Immunisations		
Children Referred for TB		
Children 18 Months and Older Referred for PICT		
Children Referred for Deworming Treatment		
Children Referred for Developmental Screening		
Children Referred to Home Affairs for Birth Registration		

4. Screening Referral Slips

This is a Community Screening Referral Slip for all referrals except for TB screening for children (See Form Below). These are to be completed in the case of referrals by the CCG.

Community Screening Referral Slip

First Name of Child:

Surname of Child:

Name of Mother/Caregiver:

isiGodi/Physical Address:

Referral Health Facility:

Date of Community Outreach:

Bilateral Pitting Oedema: Yes No

MUAC: cm

Other Findings:

Name of CCG:

Signature:

Municipal Ward:

Date:

PLEASE NOTIFY THE FACILITY OPERATIONAL MANAGER ABOUT THE REFERRAL THROUGH USUAL REPORTING CHANNELS.

5. Child Tuberculosis Screening Referral Slip

Child Tuberculosis Screening Referral Slip

First Name of Child:

Surname of Child:

Name of Mother/Caregiver:

isiGodi/Physical Address:

Referral Health Facility:

Date of Community Outreach:

TB Screening:

- Coughing or wheeze for more than two weeks ✓
- Loss of weight or unsatisfactory weight gain during the past 3 months
- Chest pains or shortness of breath
- A positive TB contact (someone living with or regularly spending time with the child)
- Fatigue/reduced playfulness
- Fever every day for 14 days or more

If any of these signs are present, kindly refer to the clinic for IMCI Management.

Findings:

Referred: Yes No

Name of CCG:

Signature:

Municipal Ward:

Date:

PLEASE NOTIFY THE FACILITY OPERATIONAL MANAGER ABOUT THE REFERRAL THROUGH USUAL REPORTING CHANNELS.

6. Ward MUAC Monthly and Quarterly Summary Graph

One block should be filled in per child with regard to their MUAC status.

Ward MUAC Monthly & Quarterly Summary Graph **Year:** .....

Municipality: ..... **Ward No:** ..... **Number of children under 5 yrs in ward:**

781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800
761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780
741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760
721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740
701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720
681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700
661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680
641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660
621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640
601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620
581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600
561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580
541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560
521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540
501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520
481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500
461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480
441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460
421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440
401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420
381	382	833	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400
361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380
341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360
321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340
301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320
281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300
261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280
241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260
221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240
201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220
181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200

196	197	198	199	200
191	192	193	194	195
186	187	188	189	190
181	182	183	184	185
176	177	178	179	180
171	172	173	174	175
166	167	168	169	170
161	162	163	164	165
156	157	158	159	160
151	152	153	154	155
146	147	148	149	150
141	142	143	144	145
136	137	138	139	140
131	132	133	134	135
126	127	128	129	130
121	122	123	124	125
116	117	118	119	120
111	112	113	114	115
106	107	108	109	110
101	102	103	104	105
96	97	98	99	100
91	92	93	94	95
86	87	88	89	90
81	82	83	84	85
76	77	78	79	80
71	72	73	74	75
66	67	68	69	70
61	62	63	64	65
56	57	58	59	60
51	52	53	54	55
46	47	48	49	50

118	119	120
115	116	117
112	113	114
109	110	111
106	107	108
103	104	105
100	101	102
97	98	99
94	95	96
91	92	93
88	89	90
85	86	87
82	83	84
79	80	81
76	77	78
73	74	75
70	71	72
67	68	69
64	65	66
61	62	63
58	59	60
55	56	57
52	53	54
49	50	51
46	47	48
43	44	45
40	41	42
37	38	39
34	35	36
31	32	33
28	29	30

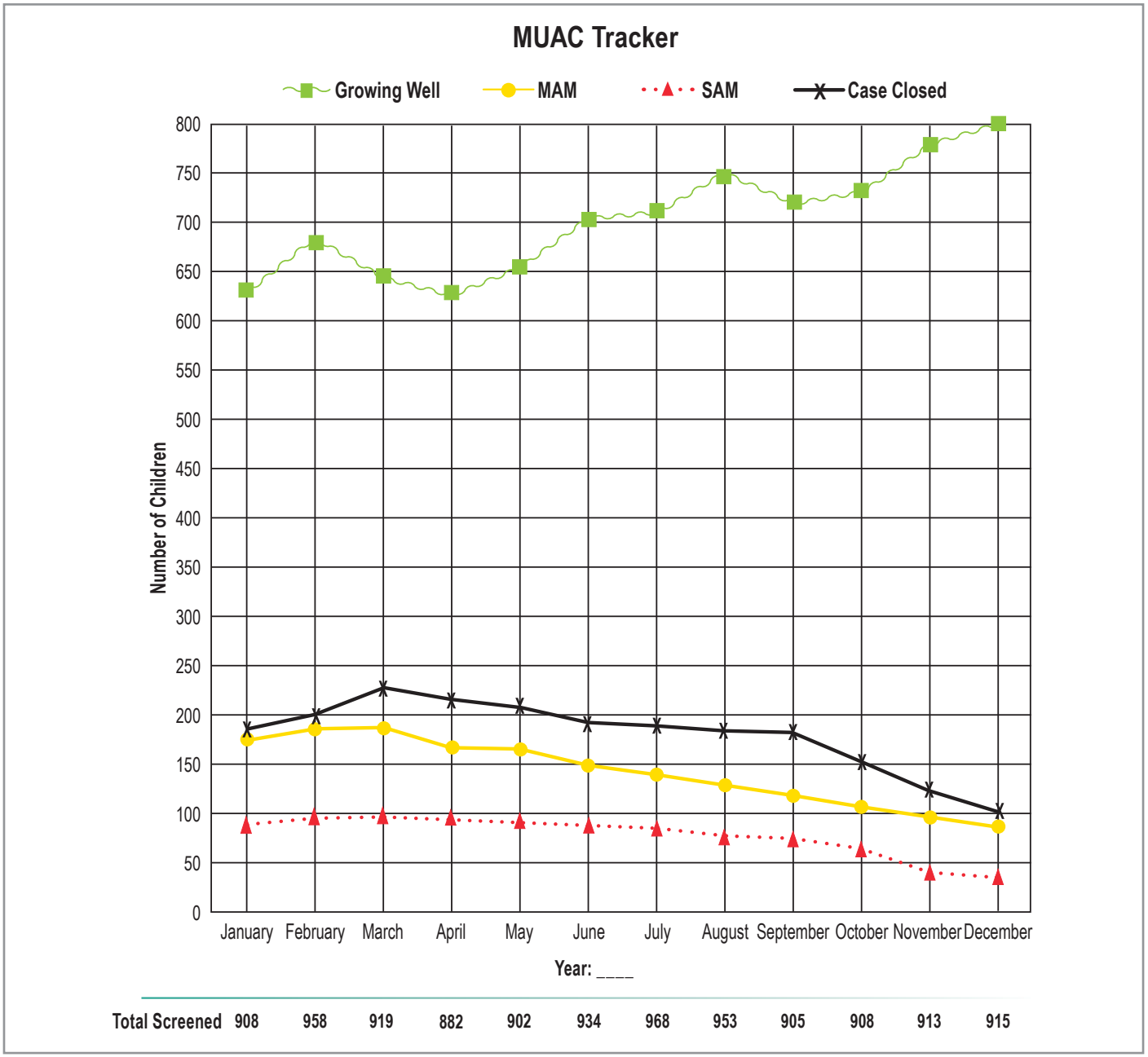
Month:

Not Acutely Malnourished - Growing Well	Moderate Acute Malnutrition	Severe Acute Malnutrition
MUAC ≥12.5cm	MUAC = 11.5 – 12.4cm	MUAC = <11.5cm OR Presence of Bilateral Pitting Oedema

7. War Room Monitoring Graphs

How to Create a Malnutrition (MUAC) Graph:

1. Take a large piece of graph paper (A1). If graph paper is not available, create your own graph paper by drawing a grid on a blank piece of A1 paper
2. On the bottom of the grid, put the months of the year
3. On the left side, put numbers in blocks of 50 until the number 800 (see example on the following page)
4. At the beginning of each month, after receiving last month's **"PHILA MNTWANA CENTRE"** reporting figures, draw dots on the graph for the following. When possible, use coloured markers that correspond to the MUAC tape colours. When not available, use different types of lines to differentiate
5. The number of children growing well **(green)**
6. The number of children who are moderately acutely malnourished (MAM) **(yellow)**
7. The number of children who are severely acutely malnourished (SAM) **(red)**
8. The number of malnutrition cases closed for the month, as discussed during the Ward Task Team meeting (black)
9. Underneath the month, write the total number of children screened for malnutrition (**green** + **yellow** + **red**)
10. Each month, connect the current month's dot to the previous month's dot by drawing either a **wavy line (for growing well)**, **solid line (MAM)** or **dotted line (SAM)** or a line of x's (case closed)

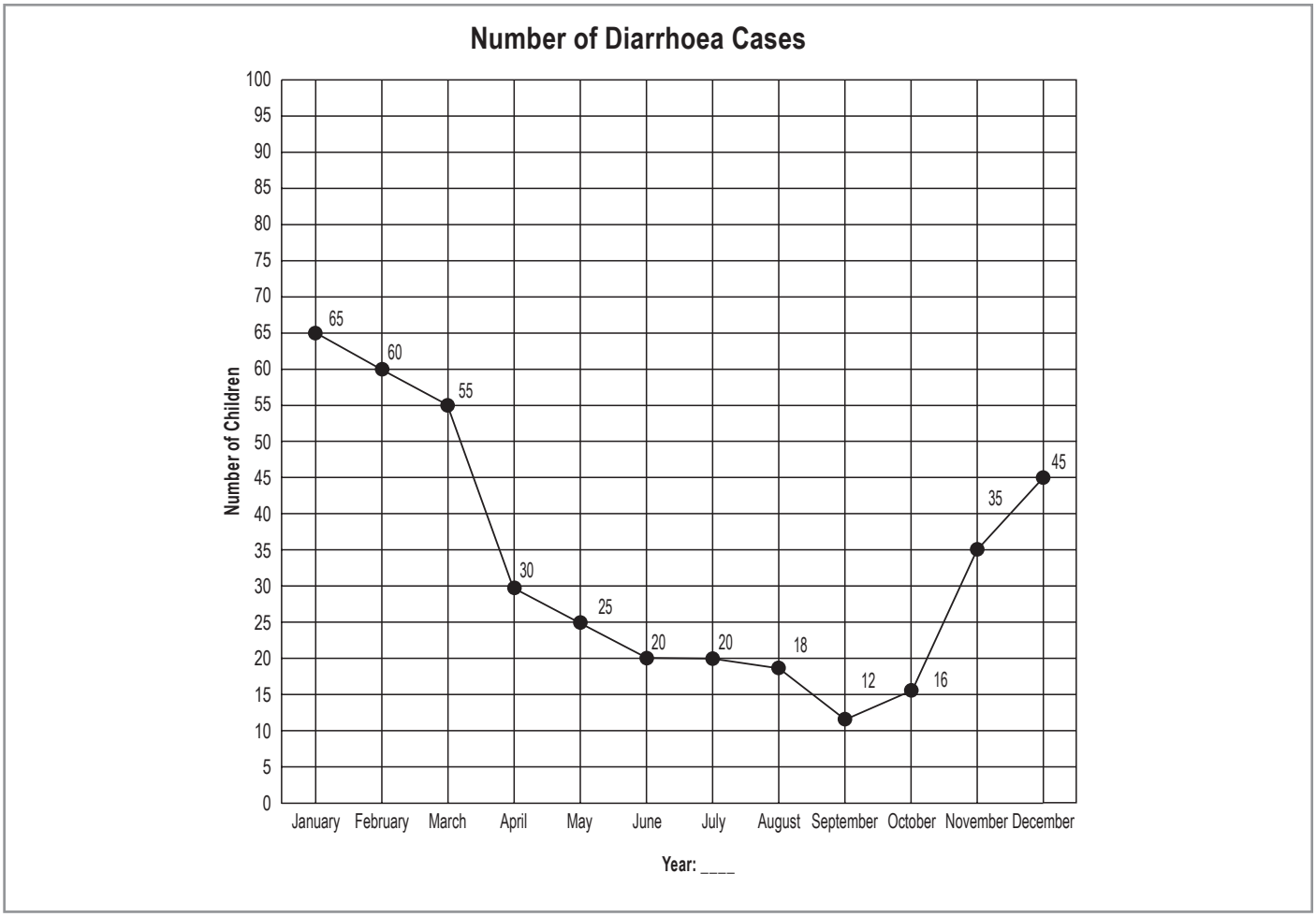


Discuss the results during War Room meetings

- Are the red and yellow figures decreasing? If not, what can you do to improve child nutrition in your ward?
- Are all children being screened at the **"PHILA MNTWANA CENTRE"** (Is the total number of children increasing/staying constant over time)? If not, how can we encourage caregivers to bring their children to the **"PHILA MNTWANA CENTRE"** every month?
- Is the number of cases closed for the month equal to the total number of children identified as malnourished (**yellow** + **red**)? If no, why not? How can the War Room ensure that all malnourished children receive the support they require?

How to Create a Diarrhoea Monitoring Graph:

1. Take a large piece of graph paper (A1). If graph paper is not available, create your own graph paper by drawing a grid on a blank piece of A1 paper
2. On the bottom of the grid, put the months of the year
3. On the left side, put numbers in blocks of 5 until the number 100 (see example below)
4. At the beginning of each month, after receiving last month's **"PHILA MNTWANA CENTRE"** reporting figures, put a dot for the number of children reported to have diarrhoea
5. Write the number of children with diarrhoea reported for that month next to the dot
6. Each month, connect the current month's dot to the previous month by drawing a straight line



Discuss the results during Ward Task Team Meetings

- How many children had diarrhoea this month?
- Was this number more or less or the same as last month?
- Is there a common cause for the diarrhoea? (e.g. water source, virus, etc)
- What can we do to bring this number to 0?

8. How to Secure your Markers

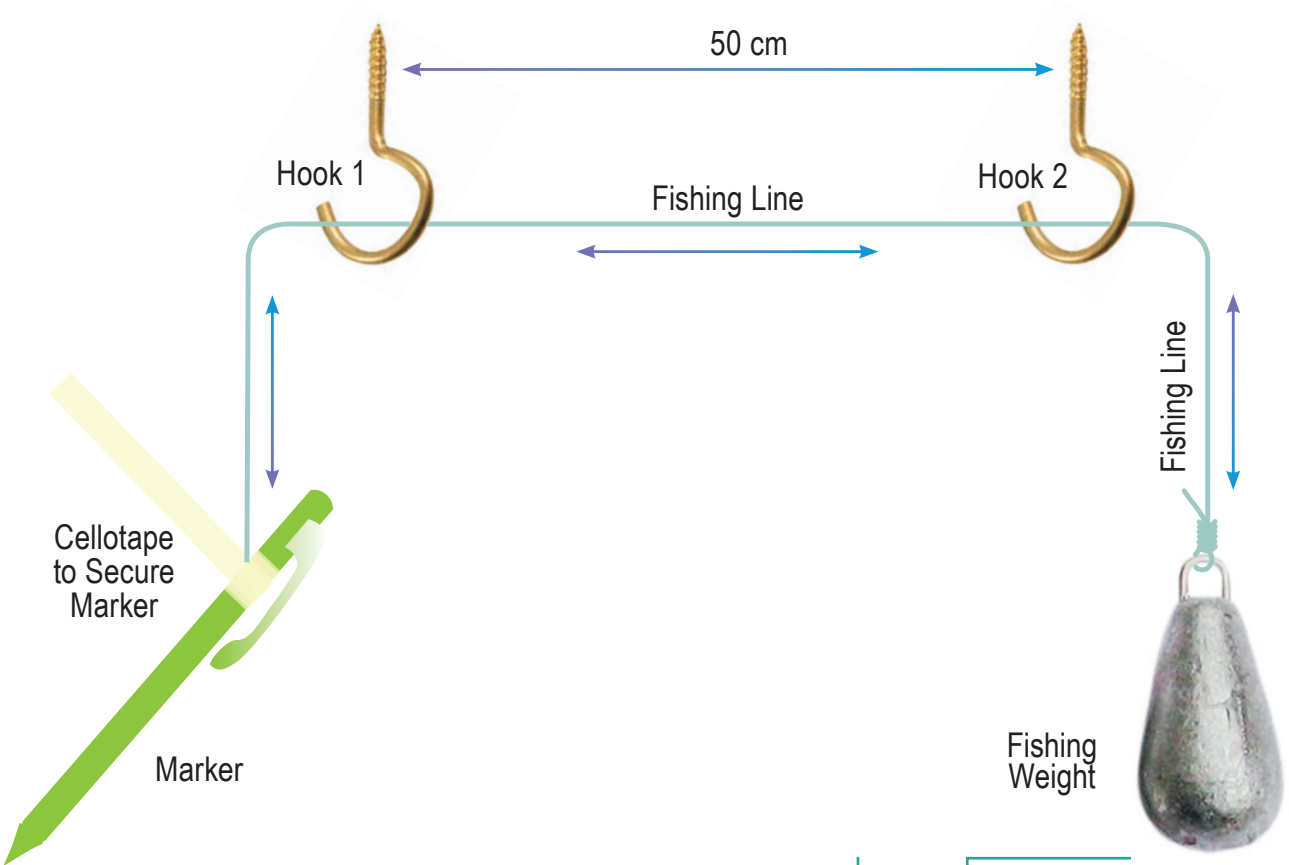
To make sure your coloured markers do not leave the War Room, you can attach them to the wall or ceiling.

You will need the following:

- 6 Screw-in Hooks
- Fishing Line
- 3 Fishing Weights with eyes on one end (ensure they are bigger than your hooks in diameter)
- 3 Markers: Green, Yellow and Red
- 1 Roll of Cellotape

Instructions on how to assemble your pens:

- Screw the hooks into the ceiling in pairs, about 50cm apart from each other (where you see the nails in the roof, there will be a wooden beam, screw into this)
- Attach one end of the fishing line to a fishing weight
- String the line through your hooks (pull the line tight until the weight stops on the hooks) and measure how long a piece of fishing line you need to comfortably reach where you will be writing on your Wall Graph
- Once you are sure of your length, cut your line and remove it from the hooks
- Knot the other end of the line around the back of your pen and fasten with cellotape. Use a generous amount of cellotape, wrapping it around the back of your pen until the line is securely fastened
- Reattach to the hooks and your pen can now be used to write on your chart
- Close up the hooks to prevent the line from coming out
- Repeat these steps **3 times** for all the markers



Case Study

Mrs Nkosi, the mother of a 3 year old girl, Nomusa, is worried that her daughter seems to be losing weight. Her husband has been unemployed for 6 months and now depends on temporary jobs. At the Phila Mntwana Center, she tells the CCG, that they now depend on one meal per day.

Read the above case study and discuss in groups.

1. How should the CCG receive and respond to Mrs Nkosi as a new client?

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2. What important steps should the CCG follow after reviewing the child's RTHB?

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3. Mrs Nkosi reports that Nomusa sometimes suffers from diarrhoea as they are using river water and have no flushing toilets. What education must the CCG give to Mrs Nkosi regarding this issue?

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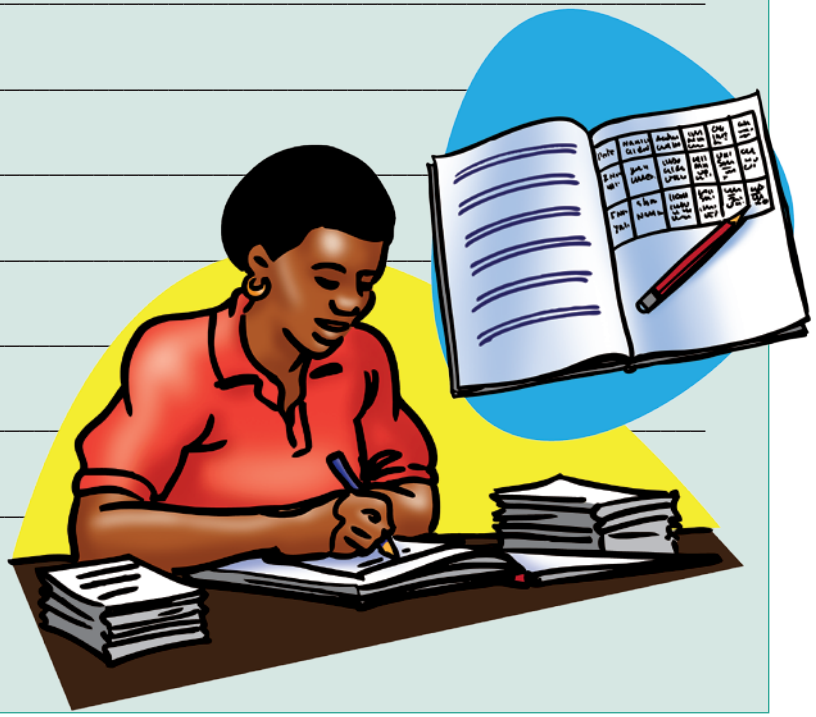
Case Study

4. Mrs Nkosi mentioned that one of Nomusa's playmates has been coughing for three weeks. What actions should the CCG take?

5. The CCG responsible for the Nkosi household needs to follow-up the case at household level. When handing over the case, what should the CCG at the Phila Mntwana centre emphasise?



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