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COPC – A PRACTICAL GUIDE

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“Medicine is a science from which one learns the conditions of the human body with regard to health and the absence of health, the aim being to protect health when it exists and restore it when absent.”

Ibn Sina (1012) The Canon of Medicine. Sina’s Canon became the most influential medical textbook in the world for 600 years.

PREFACE

Health is more than the absence of disease. It is at the heart of human wellbeing. For this reason, the aim of all care is “to protect health when it exists and to restore it when it is absent” (Ibn Sina “The Canon of Medicine” c1012). This ancient ideal of medicine is embodied into what we now call community oriented primary care (COPC). COPC is a cooperative approach to quality, cost-effective health care. It is a way of doing health that extends between people – as individuals, patients, families, health and care professionals, workers, educators – and systems and services in defined geographical spaces. It is a way of doing health that empowers, builds and enriches everyone.

“COPC – A Practical Guide” is a revised and substantially expanded version of “A Practical Guide to Doing Community Oriented Primary Care”. It is a learning aide to support ways of thinking about and doing COPC. It is there to support everyone engaged in health and care.

Section 1 covers the approaches to health care and learning used to deliver COPC. Chapter 1, “The Health Care Challenge”, explains the burden of disease and the problem of the health care system as the drivers of primary care reengineering and the NHI. It then describes the principles of COPC as a practical approach to the reform and sets out four interrelated issues that need to be addressed to ensure success. Chapter 2, “Learning for Effect”, explains the capability approach to learning as a lifelong way to continuously learn and help others learn. It describes work-i-learn, which is formal, intentional learning in the work place that uses the best available methods. And it explains the methods and techniques of facilitation to support work-*i*-learn.

Section 2 covers the most common health conditions. Chapter 3 focuses on communicable diseases, particularly, HIV/AIDS and TB. Chapter 4 focuses on non-communicable diseases, specifically lifestyle risks, diabetes, heart disease, cancer, mental health, psychological wellbeing and mental illness as well as substance use harm reduction. The focus of chapter 5 is on maternal and child health. It covers maternal and child mortality, pregnancy and the journey into life, pregnancy choices, and pregnancy risks and responses. It also explains newborn and infant feeding. Chapter 6 covers violence and injury, with sections focusing on violence and intentional injury, domestic violence and road traffic accidents and unintentional injury.

Tessa Marcus, Department of Family Medicine, University of Pretoria

Section 3 explains the practice of COPC. It is designed to enable health care teams to do COPC in an effective and consequential way. Chapter 7, “The Team and The Community”, focuses on identifying the place of practice, the health care team, and available resources. It also covers building partnerships and responding to resource gaps. Chapter 8 is about the assessment of community health. It explains information and research ethics and confidentiality. It also covers how to assess and describe health and wellbeing. Chapter 9 focuses on delivering health care. In it, planning, implementation and monitoring, and evaluation are explained.

COPC-A Practical Guide comes from a profound, collective commitment to quality primary health care among the team of colleagues associated with Prof Jannie Hugo and the Department of Family Medicine (University of Pretoria). It is a work in progress. It draws on our own practices over the past 10 years as well as the historical grounding so clearly laid by Dr Sidney and Dr Emily Kark and Edward and Amelia Jali in Pholela and the subsequent global health care movement.

The authors of health are ordinary women, men and children and the teams of professional and health care workers, learners, educators and managers who support and practically make health a daily reality. The best I can hope is that this guide will be of use to them.

September 7th 2018.

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THE HEALTH CARE CHALLENGE

1

South Africa is in the grips of a disease cocktail that leads to high rates of illness and unnecessary death at all the critical points in the human life-cycle. In its enormity and combination, the disease burden in South Africa is harmful to the health and wealth of everyone, individually and the country as a whole.

At the same time South Africa's health system is failing. In part, this is because of the nature, size and extent of the disease burden. In part, it is because of the way the system is organized. The legacy of national and international trends and biases has meant that the health system has been structured to function in an often unjust and unfair way. The divisions between private/public, urban/rural and hospital/community favor private, urban and hospital care rather than more sustainable care that meets the greatest need.

Dr Aaron Motsoaledi, the Minister of Health, sees primary health care as "the heartbeat" of an affordable and equitable health care system for the country. Since 2010, the National Department of Health, together with provincial and local authorities, have been working to build a re-engineered primary health care system. Ward based health care teams (WBOT) are expected to work with people in defined geographical areas to help health care services reduce the disease burden at the same time as they improve integrated service delivery and increase health literacy, social capabilities and individual, family and collective empowerment.

In this topic you will find out about the need for the health system to be reformed so that it can respond better to the burden of disease and meet individual and public health needs. You will be introduced to the principles of community oriented primary care. These are there to guide all health care practices. You will also learn about the capability approach to learning and how to learn. Capability is an important part of doing community oriented primary care. It builds your own capacity to deliver health care at the same time as it helps you build the capacity of the people you serve.

1.1 Health System Reform to To Achieve Health For All

The South African government is part of a global movement that has championed universal health coverage since Alma Ata (1978). Beginning in 1994, it has made health a national priority and has been able to significantly expand access to health care. However, the country is still far from being able to provide quality universal health care for all.

Per person, South Africa's disease burden generates a per capita health burden that is higher than any middle-income country and twice the global average in terms of disability adjusted life years (DALYs).

In response to both the health and system challenges, the government has initiated reforms. It is reengineering primary care and creating a system of national health insurance (NHI). These reforms give priority to primary health care and the integration of health care services. They want to create a system of health for all that extends to and from people in their homes across all health care service providers at all levels, in all health care systems.

The current health care system works in favor of costly specialist, private, urban and current hospital care. It works against integrated, generalist primary care that meets the health needs of ordinary people in their homes, neighborhoods, communities and places of learning and work.
Private doctors and other health related professionals are concentrated in the larger towns and cities. Access to health care is also geographically and socially distorted. Despite considerable effort since 1994 to provide physical access to public primary care by building public primary care clinics and district hospitals, the government has not been able to achieve equity. Worse still, there is evidence that the existing infrastructure is poorly maintained and deteriorating, with many described as being "in dire straits".

AS A HEALTH WORKER...

You need to know that primary care is the most important part of any health care system. 80% of people's health depends on it. Effective quality primary care makes the most difference to people's health, individually and collectively.

1.2 COPC - The Principles for Practice

Community oriented primary care (COPC) mobilizes clinical and public health resources in the places where people live and work. It is designed to enable everyone to contribute to and benefit from health.

COPC is guided by five principles. These steer practice so that services work with people to respond to

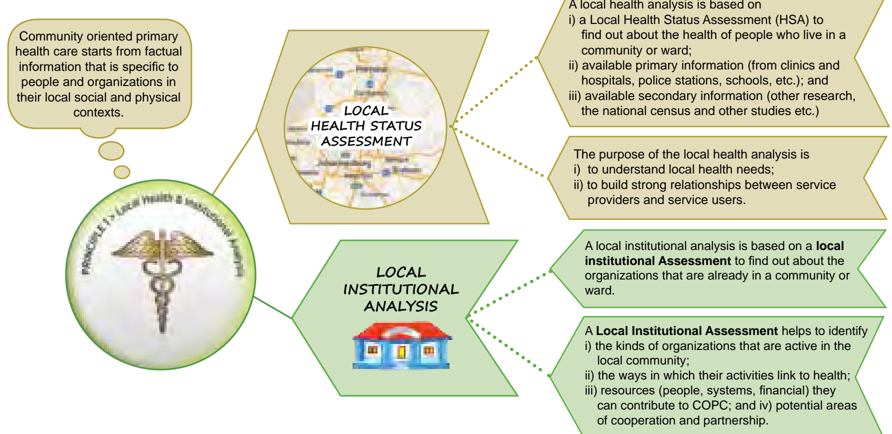
- ✓ Basic health needs; and
- ✓ The social, economic and political causes of poor health.

Doing COPC is simply about bringing public health and clinical care together
to work concretely and specifically with people in their communities.

WHAT IS COPC?	*Community Oriented Primary Care (COPC) is primary care where professionals from different disciplines and approaches work together with organisations and people in defined communities to identify and respond systematically to health and health-related needs in order to improve health.* *Tessa S. Marcus* **Community Oriented Primary Care** *L2 2013 Pearson*

Principle 1: Local Health and Institutional Analysis

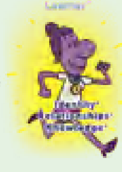
The starting point of doing COPC is to work with people in geographically defined areas or "communities". In South Africa, for example, the defined geographical areas of work for primary health care teams are the facility catchment areas that fall in wards (or parts of wards). Wards are administrative units in local municipalities and the whole country is divided administratively into local municipalities.



Putting Principle 1 into practice generates systematic information about the people who live in a facility catchment area. It helps us answer important questions, like

- Who is there?
- What is there?
- What needs to be done?
- How can it be done?
- Who can do it?

It ensures that health and care services are built on scientific information that comes from and is specific to people and institutions in defined local places. This way services use information to respond to specific needs in local contexts. And they do this by identifying and working cooperatively with existing local organizations and institutions.



EVERY HEALTH CARE WORKER...

Needs to use health and local institutional and service information to plan, implement and monitor his or her work. This information is the building block of providing quality care from home to facility to home.

Principle 2: Comprehensive Care

Comprehensive care addresses health and disease management along the health-disease continuum.

Health and disease is multidimensional. People move between being healthy, falling sick, being injured, and then recovering all or part of their health throughout their lifetime. They also often have more than one health condition that can (but also may not) relate to other health problems. And everyone everywhere also has varying degrees of risk for ill health and disease. Therefore, at any moment in time, people find themselves at different points on the health-disease continuum. This is why effective health care and disease management need to be comprehensive.

DID YOU KNOW?

By bringing South Africa into line with WHO treatment guidelines, the country runs the largest HIV treatment program in the world. Through it, the government has been able to increase life expectancy and improve maternal and child mortality.

Comprehensive care involves five types of activities:

1. Health promotion

Health promotion focuses on health. Promoting health is about enabling ordinary people to increase control over and to improve their health. It finds answers to the question: “What do people need to do to keep healthy?”

2. Disease prevention

Disease prevention looks at the problem of health from the angle of disease. Preventing disease means doing things to protect people from potential or actual health threats and their harmful consequences. It finds answers to the question: “What do people need to do to prevent disease?”

Preventing illness and disease happens before, during and after disease or health conditions appear.

a. **Primary prevention** is preventing disease before it happens. There are many examples of primary prevention. Making water safe to drink, immunising children against diseases like measles, mumps, rubella, polio and typhoid, encouraging people to use contraception and condoms to prevent unplanned pregnancy and sexually transmitted infections are three examples. Many times health promotion and primary prevention of disease activities overlap.

b. **Secondary prevention** involves testing for diseases before people are aware that they have them. Secondary prevention often works as primary prevention as well. An example of secondary prevention is testing for diabetes. If a person's blood glucose level is high, they are at risk of diabetes or they may already have diabetes. They can use the test result to prevent diabetes (primary prevention) if they don't yet have the condition.

   If they have diabetes, they can use the test results to control and prevent their condition from getting worse (secondary prevention). Screening for HIV (HCT), TB and cervical cancer (pap smear) are all examples of secondary prevention in primary health care.

c. **Tertiary prevention** is when a person has a disease and is on treatment. Tertiary prevention is designed to help slow a disease down and prevent it from causing other problems (i.e. it also works as secondary prevention). It is part of disease management.

3. Treatment

Treatment is the clinical management of a health condition or disease. Treatment involves

a. Assessing, identifying and diagnosing the health problem,
b. Developing a medical care response to it; and
c. Managing the condition.

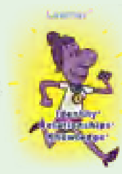
In health care, treatment is the responsibility of health care professionals. Doctors, clinical associates, dentists, professional nurses, physiotherapists, psychologists, dieticians, speech language and hearing therapists etc. are health professionals. They have been educated and trained to take responsibility for particular clinical fields and tasks. They all have a formal qualification from a higher education institution (e.g. a college or university). They also all have to be registered with and licensed by a professional body to make sure that they meet society's standards of practice. This way people can know what to expect from health care professionals and they can be held accountable for their actions.

4. Rehabilitation

Rehabilitation is health care to support recovery from illness, injury and disability. Rehabilitation is important in primary care because health problems are disabling. Disease and ill-health prevent people from doing everyday things and change the way they participate in daily life. Rehabilitation involves activities and treatments that help people keep (retain), get back (restore) or get (create) their ability to do everyday things so that they can be part of family and community life.

5. Palliation

Palliation means to relieve and reduce suffering without curing. Unlike all other health care activities, it is not designed to restore heath and sustain life. Rather, palliative care is holistic, end of life care. It attends to the quality of life and the quality of dying.



AS A HEALTH WORKER...

It is important to know that comprehensive care in the community is only possible when you work in teams with professionals who are trained in different disciplines and care workers who come from all sectors. Effective health care is always teamwork.

Principle 3: Equity

Equity is a central principle in the practice of health care everywhere in the world.

The equity principle has two dimensions

- ***Horizontal equity*** – i.e. people with the same needs should get the same care or have access to the same resources.
- ***Vertical equity*** – i.e. people with greater needs get greater care or more resources.

After: Barbara Starfield (2011) I The Hidden Inequity in health care. **International Journal for Equity in Health** *10;15.*

Equity is especially important in a society like South Africa where there is substantial inequality.

Equity is about values – being fair, necessary and just.
Equity is about justice – everyone has the same rights and duties.
Equity is about human rights – health is a right that comes with being a human being.

For there to be equity in health, healthcare needs to be accessible, affordable, appropriate and relevant.

1. Accessible.
Equity in access in a facility-based primary care system means that clinics and hospitals and private practices need to be distributed equally for everyone with the same needs and in a concentrated way where needs are greater.

The idea behind physical accessibility is that facilities must be distributed in a way that makes it easy for people to go to them. This is important in primary care, but it is not the only way of making health care physically accessible. Health care can also be taken to people.

In COPC primary care clinics, district hospitals and private practices are still an important part of primary health. However, instead of waiting for people to come into facilities, it is possible to base health teams in communities. Linked to and supported by facilities, they go to people in their homes, schools and places of work and recreation.

Integrated, generalist primary health care can meet the needs of ordinary people by serving them in their homes, neighborhoods, communities and places of learning and work.

2. Appropriate
Appropriate health care is care that responds to the condition, the person and their context. In primary health you need a broad and general approach because:

- Many health conditions start in an unclear and poorly defined way;
- It is common for people to have more than one condition or health need at the same time;
- It is common for individual health needs to be at different points along the health-disease continuum (promotion-palliation);
- It is common for personal, social and economic circumstances to influence people’s responses to their health needs.

This makes primary health like doing a puzzle.

You have to put the parts together to see the whole picture. When you have the picture you are able to see how health needs interrelate and you can prioritise.

Then you can work with a person (and family) in an integrated and holistic way to get them the help they need (refer, treat) and to support prevention, treatment and recovery.

In primary health, vertical programs (i.e. specialist, disease or condition focused) fragment services and make health care inefficient and less effective.

Equity is about striving to provide care that improves the health of everyone. Appropriate care is essential for quality care.

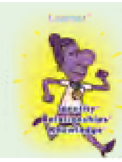
3. Affordable

Everywhere in the world the cost of care has the greatest influence on the health services people use and the health care they receive. Health can only be achieved if health care is affordable.

In South Africa, public health services are subsidised by the state. This means that the government pays for most of the costs in order to help make health care more affordable. But it is still not free, because using public health care services still costs people time and money. They have to pay to get to and from health services. They may loose money because they have to take time out of work or economic activity. And some have to contribute towards the costs of public services.

Private health care rations services by price and by the profits that can be made. It is built on inequality. It creates inequity because most people can't afford it most of the time. Some people can afford it some of the time. And only a few people can afford it all the time.

COPC can make health care more affordable for everyone, because it is works with people to improve their health in the places where most health happens - in their homes and communities.



AS A HEALTH WORKER...

It is important to know that poor health makes poor people even poorer and it leads to even poorer health.

4. Relevant

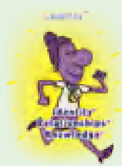
Relevant health care means providing adequate services that meet people’s health care needs and expectations. When services are not relevant they increase inequity. They lead to under-treatment, over-treatment or mistreatment. They also are a danger to the general health of a population. Prescribing antibiotics when they are not needed, (over-prescription, overuse) and misusing antibiotics (not completing treatment, sharing antibiotics) are among of the most important threats to global health safety. When antibiotics don’t work, it will not be possible to treat common illnesses and injuries.

Under-treatment is when necessary available tests, procedures and medications are not prescribed.

Over-treatment is when unnecessary tests, procedures and medications are prescribed.

Mistreatment is any form of abusive, discriminatory and prejudice behavior towards people using health care and other services.

In both public and private health care, when people fail to get the care they need, they are forced to “shop around”. Shopping for health is very costly. It takes time. It also takes money. It may not improve people’s health. It even can make health outcomes worse.



AS A HEALTH WORKER...

Remember there is a big difference between choosing health care services out of personal preference and having to make health service choices because there is no relevant quality care available close to where people live.

Principle 4: Practice with Science

The principle "practice with science" has two components. The first is that practice should be informed by science. The second is that practice should be inter-disciplinary and multi-professional.

Scientifically informed healthcare

Health care workers need to use the best available systematic knowledge to shape what they do and how they do health care. Many health care activities and practices are known to work because they have been observed and studied scientifically. This has been the case since ancient times.

> As Ibn Sina wrote over 1200 years ago
> *… both parts of medicine are science, but one part is the science dealing with the principles of medicine, and the other with how to put those principles into practice."*
>
> *Mona Nasser, Aida Tibi and Emilie Savage Smith Ibn Sina's Canon of Medicine: 11th century rules for assessing the effects of drugs J R Soc Med. 2009 Feb 1; 102(2): 78–80. doi: 10.1258/jrsm.2008.08k040 2015/08/15.*

But equally, health care is an area of knowledge and practice that changes all the time. Health care workers have to try new things because there are always new challenges.

> *"I remind myself that we must do the best under the circumstances, not hopelessly, but with ingenuity and imagination, always of course trying to improve the circumstances. All in all this is very much clinical medicine."*
>
> *Dr Ronald Ingle. All Saints Mission Hospital, Transkei 1963.*

They also have to innovate because ideas and practices that work in some situations might not work in others. Then, they have to use science to test and see if their new ideas and ways of doing things work in the ways that they expected.

AS A HEALTH WORKER...

Building your scientific skills is part of the way you learn to do community oriented primary care.

Interdisciplinary and multi-professional practice

Health and disease cover a wide range of conditions, practices and experiences that are connected to one another. This makes keeping people healthy and treating and managing disease complex. For health systems to work

i. Health care needs to be a team activity.
   A team is a group of people who share a common goal and a commitment to work with one another. Their professional and service impact should be greater than what any one person could achieve on their own.

AS A HEALTH WORKER...

You need to know that every team member has specific roles and responsibilities. At the same time, each team member also has interdependent tasks and shared responsibilities.

ii. The health care team needs to be made up of members who are core to their work. People who work together build trust and cooperation, especially when they share common goals. Working together regularly also builds continuity.
iii. The healthcare team needs to include professionals from more than one academic discipline. Professionals bring particular expertise into a team. But they also learn from and expand their own and the team's expertise through their interactions in the team.
iv. The health care team needs to be flexible and adaptive. It is not possible to have all the required professional and service skills together in every health care team at all times. This is why the team needs to be able to expand to include professionals as needs and opportunities arise.
v. The health care team needs leadership. Leaders are there to create a workplace climate that is respectful of everyone's contribution and that rewards cooperation, collaboration and initiative. Leaders must actively discourage non-cooperation, non-collaboration and interpersonal behaviour that undermine individual members.

Principle 5: Service Integration around users

Florence Nightingale, wrote in 1867
"Never think that you have done anything effectual in nursing in London till you nurse the sick poor at home."

Lois A Monteiro "Florence Nightingale on Public Health Nursing" AJHP February 1985 Vol.75 No. 2 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1645993/?page=2 2015/08/15

Service integration around users is "health care practices and services directed towards and organized around the needs of people who use and are served by health care service providers." This principle focuses on the relationships between health care services and people, both where people are patients under medical care and where people have everyday health interests and needs in their homes and communities.

Service integration around users has three components.

1. **Person centered health care**
   Person centred health care requires health care providers and services to apply 7 rules of practice:

   1. Care for a whole person (not just to look at the person's disease, condition or problem);
   2. See a person as an individual (with particular and specific health needs);
   3. See an individual as a person with a name, a sense of self, a place in the world, a future;
   4. Understand a person's individual and personal contexts. This means knowing about their experiences, responsibilities, plans and relationships;
   5. Understand a person's social context. This means knowing about the people and communities where they live and play and work;
   6. Recognise and respect individual autonomy. This is how you enable and support people to make decisions about and take responsibility for their own health care; and
   7. Make and maintain a relationship of respect and trust.

2. People and practitioners in partnership

Health care is about partnerships. Partnerships are relationships between two or more people or organisations. In health care partnerships are between people who need care and people who provide care all the way along the health-disease continuum.

AS A HEALTH WORKER...

You work in partnerships ...

- To improve the quality of care
- To be more effective
- To meet individual and community health care needs and expectations
- To empower yourself and others
- To raise the standards of performance
- To prevent and reduce behaviour that is uncivil, inconsiderate and authoritarian

3. Continuity of care

Continuity of care is about the way in which individuals experience health care and how health care practitioners provide care over time.

It is one of the main goals of all health care because it improves the quality of care people get as well as individual health outcomes.

Continuity of care is difficult to achieve in a fragmented health care system. Vertical programs, professional and institutional specialisation and the division between public, private and traditional services force people to go to different services and organisations in various places at different times. At each of these their health care is attended to by any number of health care providers who are often disconnected from one another.

Continuity can only happen when health care is connected, coherent and consistent. This means it is joined together and organised in a logical way so that it works to achieve the same purpose.

Three kinds of continuity are needed to make continuity of care happen.

1. ***Relationship continuity.*** There needs to be some kind of on-going relationship between providers and users of health care services. This relationship can be between individuals (e.g. a doctor and patient or nurses and a patient). It can also be between teams of health care providers and individuals and families (e.g. health professionals can support ward health teams that are linked to individuals and families by each community health worker).

2. ***Management continuity.*** Management continuity means that there is a consistent and coherent approach to the changing needs of a person's health condition. Management continuity is especially important where people have chronic or complex illnesses like HIV, TB, diabetes, heart conditions or schizophrenia. Continuity in management requires health care providers to have regular and close contact with patients and their carers. This way they can make and adjust treatment plans in response to changes in individual needs and circumstances.

3. ***Informational continuity.*** Informational continuity is the thread that links a person's health and care over time. It links one provider of health care to another. Informational continuity is a big challenge that is being overcome partly through new technology. In COPC, informational continuity in Tshwane is supported by AitaHealth a web enabled mobile cell platform.

1.3 COPC - The Challenges

Together and separately, the five COPC principles provide an approach to primary health care that is designed to help people and organizations meet the challenge of health and disease in communities. Putting this approach into practice faces many challenges.

Health care leaders around the world have recognized the importance of community based primary health care in a strong health delivery system. In reengineering primary care, the South African government has created a policy environment to support this commitment. There are many obstacles that need to be overcome to make community oriented primary care into a practical reality, however. These come from i) the way the health care system is structured and organised; and ii) the way the reform is being approached.

There are four key interrelated challenges.

1. **Inadequate Organisation**
   - Inflexible “one size fits all” approach that makes it an add-on at the bottom of the existing service hierarchy (e.g facility based, nurse led, outreach).
   - Under-planning and under-resourcing (people, tools, materials and equipment).
   - Under-preparation of managers at all levels of the system (from team leaders upward to municipal, provincial and hospital management).
   - Under-preparation of education and training.
   - Under support to community based health teams.

2. **Poor Integration**
   - Into the general design of the health system.
   - Into primary health care services/teams.
   - Across vertical programmes.
   - Across departments (especially social development, education)
   - Across divisions (local/provincial).
   - Across systems (public/private/traditional).
   - Of learning (workplace and continuing education).

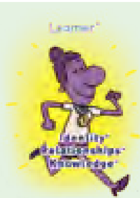
3. **Inappropriate characterization of community health work**
   - Through pay – unpaid, stipend, paid.
   - By occupational security – temporary, casual, contract.
   - By organisation of account – NGO, local government, provincial government.
   - By position – unskilled, voluntary, add-ons, subordinate.
   - By roles in service, disease or condition– home based care, health promotion, VCT, TB contact tracing.

- By education – low or no educational requirements.

4. Absent or Insufficient Education and Training

- of team leaders, supervisors and managers.
- of community health workers.
- of educators and supervisors.
- that is not designed to be work integrated and continuous.
- that is poorly linked to qualifications.

Many of these challenges are common across low, middle and high-income countries around the world. They are being successfully overcome in countries as diverse as Brazil, Malawi, Ethiopia and India. They can be overcome in South Africa.



EVERY WORKER IN HEALTH CARE...

Has a role to play in addressing these challenges. Commit to being a life-long learner, a team player and a person who strives for the best possible self-, individual-, family and community health care.

"We are making a difference in the community. People stay at home with sickness so it feels good to help them out. Most people will see the importance of healthy lifestyles and going to a clinic. You need to have a heart to do this work. You must have the patience and love to work with all different types of people in the community."

CHW City of Tshwane March 2015

2.1 A Capability Approach to Learning

All health care workers must *learn from what they do.* They must also *turn what they learn into what they do.* This means that all health care workers must learn every day, all the time and wherever they work. To do this they need an approach to learning that builds their abilities continuously.

In community oriented primary care we use a capability approach to learning. It is different from the approach to learning that you have experienced in school and many of the training courses that you have done. This module explains what it is and how to use it. You can be a successful lifelong learner if you are motivated to learn, if you use an approach to learning that grows your abilities and if you practice learning.

Understanding learning

THE PURPOSE AND PLACE OF LEARNING

WORKING IN PAIRS

Talk about what you think

1. is the purpose of learning.
2. is the best place for learning.

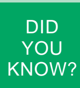
Learning involves many things. It is not simple or straightforward, which is why there are many ideas about what it is and how it happens. But before we get there, we need to understand some of the key words and concepts we use to talk about learning. So, let's begin by exploring what is meant by learning, ability, competence and capability. Then, when we describe the capability approach to learning, we will look at who is a learner, when learning happens and how learning happens.

What is learning?

To answer the question “what is learning?” we need to define it.
For us, the definition of learning is ‘any process that leads to a permanent change in capacity of a person, animal or organism, that is not solely due to physical maturation’.

Let’s break this definition down. It says:

- ✓ Learning is a process. This means that it is a series of actions; it is not just one thing or one set of activities.
- ✓ Learning leads to changes in the abilities of a person. These changes last.
- ✓ Learning involves consciousness. This means that it happens because of deliberate activities and interactions; it does not happen through natural ability on its own.
- ✓ And people, animals and even organisms have the ability to learn.



Definitions are statements about the meaning of a word or a concept. They are useful because they help us understand a thing, an idea or a practice.

Physical maturation is the physical changes that occur as we age. From birth to adolescence our physical abilities change as we learn to use and control muscles. At birth we have limited physical ability and mainly use reflexes to interact with the world. For example, sucking is a reflex that allows us to take in food. As we mature into infancy and childhood, we develop gross motor skills. These skills depend on us learning to use and coordinate larger muscles. For example, we learn to bite, chew and lick. These skills work the same muscles in our mouths that we need to learn to speak. Also we develop the muscles we need to get around and engage in the world. They help us roll, sit, crawl, walk and run. They allow us to grow our abilities and express ourselves through movement, like dancing, playing sports or taking part in other recreational activities. In early childhood we also start to develop control over the small muscles in our hands. We use them to develop our fine motor skills like writing, drawing, cutting, sewing or playing a musical instrument.

Until now, your understanding of learning is more likely to be based on the traditional definition of learning that says learning is about ‘getting knowledge and skills’. You can see that our definition is quite different. Although it includes knowledge and skills, our definition is broader. It helps us think more openly about what is involved in learning, who learners are and how to approach the learning process.

What is capacity?

In our definition of learning, capacity means the set of abilities to learn. These abilities include:

- concentrating (or paying attention and focusing for a period of time);
- remembering what we see, hear or do (memory);
- expressing ourselves (communication);
- understanding what people say or do (comprehension);
- thinking (cognition and metacognition);
- working out how to solve problems (critical thinking, problem solving);
- knowing and being aware of ourselves (self-awareness, introspection); and
- knowing and being aware of others and our surroundings (social and environmental awareness).

All of these are skills. You create and develop them every time you turn them into activities in everyday life. Here are two examples to illustrate how ability mobilizes biological and social resources.

The first is about concentration:
To concentrate means to focus on something for a period of time. The ability to concentrate is an essential skill for all learning. You have to be able to *physically pay attention* to concentrate on an activity. But equally, you have to *learn to concentrate.* You have to want to *focus on only that one thing* or activity for a long period of time and you have to practice how to concentrate.

The second is about speaking on a topic (like TB) to a person in her home:
This example is taken from the work you do every day. You probably know well that, 'there's all the difference in the world between having something to say, and having to say something.'[ii] You quickly discover that you need a whole set of abilities to do this activity. You have to have the capacity to physically speak. You also have to be able to use language. You have to know something about the topic. You have to think about what you are going to talk about.

You have to prepare what you are going to say and how you are going to say it, including making sure that you have the right vocabulary for the topic. You have to remember what you want to say. You have to think about the person you are going to speak to. You have to be aware of the environment where you are interacting. You have to have self-confidence. You have to have the confidence to speak. You have to want to speak on the topic. You have to be able to listen. And you have to be prepared to learn.

Broken down this way, you can see capacity is a complex thing. You can also see how learning changes the relationships between physical and social abilities. A person's ability to concentrate is not fixed. Learning increases the level of ability, in this example, through practice and improved motivation. The capacity to speak on a topic to someone in her home shows how learning increases the number of things a person can do and the number of ways to do it.

And this is where competency comes in. We use the term competency to understand the level of a person's capacity or set of abilities. Competency is a measure of where we are at in our learning at any point in time.

COMPETENCY

WORKING IN PAIRS

Choose an activity or area that you think you are very good at (high level of competency) and one activity or area that you think you are not very good at (low level of competency).
Discuss with each other why you think this way and how you know that you are good or bad at each.

What we learn from the activity on competency is that measuring abilities is very important. It tells us how far we have come. And it also tells us how far we need to go. So, competency is not the end goal of learning. It is a milestone in learning. It also can never be the full measure of our capacity, because of our potential to learn and improve.
Which brings us to capability.

What is capability?

Capability describes a state of being and a way of doing. As a state of being, capability is the *justified* self-confident *integration of knowledge* and skills with motivation, values and a commitment to learn. *As a way of doing*, capability is *the on-going application* of current and potential abilities and values to problems in familiar and changing situations *through active learning.*

What's in a word?
Justified means 'having a good reason'.
Self-confident means 'being sure of or trusting yourself and your abilities'.
Integration means the act of 'bringing things together'.

2

This definition of capability *as being and doing* means that it can be shown.
Capability is shown when *"people have confidence in their ability as individuals and in association with others to*

- *take effective and appropriate action,*
- *explain what they are about,*
- *live and work effectively with others, and*
- *continue to learn from their experiences*

…in a diverse and changing society.'

The last point about being able to do things in a changing world is particularly important. It tells us that we need to learn all the time in order to be able to deal with the many things we do not know about around us.

The Capability Approach to Learning

The capability approach to learning is a practical way to learn and to help others learn.

The capability approach is based on five facts about learning.

1. It is human to learn. This means that a person can and does learn.
2. Learning happens throughout the human lifespan, from the time we are born until the time we die. This means that nobody is too young or too old to learn.
3. Learning can happen anywhere. It happens at home, on the street, in school, at work, at play, etc. This means that learning is not restricted to particular formal places of learning, like schools or colleges.

4. Learning always happens in the social context of where people live, work, play and interact. It happens in the family, among friends, among colleagues and among strangers. This means that learning always involves relationships between people, things and the environment.
5. Learning improves when it is facilitated. This means that learning is made easier when a person is guided and supported in their learning.

The dimensions of the learner

The capability approach to learning starts from the learner. We need to understand who the learner is. This is a question that can be answered in many ways, but in the capability approach we are interested in the learner in terms of his or her dimensions as a person.

WHO ARE YOU AS A LEARNER?

INDIVIDUAL

What five words immediately come to your mind when you have to describe yourself as a learner?

What lies behind the words you choose to describe yourself as a learner? Do you use them to say something about your abilities, knowledge and skills? Do they describe your experiences of learning? Do they describe how they affect your sense of self and your relationship to other people? Well if they do, your words describe your capacity and your competencies.

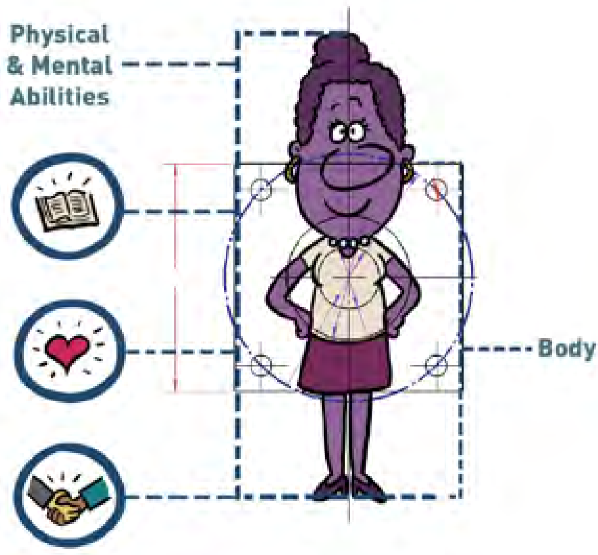
Now the question is, where do your capacity and competencies come from?

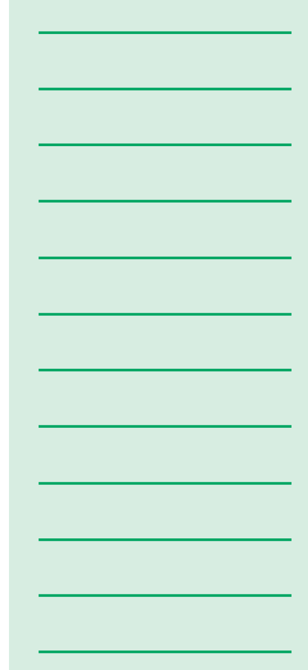
The things that you and every person can do and know, come from four sources:

1. A person's physical and mental abilities. These include to breath-touch-see-hear-smell-feel, to suck-swallow-eat, to crawl-walk-run, to gabble-speak-sing, to love-cry-hate-hurt-moan, to learn and to interact.
2. A person's knowledge and beliefs about the world and what's around them.
3. A person's sense of self and identity or how they feel about themselves, who they are and what they can do.
4. A person's relationships. This includes their beliefs about and the relationships they have with other people, things and the environment. And it includes the social relationships that they are part of and that exist in society.

The Four Sources of Human Capacity and Competency

What this tells us is that the sources of competency and capacity come from being a person. Put another way, the dimensions of what it is to be a learner are the same as the dimensions of what it is to be a person. This means that any approach to learning always has to take into account all the dimensions of a person.





2

HIV PREVENTION AND THE LEARNER

WORK IN PAIRS/GROUPS OF FOUR

1. Identify what you have been taught about how to prevent HIV during sexual intercourse.
2. Now match what you have been taught with the dimensions of the learner.

What did you find?

It is likely that most of what you have been taught about HIV prevention (and many other topics) relate to a learner's knowledge and skills. But people do not change their practices based only on the information and advice they are given. You know this from personal experience and from the work you do. This is why it is essential to also engage a person's sense of self as well as their social context, including their relationships with others, in every learning activity.

AS A HEALTH WORKER...

To support learning you have to engage with a person's

- ✓ identity and sense of self;
- ✓ relationships to others and the world around them; and
- ✓ knowledge and skills in order to help grow their choices of action.

How learning happens

Next, we have to find out about how learning happens.

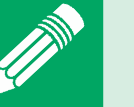
There are many things that are said about learning that we believe are true. Like 'learning happens everywhere' or 'learning happens all the time' or 'we learn from experience'.

WHAT DO YOU THINK ABOUT LEARNING?

WORK IN PAIRS/GROUPS OF FOUR

Does learning happen everywhere?
Does learning happen all the time?
Do we learn from experience?

If we look at the meaning behind these statements, we see that they challenge the way learning is organised. The idea that learning happens everywhere and all the time is really a way of arguing against the belief that learning only happens in school, college or during formal training sessions. Or that it only happens according to a timetable and a formal curriculum. The idea that we learn from experience is a way of arguing against 'book learning' or theory without practice. Understood this way, these statements are true. Learning can happen everywhere, all the time. And experience is a good source of learning.



However, when it comes to *the activity of learning* itself, none of these statements are factually true. This is because learning is an active process. It involves doing, thinking about, planning and redoing. In other words, the activity of learning requires a number of actions and procedures that are taken in some kind of combination or sequence.

The triggers for learning

Learning has to be set in motion. So, what sets learning off?

WHAT GOT YOU TO LEARN SOMETHING?

INDIVIDUAL

Choose something that you have learnt to do in the past few weeks.
What set this learning activity off?

Maybe you are asked to do something you don't know how to do. Maybe you find yourself in a situation that you have not been in before, like a change in work, a new job or a new relationship. Maybe the things you know and do are not enough to help you understand something. Maybe you are not able to deal with the situation you find yourself in. Maybe you change your goals or expectations. Maybe your health or physical abilities change.

Disturbance and disruption

Any or all of these disturbances challenge what exists. They challenge what you know. They challenge what you do. They challenge how you feel. They challenge how you relate to others. They create uncertainty. But they also create a learning need!

How learning is triggered 1- Disruption
Learning is triggered by a disruption to or a disturbance of what exists. The disruption or disturbance creates a learning opportunity that gives people a chance to check, change, develop or create competencies.

Now, you might think that this means learning automatically happens, almost without you. After all, disruption changes what exists. This change creates uncertainty. Uncertainty creates a learning need. You start learning. Or do you?

If you read the fact box 'How learning is triggered 1' it does not say this. It says that learning opportunities give people the chance to learn, to develop their abilities and competencies.

The opportunity to check our competencies and develop more, different or new abilities comes about when what we know or how we do things are disturbed or disrupted. Disturbance creates uncertainty. The capability approach to learning gives us a way to overcome the uncertainty this creates. We use it to work out the options for effective and appropriate actions.

Something else needs to happen for you to start actively learning. That something else is you. In particular, it's the things that move you to take action. In other words, your motivation determines whether you turn the opportunities that come from uncertainty into learning activities.

Motivation

How learning is triggered 2- Motivation
Motivation is the force or reason that causes someone to act or do something. From birth *onwards* humans are active, curious, inquisitive and playful creatures with an ever-present readiness to learn.

All living organisms are born with the built-in motivation to survive. Human beings (like other animal and organisms) are also moved to action by other things. The things that drive motivation come from their own physical and psychological development and needs as well as from the physical and social environment in which they live.

Motivation is at the heart of starting and sustaining any activity, including learning.

The reasons that drive a person to take action, to learn and to do, lie along a continuum. The motivation continuum is shown below.

CONTINUUM

A continuum is a range or a series of things that exist between two possibilities that have a relation to one another.

The Motivation Continuum

The red continuum shows what happens when motivation comes exclusively from outside, like from instructions, rules and rewards. People do not take in the value of the activity and make it something they believe in. They either then do not participate at all or they are unwilling and reluctant participants who do as little as possible.

The purple continuum shows what happens when motivation comes more from outside than inside. This is when instructions are linked to things like meeting goals or managing risks . It changes the way people internalise what they have to do and how they integrate the activity and their beliefs a little, so that they participate passively and less reluctantly.

The orange continuum shows what happens when motivation comes more from inside than from outside. This is when instructions are linked to people's own implementation intentions, confidence and personal values.They actively participate in the activity because they see its value for themselves and for other people.

The green shows how the source of motivation links to personal commitment and participation.

Learning (or any activity) that is completely internally motivated happens for its own sake. What this means is that a person learns about something only because it is interesting to them and enjoyable. It comes from inside. It is part of their sense of self. This natural source of motivation is very important for all learning.

For example, why would you learn to sing a song that you heard on the radio? Perhaps, you liked the words and the sound. Perhaps you liked the way it makes you feel. Maybe you like singing. Perhaps you also like learning new songs. Any or all of these reasons tell us is that you learn to sing the song because you were completely intrinsically motivated.

We all have experience of having to do or learn something that is totally motivated from outside. It is something that definitely happened to everyone in school. And even now, there are likely to be many examples in the work you do. When this happens AND you don't understand its purpose or see the reason to do it only as an instruction, you are not likely to do it at all. Or, if you feel forced to do it, you will do the task without much benefit to yourself or anyone else.

EXTERNALLY MOTIVATED ACTIVITIES

WORK IN PAIRS/GROUPS OF FOUR

Individually identify something that you do at work that is only externally motivated and you can see no value in. Explain to each other

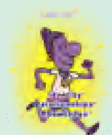
- why you think this way,
- how the activity makes you feel and
- what you do with the task.

Between the extremes of total external (red) and total internal (green) motivation there are varying degrees of motivation where internal and external reasons are brought together through a process of internalization and integration. Take TB contact tracing.

TB CONTACT TRACING

WORK IN PAIRS/GROUPS OF FOUR

Look at the motivation continuum. Think about when you do TB contact tracing. Where would you put your motivation to do this task on the continuum. Explain to each other why you feel this way and how this affects the way you do the task.

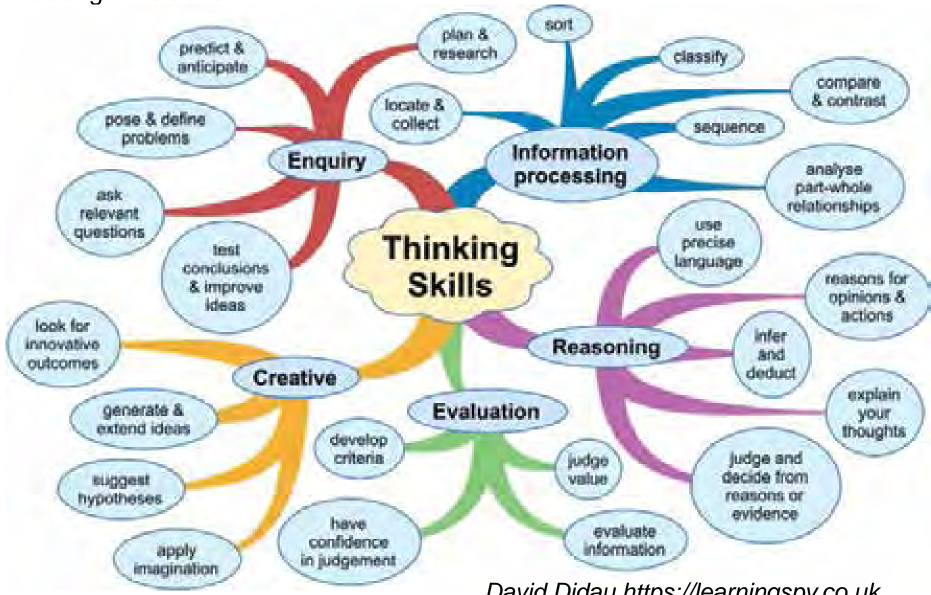


AS A HEALTH WORKER...

You are always involved in two processes. You are learning yourself and you are helping other people to learn.

The practice of learning

Learning is a practice. It involves a number of activities that require both physical and mental abilities. Each of these abilities is a skill. The mental abilities you use to do something are called cognitive (or thinking) skills. The mental abilities you use to think about how you do things (or thinking about thinking) are called metacognitive skills.



David Didau https://learningspy.co.uk

Cognition and Metacognition
The mental abilities that you use to learn (and do things) are divided into two groups – cognitive skills and metacognitive skills.

Cognitive skills *are the mental skills you use* ***to perform*** *a task, action or activity.* They are things like thinking, processing information, reading, planning, understanding and solving problems. They are linked to brain function.
You use cognitive skills to do everyday activities at home and at work. You use them to learn how to do something

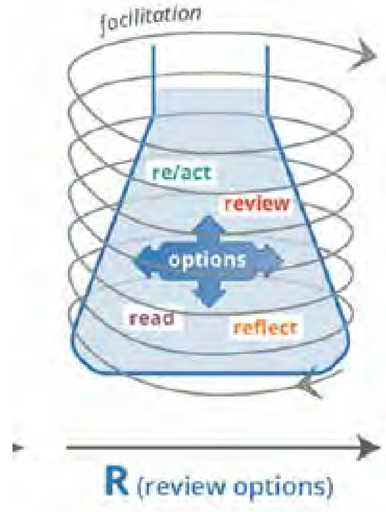
Metacognitive skills *are the mental abilities you need* ***to understand how you do and know things*** *(how you performed a task, interacted with someone etc.)*. They are skills like 'thinking about thinking', reviewing, reflecting and planning, checking and evaluating (assessing).
You need them to understand yourself as a learner.

For the most part, if you can do something, you can learn. If you can learn, you can think about learning. If you can think about learning, you can learn to do something differently, better or more effectively.

You need them to regulate how you learn.
You use them to **know what you know**

- about yourself (your motivation, self-confidence);
- about things and processes;
- about how to do things; and
- about when and how to use what you know and can do.

You use them to plan, monitor and evaluate **how you learn.**
You use them to develop strategies.
You use them to support **any** activity.



Identifying the Problem, Issue or Task

All learning happens in a context. The first skill you use to learn is to work out what has created your need to learn. It could be something that you did that did not work as well as you had hoped. It could be something you have to do that you don't know much about. It could be because you don't feel confident in doing an activity, even though you know something about it. In short, you work out where your problem, issue or task comes from.

IDENTIFY THE PROBLEM, ISSUE OR TASK

INDIVIDUAL

Take all the activities that you have been involved in during the past two weeks. Choose

1. something that you did that did not work well.
2. something you know about, but don't feel confident in doing.
3. something you are expected to do, but don't know much about.

Reviewing Options

Now, you need to move on to 'reviewing options'. This is a process of 'taking stock', finding out, looking at the choices and working out strategies to help you have options when you do any task.

There are four distinct learning activities involved in 'reviewing options'. These are 'review', 'read', 'reflect' and 're/act'. When you apply them, you use a number of thinking-about-thinking skills as well as some performance skills.

The Magic of Thinking about Thinking

- It makes you **flexible** in your approaches to a problem or task;
- It gives you **more than one strategy** to deal with challenges; and
- It helps you to know what to use/choose at the most appropriate times (**judgment**).

The techniques

- work in **all situations** for **all activities**;
- help you to see **learning as a process**;
- put **you at the center** of the activity;
- **build** your **learning capacity**; and
- make you the **agent of your own success**.

We will look at each one in turn. However when you use them depends on the learning need itself. It also depends on the ways you go about learning, what you want to achieve and how good you have become at metacognition.

Review

Let’s begin with review. To review means to go over. It is a doing word. This means it is an activity and it has a purpose. You review something in order to make a situation, problem or challenge clear to yourself.
You already have this skill, although you may not be aware that you have it and you may not use it consciously. What do you do when you are unsettled or taken by surprise by something or what some say? What do you do when you plan an activity or task? You go over it to make clear to yourself what happened or what needs to happen. In other words, you review it.
Usually when you make something clear to yourself, you ask questions. If it is about something that has happened, you may ask “what happened?”, “what was said?” or “what did I (or someone else) do?”. If it is something that you plan in the future, you may ask questions like “what’s the task?”, “what do I want to happen?”, “what do I need to do?”, “what do I need to say?”, etc.

Reviewing in learning is done in the same way. It has the same purpose as reviewing in life. You review something by asking questions in order to make clear what the issue or task is, what happened or should happen, what was done or should be done. When you use this skill *consciously* (in a deliberate and intentional way) it helps you learn how to learn. It grows your learning competency.

Reflect

To *reflect* means to step back from and make sense of something in order to improve.

The purpose of reflection is to work out how to change your practice.

Reflection is a conscious and purposive mental process. To reflect on something, you do several things. And you often do them more than once. What this means is that you go back and forth between framing the problem, working out what you know and feel, and developing solutions that you think may work. And you do this by asking questions.

When you reflect to 'frame the problem', you ask questions to help you find what caused the disturbance or your uncertainty.

Questions like "what worked well?" and "what did not work well?" help you find out about the nature of the problem. The nature of the problem may be in the task or activity itself. It may be the context in which the activity is being done. It may be your actions and competencies. Or it may be the relationship between yourself and the people involved.

Questions like "how did I feel?" or "how motivated was I?" help you find out if the problem is related to motivation.

These questions lead you to a third set of reflection questions that are essential for developing capability in learning. Questions like "what do I need to do differently?" and "what can I do differently?" get you to carefully go over what you know, your skills and your motivation. They bring into the open your own or another person's learning need. Now you have to ask, "what do I need to learn?"
Once you have identified what you need to learn, you can go about the task of bringing in the information. This is where read comes in.

REVIEW AND REFLECT ON A DISRUPTION

INDIVIDUAL

Step 1. Choose any one of the three activities that disrupted you (identified in the previous activity).
Step 2. Carefully review and reflect on it.
(What happened? What worked? What did not work? How did I or others feel? What can I do differently?
Step 3. What do you need to learn?

Read

What is reading?
Reading is a set of activities that helps you bring in and pass on or share information.

Reading something that is *written* is an effective way of bringing in and sharing information. Like listening, speaking and writing, we use it in communication. Human beings have been reading for over 6000 years.

Reading is a language skill that you learn. To read means to be able to identify and make sense of written letters, symbols, drawings, images and words. Reading involves physical and mental abilities. You need to be able to see, if you are sighted, and to touch, if you are blind or visually impaired. You need to be able to pay attention and to remember. You need thinking skills to be able to turn symbols into words (word recognition) or concepts (sums, calculations, diagrams) and to interpret and make sense of their meaning (comprehension). You need thinking-about-thinking skills to build, transfer and apply them.

Reading written and graphic text is a complex activity that combines motivation, skills and practice. The more you read, the more automatic the processes of reading become. The easier it is to read, the more pleasure you get from reading. The more pleasure you get from reading, the more ways you find to use reading to get information.

Another way of *reading* is to ask people about the topic, tasks or issues. When you ask someone what something is or how to do something or how to approach a situation or a person ("what should I do?") you are bringing in information.

READING

GROUPS OF FOUR

What's your experience of bringing information in?

INDIVIDUAL

Get information to address the learning need you identified earlier.
Read one written text and read-by-asking one person who is more expert than yourself.

Reading is a conscious (intentional and deliberate) practice of getting information from written and visual texts as well as through peers and professional experts. In reviewing options, it is an essential part of the 'doing' and 'thinking about' processes. As you will see, it is also an essential part of putting the capability approach into practice in Work-*i*-Learn learning.

Re/Act

In the 'review options' thinking cycle, to re/act means to work out possible ways to respond to a problem or a challenge. You do this by going through a mental process of synthesizing your thoughts, feelings and everything you know and have found out.[ix] Putting the pieces together gives you new understanding and a different way of seeing. This process of re/acting leads you to imagine, create and develop possible solutions and strategies.

RE/ACT

INDIVIDUAL

Using the same example that you have been working on:

1. Put the pieces together (synthesize your thoughts, feelings, your experience, what you found out, what you know).
2. Identify what has changed in your understanding (what you know, how you feel, how you relate).
3. Create possible solutions or strategies.

The capability approach to learning gives you a way of developing your ability to learn throughout your life.

If you were not as successful as you had hoped to be when you did the activities in this module, don't worry. Whatever you achieved is a good start. Learning how to learn takes *a lot* of practice. It also takes time. And learning improves when it is facilitated. This means that learning is made easier when a person is guided and supported in their learning. This is the topic 'How to build capability through work integrated learning'. But first, it is important to know about Work-*i*-Learn.

Photo courtesy:Nina Honiball

2.2 Work-*i*-Learn

1. Work-i-Learn is learning in context

Learning happens in the places where you do things. It happens in your home, on the street and in communities. It happens at school. It happens at work.

THE PLACES WHERE YOU WORK

GROUPS OF FOUR/PAIRS

Draw a mind map of the places where

1. you expect to find health care workers;
2. you work; and
3. you imagine health care workers could work.

Are there any differences? If there are difference, why do you think they are there?

It is likely that the places where you expect to find health care workers are some of the places where you work. After all, everyone expects to find health care in clinics and hospitals. But most people do not expect them to work in homes. Also, some people may expect health care workers to work in schools or factories or old age homes. But most people don't imagine that health care workers can or should work in all parts of the community.
But they should!

AS A HEALTH WORKER...

you are expected to work in hospitals, clinics and homes. You also are expected to work in all parts of communities.

- ☺ Sometimes this means you work in crèches and schools.
- ☺ Sometimes this means you work in offices, shops or factories.
- ☺ Sometimes this means you work at taxi ranks, spazas, shebeens or shelters.
- ☺ Sometimes this means you work on the streets with vendors or homeless people.

In community oriented primary care all of these places are your places of work. All of these places are also where you learn. This is because the best learning happens in the places where people do what they learn. Work-*i*-Learn is learning that takes place in context.

2. Work-i-Learn is intentional, formal learning in the workplace

We often learn things as we do them. This is called experiential learning. It comes out of our actions. It is learning that is unintentional. It is also informal. The knowledge we get in this way is very valuable. But it is tangled up and hidden in the things we do. This is why people find it hard to say what they learn 'on the job'.

And when they share what they learn this way, they usually do it because they have skills and knowledge they got from formal learning.

LEARNING THROUGH EXPERIENCE

WORKING IN PAIRS

Think about when you supported someone through a personal crisis. (Remember to keep confidentiality.)

Share with each other:

- Why did you give support?
- What support did you give?
- How did you give this support?

2

Now reflect with each other:

- How did you know what to do?
- What would you like to do differently next time?
- How are you going to learn how to make this change?

To learn *how* to make a change, you have to 'read' or find out what you need to know. This means that on its own, experiential learning is not enough. It needs to be supported by formal learning.

On its own, formal learning is not enough either. It needs to be supported by what you learn from doing. It needs the things you learn through experience.

You know this from what you have already learnt. And you know this from your experience.

For these reasons
Work-*i*-Learn is formal learning in the workplace. Work-*i*-Learn brings together learning that happens as you go about your day (as you work) and learning that does not come from shared work practices. It does this through a conscious and deliberate set of activities. These learning activities are a planned part of the work routine.

Work-i-Learn expectations

WHAT DO YOU EXPECT FROM WORK-*i*-LEARN?

WORK IN PAIRS/GROUPS OF FOUR

Together – share your expectations:

- What do you expect for yourself?
- What do you expect for your team?
- What do you expect for the individuals and families you work with?

It is likely that you have mixed expectations of yourself, of your team members and of the people you serve. We have to change this. We all need to have a common starting point. We all need to have a common expectation about learning and our role in learning.

To become the master of your own learning, you must expect two things from formal Work-*i*-Learn. When you work, expect to learn. And when you learn, expect to work.

You can expect the following practical things in formal Work-*i*-Learn:

Learning in regular, formal Work-*i*-Learn sessions

- You can expect to participate in formal Work-*i*-Learn sessions.
  - ✓ They are run once a week.
  - ✓ They are run during working hours.
  - ✓ They happen at or near where you work.

Learning that is relevant to the work

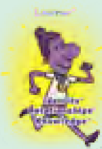
- Each Work-*i*-Learn session covers two topics.
  - ✓ One topic comes from the national training schedule.
  - ✓ One topic comes from a problem or challenge that your team or a member of your team faces in delivering services.

Learning using the capability approach

- Each Work-*i*-Learn session uses the capability approach to learning. This means that:
  - ✓ It is facilitated
  - by the team leader; or
  - by a member of the team; or
  - by a person who supports the team.
  - ✓ It focuses on the learner –
  - what you know and do;
  - what you want to be able to know and do; and
  - what you need to be able to know and do.
  - ✓ It is participatory, cooperative and inclusive.
  - Everyone is expected to learn; and
  - everyone is expected to help others learn.
  - ✓ It develops health and care capacity.
  - You learn to improve the quality of your own and other people's practice.
  - You practice improving the quality of your own and other people's learning.

Learning supported with resources

- Formal Work-*i*-Learn sessions are given resources to support learning. This means that:
  - ✓ There is a place to learn.
  - ✓ There are people to support learning – like facility managers, clinicians, master trainers and partner service providers.
  - ✓ There are learning materials.
  - ✓ There is ICT to support capacity development through on-going learning and continuous assessment.

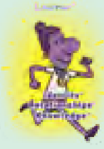


AS A HEALTH WORKER YOU KNOW THAT ...

Work-*i*-Learn has a **goal**. It is there to ensure that people get the best available quality service.

Work-*i*-Learn has a **purpose**. It is there to grow and develop individual and team capacity to deliver healthcare services.

Work-*i*-Learn is an area of **expected performance**. You are expected to learn. You can expect to be supported to learn.



Work-*i*-Learn is **planned**. It has dedicated time.
It is conducted in a dedicated space. It has dedicated resources.

Work-*i*-Learn is **good for everyone**. It benefits you, the team, the health care system and the people who need and use health care services.

3. Work-i-Learn is facilitated

WHAT IS THE ROLE OF A TEACHER?

WORK IN PAIRS/GROUPS OF FOUR

What do you think the role of the teacher is in learning? Use your own experience (at school or during training).

You probably think the teacher's role in learning is 'to give knowledge'. This is because the person doing the teaching is 'full of knowledge' and the person being taught needs to be 'filled up with knowledge'. Most of us believe something like this. We think this way because it is how we have been taught at school and in other formal education situations. So, when we say 'to teach' we think about taking something we know or do and telling, instructing or passing it on to someone else.

And because we are taught this way, this is how we teach. It is how we do patient education in facilities. It is how we do health promotion to people in their homes. It is also how we train health care professionals and health care workers.

Most of the time this way of teaching does not lead to learning. We know this from our personal experiences of learning. And we know this from our experiences at work. We know this from the way teaching practice has changed in many parts of the world. And we know this from research. So, we have to stop teaching this way. We have to find some other way to help people learn.

One way to grow people's capacity is to *facilitate learning*.

What does 'to facilitate' mean? It means to make something less difficult to do. When you facilitate learning you do things to make it easier for another person to know about, understand and do something.

There are important differences between traditional ways of teaching and facilitating learning. When you facilitate learning you approach learning differently. You have different expectations. You have different responsibilities. And you use different skills to support learning. You just do things differently, as you can see in the 'Ten Differences between Teaching and Facilitating' table below.

TEN DIFFERENCES BETWEEN TEACHING AND FACILITATING		
	TEACHING	**FACILITATING**
1	Who has knowledge, skills and understanding?	
	The teacher	The facilitator and the learners
2	What is the starting point of learning?	
	The teacher's knowledge	The learner's knowledge
3	Who is expected to learn?	
	The learner	The learners AND the facilitator (everyone)
4	Who plays the main role in learning?	
	The teacher	The learner
5	Who talks, leads, asks, concentrates, practices? Who is active?	
	The teacher	The learner and the facilitator
6	Who is passive (sits, listens, is instructed)?	
	The learner	Nobody
7	Who takes the lead?	
	The teacher	Anyone – the learners, the facilitator
8	Where does new information come from?	
	From the front (top) as a lesson or lecture	From the ground (bottom) and from the front (top) – using different, participatory methods
9	How does information flow?	
	One way – from the teacher to the learners	In all directions – from learners, to learners, between learners, to the facilitator, from the facilitator
10	What's the task of teaching?	
	To instruct, to give information to the learner	To draw out, build and help the learners grow themselves and to learn

You can see that 'to teach' and 'to facilitate' learning is very different.

When you facilitate learning, the learner is at the centre of learning. You are there to help and to guide them in their learning. What they do is what really matters. But *you* are also very important! Why? Because they need you to show, support, guide and inform them. Without your help, they may not learn what they need to know or do. Without your help, they will definitely find it harder to learn. Without your help, it will take them a lot longer to get to where they want or need to be. And you need them. They help you learn and grow.

Listening skills

When you facilitate learning you have to become an active listener. To be an active listener you have to learn to pay attention in a sustained way and you have to *take away* the habits and practices that interfere with listening.

PAYING ATTENTION

WORKING IN PAIRS

Tell me something important

Talk about your interests and expectations outside of work.

- ✓ **Person A:** Tell Person B about yourself for 2 minutes.
- ✓ **Person B:** Listen attentively. Do not say or write down anything while Person A is talking.

After 2 minutes swop roles.

- ✓ **Person B:** Tell Person A about yourself for 2 minutes.
- ✓ **Person A:** Listen attentively. Do not say or write down anything while Person B is talking.

WHAT IS THE ROLE OF A TEACHER?

WORK IN PAIRS/GROUPS OF FOUR

Together (Groups of four)

What made it hard to keep talking?

What made it hard to keep listening?

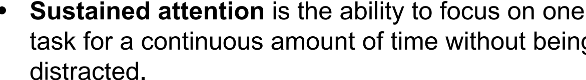
Like most people, you would have found it hard to keep talking without active listening feedback. And you would have found that active listening is not an easy thing to do. Active listening is a skill. Like all skills, you have to think about thinking and you have to practice.

There are five techniques that help improve your ability to actively listen.

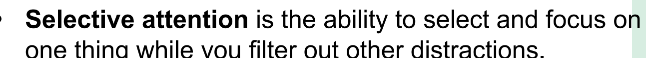
1. Pay attention

Attention is a brain function. From the section 'What is learning' you already know that attention is often the beginning of other cognitive functions that you need in order to be able to do things. There are different ways to pay attention. We pay attention in different ways depending on what we need to do, our habits and what we want to achieve.

Types of Attention



- **Sustained attention** is the ability to focus on one task for a continuous amount of time without being distracted.



- **Selective attention** is the ability to select and focus on one thing while you filter out other distractions.
- **Alternating attention** is the ability to switch focus between two tasks that require different cognitive demands.
- **Divided attention** is the ability to react to two or more different demands at the same time. Divided attention is often referred to as multi-tasking.

When you actively listen…

- ✓ Pay selective attention to what a person is communicating
  - ☺ in words;
  - ☺ in sentiment; and
  - ☺ in their body language.
- ✓ Consciously stop paying attention
  - ☺ to other things going on around you (your cell phone, a side conversation, etc.); and
  - ☺ to your own thoughts and feelings (don't mentally prepare what you want to say).
- ✓ Pay sustained attention
  - ☺ for the whole time that they are communicating.

Active Listening = Sustained + Selective Attention

2. Show that you're listening

We communicate through spoken and silent signals. Spoken signals are words and language. Silent signals are things like tone of voice and volume of speech. They are also the things we call body language – facial expression, hand gestures and posture.

When you actively listen...

- ✓ Use your body language to show you are interested.
  - ☺ Look at the person who is speaking.
  - ☺ Make sure your posture is open and showing interest.
  - ☺ Nod, smile or use other facial expressions.
- ✓ Occasionally use words or sounds to encourage.
  - ☺ Use words like “yes”, “ok”, “go on” or sounds like “mm-hmm”, etc.

3. Show that you are following

Active listening is not ‘sitting back’. That is passive listening. As a listener (and as a facilitator) your role is to encourage the person to talk and to make sure that you understand. As you hear and reflect on what is being said you may need to ask questions. ‘Following skills’ is the ability to know when to give feedback through silence and when to give feedback through questions. It is best to ask questions when a person has finished an idea.

When you actively listen…

- ✓ Show attentive silence.
  - ☺ Silence gives the speaker space and time to speak and think about what they are saying.
  - ☺ Silence shows the speaker that you are hearing them out.
- ✓ Check your understanding.
  - ☺ Clarify what a person has said by putting it in your own words and saying it back to them. You can say something like: “It sounds like you are saying…”.
- ✓ Ask questions.
  - ☺ Ask one question at a time so you don’t disrupt the person who is speaking.
  - ☺ Ask open-ended questions like: “What do you mean when you say...”.
- ✓ Summarise issues.
  - ☺ Identify the most important information, feelings, etc.

4. Don’t interrupt

Active listening is about not interrupting a person when they are speaking.

When you interrupt you are not actively listening.
When you interrupt you stop the person…

- ☹ from completing a thought; and
- ☹ from saying what they want to say.

When you interrupt you are focused…

- ☹ on your own thoughts; and
- ☹ on your own needs.

5. Respond appropriately

You respond appropriately by respecting and building understanding. You do this by reflecting back content, feelings and meaning. And you do this by elevating understanding and planning for action.

- ✓ You summarise
  - ☺ main themes;
  - ☺ common threads; or
  - ☺ essential issues.
- ✓ You develop a shared understanding of
  - ☺ content;
  - ☺ relationships; and
  - ☺ self and identity.
- ✓ You plan for action/the next step.

AS A HEALTH WORKER...

When you actively listen, you discover how the speaker views his or her situation. You are then in a position to explore, relate and assist them to find solutions to their problems.

Troubleshooting skills

Everyone comes to learn with their own sense of self, experiences and expectations. They also bring expectations about others. We can't assume that everyone will want to participate. And even when they want to take part, we can't assume they will 'play by the rules'. As a facilitator you have to learn to troubleshoot. You have to be prepared to manage individual and group behaviour that disrupts learning. You have to learn how to take control, manage individual behaviour and manage group dynamics. Below are some tips to guide troubleshooting in Work-*i*-Learn.

Troubleshooting Tips

1. Prepare in advance:
    - ✓ Plan the session.
    - ✓ Read the materials.
    - ✓ Familiarize yourself with the concepts and language.
    - ✓ Think about possible questions and answers.
    - ✓ Identify possible support.

2. Develop shared ground rules:
    - ✓ Timekeeping (dedicated learning, on time, all the time).
    - ✓ Responsibility for learning (lies with the learner, encouraged to find answers).
    - ✓ Participation (inclusive, active).
    - ✓ Respect (differences, viewpoints, effort, achievement, personal integrity).
    - ✓ Openness (critical thinking, feedback, self-correction).
    - ✓ Confidentiality.

3. Manage individual behaviour:
    - ✓ Keep the focus on ideas, not people.
    - ✓ Keep the discussion concrete, not abstract.
    - ✓ Discourage diversion – people walking in and out, side conversations, inappropriate humour, etc.
    - ✓ Encourage participation.
        - i. Create inclusive practices, like giving everyone a turn, encouraging people to talk to and work with each other.
        - ii. Ask open-ended questions.
        - iii. Get them to answer questions or find solutions.
    - ✓ Develop strategies to respond to dominant and passive learners.
        - i. Enthusiastic dominant – give them responsibility in the group, encourage self-awareness, pair complementary strengths.
        - ii. Disruptive dominant – proactively discourage their behaviour, encourage individual self-awareness, go back to ground rules.
        - iii. Passive shy – give individual support, put learner in a supportive environment, encourage practice, build confidence.
        - iv. Passive disinterested – use peer learning, understand disinterest, find interest.
    - ✓ Manage conflict.
        - i. Don't take sides.
        - ii. Use learning methods to clarify areas of agreement and disagreement.
        - iii. Summarize.
        - iv. Ask the group for a way forward that will support learning.

4. *Work-i-Learn uses the best available learning methods*

Learning methods shape the learning process. They are the practices we use to guide, stimulate and support learning. In Work-*i*-Learn, learning methods help you put the learner at the centre of learning. They help you make learning an active process. And, most of all, they help you promote learning.

There are two kinds of methods that guide learning. There is a basic method that you use for all instruction. It is called general learning rules. The changeable methods are called variable methods. Variable methods are things like modelling, role-play, peer learning, whole group, small group, individual, etc. You use them according to the context and the learning needs. Often you use more than one method and you use them in different combinations.

General rules

There are five rules of instruction to follow to create learning as a product of your actions. These rules are the basic method of facilitating learning.

Rule 1. Be problem centred

Relate learning activities to something learners do or will have to do, in context. They must learn about the whole problem.

In Work-*i*-Learn, what learners learn is linked to the tasks and challenges of doing their work. But you have to be careful to apply Rule 1 properly. You have to make sure that learning is problem centred and not topic centred. This way you make it possible for learners to understand enough to apply what they learn.

Rule 2. Activate experience

Start the learning process from learners' experiences and understanding of a problem. In other words, begin from what people know and have experience

of. This way, when they have experience of something, you mobilize their existing skills and knowledge. You uncover what they feel and how they relate to the problem. And you discover what else they can or need to learn.

When people don't have experience or knowledge of something, you need to help them build a mental model of the problem. You do this by giving them a chance either to learn from others who have the experience or you to try have them get the experience directly.

EFFECTIVE COMMUNICATION

INDIVIDUAL

Reporting a problem (e.g. Harmful Substance Use, reluctance to test for HIV or TB)

Choose something that you have experience of reporting to the team or team leader on.
Think about what you communicated.

- What did you focus on?
- What did you ask?
- What did you suggest?

CREATING A MENTAL MODEL OF EFFECTIVE COMMUNICATION

WORK IN PAIRS/GROUPS OF FOUR

Together (small group)

1. Share how you reported on the problem and compare your experiences.
   What were the similarities?
   What do you need to learn?
   What were the differences?
   What helped get others to understand what they have to do?

2. Create a mental map of the best way to report a problem.
   What should always be reported?
   What can be reported sometimes (what is problem specific or variable)?

REVIEW AND REFLECT ON A DISRUPTION

GROUP

1. Create a whole team mental map of how to report a problem.
   Share ideas from Step 2.
   Integrate these ideas into a team mental model of reporting.

REVIEW AND REFLECT ON A DISRUPTION

INDIVIDUAL

Step 1. Choose any one of the three activities that disrupted you (identified in the previous activity).
Step 2. Carefully review and reflect on it.
(What happened? What worked? What did not work? How did I or others feel? What can I do differently?

'Describe the situation, give some background, give an assessment, recommend or request some action' is an example of a mental model of how to support more effective communication in health.

By working through a mental model, you create an understanding of how to do something even when everyone may not have experience of doing it.

Rule 3. Demonstrate

- ☺ Show learners what has to be learned – don't just give information about something.
- ☺ If you want people to learn a concept, give examples and non-examples.
- ☺ If you want people to learn a procedure, show them the procedure.
- ☺ If you want people to understand a process, work with them to visualize the process.
- ☺ If you want people to change the way they do things, model ways to behave.

Rule 4. Apply

- Get learners to practice what they are learning.
  - ☺ Practice is the way learners really 'know' what they have learned.
  - ☺ Through practice, learners test their understanding and skill. They make mistakes and they learn how to respond and recover from their mistakes.
  - ☺ Through repeated practice, learners achieve mastery. They get better and better at what they are learning.
  - ☺ Through practice, learners move from being dependent to being independent practitioners.
- Support learners as they practice. You do this through the way you structure the learning – you do this through scaffolding. And you do this through feedback.
  - ☺ Feedback is the most important form of guidance that a learner can get.
  - ☺ Feedback helps learners recognize mistakes.
  - ☺ Feedback helps learners recover from mistakes.
  - ☺ Feedback helps learners avoid making similar mistakes in future.
  - ☺ Feedback encourages and keeps learners motivated.

Rule 5. Integrate

Integration is the moment when learning becomes authentic. It is taken on board. It becomes a way of doing. It becomes a way of being. It is when new knowledge, skills and understanding become part of what a person genuinely knows, does and feels.

Get learners to integrate their new knowledge, skills and understanding into their everyday life.

Give them the chance

- ✓ to publicly demonstrate their new knowledge or skill;
- ✓ to reflect on, discuss and defend their new knowledge and skills; and
- ✓ to explore new and personal ways of using their new knowledge and skills.

2

AS A HEALTH WORKER...

patience and perseverance matters. If you stop using a skill right after you have learnt it, your brain may replace that knowledge with different information. Also, if you move onto a second task while you are still trying to learn the first one, it will be like you never learned the first task.

Variable methods

The variable methods of learning that we are going to explain are modelling and role-play. You apply all the general rules of learning to these methods.

Modelling

Modelling is when you watch people do things and you copy what they do. It is something that we know small children do a lot. It is a method of learning that also works with adults.

AS A HEALTH WORKER...

you model health care all the time. You model how to respond to health. When you ask questions or explain and respond to health care needs you give people the language and the way to solve problems. You model a way of thinking and doing.Also, if you move onto a second task while you are still trying to learn the first one, it will be like you never learned the first task.

Modelling is a method of learning. Often it happens unintentionally. But you can use modelling intentionally too. You can model how to use things. For example, you can model how to use equipment like a BP machine, a thermometer, a test kit, a computer or an app on a cell phone. You can model

how to do things. For example, you can model how to do a home visit, how to ask questions, how to collect and record information, how to read for information from a document or text. You can also model how to think about thinking.

Modelling is a simple idea, but it only becomes an effective method of learning when it is prepared and done well.

As an intentional method of instruction, modelling involves an expert, learners and a facilitator. If you are the expert, you have two roles. You demonstrate the activity and you facilitate the learning. If you are not the expert, you only have one role. Another person demonstrates the skill or activity and you facilitate the learning session.
Learning through modelling is a three-part process.

An expert can be you. It can be a health professional or other service provider. An expert can also be a team member or a community member.

1. The first part of modelling is to demonstrate the skill or activity that you want learners to do. An expert shows everyone how to do the task. An expert is someone who has a lot of skill, knowledge and experience in doing the task. The whole group observes the demonstration together. This way everyone gets to see the same thing.

2.

   Remember the demonstration can be repeated as many times as is needed to help learners do what they are being shown.

3. The next part of modelling is when learners try to do what they have been shown. They practice.
   To get the most learning out of watching someone do something, it is important that
   - ✓ learners practice as soon as possible after the demonstration;
   - ✓ learners practice under supervision and with support; and
   - ✓ learners practice until they are confident and competent.

   Supervision and support should come from the expert and the facilitator and other learners. Other learners are their peers. It should also come from the way learning is organized. Learners should work with partners or in small groups. This way they all get a turn to practice. They also give and get support from one another.

4. The third part of modelling is individual application. This is when learners do what they have been shown and what they have practiced. On their own they put their skill or knowledge into practice. They are confident and they are competent. Their learning does not stop. They practice and listen to feedback, review their actions and improve all the time.

How to model learning

1: DEMONSTRATE			
a. Prepare *(Expert/Facilitator)*	**b. Do** *(Expert/Facilitator)*	**c. Consolidate** *(Expert/Facilitator)*	**d. Review** *(Expert/Facilitator)*

• Choose a suitable activity
• Work out what you will do step by step during the demonstration
• Work out what you want the learners to pay attention to during the demonstration
• Practice what you are going to do and say.
	• Choose a suitable task
	• Show each step that needs to be taken.
	• Explain the thinking behind each step that you take
	• Engage with the learners
	  • ask them what they are seeing
	  • ask them what they are learning
	• Give them feedback
		• Summarise - what you did; the thinking behind what you did
		• Restate the task or activity
			• Reflect
			  • what worked
			  • what did not work
			  • what you need to change to do it better next time

2: PRACTICE			
a. Prepare *(Learners/Small groups)*	**b. Do** *(Learners/Small groups)*	**c. Review** *(Learners/Small groups)*	**d. Consolidate** *(Learners/Small groups)*
• Go over each step of the task • Remind each other what has to be done • Remind each other what you should be thinking about • Ask about and share the thinking behind each step that you take	• Show each step that needs to be taken	• Discuss what worked and did not work • Discuss what needs to change to do it better next time	• Draw out key issues for learning • Repeat

3: APPLY			
a. Prepare *(Learner)*	**b. Do** *(Learner)*	**c. Review** *(Learner)*	**d. Repeat** *(Learner)*
• Go over each step of the task • Remind yourself what you have to do	• Do each step • Self-check – think to yourself or out loud about each step that you take	• Ask yourself what worked and did not work • Read • Re/act (prepare to do again)	

AS A HEALTH WORKER...

You are not expected to know **all** the answers. You are expected to help people find answers and solutions.
You do this together with them.
And they can do this together with each other and on their own.

Role-play

Role-play is when you act out what you would do in a situation. You put yourself in someone else's shoes and develop and use the skills you will need when you are in a similar situation or face a similar problem. Role-plays are used a lot to prepare people for real life situations before they are in them or when it is not possible or appropriate to be in them directly.

It is quite possible that you have done a lot of role-plays over the years.

A ROLE-PLAY THAT YOU HAVE DONE

Individual
- What was the purpose of the role-play?
- What did you learn about yourself from doing it?
- What skills did you learn that you still have today?

Together
- Share ideas about what learning happened and why you did or did not learn from it.

Most people find role-plays fun and entertaining. Often everyone ends up laughing. But do they lead to learning? Not when the focus is only on playing the role or acting out the situation. For learners to learn from doing role-plays, they have to do the activity and they have to review what they have done.

Like all learning activities, role-play has to be organized and structured to enable learning. This means working out what learning you want to achieve through role-play and how you are going to achieve it.

What learning

The facilitator and the learners must have a clear idea of the learning they are trying to achieve in role-play. You get to this understanding by focusing on the dimensions of the learner that are activated in real life as well as in role-plays.
This way you put the learner at the centre of learning.

All role-plays mobilize emotions, feelings and values. So, you need to ask questions like: “what emotions do I want to build?” or “what values do I want to build?” or “what sense of self do I want to build?” by doing this activity.
All role-plays engage with content and knowledge issues. So, you need to ask a question like: “what problem do I want to understand?”
All role-plays involve relationships. So, you need to ask questions like: “what interpersonal skills do I want to build?”, “what cooperation skills do I want to build?” and “what communication skills do I want to build?”.

How to achieve learning

The facilitator *and* the learners need to have a clear idea of how to achieve learning through role-play.

This is when you bring together everything you know about learning and apply it to this particular method of learning.

You already have most of the tools. You have P.I.E. You understand how learning happens – doing, thinking and ‘thinking about thinking’. You know how learning is organised. And you know how to support learning through facilitation and peer learning.

<table>
<tr><th colspan="3">HOW TO ACHIEVE LEARNING THROUGH ROLE-PLAY</th></tr>
<tr><th>FACILITATOR</th><th colspan="2">LEARNERS</th></tr>
<tr><th colspan="3">BEFORE</th></tr>
<tr><td>Prepare
✓ Plan the activity
✓ Read relevant materials
✓ Set up the physical environment to be safe, clean, inclusive, etc.
✓ Organize equipment and resources</td><td colspan="2">Prepare
✓ Plan the activity
✓ Read relevant materials
✓ Set up the physical environment</td></tr>
<tr><th colspan="3">DURING</th></tr>
<tr><td rowspan="2">Introduce the role-play
✓ Give the background
✓ Confirm the goals</td><th>LEARNERS DOING</th><th>LEARNERS OBSERVING</th></tr>
<tr><td>Introduce the role-play
✓ State the goal
✓ Give the background</td><td>✓ Listen
✓ Observe</td></tr>
<tr><td>Create a suitable social environment
✓ Establish agreed ground rules for interaction
✓ Support learning – be sensitive, don't be judgmental, be open to mistakes
✓ Motivate learning – encourage active listening, constructive criticism, feedback and reflection
✓ Manage differences, tensions and conflict
✓ Guide learning – ask questions, highlight insights</td><td>Perform the role-play
✓ Be motivated
✓ Be open to questions
✓ Be open to criticism
✓ Be open to mistakes</td><td>✓ Be engaged
✓ Be sensitive to the person
✓ Don't be judgmental
✓ Be open to mistakes
✓ Be respectful
✓ Encourage learning
✓ Build confidence</td></tr>
</table>

<table>
<tr><th>FACILITATOR</th><th colspan="2">LEARNERS</th></tr>
<tr><th colspan="3">DURING</th></tr>
<tr><td>Give learners time
✓ to prepare
✓ to perform
✓ to interact through questions or observations (feedback)</td><td colspan="2">• Ask questions
• Give feedback
• Respond to feedback</td></tr>
<tr><th colspan="3">AFTER</th></tr>
<tr><td>Facilitate Review</td><td colspan="2">Review</td></tr>
<tr><td rowspan="2">✓ Review, Reflect, Read, Re/act (individual/small group/whole group)
✓ Consolidate learning</td><td>LEARNERS DOING</td><td>LEARNERS OBSERVING</td></tr>
<tr><td colspan="2">Review, Reflect, Read, Re/act</td></tr>
</table>

Photo courtesy:Nina Honiball

2.3 Facilitating Work-*i*-Learn

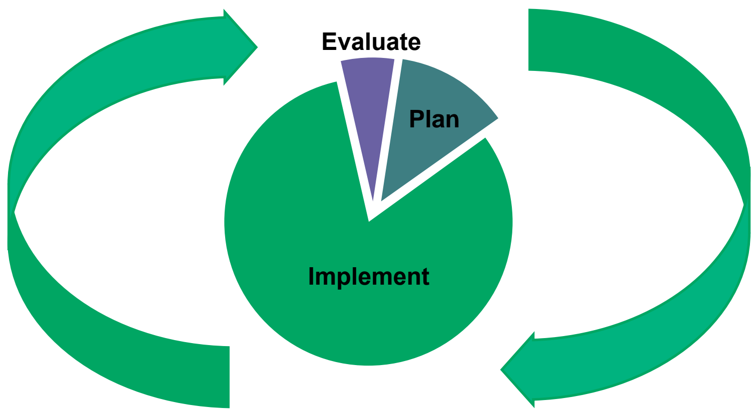
Work-i-Learn is a doing word

How do you facilitate Work-*i*-Learn?

When you facilitate learning you are doing activities that focus on helping other people learn.

To achieve what you set out to do, you have to plan. This means you have to prepare what you want to do and how you want to do it. Next you have to implement your plan. This means you have to put it into practice. And then you have to evaluate it. This means you have to work out how well your plan and your practice went. We call this procedure P.I.E or Plan-Implement-Evaluate.

Making Every Task Easy as P.I.E.

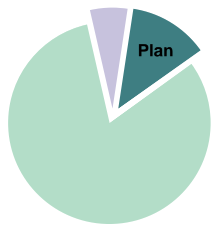


AS A HEALTH CARE WORKER...

P.I.E helps you do everything better. Use P.I.E to do everyday activities. Use P.I.E to do your work. Use P.I.E to learn. Use P.I.E to help others learn. Use it everywhere. Use it all the time.

Prepare

You have to prepare to facilitate learning. It is just like you would prepare to do any other activity. Planning helps you prepare. It is the way you think through a task or an activity before you do it.



1. **Work out what you want to achieve.** This is called the goal. As a facilitator of learning you put the learner at the centre.
   a. You are responsible for
      i. structuring the session;
      ii. managing the process; and
      iii. reflecting on your own and others' actions.
   b. You do this by
      i. preparing for the session;
      ii. guiding the process; and
      iii. stimulating and supporting learners to be in control of their own learning through practice and reflection.
2. **Make the task clear.**
3. **Work out how to get to the goal.** This is about the methods you will use to facilitate learning.
   a. There are different methods like:
      i. modelling;
      ii. peer learning; and
      iii. role-play.
   b. You choose the methods of learning to suit the tasks or activities.
      i. Modelling – to demonstrate and apply a performance or technical skill.
      ii. Peer learning – problem finding, problem solving, discussion.
      iii. Role-play – run through performance skills.
      iv. Practice – try and repeat technical skills.

c. You link the methods to the way the session and each of the activities are organized:
   i. whole group (everyone together);
   ii. small groups (groups of two, three, four or five); and
   iii. individual.

4. **Work out what resources you have or need to help you do the task.**

   a. You need reading, writing and other learning materials to get and share information. These are things like
      i. books, handouts, data, videos, and presentations;
      ii. paper and pens, flipcharts, sticky notes, beans, beads, etc.;
      iii. computer and internet; and
      iv. technical equipment (thermometer, test kit, glucometer), etc.

   b. You need to know the amount of time you have available. This is about working out
      i. the time you have for the session; and
      ii. the time you need for each activity.

   c. You need to have a place to learn. This is about
      i. organizing a place to hold the session; and
      ii. arranging the space in the session to support learning.

   d. You need to check for assistance and support. This is about finding people with additional knowledge and expertise
      i. to help build learner capacity; and
      ii. to help build your capacity.

5. **Work out how to know that learning is happening.** You do this through assessment.

   a. You use assessment to support and guide learning.
      i. It helps you and the participants know their achievements.
      ii. It helps you and each learner know what can be improved.
      iii. It helps you and each learner find ways to improve.

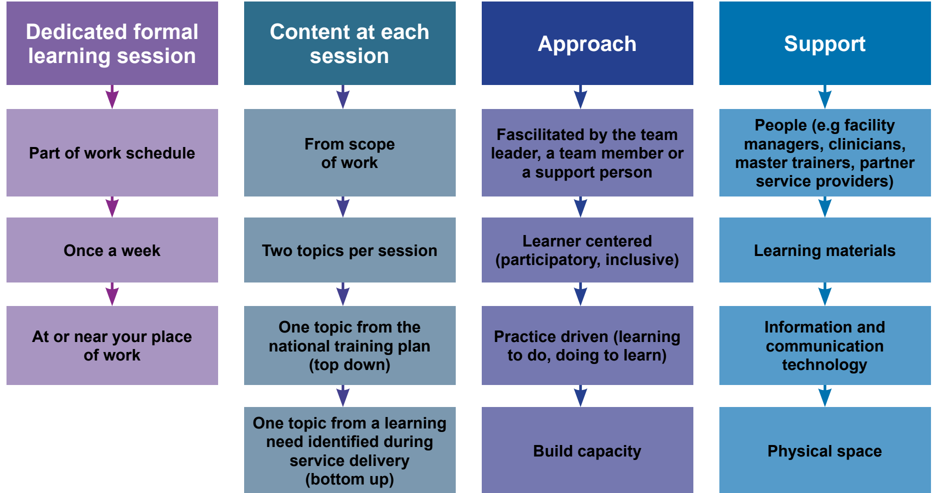
   b. You use and encourage learners to use assessment all the time

   You assess
      i. before or at the beginning of a session;
      ii. during a session; and
      iii. at the end or after a session.

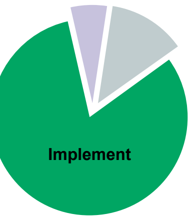
   You help the learner assess
      iv. at the beginning of the task;
      v. during the task; and
      vi. at the end of the task.

c. You use known and tested assessment strategies to support learning. These are
   i. self-assessment;
   ii. peer assessment;
   iii. rich questioning;
   iv. feedback; and
   v. sharing success criteria.

Planning Work-i-Learn



Implement



Plans are ideas. They stay on paper or in your head until you act on them. You have to bring them to life. You do this by putting them into practice.

The process of facilitating learning can happen in many different ways. A lot depends on the context in which learning happens. A lot depends on your own experience. A lot depends on the experience of the learners you are working with. You always have to be alert to the way these three factors come together.

The following steps describe one way to go about facilitating Work-*i*-Learn. It is meant for you to use as a guide. It is there to support you. Use it for as long as it is useful to you.

Confirm the subject

It is important to make sure everybody is aware of what is going to be talked about or done. When you confirm the subject, you share the learning intention of the session. You also are making sure that everyone can be an active participant.

How can you do this? Your approach depends on you and the context you are in. You can tell everyone what the subject of learning is. For example, you can say something like: "Today we are going to learn about …". If you have agreed on the subject before the session, you can ask participants. For example, you can ask: "What did we say we are going to learn about today?"

Find the learning need

The next step is to find out what the focus of the learning session should be. It is the way you work out what to prioritize. This is also a chance for you to discover important differences between teaching and facilitating.

Are you surprised by this step? Aren't you supposed to know what to focus on? Isn't that what teaching is about?

HOW TO FACILITATE.

WORK IN PAIRS AND INDIVIDUAL

Together

1. Read together and talk about the ten differences between teaching and facilitating (page 48).

Prepare on your own

2. Choose an issue in a topic that you know well. For example, the issue can be using a condom; the topic is preventing HIV or STI transmission.
3. Think about the first thing that you would do 'as a teacher' after you have introduced the issue. Now think about the first thing you would do 'as a facilitator'.

Together – each one gets a turn

4. Do the first thing you think you should do in your role as a facilitator.
5. Talk about what you did.
    - What was your doing word (verb)?
    - How was your approach different from the way you usually do it?
    - What was the response of the learner?

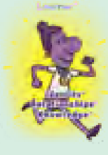
2

Ask

How do you find out about what people need to learn about a topic or a task?
You ask them questions.

- ✓ You can ask learners what they know.
- ✓ You can ask them what they are able to do.
- ✓ You can also ask them what they want to know or what they want to do.
- ✓ Or you can ask them what they don't know or what they are unsure of.

Your responses depend on your own learning background and experience. It is quite possible that you do not usually begin by asking people what they know or don't know about something before you 'do' education. If you usually do begin by asking – well done! You are already on the way to building capability.



AS A HEALTH WORKER …

You discover a person's learning need by asking them what they know, don't know or want to know about an issue or topic.

Integrate and make sense

You now have to bring together and make sense of what people have told you. You can do this on your own or you can do it together with all the participants. How you do it depends on three things.

i. It depends on what you have been told.

- It is easy for you to make sense of what needs to be learned when most people share a similar, clear learning need. You can do this on your own.
- It is hard to make sense of where the focus of learning should be when people have many different learning needs. It is better to work together with them.

ii. It depends on your own knowledge and skill in making sense of what you have learned.

- You learn to make sense of things and to prioritize tasks and issues through practice.

- It is better to work together with learners
  - if you are new to facilitation; and
  - if you don't feel confident in your ability to work out what is most important.

iii. It depends on what you want to achieve.

- It is better to work together with learners
  - if you want to increase their ability to make sense of information; and
  - if you want them to select a focus themselves.
- It is better to make sense of what you have been told on your own
  - if you have too little time; and
  - if you are going to do the same thing with other subject content or skills.

SOMETHING YOU KNOW A LOT ABOUT

WORK IN GROUPS OF FOUR

Together

1. Brainstorm what you think people need to learn about. (e.g. using a condom)

On your own

2. Identify your own learning need (what do you need to know or understand).

Together

3. Compare your learning needs with what you think other people need to learn.
4. Work out what you think the focus of learning should be.

When you talked about other people's learning needs you probably focused mainly on 'knowledge' and 'skills'. In the using a condom example, this would be things like:

- what a condom is;
- who uses a condom;
- why it is important to use a condom;
- how a condom works;
- when to use a condom; and
- where to get a condom.

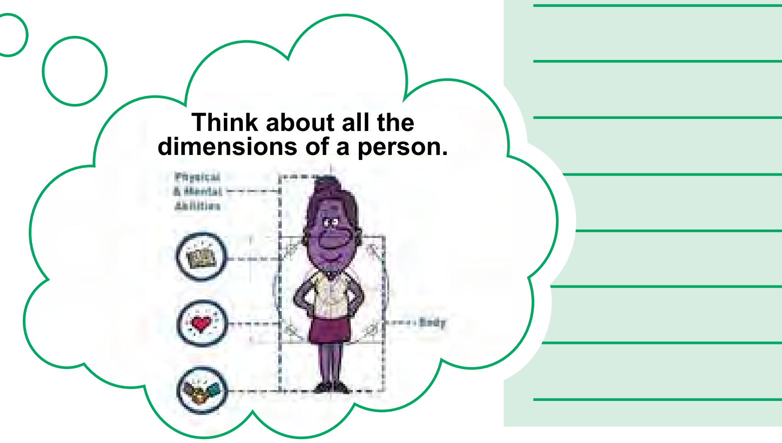
This information is important. It needs to be shared and understood.

Is it enough to know about something? Is it enough to have a technical skill?

Usually not. For example, many people know about condoms. Many people even know how to use them. But they don't use them. So, what else should you focus on in learning?

Well, issues in health and care are personal. They are about who you are and how you feel about yourself. They are also social. They are about how you relate and interact with other people around an issue. They involve you as a whole person. So, learning has to focus on all the dimensions of a person.

Using condoms, for example, is about how people feel about themselves and their own bodies. It is about identity and sense of self. Using condoms is also a social interaction. It is about how people feel about and relate to other people and other people's bodies. So, the focus of learning possibly needs to be about how to negotiate safe sex. It needs to help people become self-confident and socially confident enough to practice safe sex.



REVIEWING TO FIND A FOCUS IN LEARNING

WORK IN THE SAME GROUPS OF FOUR

Together

1. Discuss any changes you want to make to your focus of learning.
2. Write down your reasons for choosing this focus.

Facilitate

Everything has an impact on learning. Although you will not be in control of many things, when you facilitate learning you do everything you can to put learners at the centre of all the learning activities.

In the capability approach to learning, the product of your actions is to help you become a learner

- ✓ who is able to develop and expand your capacity to do things; and
- ✓ who is able to help other people develop and expand their abilities do things.

Learning space

It is important to make sure that everyone is in the presence of each other. For this to happen you need to create the best possible learning space. You can do this by changing the way you arrange the seating and work area.

Try to have learners sit either in a circle or in small groups.
This way you

- ✓ encourage cooperation;
- ✓ stimulate participation;
- ✓ increase motivation; and
- ✓ change the balance of power.

Learning sessions

It is important to maximize individual and group learning. You can do this by shaping the way learning sessions and activities are organised. Learning sessions can be broken down into whole group activities, small group activities and individual activities. You can use all three approaches in any session. But there are some very good reasons to work in small groups of three to five people as often as possible.

1. Small groups are closest to real life.

    a. Health care consultations in facilities or in homes are mostly with individuals or small groups of people.

    b. Health care workers usually do their daily work in small teams.

2. Small group learning is one of the best ways to learn.

   a. It is participatory. Everyone is an active learner.
   b. It builds good communication skills, like listening, questioning, and clarifying.
   c. It builds cooperative practice. Everyone has to find a way to work together on tasks or activities.
   d. It supports peer learning by sharing expertise.
   e. It builds individual confidence.
   f. It promotes individual responsibility for learning.

3. Formal small group learning works well when
   a. the task or activity is clear.
   b. people are assigned to groups to help learning.
      - ✓ Consider people's experience and knowledge (mix learners by ability and competency).
      - ✓ Consider who people work with every day (work responsibilities).
      - ✓ Consider who people like (personal preferences).
   c. roles are assigned to people in the group. Assigning roles creates accountability, increases participation and accountability, and deepens learning. There are four common roles in group work:
      i. leading (present, explain, extend, show);
      ii. responding (ask, extend, give feedback);
      iii. orienting (keep the task on track and on time); and
      iv. reporting (clarify, consolidate).

Learning process

Learning is an active process. The purpose of facilitating learning is to help people build their capacity to do, know and understand things. You have a very specific and important role to play. Your role as facilitator is to guide, to stimulate and to support learners.

MAKING SENSE OF WORDS

WORK IN THE SAME GROUPS OF FOUR

On your own

In your first language (the one you learned at home):

- What is the word for 'to guide'?
- What is the word for 'stimulate'?
- What is the word for 'support'?

Together

1. Share your knowledge and experience.
   - What does each word mean?
   - How would you use each word in practice?
2. Reflect together.
   - Does everyone use these words the same way?
   - What does the meaning we give to each word say about how we think about facilitating learning?

The meaning we give to each of these words tells us about what we think our role is when we facilitate learning. Let's look more closely to see if what we think is what is expected of us.

To guide

Often, when we guide someone, we give the person advice. And when we give someone advice, we often tell the person what to do. Sometimes this works. But most of the time it does not work to guide people in this way.

In the capability approach, your role is to help learners learn. You are there to help them discover answers and solutions for themselves. This changes what we mean when we say we guide learning. As a facilitator you guide learning by asking and listening.

2

This changes what is expected of you. You do not have to be an expert in the topic or subject. But you do have to become expert in asking and listening. You do have to become expert in how to stimulate and support learners to find answers and solutions. And you become expert by practicing and learning.

To stimulate

In English, the word to stimulate means to spark interest. It also means to encourage, to keep something going and to grow.

WHAT SPARKED YOUR INTEREST

WORK IN PAIRS

Together (one at a time)

Find out about something that the other person

- really likes to do;
- what got him or her interested in it; and
- how he or she stays interested.

On your own

- Write down the questions you asked.

Together

Reflect on your experience of facilitating.

- What happened when you asked questions?
- What did you do with the answers?

You learn several things when you do this activity. As a facilitator you learn some facts. You learn what the other person really likes to do. You learn what sparked his or her initial interest and what keeps this interest going. You also learn about the role of questions in facilitation. To understand something, you need to ask more than one question. And the answers you get lead to other questions. This means that you learn about facts and about processes at the same time as you ask questions.

The same things happen when you answer questions. The questions make you think about the facts. They also make you think about the processes that get and keep you interested. They can even make you think about the meaning of the word ‘to stimulate’.

So, asking questions is a very important way to stimulate learning.

Remember: You are always a learner and a facilitator of learning.

To support

In English, the word to support has many meanings. This is likely to be true for your first language as well. In every language, the meanings of words depend on what we are talking about. Their meaning depends on the context we use them in.

In the context of Work-*i*-Learn, when you support learning it means you help, assist and encourage a person to learn.

To help and assist

To help and to assist are different ways of saying to make something easier or more possible. There are many ways to help and assist people. But when you facilitate learning there are some things that you must do.

Prepare

You have to prepare. You help people learn when you know what you are doing and you know what you expect of them. You can only know this by planning. This means putting the ‘P’ in P.I.E into practice. When you are unprepared you will confuse learners and they will quickly loose interest.

Communicate

You need to communicate clearly. You need to say what you want people to do. You need to make sure learners understand what is expected of them. You need to let learners know their progress. You need to encourage them to share their challenges.

2

You communicate by informing, asking, listening and discussing. Among other things, you can

- ✓ share the learning intentions of the session;
- ✓ share success criteria;
- ✓ give and take feedback; and
- ✓ prompt learners towards the goal.

Remember, communication is an essential skill in health care.

Maximize participation

Make sure everyone is part of the session. You can do this in different ways. Amongst other things, you should

- ✓ give each person time to talk;
- ✓ develop a shared vocabulary for a problem or issue;
- ✓ organize learning so people work in pairs and groups of four as much as possible;
- ✓ break tasks into smaller parts;
- ✓ give individual support as soon as it is requested;
- ✓ respond to mistakes as positive ways to learn;
- ✓ ask questions; and
- ✓ listen.

Empower

You empower people by always making them the centre of learning. Suggestions of possible ways to empower learners are listed below.

- ✓ Get learners to take the lead in providing information.
- ✓ Get learners to take the lead in showing skills.
- ✓ Get learners to take the lead in sharing values.
- ✓ Give learners responsibility for finding answers or solutions.
- ✓ Give learners responsibility for providing feedback to one another.
- ✓ Be open about not knowing or being unsure about something.
- ✓ Admit to mistakes.

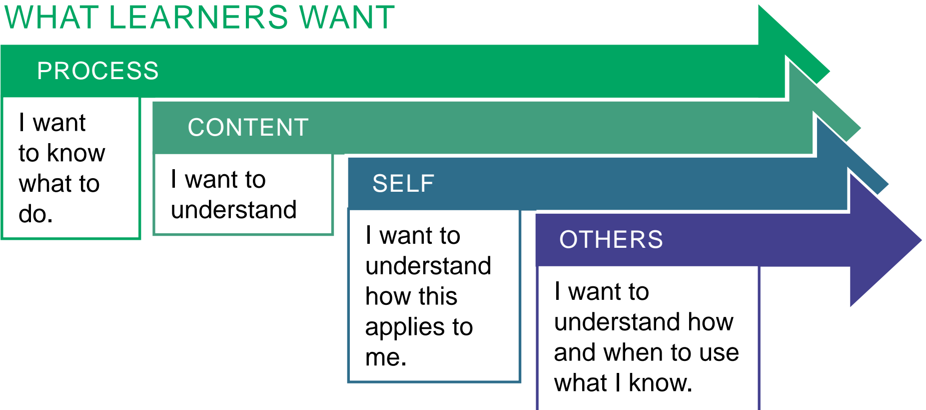
Consolidate

You consolidate learning through activities. You consolidate learning by working with people

- ✓ to summarize what has been done;
- ✓ to underscore the main learning points; and
- ✓ to think about what still needs to be done.

Always keep in mind that what learners want from learning is just as important as what you want them to learn!

The diagram shows the different things that learners want when they learn about a process and when they learn content.



Encourage

To encourage means to reassure and persuade someone to do something. It is about motivation.

A PERSONAL LEARNING EXPERIENCE

WORK IN GROUPS OF FOUR

Together (one at a time)

Share an experience of being discouraged to learn.

- How were you discouraged?
- Why do you think you were discouraged?
- How did it make you feel?

Share an experience of being encouraged to learn.

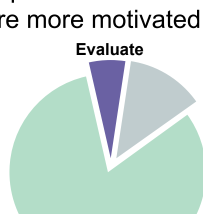
- How were you encouraged?

Why do you think you were encouraged?

How did it make you feel?

Reflect on the differences between the experiences of being encouraged and being discouraged.
- What happens to learning?
- What happens to motivation?

Most of us find it hard to learn or to do something when we are discouraged. We lose interest. We lose motivation. Often, we give up. The opposite is also true. Most of us find it easier to learn or do things when we are encouraged. This happens even when something is difficult or new. We are more motivated because we have the support. So, we try. And we learn!



Evaluate

EVALUATION AND ASSESSMENT

WORK IN PAIRS

Individual
When you hear the words ‘evaluation’ and ‘assessment’…
What three words do you immediately think of?
- Write these words down.

Together
Share your immediate thoughts about ‘evaluation’ and ‘assessment’.
- Say what you think and feel.
- Say why you think and feel this way.

Reflect on the way you think and feel about evaluation.
- What do you need to change?

When people hear the words ‘evaluate’ and ‘assess’, they often immediately think about being tested and judged. These words also often make people feel anxious or afraid. This is especially the case when evaluation or assessment is used in the context of learning.

But in real life, we test, assess and evaluate things all the time. And we do this ‘naturally’, often without too much fear or anxiety, because we want to know if the things we do, work. For example, when we prepare food, we check ourselves. We ask ourselves questions like “do I have all the ingredients?”; “am I following the recipe?” and “how much time do I have?”. We test to see if the food tastes the way we want it to taste. We test to see if it is ready to eat. We also assess how people receive it. We ask ourselves questions like “are they eating?” and “do they like it?”. We ask them questions like “how’s the food?”, “are you enjoying it?” and “why do you say this?”. Then, we take all the information we have, and we evaluate what worked and what didn’t work. We review what we did and felt. We review what people did and said. And we do all this so that we can do better the next time we prepare the dish. We do all this so that we can learn.

Let us take this example and use it to ‘think about thinking’.

ASSESSMENT STRATEGIES USED IN THE EXAMPLE OF PREPARING AND SHARING FOOD

WORK AS INDIVIDUALS OR IN PAIRS

Individual

Underline the sentence or sentences in the above example about preparing food that refer to:

- Self-assessment
- Peer assessment
- Rich questioning
- Feedback

What you should discover from this activity is that the strategies we use to assess and evaluate the things we do in everyday life are the same ones we need to use to support learning in Work-*i*-Learn.

Self-assessment

Self-assessment is a strategy that you use to help you take charge of and control over your learning. Self-assessment is about observing, checking and evaluating your sense of self and your emotions, your relationships, your knowledge and skills and your physical and mental abilities. It is something everyone can learn to do. It is something that you get better at doing the more you practice it.

Self-assessment helps you plan and organize your thoughts.

- It helps you check your knowledge and skills.
- It helps you check your motivation.
- It helps you evaluate your own work.

Remember to think about all your dimensions as a learner.

The checklist of questions below is a support structure to guide your thinking.
You can use it for as long as you need it.

You assess yourself before you do a task or an activity. You do this to see how ready you are to do it. You can ask yourself questions like:

B	What is the task?
E	What is my goal?
F	What information do I need?
O	What strategies do I need?
R	What time and resources do I need?
E	How motivated am I?

You assess yourself while you are doing a task or an activity. You do this to check your progress against your goal. You can ask yourself questions like:

D	Am I clear about what I am doing?
U	Does the task make sense?
R	Am I reaching my goal?
I	Do I need to change what I am doing?
N	Do I need to change the way I feel?
G	How motivated am I?

And you assess yourself after you have done a task or an activity. You do this to review and evaluate how you performed.

A	Have I reached my goal?
F	What worked?
T	What did not work?
E	What do I need to do differently next time?
R	What should I change about the way I feel next time?

Peer assessment

The word 'peer' means equal. In the workplace, peers are people who are equal to you because they do the same kind of work you do. Or they are equal to you because they occupy the same position in the organization as you do. Colleagues are people who work in the same organization as you do. They do not necessarily do the same work as you do. They are not necessarily equal to you. So, your peers are you colleagues. But all your colleagues are not your peers.

THE PLACE OF PEERS IN ASSESSMENT

WORK IN GROUPS OF FOUR

Together

Draw a mind-map of the people at work.

- Work out who are your peers and who are your colleagues.
- Put a symbol = (equal); ^ (above); and v (below) to show their position in the organization in relation to you.

Share ideas about

- Who should help you learn (put an H); and
- Who should assess your learning (put an A).

When it comes to learning, it is likely that many of you go to your peers when you need to know how to do something new or if you don't understand something. You may do this because you find it easy to ask them for help. You also feel confident enough in their knowledge and skills. And you also help them when they ask you. When it comes to colleagues, you may or may not ask them to help you. A lot depends on the culture of the organization, the personal relationship you have

with them and your own sense of self-confidence. But you probably feel that they should help you, especially if you are junior to them.

So, in general, you are likely to feel that peers and colleagues should help you learn. And you are quite correct. They should and they can.

When it comes to assessment, it is likely that many of you feel that you should be assessed by colleagues in positions above you. It is also possible that many of you think peers should not assess you. You may think this way because you don't feel that it would be fair. How can they judge? You also may think they don't know enough to assess you. Aren't peers equal to each other? You also may not value their assessment as being a true reflection of your ability. They either will be too kind, because you work together, or they will be unkind, because they see you as competition. So, in general you are likely to feel that colleagues should assess you and peers should not assess you.

These and other concerns about peer assessment are real. This is why it is important to be very clear about the learning you want to achieve. We use two forms of peer assessment in Work-*i*-Learn: routine feedback and structured peer review.

Routine feedback

The main form of peer assessment is routine feedback. You will learn more about feedback further on.

Routine feedback is the main form of feedback. Feedback comes from the people who you work with. It is a valued and routine part of how you work and learn.

For now, it is important to know that peer feedback works because it is easy to get and easier to understand.

But it only works well where there is trust, support and collaboration.

Everyone also needs to feel that they are responsible for their own learning and the learning of their peers.

Creating a work culture that supports learning is everyone's responsibility.

Structured peer review

The second form of peer assessment in Work-*i*-Learn is structured peer review. It is a form of evaluation. It follows a formalized set of objectives, activities and procedures. It involves people who are doing the same kind of work but who do not work together every day. They observe each other, exchange experiences and reflect together. They leave with focus and a plan of action. The process is documented and used to guide Work-*i*-Learn and service delivery. Structured peer reviews are repeated in order to provide ongoing feedback to support quality improvement.

Structured Peer Review: What is done in Gauteng

Pairs of whole ward based outreach teams review each other. Everyone in both teams is involved in the review and some people from each team also act as reviewers.

The review is guided by seven benchmarks. These are the activities and processes that enable WBOTs to deliver community based services. They are (1) mapping; (2) support, networks and partnerships; (3) infrastructure and functional equipment; (4) work integrated learning; (5) information management; (6) service tasks and activities; and (7) visits and management. The review lasts three days. The review team comes together and prepares at one site. For a day, they meet and interview key WBOT role players. They also participate in routine daily practices. On the second day, they follow the same process at the other team's site. On the third day, both teams reflect together in a peer exchange seminar. They identify a focus area for improvement and plan how to achieve it.
The review is repeated at four-to-six-month intervals.

Feedback

Feedback is an essential activity in learning. It is something that everyone should expect to be able to give. And it is something that everyone should expect to receive.

REVIEW AND REFLECT ON A DISRUPTION

INDIVIDUAL

Think of an example of bad feedback at work. Remember not to mention anyone by name.

THE DIFFERENCE BETWEEN GOOD AND BAD FEEDBACK

WORK IN GROUPS OF FOUR

Share examples.
Talk about why you think the feedback was bad.
Discuss how it could have been done differently to be good feedback

Everyone has experience of receiving bad and good feedback. For many of us, feedback is bad because of **what is said**. Often, it is bad because of **how something is said**. It may also be bad because of **where or when it is given**. Feedback is good for all the same reasons. So, from experience, we all know that feedback can be good or bad. We all also know that it affects how we feel and what we do.

Good feedback supports learning. It lets you know how you are doing and gives you ways to work out how to improve. Bad feedback either does not help you at all or, at its worst, stops or prevents learning.

We all have to be able to give good feedback in health care. It is how we help people take responsibility and control over their own health. It is how we help each other learn to deliver quality health care. It is how we develop our own abilities. It is how we improve our relationships at work. And it is how we increase the effectiveness of what we do.

Feedback is a communication skill. There is no single way to learn how to give feedback. But it is something that you can learn. Like all learning, you get better at feedback when you practice and you think about your practice.

AS A HEALTH CARE WORKER...

Feedback is not criticism or praise. When you criticize or praise you judge the person. You focus on their attributes or who they are. You make them feel threatened or entitled.

When you give feedback, you should focus on a person's actions or activities. You should focus on their abilities and the things they can change. You should encourage people to learn and improve. Criticism is about power. Feedback is about empowerment.

Good and bad feedback to support learning

As a starting point it is important to be able to know the difference between good and bad feedback. This way you have a clear idea of what your goal is and what skills you need to achieve it.

Skill: Know where to focus

- ✓ Good feedback is when you focus on the task, the activity or the behaviour. For example:
  - ☺ "When you told him how to take his medicine, did you think about…?" or
  - ☺ "When Mpho's mother was talking about her, what could you have listened for? "
- ✗ Bad feedback is when you focus on the person. For example:
  - ☹ "You are so clever." or
  - ☹ "You are not a very good listener." or
  - ☹ "Who's to blame?"

Skill: Identify relevant information

- ✓ Good feedback is when you are specific. Focus on one or two things. Describe things that are the most common or will produce the greatest gains. For example:
  - ☺ "When you showed him the TB medicine, it was good that you explained the phases of treatment."
- ✓ Bad feedback is when you are general or when you respond to everything. For example:
  - ☹ "You know a lot about TB medicine."

Skill: **Correct mistakes**

It is normal to make mistakes. We learn from mistakes when we get feedback that helps us correct the mistake.

- ✓ Good feedback is when you help the person recognize the mistake. For example:
  - ☺ "I was not too clear about what you were trying to say about breastfeeding and HIV. Can you explain again?"
- ✓ Good feedback is when you help the person understand the reason for the mistake. For example:
  - ☺ "Why do you think this might not be correct?"
- ✓ Bad feedback is when you point out the mistake. For example:
  - ☹ "You are wrong to say breastfeeding is only good for HIV+ women."
- ✓ Bad feedback is when you give the correct answer. For example:
  - ☹ "Breastfeeding is best for babies of HIV+ and HIV– mothers."

Skill: **Guide thinking**

- ✓ Good feedback is when you help the learner think about what they are doing, and help raise their ability. For example:
  - ☺ "When you tell him how to take his medicine…
    …what else can you say to help him?" or
    … have you thought about another way of supporting him?"
- ✓ Bad feedback is when you tell the learner what to think. For example:
  - ☹ "When you tell him how to take his medicine…

    …you should tell him to take it twice a day, with food." or

    … you should support him by doing this…"

2

***Skill:* Reinforce and extend the positive**

- ✓ Good feedback concentrates on extending people's abilities.
  - ☺ For example, "I can see what you have achieved. Can you add something to go further?"

There are also some processes that you can follow to make feedback more effective.

- ✓ Use feedback to set goals.
  - ☺ Feedback can be an effective way to help people achieve goals.
- ✓ Give feedback on time.
  - ☺ Feedback is most effective during or immediately after a task or before the person tries to do it again.
- ✓ Give feedback on achievements as well as errors or mistakes.
- ✓ Get feedback on your feedback.
  - ☺ Encourage people to share what they have heard you say and how they feel about what they have heard.
  - ☺ Reflect on the process on your own and with each other. You can do this by asking questions like "what is working well?"; "what do I or we need to improve on?" and "what help do I or we need?".

AS A HEALTH CARE WORKER...

Feedback is an essential skill.

You use feedback to build your own ability.

You use it to build the ability of other people.

It is a skill you learn through practice.

It is a skill that you learn with the help of peers, colleagues, patients and people in the community.

Talita de Beer

Pre-reading

1. What is the **heading** of this **module**?

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2. While thinking about the heading, what do you think the module is about?

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3.1 **Scan** through the module and read all the **subheadings**. Use a star (Ӿ/*) to mark all the **sections** that **seem** new or **unfamiliar** to you.

3.2 After scanning through the module, write down what you think the module is about (give more **detail** than in Question 2 above):

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4. What do you know about the **topic**: Literacy?

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5.1 What would you like to know about Literacy? Write down at **least** three questions:

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Heading: a word or sentence at the top or beginning of a paragraph to serve as a name.

Module: an educational unit in a series that covers one topic.

Scan: looking quickly at a text to find specific information, in other words not reading the text word for word.

Subheadings: names of sections that fall within the main heading.

Section: a specific part or portion of something that is written.

Seem: to give the impression of being.

Unfamiliar: not well-known; new.

Detail: smaller parts that form the whole; extra information.

Topic: the subject matter.

Least: the smallest or least possible.

5.2 Answer your questions as you read through the module:

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6. See if you can answer these questions below. If you cannot answer them now, answer them as you read through the module.

6.1 What is reading comprehension?

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6.2 Give two reasons why people may struggle to understand what they read.

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6.3 Write down the three steps of reading.

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6.4 Name five ways in which you can **improve** your reading comprehension.

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6.5 Name three types of graphic organisers.

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7. In this module I have tried to look for words that may be new to you and have written down their definitions. You will find these words throughout the module on the outside edge of the page, written in **bold** with their definitions. Read through these words and underline or highlight the words that are new to you. Write the words that are new to you in the space **provided** below and write their **definitions** next to them. Remember to look out for these words as you read through the module so that you can see how and where these words are used.

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Improve: to make something better.

Bold: writing that is thicker than normal so that the word stands out from between the other words.

Provided: given.

Definition: a statement that gives the meaning or essential nature of a word or phrase.

Reading

2.1 What is literacy?

'Literacy' is **defined** as 'the quality or state of being literate' (Merriam-Webster online dictionary). And to be **'literate'**, in its most basic form, means to be able to read and write. So, when we talk about literacy, we talk about the **ability** to read and write.

Sometimes people can read, but only very easy documents or books that don't contain difficult words. Sometimes people can write, but only short sentences and they cannot use difficult words or **explain** difficult **procedures** in writing.

Sometimes people can read and write very well in one language, but not in another language. This is often the case with English, which is used in many countries, but for many people it is only their second or third or even fifth language.

In South Africa, English is the language that is used most often for business, **commerce**, education and the law. So, even though some people may be very literate in their home language, because of their **lack** of **English Literacy** they may struggle to do business or to learn in English.

Defined: explained as; give the meaning.

Ability: to be able to do something.

Explain: to make something known or more understandable.

Procedure: steps that follow in a specific order.

STOP & CHECK

Explain this section ('What is literacy?') in your own words. Write it down and then share it with a colleague. Begin with: 'What this section is saying is…'

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2.2 Why is literacy important?

Imagine using your phone without being literate. Imagine you want to phone a friend, but you don't know how to spell her name. How would you be able to look up her number in order to phone her? Or imagine you could not read numbers. You would not even be able to type in her number if someone told you what it was.

This is a very **basic** example, but let's take it a little further. In your case, you are able to read and write, **else** you would not be reading this. But what if you were not able to read very difficult documents, like lawyers' documents? If your grandmother passed away, for instance, you would not be able to read and understand her will.

Commerce: exchanging or buying and selling of goods.

Lack: to be in need of something.

English Literacy: to be able to communicate (speak, read and write) in English.

Imagine: to form a picture in your mind of something that is not there.

Basic: simple or easy.

Else: otherwise.

Yes, not everyone can be expected to understand all the words in the world, but we must have **techniques** that can help us when we need to understand what we are reading.

AS A HEALTH WORKER...

literacy is important, because you must be able to…

- Read and understand health communication.
- Read and understand your learning material.
- Read and understand communication from your managers.
- Read and understand medication instructions to help clients understand how to take their medication.
- Read and understand your employment contracts.
- Can you add anything to this list?

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2.3 How do we improve our literacy?

Literacy is a skill, like being able to speak a second language or being able to play an instrument or do a sport. It requires practice and you need to do it regularly to stay **'fit'**. As with other skills, there are also **strategies** that you can practise and use which will help you get better at it.

To improve literacy, we can look at the following three aspects of literacy:

1. reading **comprehension** (understanding what you read),
2. writing, and
3. listening **comprehension.**

Technique: a method for achieving something specific.

What is the most important point in this section ('How do we improve our literacy?')?

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Fit: to be healthy or in a state in which you are able to do something.

Strategy: a careful plan or method.

Comprehension: understanding.

WRITING AS YOU READ

What is the most important point in this section ('How do we improve our literacy?')?

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Understand: to grasp the meaning of something.

Etc.: and so forth (et cetera).

Alphabet: a set of letters used to write words.

Assume: to suppose; to take something for granted or as true.

WRITING AS YOU READ

Write down a sentence for each of these four paragraphs ('What are the strategies for improving reading comprehension?') to explain the most important thing about that paragraph – you will have four sentences, one for each paragraph.

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ANSWER THE QUESTION

We are going to focus on reading comprehension.

2.4 What is reading comprehension?

Sometimes people think the point of reading is to say the words right, but once you've learnt to say the words right, what happens next?

Actually, the main point of reading is to understand the words and sentences, so that we can use them to communicate – to **understand** how to take our medication correctly, to understand what our contracts say, to learn new things, to share our experiences, to develop our minds, **etc**. To understand what we are reading, is called **reading comprehension**.

Reading is not a skill that we are born with, it is a skill that we need to learn and practise often so that we become better at it. First, we need to learn the **alphabet** and the sounds of the letters. Then we have to put these letters together to make words and, in this way, we learn to read the words. Once we can read a few words, we learn to put them together in order to read sentences. But as we learn to read words and sentences, we must also learn to understand what we are reading. And then we need to learn to read and understand more difficult words and sentences.

In this module, we are **assuming** that you can already read words and sentences. Instead, we will focus on the ways in which you can improve your understanding of what you read.

2.5 What are the strategies for improving reading comprehension?

There are a few strategies that can help improve our reading comprehension. Research has shown that it is best to use more than one strategy and that we have to practise these strategies.

You may already be using some of these strategies and be aware of it, or you may be using them without knowing that you are. Some of these strategies may be completely new to you. Try to practise all of them and then choose the ones that you feel most comfortable with and which you know help you to

understand what you are reading. Do not choose the ones that are easiest, choose the ones that really work for you. If you practise a lot you may learn to use some of these strategies without being aware of it.

Part of understanding these strategies is knowing where and when to use them. Some of these strategies you need to do before you start reading, others you use while you are reading and the rest you do after reading.

In this module I am going to explain these strategies and give you a few examples, but you are also going to practise these strategies so that you can apply them to the other COPC modules. The point is for you to improve your understanding of what you read in every part of your daily life.

There are two important things that you need to commit to, before you commit to learning these strategies:

1. You need to read as often as you can, so that you can practise these strategies and so that you can learn new words.
2. You need to write as often as you can, because research has shown that writing helps us to improve our reading comprehension.

Before we look at the specific strategies, let's look at the process of reading. There are three steps to reading and each of these steps have reading strategies specific to them.
The three steps are (1) **pre-reading**, (2) reading and (3) **post-reading**.

1. Pre-reading:

Before you read you need to prepare yourself for what you are about to read. You need to know what you are going to read about and think about what you already know about the topic, so that while you read you can check whether you are learning something new and whether you understand the new information.

What is the focus of this module?

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Pre-reading: 'pre-' is called a prefix, which means that it is not a word on its own, but rather a syllable (part of a word) that we put in front of a word to change its meaning. 'Pre-' means 'before'. Here the full meaning is: before reading.

Post-reading: 'post-' is a prefix that means 'after'. The meaning of 'post-reading' is 'after reading'.

STOP & CHECK
Explain what a prefix is to a friend.

WRITING AS YOU READ
Can you think of more words with the prefixes 'pre-' and 'post-'?
Like pre-primary and Post Traumatic Stress Disorder.

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Paragraph: a section of writing that consists of a few sentences and is separated from other paragraphs with an open line.

Decoding: to recognise and interpret.

Word recognition: to notice or recognise words that you know.

Recognise: to perceive something that you already know.

Fluency: being able to use a language easily and accurately.

Background knowledge: everything that you know about something or knowing many things about something.

2. Reading:

While you are reading the information, it is important to make sure that you understand what you are reading. It is good to stop every now and then, while you are reading, and ask yourself if you understand what you have just read.

Some reasons why people do not understand what they read:

1. **Sometimes people struggle to read the words.** People may struggle to put the sounds of the letters together to form the word and know what the words are. When this happens, people will struggle to read because letters are the building blocks of words. Words are the building blocks of sentences and sentences are the building blocks of **paragraphs**. So, to understand what you are reading, you need to be able to read and understand the words. This is called **decoding** and **word recognition**.

2. **People may struggle to read when they cannot recognise words quickly**. When people have to sound out all the words in a sentence, it takes so much effort that they forget the earlier words and cannot put the whole sentence together to find out what it means. To be able to understand what you read, you have to be able to **recognise** most words quickly so that you can focus on the meaning of the sentence and not on trying to work out each word. This is called **fluency**.

3. **Sometimes people can read well, but when they read something with many words that they have never seen or heard before (words that they do not understand), they will understand very little of what they are reading.** To understand what you are reading, you have to understand what all the words mean. This can also be seen as **background knowledge**. When you are reading about a topic that is new to you, you will have to concentrate more and look up the meaning of several

words in a **dictionary** and sometimes **reread** a sentence, so that you can start understanding what you are reading. This is about the **reading level** and **vocabulary** of the **text**.

4. **People may struggle to focus while they are reading, making it difficult to understand what they are reading.** There are many reasons for why people may struggle to focus. Some reasons could be situational, like being tired or trying to read while your friends are having a **conversation**. If you don't read often, you may struggle to concentrate because it takes practise and effort. Some people may struggle to read because they have Attention Deficit Disorder, which means that they struggle to concentrate in general. This is not very common. You have to be able to concentrate and focus in order to understand what you are reading. This is called **focus** and **attention**.

5. **There are skills and strategies that people use to help them understand what they read. People who struggle to understand what they read often don't use these skills and strategies.** While you are reading there are ways in which you can test to see if you understand what you are reading, like asking yourself questions about what you are reading or stopping after each paragraph and asking yourself if you understand what you have just read. This is called **comprehension skills** and strategies.

We will discuss these skills and strategies in a bit.

3. Post-reading:

I have introduced pre-reading and reading, now we are going to look at post-reading. After you have read a chapter or a module, it is good to check your understanding by **summarising** or answering questions. When you are not sure of something, it is good to go back and read that bit again. If you realise that your questions are still not answered, it is good to find something else to read that will answer your questions.

Dictionary: a reference source with words and their meanings, in alphabetical order.

Reread: to read again.

Reading level: how easy or difficult the reading material is.

Vocabulary: all the words of a language.

Text: written or printed matter on a page.

Conversation: talking together to share ideas, opinions and meanings.

Focus: to put all your thinking energy onto one point; concentrating on one thing.

Attention: applying the mind to something.

Comprehension skills: skills that help you understand.

Summarise: to cover the most important points, without giving detail.

ANSWER THE QUESTION

What are the three steps of reading?

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Mental picture: a representation of the outside world in a person's mind.

Activate: to make active or alive.

Prior knowledge: 'prior' means earlier, so here 'prior knowledge' means knowledge that you have gained before.

STOP & CHECK

Explain 'Scanning and predicting' to a colleague. Use these prompts:

- Scanning is…
- Predicting is…
- To scan and predict you must…

Predicting: to foretell something in advance based on observation or experience.

Graph: a picture that shows the relationship between different situations, usually with different sized columns or a line that shows how something increases or decreases.

Now we will look at specific techniques. I will discuss them under the three reading steps: pre-reading, reading and post-reading, so that you will know where or when to apply these techniques.

2.6 Pre-reading: comprehension skills and strategies

Before you read, especially when you are reading your COPC modules, it is good to get a **mental picture** of what you are about to read, so that you can **activate** what you already know about the subject (**prior knowledge**) and think about what you do not know so that you can focus on learning new information about the subject. There are a few ways in which you can do this:

1. Scanning and predicting

What:

Scanning means to 'look quickly'. When we 'look quickly' at the subheadings of a module, we create a mental picture of what to expect when we read the module. Creating this mental picture is called **'predicting'** – we are trying to predict what we are going to read. When we do this, we are more open to trying to understand what we are reading and also to noticing when we read something that is new to us. When we do this, we will also notice which sections we already have knowledge of and which sections we know nothing about, so that we can spend more time and energy on understanding the sections that are new to us and less time on reading the sections that we already know.

How:

- Look at the heading of the module and ask yourself: "What is this module about?"
- Scan through the rest of the module by reading the subheadings and looking at any pictures or **graphs**. Ask yourself what the subheadings and pictures tell you about what you are going to read. When you do this, you are trying to predict what the module is about.

Example:

On page 91 you were asked to look at the heading of the module and write about the topic of the module. You were also asked to scan through the module and write what you think the module would be about. Go back to page 91 and look at Questions 1 to 3 again.

2. Accessing prior knowledge

What:

Because we are all exposed to life and we all have many experiences, there are very few things that we know nothing about. Often, we already have knowledge about topics that we are going to read about. Sometimes this knowledge comes from personal experiences that we have had. For example, if you have broken your arm and had to wear a cast, you will know what a broken bone looks like on an x-ray and you will know how long you should keep a cast on, because you have gone through the experience. Sometimes this knowledge is because you have learnt about it somewhere else, like if you have studied nursing you will know many things about health that you had to learn to pass your exams. Sometimes this information comes from other people. Your friend might have a baby and she will tell you about breastfeeding and formula milk, or the different sizes baby-clothes come in. Often this knowledge is correct, but sometimes what we know may be wrong, because of people telling us the wrong thing or because we understood something **incorrectly**.

Before we read about something, it is good to think about what we already know about that topic, so that we can **confirm** the things we already know, add new things to what we know and also correct the wrong information we may have. While we are reading, we can look for things that we do not know yet and spend more time on trying to understand them.

It is also easier to **remember** new information when we can 'hook' this information onto information that we already have, like this wagon is hooked onto the rest of the train.

Access: the ability to get or use something.

WRITING AS YOU READ

Write three to five sentences to summarise this section ('Accessing prior knowledge'):

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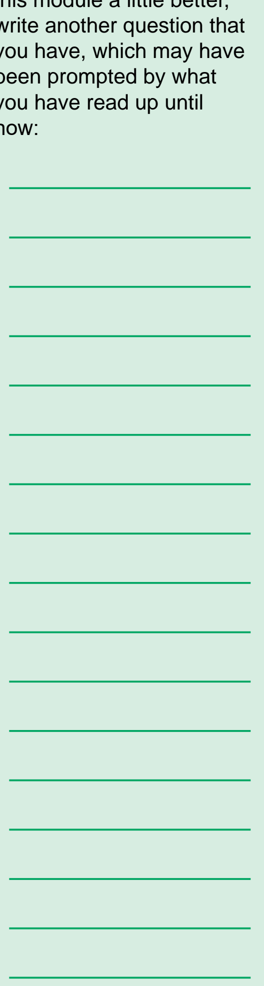
Incorrectly: wrong; not correct.

Confirm: to affirm; verify; support; to say that something is true and correct.

Remember: to bring to mind or think of again.



Motivation: something that causes a person to act – usually a need or desire.

Interested: paying attention to something because you like it.

CHOOSE

Now that you understand this module a little better, write another question that you have, which may have been prompted by what you have read up until now:

How:

- One way of accessing prior knowledge is to write down what you already know about the topic that you are about to read.
- If you are a group of people (like your fellow CHWs) who have to read about the same topic, another way of accessing prior knowledge is to discuss the topic in the group, before you read the module.
- Of course you can also just spend a few minutes thinking about what you already know about the subject, but remember that writing will also help to improve your reading comprehension, so it is good practice to write down what you know.
- If you write down what you already know, you can also come back to what you have written after reading the module and add new information to your notes and correct wrong information.

Example:

In the pre-reading exercise on page 91 you were asked to think about and write down what you already know about 'Literacy'. Go back to page 91 and look at Question 4.

3. Choose what you want to learn/read

What:

Motivation is probably the most important factor of reading. If you are not **interested** in what you are reading, you will not focus to try and understand what you are reading. You will also not try to remember what you are reading.

Sometimes we may think that we are not interested in what we have to read, but there are a few ways in which we can spark our interest.

How:

- Ask your *own* questions. Think about what *you* would like to know about the topic and then write down those questions. Do not write down questions that you think your **supervisor** or someone else would like you to write down – it is important that you write down questions that interest you. As you read the module, look for the answers to your questions.
- Choose what you want to read. Choose the part of the module that interests you; the section that you think: "I want to read this!", and read that part first. Once you have read that part, you may have new questions and will be interested in reading the rest of the module.

Example:

See Question 5.1 and 5.2 in the pre-reading exercise on pages 91 and 92 where you wrote down your own questions.

4. Read and answer questions before reading the module

What:

When you read questions about the module before you read the module, you will keep your eyes open for specific information while you are reading, so that instead of reading just for the sake of reading, you will be reading with the purpose of looking for and understanding information.

If you try to answer these questions before you read the module, you will get an idea of what you know and what you don't know about the topic. As you read, you will look for the answers to the questions that you could not answer. Or you may realise that you may have gotten some of the answers wrong and then you can correct them and improve your knowledge.

Supervisor: someone who is in charge of a unit or operation.

ANSWER THE QUESTION

Name one reason why reading the question before reading the module will help you understand what you read:

Marine biology: the scientific study of life in the sea.

Context: the other words and sentences around the word that help to reveal its meaning.

UNDERSTAND THE WORDS

Underline the words on this page that you don't understand. Write them all down here, look up their meanings and write the meanings down as well.

How:

- Look through the module and at the end of the module to see if there are any questions written by the writer of the module. Read through these questions and try to answer them. Write your answers down, so that you can practise writing and also so that you can check your answers while you are reading.
- While you are reading, look for the answers to the questions and write them down.
- If there are no questions, ask your supervisor for questions or ask your own questions.

Example:

Questions 6.1 to 6.5 in the pre-reading exercise (page 95-96) are examples of these types of questions. There are also questions asked throughout this module which are intended to help you with understanding the information.

5. Understand the jargon

What:

'Jargon' is what we call words that are specific to a topic. These words are not everyday-words like 'jump', 'bladder' and 'computer' which all people understand. Not all people will understand the jargon of **marine biology** or medicine, and not all people have to understand the jargon of all topics. But if you are going to learn about a new subject, then learning the jargon of or the words specific to that subject is part of what you need to do. This is important, because understanding the jargon is part of understanding the topic.

Not only is it important to understand the words, it is also important to understand where and how these words are used in sentences – to understand the **contexts** of the words.

How:

- Scan through the module to see if you can find any words with their definitions. This may be as a **vocabulary list** at the start or the end of the

module, or words may be explained in the text as they appear. Read through these words to see which ones you know, and mark the ones that you don't know.

- Keep an eye open for these words while you are reading so that you can see where and how these words are used – the contexts of the words.
- If there are no vocabulary lists or explanations of the words in the text, create your own list by writing down the words that you don't understand as you read, and looking up and writing down their meanings. This will be explained in more detail in the section on reading.
- Online dictionaries that you can try out:
  - Merriam-Webster Online: *https://www.merriam-webster.com/*
  - Cambridge Dictionary: *http://dictionary.cambridge.org/us/*
- Dictionary apps that you can download onto your phone:
  - WordWeb: *http://appcrawlr.com/android/wordweb-english-dictionary*
  - Merriam-Webster App: *http://appcrawlr.com/android/dictionary-merriam-webster*

Vocabulary list: a list of words and their meanings.

Example:

In this module we explain some of the words as you read them – these words are printed in **bold** and their definitions are given in the right/left **margin**. Not all of these words are jargon (specific to 'Literacy'), but many of them are, like **'glossary'**, 'vocabulary list', and 'reading comprehension'.

Margin: the outside edge of a page – outside the main body of writing or printing.

Glossary: a collection of words and their meanings.

PRE-READING

Choose one of the pre-reading comprehension skills and write down why you think the technique will help you personally to improve your reading comprehension.

ANSWER THE QUESTION

Why do you think we say 'reading is thinking'?

Unfortunately: in an unlucky or unsuitable manner.

To make sense: to understand; to figure out.

Habit: a behaviour pattern that develops through repeating it often.

Automatically: without thinking about it; spontaneously; unconsciously.

Aware: showing perception and knowledge of something.

Passage: a short piece of written or printed work that focuses on one point.

Conscious: to be aware; marked by thought.

2.7 Reading: Comprehension skills and strategies

~ *Reading is thinking* ~

When you are reading something that you do not understand, it is easy to read without thinking, just to get through the text. **Unfortunately**, if that happens you might as well stop reading and spend your time on something else. This is because the point of reading is **to make sense** of what you are reading in order to communicate or learn something new. You have to think as you read.

If you are not in the **habit** of thinking while you are reading, there are a few strategies that you can use that will help you to get into this habit.

A few of these strategies are explained here.

1. Stop & check

What:

Readers who read with good understanding often ask themselves while they are reading if they understand what they are reading. They do this **automatically**, because it has become a habit. This means that they do not actually ask themselves if they understand, but they are **aware** of their understanding. The moment they realise that they don't understand what they are reading anymore, they will stop and read the **passage** again and again until they are certain that they understand it.

Readers who do not read with understanding have to learn to do this **consciously**.

How:

- After each paragraph, stop reading and ask yourself: "Do I understand what I have just read?" Be honest with yourself.
- An easy way to check if you understand what you have just read is by trying to explain it either to yourself or to someone who is willing to listen. You can start with these words: "So, what this

paragraph is saying is…". It is best to use your own words when you are explaining.

- You can also write down your explanation.
- If you realise that you do not understand what you have read, or that you don't understand ALL of it, go back and read the paragraph again until you understand it.
- If you still do not understand what you have read, ask someone who understands to explain it to you or read another text about the same topic.

Example:

Read through the 'How' section of 'Stop & check' again. After reading each **bullet point**, stop and ask yourself if you understand what you have just read. Be honest with yourself. Read the bullet point again if you are not sure of your understanding.

2. Writing as you read

What:

Writing in itself will improve your reading, but apart from that, writing as you read will help you to enforce the Stop & check technique described above.

How:

- After reading each paragraph, stop and write down one sentence that summarises the paragraph. This means that you have to decide what is the one most important thing that the paragraph wants you to know, and that is what you write down. Writers who write well only has one idea per paragraph and this they write in the **topic sentence** which is **often** the first or second sentence in the paragraph. All the other sentences are only there to explain the topic sentence, to support the topic sentence, give more information about the topic sentence or to give examples.
- Another method that you can use is to underline the topic sentence in the paragraph and then rewrite it in your own words. That is, rewrite it in a way that makes most sense to you.
- You can also underline and write down all the **keywords** and key **phrases** in the paragraph.

STOP & CHECK

Explain or write down how 'stop & check' works in your own words:

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Bullet point: a symbol that introduces items in a list (for example: • or –).

Topic sentence: a sentence that summarises the whole paragraph.

Often: many times.

Keywords: the most important words in a passage.

Phrase: a few words that together forms one idea or concept.

WRITING AS YOU READ

Underline all the keywords in the passage 'Writing as you read'.

General: involving the whole rather than limited details.

Idea: a central meaning.

Specifics: details.

Selected: chosen.

Related: connected.

I explain how to find the topic sentence and the keywords below.

How to identify the topic sentence in a paragraph:

- **Step 1:** Find the topic of the paragraph:
  - Scan the paragraph to look for a word, phrase or **idea** that is repeated often throughout the paragraph. Underline the word, phrase or idea in pencil. This is possibly the topic of the paragraph.
  - Now you have to check if the word, phrase or idea which you underlined is really the topic of the paragraph. To do this read each sentence carefully to see if the sentence says something about the word, phrase or idea which you underlined. If every sentence is about the word, phrase or idea which you underlined, then you have discovered the topic of the paragraph.
  - You may have underlined more than one word, phrase or idea or while checking you may discover that the word, phrase or idea which you chose at first is not the topic of the paragraph. This is OK, you can change your mind. The topic of the paragraph is the 'thing' that every sentence in that paragraph is about.
- **Step 2:** When you have the topic of the sentence, look for the most **general** sentence about the topic. That means, look for the sentence that does not give any **specifics**.
- **Step 3:** Test to see if you have **selected** the correct topic sentence by checking if the other sentences are **related** to that topic sentence and if the sentence gives you *information* (something that you must know). If all the other sentences relate to the sentence you selected and the sentence gives you information, then you have chosen the topic sentence.
- You will have to practise finding the topic sentence.

Example:

Let's take the following paragraph from *A Practical Guide to Doing Community Oriented Primary Care* (page 4) and find the topic sentence together:

1. First, we need to scan the paragraph to look for words, phrases or ideas that are repeating.

> TB is spread in tiny drops that are invisible to the naked eye. It is spread in the air when a person with active TB coughs, sneezes, speaks, sings or laughs. The drops float around for a long time especially in places that are dark and poorly ventilated. Sunlight and wind (fresh air) destroy TB.

Can you see that the word 'TB' is repeated three times and appears in each of the sentences? Let's circle the word 'TB'. We also see that the word 'drops' is repeated two times and in the third sentence we can safely assume that the word 'drops' refer to TB drops. So, the topic of the paragraph is TB drops (that TB spreads in drops).

> TB is spread in tiny drops that are invisible to the naked eye. It is spread in the air when a person with active TB coughs, sneezes, speaks, sings or laughs. The drops float around for a long time especially in places that are dark and poorly ventilated. Sunlight and wind (fresh air) destroy TB.

2. Now we have to read each sentence carefully and decide which sentence is the most general (least specific).

- The first sentence tells us that TB is spread in tiny drops.
- The second sentence gives more information about how these drops are spread from person to person – through coughing, sneezing, speaking, singing and laughing. So, this sentence is a bit more specific.
- The third sentence gives more information about how long these TB drops can float around in dark and poorly ventilated places. This sentence is also more specific.
- The last sentence gives information about how these TB drops can be destroyed. It also gives more specific information.

Can you see that the first sentence is the most general one? It tells us about how TB is spread in tiny drops in a more general sense. Thus, the first sentence is possibly the topic sentence.

> TB is spread in tiny drops that are invisible to the naked eye. It is spread in the air when a person with active TB coughs, sneezes, speaks, sings or laughs. The drops float around for a long time especially in places that are dark and poorly ventilated. Sunlight and wind (fresh air) destroy TB.

3. Now we have to test if the sentence we have chosen is actually the topic sentence. As mentioned, the way to test if the sentence we chose is the topic sentence is to see if all the other sentences relate to the topic sentence. Let's test.

- The second sentence relates to the first sentence, because it tells us how the TB drops are spread from person to person.
- The third sentence relates to the first sentence, because it gives us information on how these TB drops survive.
- The last sentence relates to the first sentence, because it tells us how the TB drops can be destroyed.

Therefore, we can safely say that the first sentence is indeed the topic sentence:

Let's do a second example, also from *A Practical Guide to Doing Community Oriented Primary Care* (page 27):

1. First, we scan the paragraph for words, phrases or ideas that appear throughout the paragraph. Use a pen or pencil to circle the words:

> To understand why blood pressure is a very serious cardiovascular health risk we have to begin by understanding what blood pressure is. Blood pressure is the force that blood puts on the walls of blood vessels. This force goes up when the heart contracts and pushes blood through the blood vessels that carry it around the body. It goes down when the heart relaxes, although there is always a certain amount of pressure on the walls of blood vessels.

Do you agree that the word 'blood' is the one that appears most in the paragraph? Let's underline or circle the word 'blood' and then test to see if we have found the correct topic of the paragraph:

> To understand why blood pressure is a very serious cardiovascular health risk we have to begin by understanding what blood pressure is. Blood pressure is the force that blood puts on the walls of blood vessels. This force goes up when the heart contracts and pushes blood through the blood vessels that carry it around the body. It goes down when the heart relaxes, although there is always a certain amount of pressure on the walls of blood vessels.

Now, let's read the paragraph carefully to see if the topic of the paragraph is 'blood' – read through the paragraph by yourself before you read through the analysis below:

- The first sentence talks about 'blood pressure' and not 'blood' only and it says that we need to understand what blood pressure is.
- The second sentence explains what blood pressure is ('force').
- The third and fourth sentences explain how this 'force' goes up and down – in other words how blood pressure goes up and down.

When we think carefully about what this paragraph is trying to tell us, we will realise that this paragraph is not telling us much about blood itself, but it is actually telling us about 'blood pressure' – what it is and what causes it to go up and down. Therefore, we should rather say that the topic of this paragraph is *blood pressure*, sometimes described as *force*.

> To understand why blood pressure is a very serious cardiovascular health risk we have to begin by understanding what blood pressure is. Blood pressure is the force that blood puts on the walls of blood vessels. This force goes up when the heart contracts and pushes blood through the blood vessels that carry it around the body. It goes down when the heart relaxes, although there is always a certain amount of pressure on the walls of blood vessels.

2. Secondly, we have to read through the paragraph again to find the most general sentence. Try finding the sentence yourself:

- The first sentence is very general by urging us to understand blood pressure before we try to understand why it is a very serious health risk.
- The second sentence is also general, because it gives a general explanation of blood pressure. This sentence, however, is a bit more specific than the first one.
- As we mentioned before, the third sentence explains what causes blood pressure to go up and is thus a sentence that gives specific information about blood pressure.
- The fourth sentence also gives specific information about blood pressure by explaining when blood pressure goes down and also adding that there is always some blood pressure.

From this analysis we can say that the first sentence is the most general and therefore possibly the topic sentence. But we still need to test our thinking.

2. To test, let us see if all the other sentences relate to the topic sentence we chose:

- Does the second sentence relate to the first sentence? The second sentence is a definition of blood pressure and in the first sentence we have been asked to understand what blood pressure is. So, yes, the second sentence definitely relates to the first sentence.
- The third sentence describes a specific aspect of blood pressure, so it does relate to the first sentence, but it relates more directly to the second sentence by explaining blood pressure in more detail.
- The fourth sentence also serves to explain blood pressure in more detail, and therefore also relates more to the second sentence than the first sentence.

Here is a visual explanation:

To understand why blood pressure is a very serious cardiovascular health risk we have to begin by understanding what blood pressure is. Blood pressure is the force that blood puts on the walls of blood vessels. This force goes up when the heart contracts and pushes blood through the blood vessels that carry it around the body. It goes down when the heart relaxes, although there is always a certain amount of pressure on the walls of blood vessels.

Can you see that I said that the first sentence relates to the second sentence as much as the second sentence relates to the first sentence? – look at the blue and orange arrows. This is because, sometimes we need to think a little bit more about the topic sentence than just following the three steps as shown above. Yes, we have decided that the first sentence is the *most general* sentence, but we also have to choose the sentence that gives us the *information*. If we want to *learn* something from this paragraph, what do you think will be more important to remember? To know that we must understand what blood pressure is in order to understand why high blood pressure is a risk (sentence 1) OR to know what high blood pressure is (in other words, the definition of high blood pressure in sentence 2)? The definition of high blood pressure is more important, because it gives us information – the second sentence is the most important. In a final step, let's look at all four sentences again:

- Sentence 1: This sentence serves as a **teaser** to get the reader interested in the information that will follow and it **emphasises** that the information that follows is important.
- Sentence 2: This is the topic sentence, because it gives a general definition of blood pressure and all the other sentences relate to this one.
- Sentence 3: This sentence gives us more specific information about blood pressure.
- Sentence 4: This sentence also gives us more specific information about blood pressure.

Teaser: intended to arouse interest or curiosity.

Emphasise: to stress in order to give importance to something.

Therefore, the topic sentence is: ‘Blood pressure is the force that blood puts on the walls of blood pressure.

To understand why blood pressure is a very serious cardiovascular health risk we have to begin by understanding what blood pressure is. Blood pressure is the force that blood puts on the walls of blood vessels. This force goes up when the heart contracts and pushes blood through the blood vessels that carry it around the body. It goes down when the heart relaxes, although there is always a certain amount of pressure on the walls of blood vessels.

THE TOPIC SENTENCE

Now, practise the three steps of finding the topic sentence:

Step 1: Find the topic of the paragraph and test to see if the topic is correct.

Step 2: Find the topic sentence based on the topic of the paragraph.

Step 3: Test to see if the topic sentence you chose is correct.

Use this paragraph from *A Practical Guide to Doing Community Oriented Primary Care* (page 97). Use pens and pencils and circle, underline and mark what you need to here on the paragraph:

Relationship continuity. There needs te be some kind of on-going relationship between providers and users of health care services. This relationship can be between individuals (e.g. a doctor and patient or nurses and patient). It can also be between teams of health care providers and individuals and families (e.g. health professionals can support ward health teams that are linked to individuals and families by each community health worker).

When you have gone through Steps 1 to 3, write down the topic sentence below:

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How to identify the keywords and key phrases in a paragraph:

Keywords and key phrases are the most important words and phrases in a paragraph. Those are the words and phrases that you will use when you explain what you are reading to someone else. Even though you will use your own words in general to describe what you are reading to that person, there are some words that you will use that come straight from the passage you are reading. These are the keywords and phrases.

One way of identifying the keywords and phrases is to ask the following five **W**-questions of each paragraph or section that you are reading and highlighting the answers to these questions:

- **W**ho is important?
- **W**hat is important?
- **W**here is this important?
- **W**hen is this important?
- **W**hy is this important?

Some of these questions may not have answers, but at least one of them will; and this answer will be a keyword or phrase.

Example:

The following paragraph is taken from page 69 of *A Practical Guide to Doing Community Oriented Primary Care*. Read through it and then ask the five W-questions and highlight or underline the answers.

> Unborn babies sleep and move around during pregnancy. From about 18-25 weeks into the pregnancy a mother-to-be will begin to feel her baby's movements and will soon notice a pattern. This is good because she will then be able to know if there is a change. If a mother notices a dramatic decrease in her baby's movements she should get medical help.

Let's look at the results. I used the following colour code:

Who is important?

What is important?

Where is this important?

When is this important?

Why is this important?

Unborn babies sleep and move around during pregnancy. From about 18-25 weeks into the pregnancy a mother-to-be will begin to feel her baby's movement and will soon notice a pattern. This is good because she will then be able to know if there is a chance. If a mother notices a dramatic decrease in her baby's movements she should get medical help.

We managed to find an answer to all the questions, except for 'Where is this important'. But as this information is important everywhere, it does not have to be said.

Can you see that once you understand this paragraph, it is easy to explain it to your colleague by only looking at the keywords and key phrases highlighted here?

KEYWORDS AND KEY PHRASES

Now, practise finding the keywords and key phrases by yourself by asking the five W-questions (from *A Practical Guide to Doing Community Oriented Primary Care*, page 44) (use a pencil and work on this paragraph here):

Domestic violence happens amongst all groups and classes of people in all societies. Abusers and victims of domestic violence are female and male. They can be children and adults, young or old. Victims of domestic violence are in heterosexual relationships and homosexual relationships. They come from all socio-economic classes and occupations. They come from all relligious affiliations.

Write down the W-questions with their answers (the keywords and key phrases) here:

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ANSWER THE QUESTIONS

What does it mean if you can answer a question about the text?

What must you do when you cannot answer a question?

Why do you think the answer to one of your own questions may not be in the reading material?

Relevant section: the applicable section. The section where you think the answer may be.

3. Answer questions

What:

Some learning material ask questions as you read the text. These questions are there for you to check if you understand what you are reading. If you can answer the questions correctly, it means that you understand what you have read. Answering questions as you read also helps you to think about what you are reading, because you have to understand what you are reading in order to answer the questions.

Remember the questions that you asked and looked at while doing the pre-reading? (page 91-93) These are also questions that you answer while you are reading.

How:

- If the learning material has questions in the text, you simply have to read the question and answer it. If you cannot answer the question, read the paragraph or section again and look for the answer to the question while you are reading. If you can answer the question, write your answer down and then read the paragraph or section again to check that your answer is correct. It is always better to write the answer in your own words, as often as possible.
- If you are focusing on answering the questions that you asked and looked at in the pre-reading, keep your eyes open for clues to the answers as you read. If you think that you have found the answer or a clue to the answer, go back and read the question again to make sure. If you have found the answer or part of the answer, write it down, preferably in your own words.
- Because you have scanned the subheadings and read the questions during the pre-reading, you may have an idea of where in the module the answer to each question will possibly be. When you reach the **relevant section**, read the question again and then read the section carefully to see if the answer is in that section.

If the answer is not in that section, it may be because it is in another section or it may be that you have not read carefully enough.

- It may be that some of the questions that you have created yourself will not have answers in the module or text that you are reading. If that is so, you will have to find your answer in another book or piece of information.

Example:

Question: Why does it help to answer questions as you read a text?

Answer: Questions help you to think about what you are reading. When you answer a question correctly, you know that you understand what you are reading.

4. Spend more time on what you don't know or understand

What:

It is easy to read something that you understand and know, but it takes much more effort to read something that is **unknown** to you or that is difficult to understand. If we are not interested in reading, we will skip over the parts we don't understand and rather read the bits that we do. But then we will not understand what we are reading and we will not learn new things. We must teach ourselves to read the bits that we do understand quickly and rather spend more time on the bits that we find hard to understand.

How:

- While you are scanning through the module, as we discussed in the pre-reading section, you should recognise which parts of the module seem familiar and which parts seem completely new to you. Mark the parts which look new or unfamiliar to you with a star or an arrow or by highlighting the subheading. While you are reading through the module you will notice your star (arrow or highlight) and know that you have to concentrate more while you are reading that specific section.

WRITING AS YOU READ

Find and underline the topic sentence in the 'What'-paragraph. Rewrite the topic sentence in your own words:

Unknown: not known; not generally recognised.

Synonyms: two or more words that have the same or similar meanings.

Persevere: to keep going on, regardless of difficulties.

Picture: create a picture in your mind; imagine.

Exactly: being very specific.

WRITING AS YOU READ

Underline the keywords and key phrases on this page, and write them down:

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- When you get to the end of a paragraph and you do the 'Stop & check' as discussed above, and your answer is: "No, I don't understand what I have just read", try to understand why that is so.
- Perhaps you were not concentrating while you were reading and if you read through the passage again while concentrating more, you will understand it.
- Perhaps there are some words in the paragraph that you do not understand, then you must look up the meanings of the words and read the paragraph again with the meaning in mind. You can also look for **synonyms** to the words, synonyms that you do understand, and put them in the sentences and read the paragraph again with the synonyms instead. Be careful when using synonyms – not all synonyms have the exact same meaning as the original word. Also, some words can be used in different ways and will have different synonyms for different contexts.
- Perhaps you do not understand the context or you don't have enough background knowledge to understand what you are reading. The more you know about a topic, the easier it will be to understand new information on that topic. This means that the more you read, the more you will understand – it helps to **persevere**. But if you are really struggling to understand, it is always good to ask someone to explain the information to you.

When you know why you did not understand the paragraph, do what you need to do to help you understand the paragraph while reading it again.

- Try to **picture** what you are reading – imagine what it would look like or be like. Or try to think of similar experiences that you may have had.
- If you are still struggling to understand what you are reading, try to separate what you do understand from what you don't understand. Underline everything that you do understand and circle everything that you don't understand. This will give you a better idea of what **exactly** you don't understand. Sometimes it feels as though we don't understand anything, but if we

look closely we will realise that there are only a few words or only one sentence that we don't understand. When you are done underlining and circling, look up the meaning of the words that you don't understand or ask someone to explain the sentence to you.

- If you have tried understanding by yourself, but you are still not sure, ask someone to help you.

Example:

This example shows part of the index of *A Practical Guide to Doing Community Oriented Primary Care* (page iii) and stars indicating the sections which the reader felt would be new to her:

The Relevance of COPC in Present day South Africa 1
1.1 The Health Challenge - The Burden of Disease 1
1.1.1 Infectious Diseases 2
HIV/AIDS 2
Activity 1 - Working in pairs 3
Tuberculosis (TB) 4
Activity 2 - Working in pairs 6
★ 1.1.2 Maternal Mortality and Infant and Child Death and Illness 8
1.1.3 Non-Communicable Diseases 15
Healthy LifeStyle 'Big Five' 18
★ Diabetes 19
Activity 3 - Group 24
Cardiovascular Diseases 25
Activity 4 - Working in pairs 31
★ Cancer 33
Activity 5 - Working in pairs 36
1.1.4 Violence and Injury 37
Activity 6 - Working in pairs 39

5. Understand the words

What:

As mentioned before, learning about something new is also about learning the words – jargon. Often when we don't understand what we are reading, it is actually just because there are words that we do not know the meaning of. Once we understand the words, and where and how they are used, we will understand what we are reading. The more we read a word in context, the better we will understand it, and eventually we will even be able to use the word ourselves.

Repetition: the act of repeating; to **repeat**.

Repeat: to do or make again.

Consult: to refer to; to look at.

UNDERSTAND THE WORDS

Underline the words on this page that you don't understand. Look up the meanings of these words and write each meaning above each word.

How:

- The first way was mentioned in the pre-reading section above – look for vocabulary lists or words explained in the text and note which ones are new to you. Then, keep your eyes open for the words while you are reading, so that you can learn where and how the words are used in the text. You will probably not remember the word's meaning anyway, and will have to go back to read its meaning again when you find it in the text. This is always a good thing, because **repetition** will help you remember. You can also write the meaning of the word or draw a picture that will help you remember above the word in your text.
- Some learning material only has a glossary at the very back. Trying to read through the whole glossary before you read the material will be worthless, because trying to learn words out of context is really hard and the chance that you will forget them is very high. What is worthwhile, though, is to **consult** the glossary as you read the material and find words that you don't understand. When you read a word that you don't understand, stop immediately, look for the word in the glossary and read its meaning. If it is your own book, write the meaning of the word above or below the word where it is used in the material, so that when you read the material again, you won't have to go to the glossary again if you have forgotten the meaning of the word.

It is always good to read with a pencil in your hand and to underline all the words that are new to you as you read. It also helps to write your own notes about what you are reading. When you find a word that you don't understand, stop reading, underline the word and look for its definition in a dictionary or in the glossary. Nowadays it is easy to look up the meaning of words online, so we don't have to carry a dictionary everywhere. Write down the definition of the word, or even just a synonym of the word that you do understand, above the word, so that you can easily see what it means. Remember to be careful with synonyms that don't have exactly the same meaning as the original word.

See page 15 for the URL links to online dictionaries.

- You can also create your own personal dictionary by writing words that are new to you and their meaning in a small book. If you do this, you can see how many new words you are learning, go back to check words that you have already written down and mark the words that you know so well that you are already using them yourself.

Example

user friendly.

One common way of giving meaning to data and making it accessible is to create tables. Lets begin with the demographic data that we have.

Demographic data ', especially age and gender,

READING

Choose one of the reading comprehension skills and write down why you think the technique will help you personally to improve your reading comprehension.

Creative: the ability to create; creating anew.

ANSWER THE QUESTIONS

Think about the new things that you have learnt while reading this module – is there anything that you don't understand completely? Write it down here:

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Why do you think you don't understand it?

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2.8 Post-reading: Comprehension skills and strategies

After reading, there are also a few things that you can do to help yourself understand and remember what you have read.

1. Write down new things

What:

When you have finished reading the module or chapter, take a moment to write down all the new things that you have learnt while reading. Doing this will help you to think about what you have read and you may realise that there are some parts of the text that you still don't understand. Writing down what you have learnt will also help you to *remember* the things that you have learnt. You will also realise how much you have understood.

How:

- You can write the new things that you have learnt as a paragraph or a list or as a mind map or in any **creative** way that you find interesting. I will explain some of these methods later.
- Put in as much detail as is necessary for you to understand and remember what you have read.
- If, while writing these down, you realise that there is a section of the information which you still don't understand properly, go back and read the section until you understand it. As mentioned before, if after trying your best, you still do not understand, ask someone to explain it to you or read another book that explains the information differently.

Example:

Write down one new thing that you have learnt by reading this module, here:

____

____

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2. Revisit pre-reading questions and answers

What:
Once you have read through the whole module or chapter, you need to make sure that you have answered all the questions that you asked and looked at in the pre-reading. If you are able to answer all the questions correctly, it means that you understand the most important sections of the module, and that is the point of reading it!

How:

- Go back to the questions which you asked before reading (in the pre-reading) and see if you managed to answer all your questions. Read through all your questions and answers to make sure that there isn't anything that you need to add to any of your answers. If you were not able to answer all your questions, check to see if you can answer them now. Go back to the module and read the relevant sections to see if you can answer all the questions. Remember that because these are your own questions, the answer may not be in the module. If this is so, try to find the answer somewhere else by reading another book or text.
- Go back to the questions by the writer which you tried to answer during the pre-reading. Did you manage to answer all these questions as you read? If not, go back to the relevant sections, reread them and try to answer these questions.
- Go back to all the questions asked by the writer in the text and see if you managed to answer all of them. If you did not, try to answer them now.
- If you realise that you are still struggling to understand something, because there is a question which you cannot answer, ask someone to explain to you or find something else to read that will explain the information differently.
- Check your answers with a colleague, with your supervisor or see if there is a section in the module that provides answers to the questions.

Example:

See Questions 2.1 to 2.5 on page 135 in the Post-reading section.

WRITING AS YOU READ
Write one sentence for each paragraph in the 'How' section.

Summary: a short piece of writing that only gives the most important points of a much longer piece of writing.

Appropriate: the right thing or situation; suitable; fitting; applicable.

Main point: most important fact.

Introductory sentence: the first sentence that explains what the summary is about.

Closing sentence: the last sentence that ends the summary.

STOP & CHECK

Write down what a summary is and how to write one:

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Sums up: give a summary; a shorter version.

Compare: to see what is the same and what is different.

3. Write a summary

What:

A **summary** is a much shorter version of an original text. When we write a summary, we only write the most important information down. Summarising helps us to think about what we have read, and as we write a summary we may realise that there is some of the information that we don't understand completely. We can then go back and read the **appropriate** section again until we understand it.

How:

- An easy way to write a summary is to look at each paragraph and decide what the **main point** in each paragraph is. The main point is what you write in the summary. You may want to add an **introductory sentence** at the beginning and a **closing sentence** at the end of your summary. This means that a summary of a chapter that is ten paragraphs long will have between ten and thirteen sentences. Be careful: not all writers know that they are supposed to only have one main point per paragraph, and may have more than one main point per paragraph. You need to mention all the main points in your summary.
- If a module is very long, writing one sentence per paragraph will not be wise. You may want to write a few sentences for each section instead. Or you may choose to write a separate summary for each section of the module.
- Writing the summary will be much easier if you have taken the time to write a sentence that **sums up** the paragraph after reading each paragraph, as we discussed in the 'Reading' section.
- **Compare** your summary with your friend or colleague's summary to make sure that you have not left out any of the important points.
- Remember that writing helps to improve reading comprehension.

Example:

The following is an example of a summary of this section **(Section 3. Write a summary)**:

Summary

- Only important points
- Helps me to notice what I don't understand

How

- About one main point per paragraph
- Introductory and closing sentence
- Few sentences per section or a summary per section
- Compare with others to check
- Writing improves reading comprehension

4. Create a graphic organiser

What:

Instead of writing a summary, you may choose to create a graphic organiser instead. A graphic organiser is like a summary in the sense that we still need to mention all the main points, but instead of writing a full sentence for each main point, we can write a word or a phrase and perhaps draw a **suitable** picture. These words and phrases are then **positioned** on the page in way that shows their relationships to one another. There are many different ways in which these words and phrases can be positioned and this will depend mainly on how these words and phrases are related. A few examples are mind maps, concept maps, flow charts, and hierarchies. We can use our summaries to create graphic organisers or we can use our graphic organisers to plan our summaries.

How:

- Collect the words and phrases: go through the section, chapter or module and write down all the most important words and phrases. If you have written a sentence for each paragraph during the reading process (as discussed above), you can look at these sentences to find the most important words and phrases.
- Once you have all your words and phrases, think about how they relate to one-another and decide which graphic organiser would be the best to use.

Suitable: fit for the purpose; right for the situation.

Positioned: to place in a specific area.

CREATE A GRAPHIC ORGANISER

Create/draw a flow chart to show the steps of creating a graphic organiser:

Attribute: a quality, character, or characteristic ascribed to someone or something.

Aspect: an element or feature to consider.

- Create your graphic organiser – reread sections that you are unsure of to make sure that you understand the information.

Examples:

A few types of graphic organisers:

- **Matrix**

What: A matrix is a table in which different things, people, places or events are compared in order to see which **attributes** are the same and which are different. You have to decide which **aspects** you want to compare and which relationships you want to highlight.

When to use: When there are aspects that you can compare based on similar attributes, for example you can compare different diseases by looking at their symptoms, causes and treatment, or you can compare different WBOTs by looking at the number of CHWs, the location and disease burden in the area.

Example:

Information from *A Practical Guide to Doing Community Oriented Primary Care* (page 202-203).

	FORMATIVE EVALUATION	MID-WAY EVALUATION	SUMMATIVE EVALUATION
TIMING (when)	Before the project, task or programme begins	While the project, task or programme is in progress	When the project, task or programme is finished
PURPOSE (improve/ to prove)	To support *improve*ment	To *improve* and to *prove*	To *prove* and to demonstrate results
PURPOSE (detail)	• To determine the need, scope and focus of the intervention • To provide baseline information	• To improve the processes based on observations and feedback • To prove that the intervention is starting to work (value and outcomes) so that project, task or programme can continue	• To prove the effects of the intervention • To measure the extent to which the outcomes have been met

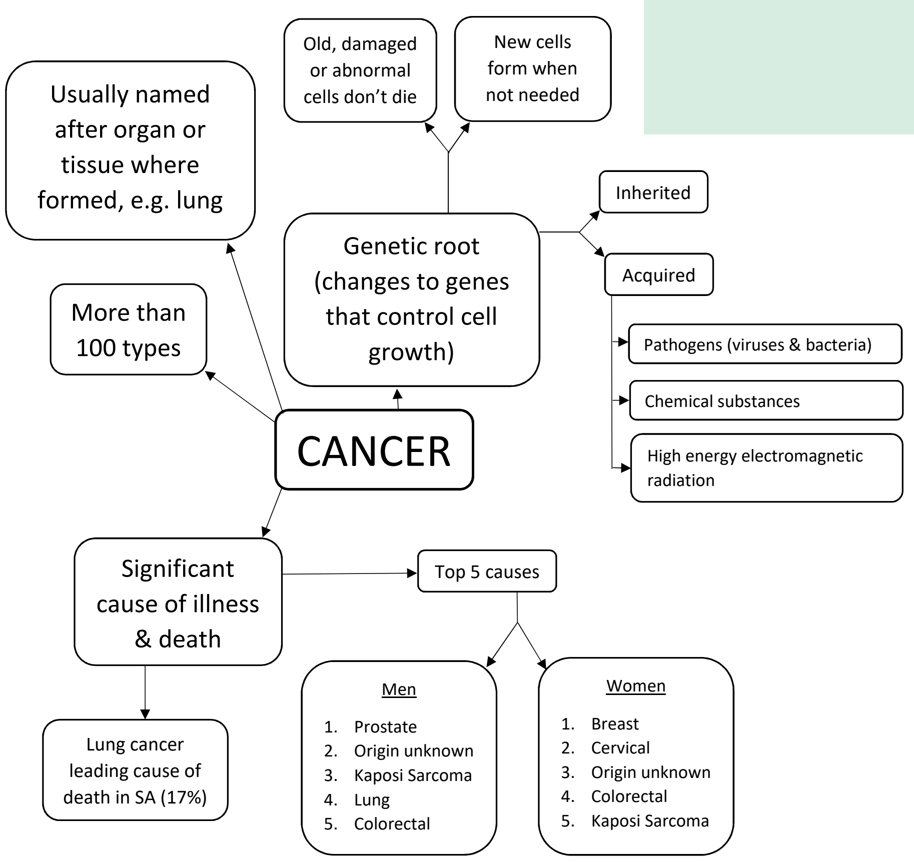
- **Semantic Maps**

What: These are web-like organisers also called mind maps or spider maps. The main topic is placed in the middle and all the related **sub-concepts** (keywords and key phrases) are arranged around the main topic and linked to it to show the relationship. You can use pictures instead of words, as this will help you remember better.

When to use: When you want to summarise all the information of a specific topic onto one page, for example types of diseases; COPC principles.

Example:

Information from *A Practical Guide to Doing Community Oriented Primary Care* (page 33-34).



Sub-concepts: the second level or next level of **concepts**.

Concept: an idea, expressed as one or a few words, that is particular to a situation, for example the concept of gravity, the concepts of health care.

Linking word/phrase: a word or a phrase that links two concepts to show what the relationship is between the two concepts.

Verb: a doing-word; a word that indicates an action, for example jump.

Hierarchical: graded or ranked, so that lower ranks are subordinate to the ranks above.

Font size: the size of the letters.

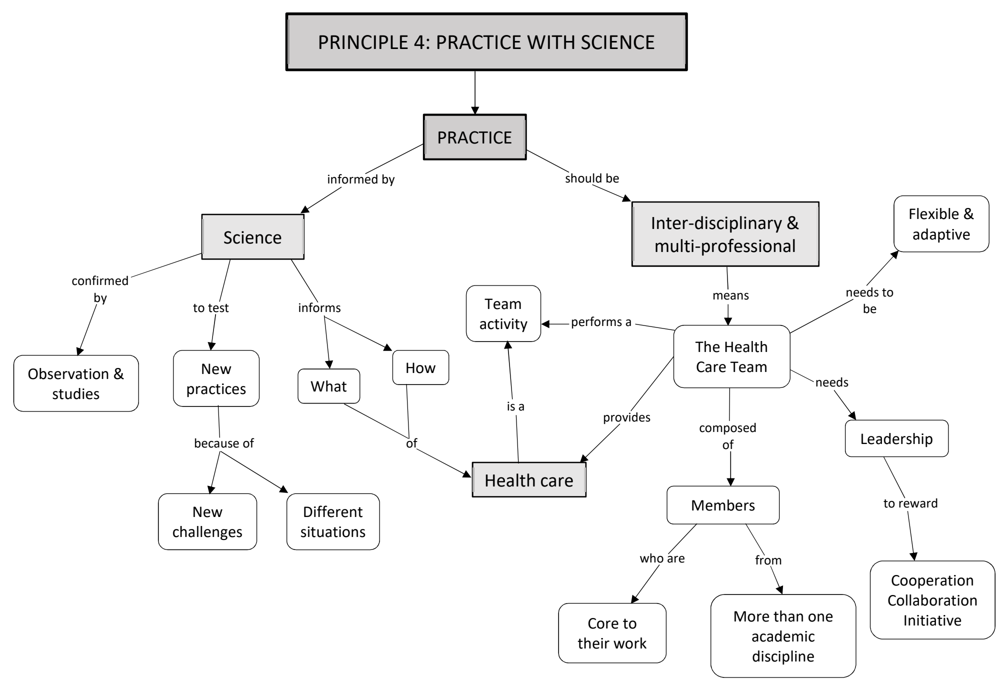
- **Concept Maps**

What: Concept maps include concepts usually in boxes or circles with lines connecting concepts that are related. The concepts are the main ideas or keywords of the text. On the connecting lines are words (**linking words** or **linking phrases**) indicating the quality of the relationship between the two concepts. Usually the linking words are **verbs**. Often the concept map is constructed **hierarchically** with the most general, most inclusive concept at the top and less general, less inclusive concepts following below. Different colours, **font sizes** and shapes of the circles or boxes can also help to indicate the different levels or hierarchy in the concept map.

When to use: To display the knowledge from any discipline or module.

Example:

Information from *A Practical Guide to Doing Community Oriented Primary Care* (page 92-94).



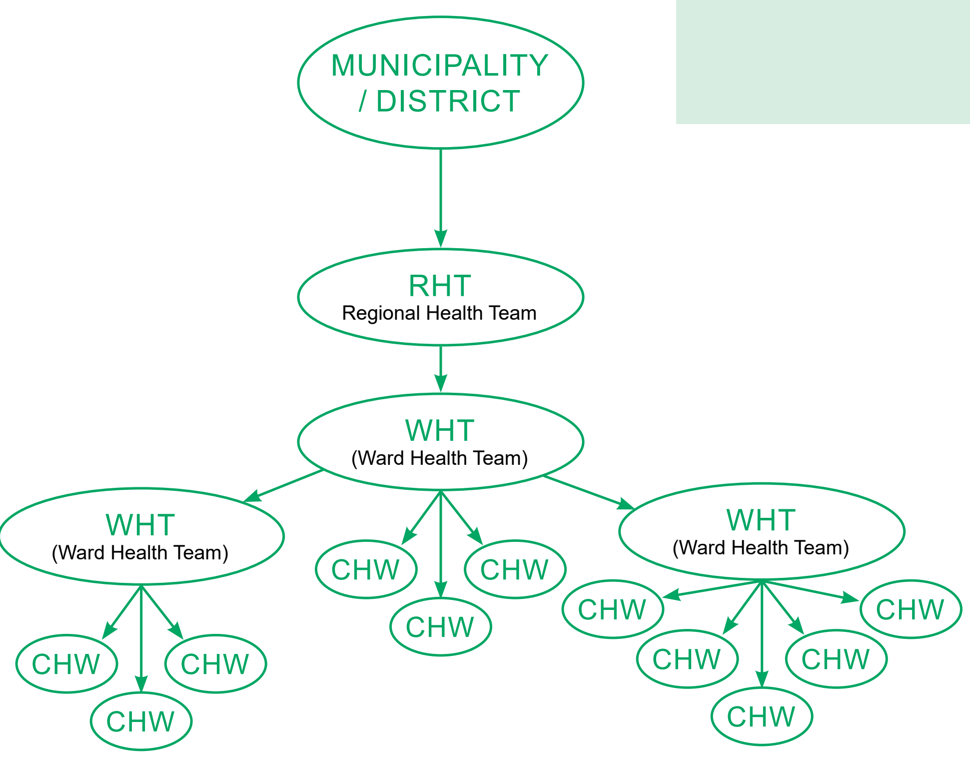
- **Tree diagrams**

What: A tree diagram is a hierarchical diagram that describes the **superordinate** and **subordinate** relationships of concepts. A tree diagram can also be used to show the relation between more general and less general concepts, or how some concepts are included into other concepts. They are called tree diagrams because of what they look like: branches **dividing** into smaller branches.

When to use: Tree diagrams are often used to show family trees, hierarchical models and structures in society.

Examples:

Information from *A Practical Guide to Doing Community Oriented Primary Care* (page 107).



Superordinate: the more general and **inclusive** concepts.

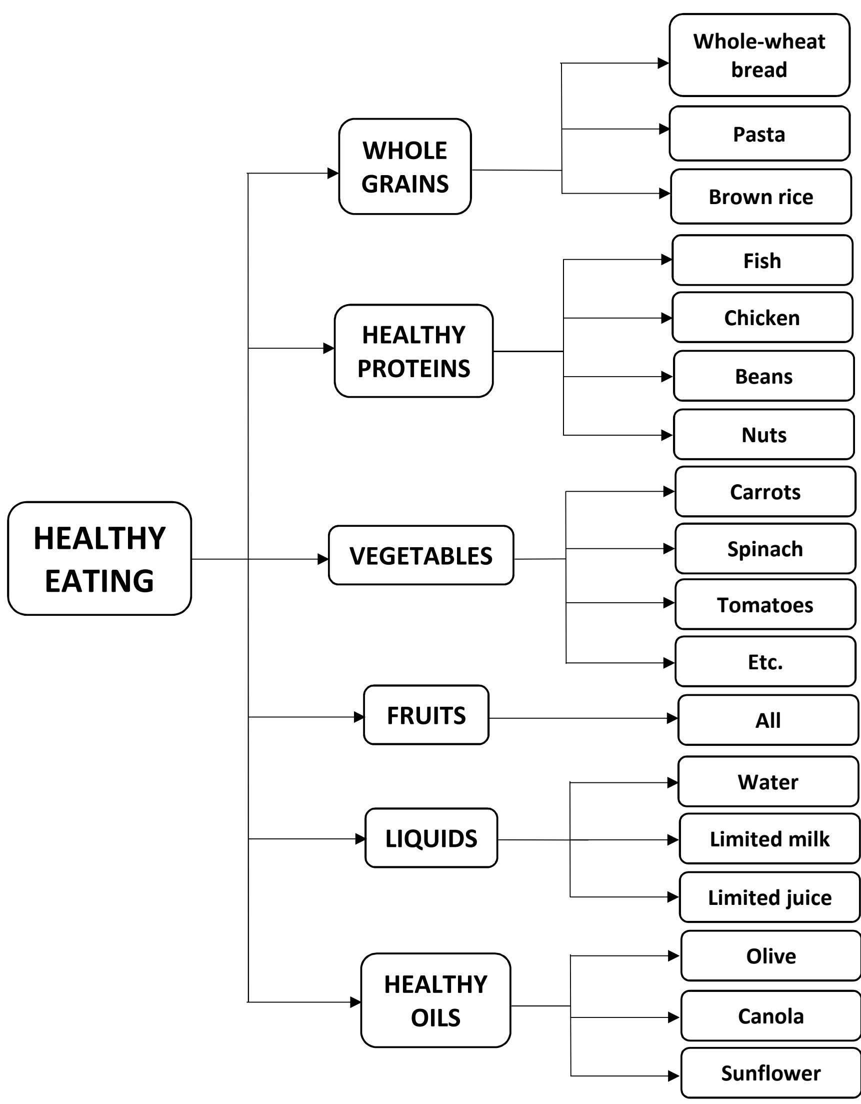
Subordinate: the more specific and **exclusive** concepts.

Divide: to separate into more parts.

Inclusive: to cover, include or contain everything.

Exclusive: to only include certain things and leaving other things out, to be specific.

Information from *A Practical Guide to Doing Community Oriented Primary Care* (page 66).



- **Venn Diagrams**

What: In a Venn Diagram we make use of two or more circles that **overlap** to compare different concepts. Each circle **represents** a concept. The parts of the circles that overlap represent the **similarities** of the concepts. The parts of the circles that don't overlap represents the **unique** areas of each concept.

When to use: When you need to compare very few concepts (about two to six concepts) and want to show where the concepts or how much of the concepts overlap.

Overlap: to cover the same area or to have something in common.

Represent: to serve as a sign or symbol of something.

Similarities: those aspects which are the same.

Unique: different; not the same.

Example:

Information from *A Practical Guide to Doing Community Oriented Primary Care* (page 72-73).

Sequence: a continuous or connected series.

- **Flow Charts**

What: A flow chart is a chart in which a **sequence** or a series of steps are displayed. The chart clearly shows which step is first and how the rest of the steps follow onto each other.

When to use: Any process that has definite steps can be displayed as a flow chart, especially action plans.

Example:

Information from *A Practical Guide to Doing Community Oriented Primary Care* (page 121-125).

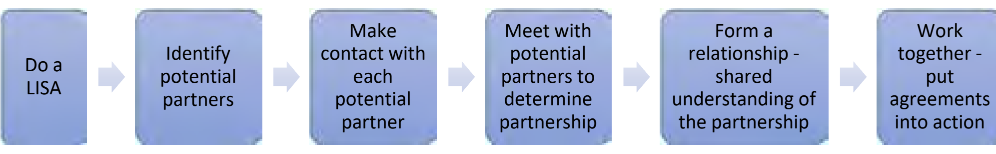


Photo courtesy:Nina Honiball

5. Create a double-entry journal

What:

A double-entry journal is a journal in which we connect what we have read to ourselves or our personal experiences. In this way we use our personal knowledge and experiences to help us understand what we are reading. When we connect what we are reading to our experiences, it also becomes easier for us to remember what we are reading.

How:

- Take a page and divide it in half **vertically** (down the middle of the page).
- At the top of the one side write: 'Idea from text', and at the top of the other side write: 'My **connection**'.
- On the side named 'Idea from text', write down a few ideas or information from the text. You will have to choose these ideas based on the connection that you can make.
- On the side named 'My connection', write down your connection to each of the ideas which you wrote down on the other side. Your connection can be your personal experience, knowledge or a reaction that you have to the idea.

Example:

Read through the extract from *A Practical Guide to Doing Community Oriented Primary Care* (page 1) below:

> South Africa is in the grips of a disease cocktail that leads to high rates of illness and unnecessary death at all the critical points in the human life-cycle. In its enormity and combination, the disease burden in South Africa is harmful to the health and wealth of everyone, individually and the country as a whole.
>
> At the same time South Africa's health system is failing. In part, this is because of the nature, size and extent of the disease burden. In part, it is because of the way the system is organized. The legacy of national and international trends and biases has meant that the health system has been structured to function in an often unjust and unfair way. The divisions between private/public, urban/rural and hospital/community favor private, urban and hospital care rather than more sustainable care that meets the greatest need.

Vertical: up-and-down (opposite of left-to-right). For example:

Connection: connecting or linking; making a link.

From this extract I will show you an example of the double-entry journal:

IDEA FROM TEXT	MY CONNECTION
1. '…the disease burden in South Africa is harmful to the health and wealth of everyone…'	1. Even when I am healthy I am affected by the disease of others, because when many other people are too sick to work this impacts on the economy of the country. How I deal with the diseases that I get affects other people, because if I am not careful I may spread my disease to other people.When I am too sick to work this places burdens on other people who have to do my work as well.
2. '…South Africa's health system is failing…because of the way the system is organized.'	2. Too few staff, which means that people are sent home without being helped.
3. '…the health system has been structured to function in an often unjust and unfair way.'	3. 'Health' is a basic human right, but in reality, the people who really need medical help do not always get it.

POST-READING

Choose one of the post-reading techniques and give a few reasons why this technique will help you understand what you read better.

3. POST-READING

1. Write down all the new things that you have learnt in this module (do not write pages, only short sentences in point form).

2. Go back to your pre-reading questions. Read through the questions and your answers.

2.1. Did you manage to find answers to your own questions?

2.2. Did you manage to answer all of them? If not, try to answer the ones that you have not answered yet by going back to the relevant section and reading it again.

2.3. Are all your answers complete? Add any extra information.

2.4. Are all your answers correct? Correct all the answers that you realise are wrong. If you are not sure, compare your answers with those of your colleague, ask your supervisor or check the answers at the end of the module.

2.5. Are all the answers in this module, or do you have to do extra research to find the answers?

Feedback: helpful information that is given to someone to say what can be done to improve a performance or piece of work.

3. Choose a section of the module and write a summary of that section. Ask a colleague or your supervisor to read your summary and give you feedback.

4. Choose another section of the module and create a graphic organiser from the information. Share your graphic organiser with a colleague and ask for **feedback**.

5. Create a double-entry journal by choosing at least five ideas from the module and connecting them to your own experience. Share your double-entry journal with a colleague and discuss your connections.

IDEA FROM TEXT	MY CONNECTION

COMMON KEY CONDITIONS AND DISEASES

WHAT IS THE BURDEN OF DISEASE?

"The burden of disease" is defined as "a comprehensive measure of the health status of the nation". It is based on an assessment of all causes of ill health and death.

After Debbie Bradshaw et al **Initial estimates from the South African National Burden of Disease Study**, *2000 MRC Policy Brief No.1 2003*

In South Africa, the disease burden is made up of four epidemics.

Infectious diseases. These are diseases that spread form person to person, like TB, HIV and other sexually transmitted diseases.

Maternal and child illness and death. These are diseases and health conditions that relate to human reproduction and infant and child development.

Non-Communicable diseases. These are diseases that are not infectious, but have serious long lasting health consequences for people, like diabetes, heart disease, epilepsy, mental illness and others.

Violence and Injury. These are health conditions that come from the way people live in society. They include road accidents and accidents in the workplace as well as intimate partner, criminal and political interpersonal violence.

INFECTIOUS DISEASES 3

NON-COMMUNICABLE DISEASES 4

MATERNAL AND CHILD HEALTH 5

VIOLENCE AND INJURY 6

INFECTIOUS DISEASES

3

INFECTIOUS DISEASES

Infectious diseases are communicable diseases. This means that they pass from person to person or from animals to people. They are spread by organisms, like bacteria, viruses, parasites and fungi.

HIV and TB are the two main infectious diseases. They are the most common and they weigh most heavily on the population and the health care services.

3.1 HIV/AIDS

AIDS (Acquired Immune Deficiency Syndrome) is caused by HIV, the human immunodeficiency virus. People can get infected with HIV when their bodies come into contact with HIV infected blood, semen, rectal and vaginal fluids and breast milk. HIV can get into the body through a scratch, a cut, a sore or any damaged tissue on the skin outside or inside the body. It can also cross mucous membranes that line many surfaces inside the body. HIV is most commonly passed from person to person during sex. It also is passed from mothers to babies, especially when there is mixed infant feeding.

DID YOU KNOW?

Definitions are statements about the meaning of a word or a concept. They are useful because they help us understand a thing, an idea or a practice.

HIV transmission is prevented by not allowing HIV to penetrate the human body.

WORKING IN PAIRS

What would you say?

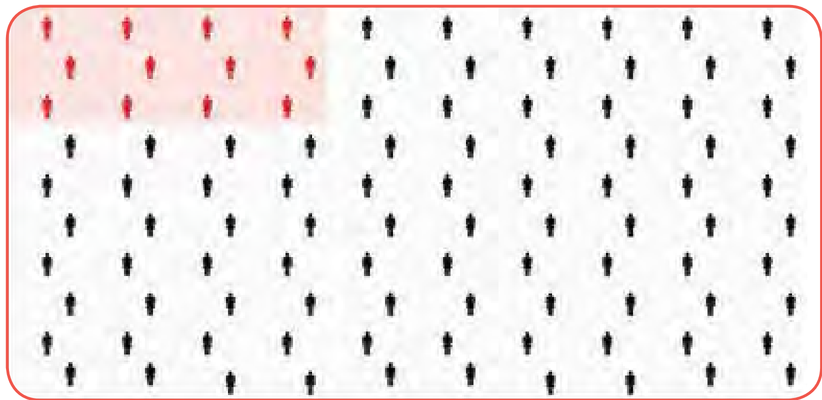
Scenario 1
A 14 year old girl comes home from school and says "I have a date with someone in Grade 12.

Scenario 2
A teenage boy wants his girlfriend to prove her love by having sex.

In South Africa in 2016

- 270 000 people were newly infected with HIV.
- About 18,9% of all adults aged 15-49 were HIV+.
- Over 30% of women presenting for ante-natal care were HIV+
- HIV Infection in South Africa: 12,7 in every 100 people are HIV+

HIV Infection in South Africa



Graphic by H F Kinkel, 2014

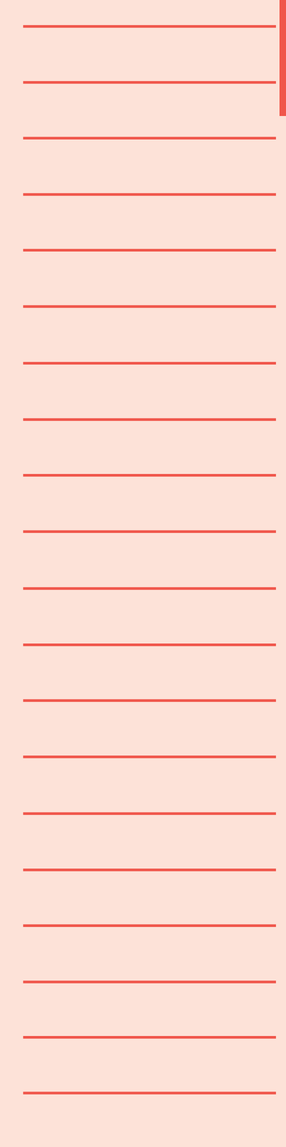
Treatment

HIV can be treated with antiretroviral therapy (ART). ART only works if people take their medication every day for the rest of their lives. At the end of 2016 the government was supporting 3.9 million on ART.

HIV FACTS

Facts about HIV

- ☺ HIV can be prevented.
- ☺ Practice safe sex, use condoms every time.
- ☺ Treat ALL sexually transmitted infections.
- ☺ Prevent harmful alcohol and substance use
- ☺ HIV can be treated
- ☺ All HIV+ children and adults are entitled to HIV treatment (ART)
- ☺ All HIV+ children and adults can be supported to manage and control their condition
- ☺ HIV cannot be cured
- ☺ HIV+ people live healthy and productive lives.
- ☺ HIV+ people can learn to manage their disease, take their medications every day and practice safer sex.



3.2 Tuberculosis (TB)

TB is caused by bacteria, the *mycobacterium tuberculosis*. It most commonly attacks the lungs or throat but it can attack any part of the body. Only TB disease of the lungs (Pulmonary TB) and throat is passed from person to person. There is a difference between TB infection and TB disease.

TB infection

TB is spread in tiny drops that are invisible to the naked eye. It is spread in the air when a person with active TB coughs, sneezes, speaks, sings or laughs. The drops float around for a long time especially in places that are dark and poorly ventilated. Sunlight and wind (fresh air) destroy TB.

When a person breathes in TB they can become infected with TB. Almost one third of the world's population has latent or inactive TB. This means that they have been infected with TB but their immune system is strong enough to make it inactive. People with ***inactive* TB** do not have TB disease. They do not have symptoms and can't pass TB on to others.

People with TB infection can develop TB disease. This depends on people's health. In general a person with TB infection has a one in ten (1:10) chance of developing active TB. However, if their immune systems are weakened for any reason they have a much higher risk of developing active TB in their life times.

Smoking, living with HIV, hunger and malnutrition, diabetes and other chronic diseases all weaken the human immune system and increase TB infected people's risk of developing TB disease.

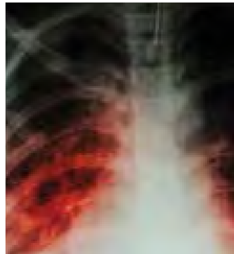
TB Disease

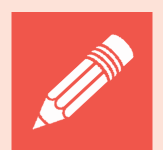
TB disease is when a person's body is not able to fight the TB infection and they become sick. People with TB disease often feel weak or sickly, lose weight, have fever, and have night sweats. If their TB disease is in the lungs, they may also cough and have chest pain, and they may cough up blood.

DID YOU KNOW?

Untreated TB disease is highly infectious. One person who tests positive for active TB infects between 11 and 22 other people.

Robin Wood, Stephen D Lawn, Simon Johnstone-Robertson, Linda-Gail Bekker **Tuberculosis control has failed in South Africa – time to reappraise strategy S** Afr Med J 2010;100:111-114.

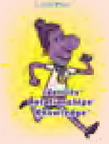




TB and AIDS together with heart disease are leading causes of death.

TB and HIV are generalised epidemics in South and Southern Africa. They feed one another, even though the causes of these two infectious diseases are different.

About seven in 10 people with TB (73%) are also HIV positive. And half or more of HIV positive people (50-60%) develop active TB. People with HIV have 26 to 31 times more chance of developing TB disease because their immune systems are weakened.



AS A HEALTH WORKER...

Know the facts about HIV and TB.
Know how to help people prevent HIV and TB disease.
Know how to help people stay on treatment.

DID YOU KNOW?

TB is the No 1 leading cause of death in South Africa.

Statistics South Africa. Mortality and causes of death in South Africa, 2015: Findings from death notification.

AS A HEALTH WORKER...

- Teach everyone six ways to stop the spread of TB
- Support everyone to test for active TB
- Detect and treat everyone with active TB
- Detect everyone who has latent TB and a weakened immune system
- Support people to complete the full TB treatment course.

Six Ways to Stop the Spread of TB

Cover your cough and sneeze. Open windows and doors.

Sleep away from other people.

Wear a mask when you have to be close to other people.

Keep away from infants and children as much as possible.

Meet, eat, sit, rest, talk, relax outside in the sun and fresh air.

Test every one at home for TB. Stick to your treatment plan.

SIX WAYS TO STOP THE SPREAD OF TB

MAKING SEX SAFER FROM INFECTION

WORKING IN PAIRS

What would you say?

Scenario 1

A 25 year old man is living alone in a shack. He has watched two relatives die of TB. He has lost weight, has a cough that won't go away and night sweats. He is afraid and is worried that he is going to die as well.

Scenario 2

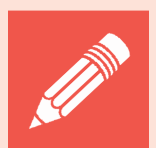
You are visiting a home to provide home based care to an old lady who is bedridden. The home is small and dark. There is only one door and a very small window. They are both kept closed because
the old lady and her 49 year old are afraid of thieves. While you are caring for her you notice that her son coughs all the time. He tells you that this cough is new. He says he was on TB medicine, but he stopped when he felt better.

There are three very important reasons to complete the full TB treatment course:

1. When people stop their TB medication TB treatment fails and TB disease becomes more life threatening because it is drug resistant.

2. Drug resistant TB (MDR TB and XDR TB) is very hard and costly to treat.

3. TB becomes more dangerous to everyone because people can be infected with MDR and XDR TB. This means that they if they develop TB disease they will have drug resistant TB.



3

Taking medications always has side effects. Patients have to learn to recognize these. They also have to be helped to manage side effects and drug interactions.

AS A HEALTH WORKER...

help patients and the people who support them

- ☺ To know and understand the side effects of medicines.
- ☺ To write down and keep a record of side effects.
- ☺ To tell the clinician or clinical team about side effects.
- ☺ To recognize a medical emergency.
- ☺ To understand the importance of taking medicines properly

Five Checks to Take Medicine Right

- ✓ The right medicine.
- ✓ In the right amount.
- ✓ At the right time.
- ✓ In the right way.
- ✓ For the whole course of treatment.

1. HIV counselling and testing

You should receive:

- Post-test counselling after your HIV test
- Information on living with HIV and how to stay healthy, including using condoms
- Details of support groups

Please refer to the HCT Care Pathway for the complete counselling and care that you should receive.

2. Visit the doctor/nurse to get baseline tests and start ARVs

When you test positive for HIV you need to take some other tests. You should get

- ✓ a CD4 count test to check your viral load;
- ✓ checked and tested for TB;
- ✓ checked and tested for pregnancy if you are a woman.

When you test positive you need to be prepared to start ARV treatment. You should

- ✓ be asked questions to help you understand what is involved in treatment
- ✓ be started on ARV treatment, if you are ready to begin treatment;
- ✓ learn about ARV medicines and their side effects;
- ✓ learn about the importance of taking ARVs properly and in the way you have been told'
- ✓ learn about disclosing you HIV status to family and friends;
- ✓ learn about the importance of having support from a treatment buddy and joining support groups

3. Take ARVs

Take ARVs at the same time every day for the rest of your life, even after you start feeling better.

4. Monthly visits to the clinic

- Visit the clinic to collect ARVs and for a check-up as advised.
- If you take your ARVs exactly as prescribed you may be able to use more convenient and faster ways of getting your medicines. Talk to your CHW or clinic staff about these options.

5. Follow-up visits

Ask the healthcare workers at the clinic when you will need to have follow-up tests done.

6. Adherence

- Continue taking ARVs as prescribed every day for the rest of your life, even when you feel healthy.
- See a healthcare worker if you experience side effects of the ARVs.
- Maintain a healthy lifestyle.

ART AND TB TREATMENT FACTS

Adapted from Debbie Norval, Lee Dandridge, Debbie Els "Palliative Care for Community Home Based Care Course: Learner Guide" 2012
Sungardens Hospice Pretoria: Centre for Palliative Care learning

Treatment depends on patients being empowered to take responsibility for their own health.
Successful treatment of HIV and TB depends on helping people manage their medications and take responsibility for their health.

Treatment is Teamwork
Chronic disease management is always teamwork. This is true for HIV and TB as well as diabetes, heart and vascular disease and other NCDs. It requires health care providers at all levels to work as a team - with each other and with the person and their support system.

Treatment works when patients stay the course
A patient who is HIV+ has to take anti-retroviral therapy (ARVs) every day for the rest of his or her life.

REMEMBER:

The person on treatment determines who they want to support them. It can be family members. It can be friends. It can be their CHW or other health care providers.

A patient diagnosed with TB has to take TB treatment until they no longer test positive for TB.

- Drug responsive treatment means taking TB medicine every day for 6 months (for first time pulmonary TB treatment) to 8 months (re-treatment of pulmonary TB).
- Treating multi-drug resistant TB means taking treatment for 18 -24 months.

Treatment works when patients are supported to stay the course.
A treatment plan makes it easier complete TB treatment and stay on ARVs. Everyone in the team, including the patient and his or her supporters need to know, feel comfortable with and follow the treatment plan.

The plan should set out:

- When the medicines should be taken.
- Ways to remember to take medicines.
- Food and drink choices that need to be made.

- The preferred supports needed.
- Ways to monitor adherence (Directly Observed Treatment, planning to accommodate medications for more than one condition – eg. TB, HIV, diabetes.
- Ways to monitor changes.

The treatment plan has to adapt to side effects, drug interactions and changes in a persons physical, mental and social well-being. Taking medications always has side effects. The patient has to be able to recognize these and helped to manage them.

Health care workers can help patients manage their side effects and drug interactions in the following ways:

- Be familiar with and share information with the patient and her/his supporter about the side effects of medicine.
- Encourage and help patients to record (write down) the side effects.
- Record the side effects in their own notes.
- Share and/or support patients to share the side effects with the clinical team.
- Learn about and be well prepared to deal with major side effects. These can be a medical emergency.
- Learn about and help patients understand drug interactions and their effects.
- Learn about and help manage the team's solutions to ongoing treatment adherence.

Current HIV treatment is only effective if people take their antiretroviral medication (ART) consistently most or nearly all the time (70-90% adherence). Nearly 40% of patients do not remain on ART six years after initiating treatment.

B Nachega J, C Marconi V, U van Zyl G, M Gardner E, Preiser W, Y Hong S, et al. HIV treatment adherence, drug resistance, virologic failure: Evolving concepts. Infectious Disorders-Drug Targets. 2011; 11(2):167-74.

FACTS ABOUT ART AND TB TREATMENT IN ADULTS

An HIV or TB positive diagnosis often leaves a person feeling overwhelmed, with many questions and concerns. It's important to remember that there is treatment for both diseases, and that TB, in fact, can be cured.

- Treatment for HIV consists of the combination of antiretroviral (ARV) drugs to maximally suppress the HIV virus and stop the progression of HIV disease. ART also reduces the risk of HIV transmission. ART cannot cure HIV. But it helps people with HIV live longer, healthier lives.
- Active, drug-sensitive TB disease is treated with a standard 6-month course of four drugs. The vast majority of TB cases can be cured when medicines are provided and taken properly.
- Drug-resistant TB is much more difficult to treat, with treatment lasting from 9-24 months

Healthcare workers will determine the timing of HIV and TB treatment. They should also discuss the importance of medication adherence, taking HIV and/or TB medicines every day and exactly as prescribed.

Individuals who are **HIV positive and do not have TB** need to talk to health care workers about medicine to prevent TB.

Adherence to the treatment prevents HIV and TB bacteria from multiplying. Not taking these medicines every day and exactly as prescribed can lead to drug resistance and treatment failure.

Tell your health care worker about other prescription and over-the-counter medicines, vitamins, nutritional supplements, and traditional medicines you are taking or plan to take. Other medicines you take may interact with the medicines in your prescribed regimen. A drug interaction can reduce or increase the effect of a medicine or cause side effects.

Tell your health care worker about anything that can make adherence difficult. This can be like not wanting to disclose your HIV and/or TB status or alcohol or drug use can make it hard to follow the treatment regimens. Describe your routine at home and at work to your health care worker. Working together, you can arrange your medication schedule to match your day-to-day routine.

Ask your health care worker for written instructions on how to follow your HIV and/ or TB regimen. The instructions should include the following details:

- The name of each HIV and TB medicine you are taking
- How much of each medicine to take
- When to take each medicine
- How to take each medicine (for example, with or without food)
- Possible side effects from each medicine, including serious side effects
- How to store each medicine

To maintain adherence over the long term, try some of the following strategies:

- Take your HIV and/ or TB medicines at the same time every day.
- Set the alarm on your cell phone to remind you to take your medicines. (An alarm clock will work too.)
- Ask your family members, friends, or co-workers to remind you to take your medicines.
- Keep your medicines nearby. Keep a back-up supply of medicines at work or in your purse or bag.
- Plan ahead for changes in your daily routine, including weekends and holidays. If you're going away, pack enough medicine to last the entire trip.
- If it is possible, use a 7-day pill box. Once a week, fill the pill box with your medicines for the entire week.
- Ask your health care worker to help you make a medicine diary. Enter the name of each medicine; include the dose, number of pills to take, and when to take them. Record each medicine as you take it. Reviewing your diary will help you identify the times that you're most likely to forget to take your medicines.
- Keep all of your medical appointments. Use a calendar to keep track of your appointments. If you start to run out on medicines before your next appointment, contact the clinic or ask your community health worker to help you.
- Find out about support groups for people living with HIV in the community.

Unless your health care worker tells you otherwise, take the medicine you missed as soon as you realize you skipped it. But if it's almost time for the next dose of the medicine, don't take the missed dose and instead just continue on your regular medication schedule. Don't take a double dose of a medicine to make up for a missed dose.

APPENDIX 4 FACTS ABOUT ART AND TB TREATMENT IN CHILDREN

Antiretroviral therapy (ART) and TB treatment are highly effective in children. Rapid initiation of ART restores and preserves children's immune functions and prolongs life. ART also promotes normal growth and development. Early TB treatment in children is also generally effective, even in very young children with compromised immune systems.

Children diagnosed with HIV and/or TB need help from parents and caregivers to take both these treatments. It is important to give children their treatment every day, as prescribed. Just like adults, treatment can fail and TB and HIV can become drug resistant if they do not take their medicines every day, exactly as prescribed.

To make sure children take their medicines properly there are things that parents and caregivers need to know and do.

- ✓ Know how to give the medicines correctly.
- ✓ Give them the right amount of medicine (correct dosing).
  - ☺ The amount of medicine or dose depends on the weight of a child.
  - ☺ Weigh the child every month.
  - ☺ Adjust the dose as the child grows and gains weight.
- ✓ Have a daily checklist of the number and amount of medicines the child has to take everyday.
  - ☺ You won't get by the number and amount of medicines the child needs to take every day.
  - ☺ It helps you keep track of the change in doses.
- ✓ Learn how to get infants and young children to take their medicine when they have a bad taste.
- ✓ Find a way to make sure children don't miss doses when they are at school or away from home.
- ✓ Know about and learn to manage the side effects of the medicines.

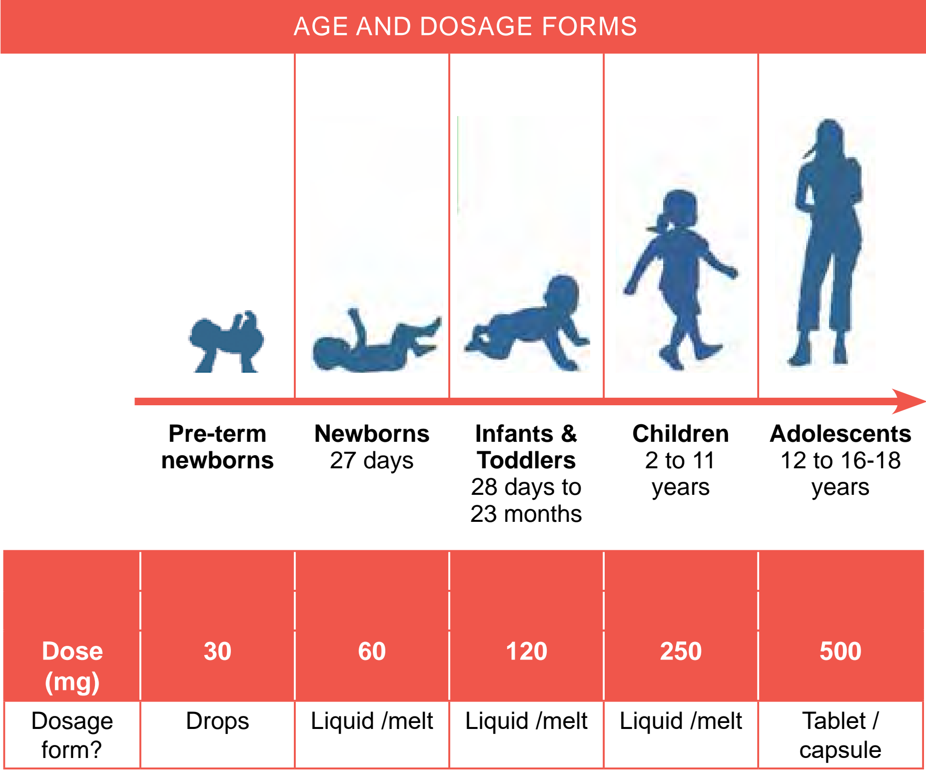
It is harder to make sure children keep taking medicines properly when you do not tell family or friends who you trust about the child's HIV and/or TB status.

Learning to give the right dose using a syringe

Parents and caregivers need to learn how to use a syringe and how to measure the exact amount of medicine.

- ☺ Use a plastic medication syringe (not a spoon).
- ☺ Fill it with medicine to the exact line.

- ☺ Sit the child up. Never give medicine lying down because it can cause choking.
- ☺ Place the syringe beyond the child's teeth or gumline. Some young children become cooperative if you let them hold the syringe. Have them place it in their own mouth. Then all you have to do is **gently push** the plunger.
- ☺ **Slowly drip** or pour the medicine **onto the back of the tongue** or the pouch **inside the cheek**.
- ☺ **Do not squirt** the medicine into the back of the throat. It can cause the child to choke.
- ☺ **Practice** in front of a healthcare worker, councilor or person who knows how to use a syringe and measure doses correctly.
- ☺ Always rinse the syringe just after use to keep it clean.
- ☺ **Do not share the medicine** with other children.
- ☺ Do not share the syringe with other children.



Dose (mg)	**30**	**60**	**120**	**250**	**500**
Dosage form?	Drops	Liquid /melt	Liquid /melt	Liquid /melt	Tablet / capsule

HOW TO ADMINISTER LIQUID MEDICATION TO CHILDREN

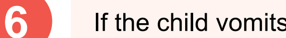
1 Use the amount of medicine thats right for the child's age and weight.

2 Use a dropper or a syringe. Draw in the medicine until you get to the right amount needed for the child.

3 Gently aim the medicine in the mouth towards the inside of the cheek.

4 **NEVER MIX MEDICINES**

5 **NEVER GIVE A DOUBLE DOSE**



6 If the child vomits

- Before 30 minutes - give the dose again.
- After 30 minutes - wait until its time to give the next dose.

SOUTH AFRICAN NATIONAL HIV TESTING ALGORITHM

HIV counselling and testing (HCT) is a package of prevention, counselling, care and support. HCT is a service for the benefit of the person who takes a test, their sexual partners and the wider community.

HCT is a package of prevention, counselling, care and support. It supports a person in different ways. It helps each individual

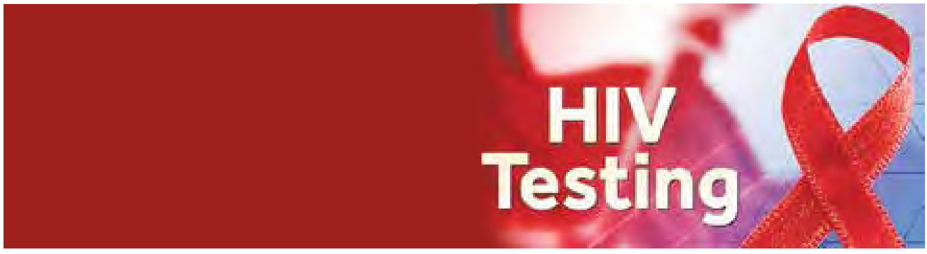
- ✓ Make an informed decision
- ✓ Get clinical services
- ✓ Get practical and emotional support
- ✓ Increase knowledge to prevent HIV transmission
- ✓ Live positively with HIV.

HCT upholds people's basic human rights.

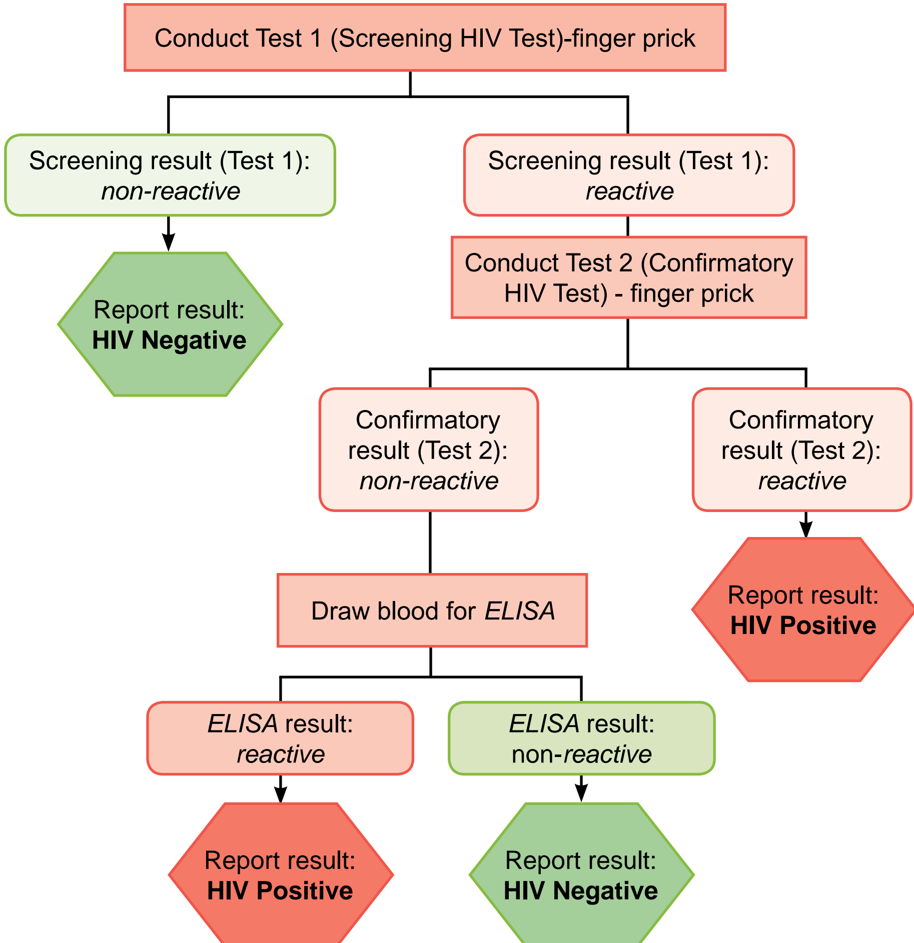
Core Principles of HIV Counselling and Testing in South Africa

- Client(s) and patient(s) must be provided with sufficient information about HIV counselling and testing (HCT), so that they can give their explicit and voluntary informed consent to receive services.
- HCT services must be confidential.
- HCT services must include accurate and sufficient counselling that addresses the person's needs and risks.
- HCT services must follow national guidelines for testing to ensure accurate and correct test results.
- HCT clients and patients must be linked to care. This includes prevention, care and treatment, as well as other clinical and support services.

The diagram on the next page illustrates the process for HIV testing.



Re-testing is recommended for persons with an HIV-negative test result

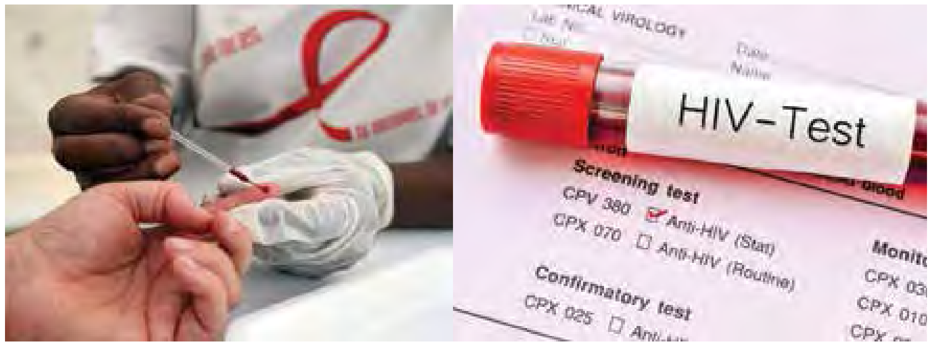


Window period repeat test

All individuals should test for HIV; after the first initial HIV negative test, a repeat window period test to be conducted at 6 to 12 weeks.

Retesting

- Clients with low risk and no exposure to retest once every year.
- Clients at high risk to retest every 6 to 12 weeks
- Pregnant women who have tested HIV negative in their initial ANC booking to retest on every scheduled ANC visit.
- Clients who have an STI to re-test in 6 weeks.
- Clients presenting with opportunistic infections (OIs) to re-test in 6 weeks.
- Clients with continuing or ongoing risk of acquiring HIV; re-test in 6 weeks.
- Have specific incidents of known HIV exposure within the past three months; re-test in 6 weeks.
- Received an HIV-negative test result on a baseline HIV test for an incident of possible HIV exposure (occupational or rape) in the past 72 hours; in this case, and if Post-Exposure Prophylaxis has not been initiated, re-test at 6 weeks after exposure, and if the results are still negative, the person should be re-tested again at 12 weeks after exposure.



NON-COMMUNICABLE DISEASES

4

Non-communicable diseases (NCDs) are a group of diseases that are not infectious. This means that they do not spread from person to person. The major NCDs are **diabetes**, **cardiovascular** diseases (diseases of the heart and blood circulation system), chronic **respiratory** (breathing and lung) diseases and **cancer**. These diseases are among the leading causes of preventable illness, disability and death.

DID YOU KNOW?

Over 55% of all deaths in 2015 were caused by NCDs.

Statistics South Africa. ***Mortality and causes of death in South Africa****, 2015: Findings from death notification*

Musculoskeletal injury and disease (like osteoarthritis), **mental illness**, epilepsy, oral and dental disease, eye disease and kidney disease are also common non-communicable diseases. These "silent" chronic disorders are important because they cause disability and seriously affect individual and family life even though they are not major causes of premature death in South Africa. They also add to the country's burden of disease.

DID YOU KNOW?

The burden of chronic musculoskeletal disorders in developing countries is 2.5 times greater than in the developed world.

Woolf AD, Pfleger B. **Burden of major musculoskeletal conditions.** *Bull World Health Organ 2003;81(9):646-56.*

About 8-20% of people over the age of 60 in Sub-Saharan Africa have osteoarthritis in the knee joint.

Adebajo A, Gabriel SE. **Addressing musculoskeletal health inequity in Africa.** *Arthritis Care Res (Hoboken) 2010 Apr;62(4):439-41.*

About 30% of South Africans report a life time history of at least one mood, anxiety, substance or impulse control mental disorder.

Stein DJ, Seedat S, Herman A, et al. **Lifetime prevalence of psychiatric disorders in South Africa.** *Br J Psychiatry 2008 Feb;192(2):112-7.*

Tessa Marcus, Department of Family Medicine, University of Pretoria

5.1 Disease Risk "Lifestyle Big Five"

In health care, a risk for a disease or condition means the statistical chance (or the degree of likelihood) a person will get the disease. For many non-communicable diseases, there are two groups of risk.

One group of risks is influenced by people's actions - what they eat and drink, their activity levels, and their habits (like smoking and drinking) – in other words, their lifestyles. These risks are **modifiable**, which means that people can do things to influence their chances of developing these kinds of diseases. The risks are changed by what people do and how they live, including the choices they make.

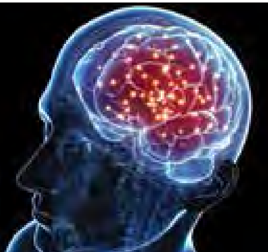
The other group of risks is **not modifiable.** They are caused by things that people have no control over, like their family history (genetic), the process of aging or their origin.

The modifiable risks for non-communicable disease have common roots in three aspects of people's lifestyles:

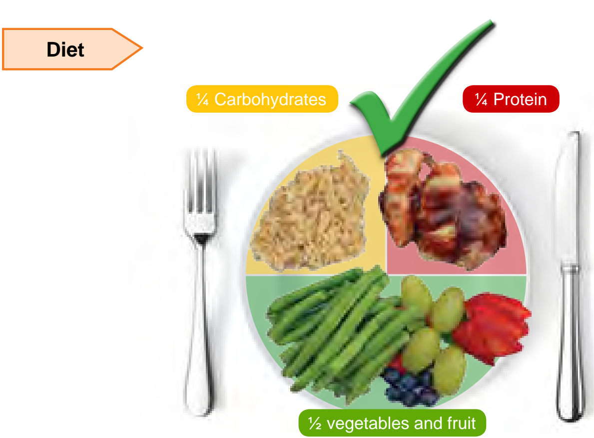
- **Unhealthy eating** = how much we eat and drink, what food and drink we take in and how often we eat and drink.
- **Insufficient and inappropriate physical activity** = little (or no) sustained vigorous or moderate walking or other exercise for 30 minutes a day for 3 or more days a week- that is adjusted to individual health status.
- **Smoking** = cigarette or any other form of tobacco use.

AS A HEALTH WORKER...

You should know that many NCDs can be prevented, modified and controlled when people change their lifestyles and take charge of their own health.



Diet



Exercise

Don't smoke

4

Healthy Lifestyle Choices that Reduce NCD related death risks

What	Why	By how much (%)
Not smoking	Protects arteries	**28 %**
Exercise 30 min or more daily	Slows the heart rate, lowers BP	**17 %**
Ideal weight	Less toxic chemicals released from fat cells	**14 %**
Ideal diet	High unsaturated fatty acids, high vegetables and fruit, low red meat	**13 %**
Modest alcohol	Red wine preferred, contains melatonin	**7 %**
All five	Remaining 21% may be stress related	**79 %**

Reference Lionel H Opie "Lifestyle and Diet" SA Journal Diabetes and Vascular Disease Vol 12 No 1 (July 2015:5-7)

This section provides a brief introduction to diabetes, cardiovascular disease, cancer, mental health & psychological wellbeing as well as mental illness.

5.2 Diabetes

Anywhere between 7,5% (national) and 13% (urban) of South African adults aged 20 years and older suffer from diabetes. Most diabetes goes undiagnosed or it is only diagnosed when the disease is at an advanced stage. This is why diabetes has moved to being the second underlying cause of death in 2015, accounting for 5,4% deaths. About one in five people already have complications of the disease when they are diagnosed for the first time.

What is diabetes

Diabetes. is a disease where there are high levels of glucose in the blood. This happens when the pancreas does not make enough insulin.
Insulin is the specialized chemical (a hormone) that takes sugar (glucose) made from the food we eat out of the blood into the body's cells. When there is not enough insulin, glucose stays in and builds up in the blood and the cells don't get the energy they need to function. High blood sugar over time leads to diabetes.

Type 1, Type 2 and Gestational Diabetes

There are three types of Diabetes
Type 1 Diabetes – is when the pancreas makes very little or no insulin. Type 1 diabetes is an autoimmune disease. It is most common in children but it can occur at any age. Fewer than 1 in 10 people with diabetes have Type 1. A person with Type 1 diabetes must take insulin every day to stay alive.

Type 2 Diabetes – is when the body does not use insulin properly. It can't carry sugar into the cells. After a while it is unable to make enough insulin to overcome this resistance. Most people with diabetes (90% or more) have Type 2 diabetes. Type 2 diabetes can be prevented. People with Type 2 diabetes can restore their insulin function by managing their blood sugar through diet and exercise.

Gestational Diabetes – is diabetes that is triggered by pregnancy and it usually goes away after delivery. Gestational diabetes mostly happens in late pregnancy, after the baby's body is formed but while the baby is still growing. Diabetes in pregnancy can be managed by diet. It is a risk to the health of both the mother and the baby if it is not controlled. Even if it is controlled, women with gestational diabetes have a greater chance of developing Type 2 diabetes later in life.

Diabetes is a very serious disease, because it affects all the cells and all the systems in the body. It puts people at risk of major health conditions, like heart attacks and stroke. In fact, people who have diabetes are 2-3 times (men) and 3-5 times (for women) more likely to develop cardiovascular disease than people without diabetes. They also have worse health outcomes after surviving a stroke or a heart attack because of their diabetes

High blood sugar also puts people at risk of other major health conditions, including:

- Kidney problems
- Numbness in the legs and feet
- Sores that don't heel
- Eye disease and vision problems, including blindness
- Erectile dysfunction.

Detecting and Preventing Diabetes

There are several common signs that warn a person that their blood sugar levels are high and have or may develop diabetes. However, not everyone gets them. Also many people who do get them don't make the link between their symptoms and the disease. Worst of all, most people don't know that they can bring down their sugar levels and prevent or manage their diabetes through diet, exercise and by stopping smoking.

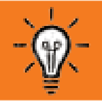
REMEMBER:

You can prevent or manage diabetes through diet, exercise and by stopping smoking.

4

Group Walk Mamelodi. Photo: Phil Mahuma

Make the Right Link – Use the TTHTV Symptom Checker



REMEMBER:
On their own, each of these signs can have many causes.

What to look out for *(Symptom)*	Why this happens *(Cause)*	The questions to ask to make the right link *(Symptom Checker)*
Extreme **Thirst** **Toilet** Need to urinate more often than usual	People who feel thirsty all the time and have to urinate more than usual often wrongly link these changes to changes in the weather or their environment. When the kidneys are not able to filter and absorb sugar (glucose) in the blood stream it is separated and expelled into the urine. To do this, the body has to take fluid from body tissues. This makes people thirsty. They drink more and urinate often.	Do you feel thirsty after you have drunk a full glass or bottle of water? Do you get up to drink during the night? Do you feel thirsty most of the time? Do you need to urinate (wee) more often than you usually do?
Hunger Feeling very hungry even after eating. **Thinner** Sudden unexplained weight loss	Diabetes is most often associated with being overweight. But it can cause sudden unexplained weight loss. This happens because diabetes stops glucose (sugar) from reaching the body's cells. Also the body gets rid of sugar through frequent urination. For both these reasons, even if a person is eating enough their body is not getting the energy it needs to function.	Do you feel hungry, even after eating? Do you feel hungry after eating more than you normally do? Have you suddenly lost weight unintentionally?

Tired Extreme fatigue	People often don't link feeling extremely tired with diabetes because they live busy lives and there can be many reasons for feeling fatigued. There are two reasons why high levels of sugar in the blood cause fatigue – the cells in your body are not getting the food they need to function; and your body is using more energy to get rid of excess glucose and to fight off infections.	Do you feel • too tired to do normal every day tasks? • You have no energy, even after a night's sleep? • Down and depressed?
Vision changes	People often mistakenly associate changes in their vision with getting older rather than being caused by diabetes. Changes in vision, including blurred vision and vision loss, happen because high blood sugar levels pull fluid from the body's tissues including the tissue of the eyes.	Have you noticed changes in your vision? Has your vision becoming blurry? Has your eyesight suddenly gone worse?
Gum disease and bad breath	People often don't think of diabetes when they have gum disease and bad breath. But they are linked. Your saliva (spit), like your blood, has glucose. High glucose levels in your saliva help harmful bacteria grow. These bacteria combine with food to form a soft, sticky film called plaque. Plaque also comes from eating foods that contain sugars or starches. Some kinds of plaque cause tooth decay or cavities. Other kinds of plaque cause gum disease and bad breath.	Have you noticed changes in your mouth like • your teeth are coming loose? • you have sores that are slow to heal? • your gums are sore or inflamed? • you have bad breath that does not go away after you brush your teeth? • your tongue is dry and rough?

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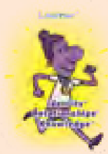


AS A HEALTH WORKER...

You need to know that:

- Not everyone gets these warning signs.
- Many people who get warning signs don't make the link between them and diabetes.
- Most people don't know that they can prevent or manage diabetes by acting on the signs, checking their blood sugar levels.

DIABETES

What do people know about Diabetes?

Working on your own, interview an adult (an older relative or friend) to find out what they know about diabetes ("sugar") and the signs of diabetes.
Record and compare their responses. Write down what you have learned and reflect on what you need to do as a health worker in the community (think/discuss/write and plan).

Diabetes 'finger prick' test

The way for a person to know their risk of developing diabetes or if they already have diabetes is to do a simple test that checks the amount of glucose (sugar) in their blood.

AS A HEALTH WORKER...

- ✓ You can help.
- ✓ Encourage people to test their blood sugar levels.
- ✓ Assist them learn to bring down their blood sugar levels through diet, exercise and not smoking.

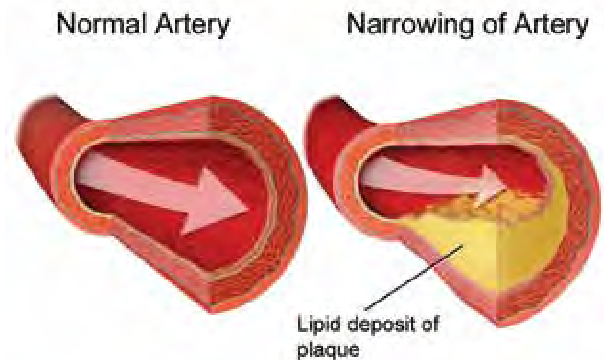
5.3 Cardiovascular Diseases

The cardiovascular system is the medical name given to the heart (cardio) and blood vessels (vascular) in the body.

Cardiovascular diseases are a group of disorders of the heart and blood vessels. According to the WHO, they include:

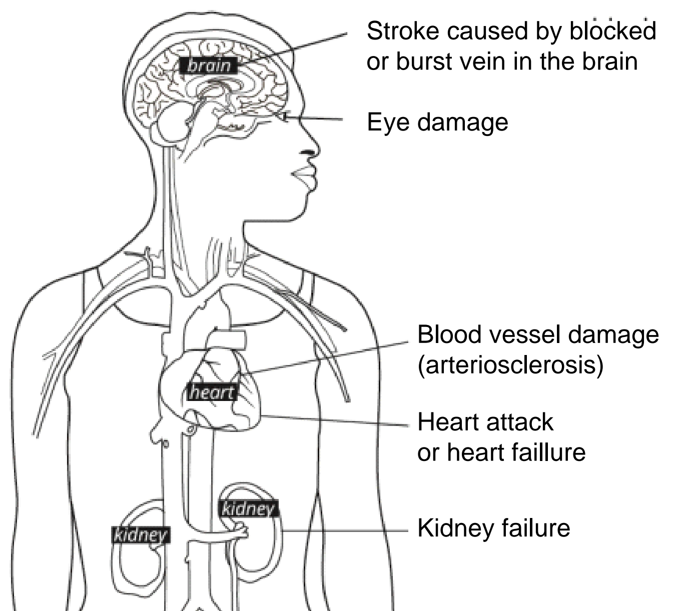
- "Coronary heart disease: - disease of the blood vessels supplying the heart muscle.
- Cerebrovascular disease: - disease of the blood vessels supplying the brain.
- Peripheral arterial disease: - disease of blood vessels supplying the arms and legs.
- Rheumatic heart disease: - damage to the heart muscle and heart valves from rheumatic fever caused by streptococcal bacteria.
- Congenital heart disease: - malformations of heart structure existing at birth.
- Deep vein thrombosis and pulmonary embolism: - blood clots in the leg veins, which can dislodge and move to the heart and lungs."

These disorders lead to heart failure, heart attack and stroke – events that seem to come out of nowhere. Although they are sudden, these events often are the result of cardiovascular diseases that build up over time.



4

Untreated hypertension (chronic very high blood pressure) can lead to...



DID YOU KNOW?

In South Africa, 225 people die from heart disease every day and 10 people suffer a stroke every hour.

The Heart and Stroke Foundation South Africa. *http://www.heartfoundation.co.za/* Accessed on 22 March 2018

The main modifiable risks for (most) cardiovascular diseases are:

- high blood sugar levels (which leads to diabetes);
- diabetes;
- high blood pressure; and
- high blood fats (called blood lipids).

Each of these conditions damage blood vessels and affect the way the heart and other organs in the body work.

High levels of blood sugar and diabetes has already been discussed in the previous section. So what about the other two - high blood pressure and high blood fats?

High Blood Pressure and Hypertension

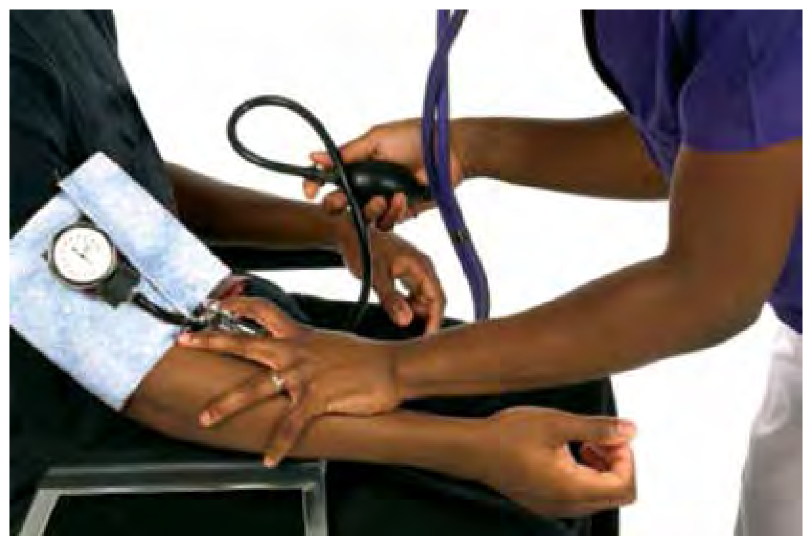
To understand why high blood pressure is a very serious cardiovascular health risk we have to begin by understanding blood pressure. Blood pressure is the force that blood puts on the walls of blood vessels. This force goes up when the heart contracts and pushes blood through the blood vessels that carry it around the body. It goes down when the heart relaxes, although there is always a certain amount of pressure on the walls of blood vessels.

Blood pressure can be measured. The units used to measure blood pressure are mmHg, which stands for millimeters of mercury. Two numbers are needed to describe a person's level of blood pressure. One number describes **systolic pressure**, which is taken when the heart beats while pumping blood. The other number describes **diastolic pressure**, which is taken when the heart rests between beats. Usually blood pressure is written as the systolic number before or above the diastolic number (120/80 mmHg).

Blood pressure changes all the time. This is because the heart adjusts to a person's activity levels, including whether they are asleep or awake, their body temperature, their emotional state, their posture and medications. It also is influenced by a person's age, sex and even by their height.

What this means is that normal blood pressure is a range rather than a number.

The way to know if a person's blood pressure is high is to test it. It is important to take blood pressure accurately, more than once and over days or weeks to determine if a person's blood pressure is high.



DID YOU KNOW?

Normal blood pressure
An adult's blood pressure is considered to be normal when systolic pressure is below 120 mmHg and diastolic pressure is below 80mmHg (120/80 or below).

High blood pressure is when a person's blood pressure levels are consistently above 120/80 mmHg.

Hypertension is the extreme end of high blood pressure. An adult has hypertension when his or her blood pressure levels are **consistently above** above140/90mmHg.

46% of women and 44% of men in South Africa have hypertension (BP above 140/90mmHg).

Among people over 50 years of age:

- 3 out of 4 men (75%) and 4 out of 5 women (80%) have hypertension.
- Most of them (62%) are not aware that they had the condition.
- Nearly all of them (92,2%) do not have their hypertension under control.

AS A HEALTH WORKER...

You need to know that

- hypertension is a silent killer
- hypertension and high blood pressure are strongly associated with two things that people can't change:
  - 😐 older age; and
  - 😐 family history
- hypertension and high blood pressure are strongly associated with five things that people can change:
  - ☺ BMI (being overweight or obese).
  - ☺ Eating habits (what we eat, drink and especially the amount of salt and sugar we have).
  - ☺ Smoking (tobacco, cigarettes)
  - ☺ Physical activity (exercise)
  - ☺ Mental health (stress and depression)

AS A HEALTH WORKER...

You can help

- Educate people about blood pressure and what the numbers mean;
- Get people to check their blood pressure;
- Identify people at greatest risk for high blood pressure;
- Assist individuals and families to learn how to bring blood pressure levels down through diet, appropriate exercise, stopping smoking and by taking medications properly.

4

High Blood Fats or Increased Lipids

The third risk factor for cardiovascular disease is high levels of fats in the blood stream. Lipids (e.g. cholesterol and triglycerides) are fats that the body makes and/or gets from food. These fats play an important part in keeping the body healthy. However, they also cause cardiovascular diseases when their levels in the blood get too high. Over time, cholesterol, calcium, and other substances form fatty deposits called plaques. Plaques collect on the inner walls of the arteries. They make these veins narrower, causing less blood to flow through them. Plaques also burst and create blood clots which can stop the flow of blood altogether.

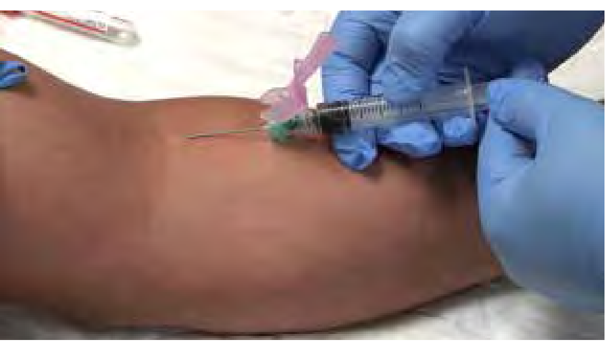
The Disease we don't see

Cross section of artery

High levels of blood fats can:

- Reduce blood flow around the heart causing chest pain (angina);
- Stop oxygen and energy from getting to the heart causing heart attacks.
- Reduce or block blood flow to the brain causing stroke.

Just like with blood pressure and blood sugar, it is important to keep blood lipids at a level that is healthy. To do this a person needs to do a blood fat test, also sometimes called a test for cholesterol. This test is done using blood drawn from a vein by a health professional.



Health professional draws blood for a blood test

BLOOD LIPID TEST

WORKING IN PAIRS

Find out what is tested and what the numbers mean when a person does a Blood Fat (or Blood Lipid) Test.
Create a table that sets out the answers.
You can go to any reputable website including *http://www.heartfoundation.co.za/cholesterol or http://heartuk.org.uk/health-and-high-cholesterol/cholesterol-tests---know-your-number#sthash.uU5ze2CO.dpuf*

Live smart for a healthy heart

- ✓ Healthy lifestyle choices could prevent about eight out of ten heart attacks and strokes.
- ✓ Know and control the numbers – blood sugar, blood pressure, blood fats.
- ✓ Lifestyle changes – especially healthy eating, physical activity, weight reduction and stopping smoking – are all low cost and effective ways to prevent and control high blood sugar, high blood pressure and high blood fats.

AS A HEALTH WORKER...

It is better to prevent disease than to manage and control it.
Encourage and assist people

- to take responsibility for their own health
- to check their blood glucose levels
- to check their blood pressure
- to know their numbers (sugar, pressure, blood fats)
- to eat for health
- to be physically and mentally active
- to learn and discover so that they can become more expert in their own health care.

Five Cold Facts that We Can Change

- 68% of women and 31% of men are overweight or obese.
- Nearly 6 in 10 (59,7%) older South Africans (50+) are physically inactive.
- 78% of older South Africans (50+) have hypertension.
- More than 6 in 10 (64%) older South Africans (50+) have central obesity. This is high risk waist-to-hip ratios of more than 0.90 for men and more than 0.85 for women.
- Nearly 7 in 10 (68,4%) older South Africans (50+) eat too little fruit and vegetables daily.

Fan Wu et al Common risk factors for chronic non-communicable diseases among older adults in China, Ghana, Mexico, India, Russia and South Africa: the study on global AGEing and adult health (SAGE) wave 1 BMC Public Health 2015, 15:88 doi:10.1186/s12889-015-1407-0 2015/06/08

5.4 Cancer

Cancer is a group of related diseases that have a common genetic root in the way cells form, grow and divide.

Cells are the building blocks of our bodies. They are small compartments that hold the biological equipment to keep organisms alive. They make up every part of the body. They are programmed by a genetic code (their DNA) to grow and divide as the body needs them. When they grow old or become damaged they die and new cells take their place.

Cancer develops when this orderly process breaks down. What happens is that old, abnormal or damaged cells survive when they should die and new cells form when they are not needed. These new cells can grow and divide without stopping, forming tumors (lumps of tissue) or they can crowd out healthy normal cells.

There are more than 100 types of cancer. They are usually named after the organ or tissue where the cancer forms, for example, breast cancer, cervical cancer, prostate cancer, skin cancer, liver cancer or bone cancer.

Cancer is caused by changes to genes that control the way our cells function, especially the way they grow and divide.

The changes that cause cancer have two common sources.

- They can be inherited from our parents. Only a small number of cancers are inherited.
- They can be acquired from the environment. Most cancers are acquired during a person's lifetime.

In South Africa among the many types of cancer, lung cancer is the 3rd most common cancer in men (just under 5%) and the sixth most common cancer in women (about 3%). Breast cancer, followed by

cervical cancer, are the leading causes of cancer in women. (22% and 16% of female cancers respectively.) In men, the two most common cancers are prostate cancer (19%) followed by colorectal cancer (5%).

The Top Ten Causes of Death from Cancer in South Africa (2015)

Ranking Type of Cancer by Number of Deaths in South Africa 2000: Total Population, Women, Men

Cancer Type	*Rank by number of deaths for Total Population*	*Rank by number of cancer deaths in Women*	*Rank by number of cancer deaths in Men*
Lung	1	3	1
Oesophagus	2	4	2
Cervix	3	1	n/a
Breast	4	2	18
Liver	5	6	4
Colorectal	6	5	6
Prostate	7	n/a	3
Stomach	8	7	5
Pancreas	9	8	9
Leukemia	10	10	8
Ovary	15	9	n/a
Larynx	13	19	10
Mouth	11	13	7

n/a means that these cancers do not apply to women or men because they do not have the body part.

DID YOU KNOW?

Acquired cancers are triggered by:

- disease causing agents (or pathogens) like viruses and bacteria;
- chemical substances that are found in nature; industrial, household and beauty products; tobacco; pesticides, smoke and dust; and
- high energy electromagnetic radiation that comes from ultraviolet light (especially the sun or manufactured tanning beds) and frequent exposure to medical Xrays or gamma rays.

On their own or together, these cause mistakes to occur as cells divide.

RISKS FOR CANCER

WORKING IN PAIRS

The top causes of death from cancer in South Africa (2000) are set out in the table above.

1. Choose one cancer from the list in the table.
2. Describe the main risk factors for the type of cancer.

PREVENTING THE COMMON RISKS

GROUP / CLASS

1. What risk factors are common for these cancers?
2. In what ways can risks be reduced or cancers prevented?

5.5 Mental Health and Psychological Well-Being

WHAT IS MENTAL ILLNESS?

WORK IN GROUPS OF 4

INDIVIDUAL

1. Without thinking about it, write down five words that you would use straight away to answer the question: What is mental illness?

TOGETHER

2. Talk about your responses:
   - your thoughts;
   - why you think this way; and
   - how mental illness makes you feel.
3. Talk about the similarities and the differences in the responses in the group. What do they tell you about the issues and where to focus in mental health care?

5.5.1 Understanding mental health

All of us have ideas and feelings about mental illness. In the discussion you all probably talked about a person's emotional state. Perhaps you used words like 'he is not normal' or 'she is not herself'. You all probably talked about how a person is behaving. It is common in South Africa to say a person is 'thinking too much' when we refer to them as being mentally ill.

Most people are afraid of mental illness. They are personally afraid that they might become mentally ill. Many people are also afraid of people with mental illness. Our fears come from different sources. They come from

- what we hear and see around us;
- our own actual experience;
- not understanding mental illness;
- not knowing what to do; and
- not having direct experience of people with mental health conditions.

The fact is, we all have views on mental illness. Many of us have indirect experience and some of us have direct experience of mental illness.

Mental illness is like all physical illness. There are different kinds of mental disorders and diseases. They have different causes. They last for different lengths of time. They are different in their seriousness. They need different kinds of care.

What about mental health? Do our views and our more limited experience of mental illness mean that we all know something about and have views on mental health? Well yes! This is because nearly everyone has personal experience of mental health and our experience affects our views. We are all aware that mental health is about physical health, our thoughts and feelings, and our emotional state. We often use words like 'normal' or 'being alright'. We are all aware that mental health influences our behaviour. We know that mental health is about being able to function and live well in the world. It helps us do things, get through challenges and solve problems. It helps us make and keep relationships with all the people in our. And it shapes our understanding of the world around us.

Mental health and physical health influence each other. They influence each other through the way the body parts function. They influence each other through what we do and how we interact in our environment. For example, smoking cigarettes and not doing regular exercise decreases our immune function. Also, not sleeping enough and being tired affects our concentration and can lead to accidents.

Mental health is like all health. In our lifetime, our mental health shifts from good, to average or poor, and back again. We can also get mental illnesses or disabilities that last for shorter or longer periods of time.

Mental health is about physical and psychological well being.

What does this mean?

1. A person can have poor mental health without having a mental illness.
   - ☹ We all have personal experience of feeling sad, stressed or overwhelmed by something in our lives.
   - ☹ Our mental health becomes poorer when problems weigh us down.
   - ☺ Our mental health gets better when we find ways to get through problems and we start to cope.
2. A person can have good mental health with a diagnosis of a mental illness.
   - 😐 Mental illness is like many other conditions.
   - ☺ Mental health gets better when a person's illness or condition is under control.
   - ☹ Mental health gets worse when a person's illness or condition is not under control.
3. Good mental health is about finding, keeping and restoring physical and psychological well-being.
   - ✗ It is not about being free of worries or problems.
   - ✓ It is about being realistic about worries and problems.
   - ✗ It is not about feeling happy and confident all the time.
   - ✓ It is about being aware of yourself and managing your feelings.
   - ✗ It is not about being disease free.
   - ✓ It is about understanding and managing illness and disease to achieve the best possible outcomes.

AS A HEALTH WORKER...

the goal of health care in the community is to promote mental health and to reduce the impact of harms that may result from mental illness. You do this by supporting and helping people restore or achieve balance in their psychological well-being.

5.5.2 Psychological well-being

RYFF'S SIX PARTS OF PSYCHOLOGICAL WELL-BEING

(Ryff CD. Psychological well-being revisited: Advances in the science and practice of Eudaimonia. Psychother Psychosom. 2014;83(1):10–28. doi:10.1159/000353263.)

Psychological well-being is important because it influences how people negotiate their way through life. Psychological well-being is not a fixed state. It changes over time as a person develops and grows. And it changes in time, as a person is faced with challenges. It is something we can all work on as we work on ourselves. It is something we can help other people with when provide health care in the community.

Psychological well-being is linked to how we perceive ourselves and how we relate to other people and the social environment around us. There are six sides to psychological well-being. A person can be at a different point along the continuum between high and low psychological well-being on each one. And a person's position on each one can and does change.

Research shows us that for everybody, good psychological well-being is linked to having better physical health and living longer. This applies to people who are wealthy and it applies to people poor and socially disadvantaged, even though they are known to be at greater risk for poor health.

Although a person's level of psychological well-being can be stable over time, it is not fixed.

Research shows that there are learning and support interventions that lead to improved psychological well-being and better health for people with debilitating mental health disorders like chronic major depression or anxiety.

These and other interventions also work to promote psychological well-being and prevent mental health disorders during the life course. They work with children, teenagers and adults.

Let's look at each of Ryff's six parts of psychological well-being:

Self-acceptance

SELF-ACCEPTANCE

INDIVIDUAL AND IN PAIRS

Divide a piece of paper into two columns.
In column 1 list all the negative things you say about yourself.
In column 2 list all the positive things you say about yourself.

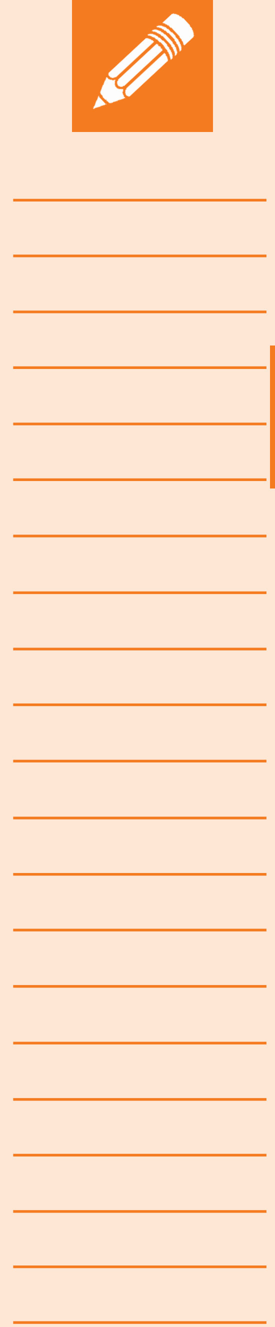
NEGATIVE THINGS	POSITIVE THINGS
(weaknesses, dislikes)	(skills, interests, personal qualities and strengths)
1	1
2	2
3	3
4	4
5	5
6	6
7	7

PAIRS (IN TURN)

1. Ask each other about one negative thing that you feel comfortable to share. Ask: "How does it make you feel?"; "How does it make you act?"; "Do you believe it to be true all the time or some of the time?"; and "Do you believe you can change it on your own or do you feel like you would need help in changing it?".

2. Now ask each other about the positive things. Ask: “How does it make you feel?”; “How does it make you act?”; “Do you believe it to be true all the time or some of the time?”; and “Do you believe you can change it on your own or do you feel like you would need help in changing it?”.

3. Talk about the differences between negative and positive beliefs that people have about themselves. What do they tell you about self-acceptance?



Everyone has things about themselves that they do and do not like. Everyone has done things that they would rather not have done. But they have also done things that make them feel pleased with themselves. This is what it is to be human. Self-acceptance is about learning to live with yourself as a complex human being. It is about accepting who you are as a person.

Self-acceptance is part of psychological well-being. It is the way we create balance in our mental health. People who have poor or low levels of self-acceptance live in a world of negative feelings and behaviours. They judge themselves harshly and are highly self-critical. They often deny their feelings and emotions. They find it hard to learn from past mistakes. They find it hard to set realistic goals. And they often struggle with relationships. They also may find it difficult to recognise and appreciate their strengths and positive qualities.

Self-acceptance is about having a sense of belonging and feeling worthy. It is about building psychological and social competence. It is about developing a realistic and compassionate assessment of the self. People with high self-acceptance reflect on their behaviours or feelings in order to improve rather than punish themselves. This means that a person is able to recognize good things and achievements AND accept negative characteristics, mistakes or failures without losing worth.

Below you can find some small self-acceptance exercises to promote and support mental health. They work for children, teens and adults. You can apply them to yourself and you can use them to support others.

SELF-ACCEPTANCE EXERCISE 1

Write about three things that went well this week.

THREE GOOD THINGS THAT HAPPENED TO ME THIS WEEK			
Name it (e.g. I was praised for my work)	Describe what happened.	How did you feel at the time?	How do you feel now?
1			
2			
3			

Self-acceptance is about acknowledging and learning from positive experiences. You learn what positive experiences feel like. You learn how they affect the way you act. You learn how they increase your psychological well-being.

SELF-ACCEPTANCE EXERCISE 2

INDIVIDUALLY OR IN A GROUP

Ask yourself:
Am I being too self-critical?
Think about an issue that you often criticize and judge yourself about (e.g. your social skills, ability, study habits, tidiness, appearance, etc.).
Write down:
What do you usually say to yourself about this issue? How do you say it to yourself?

What would you say to a friend who was struggling with the same issue? How would you say it to him or her?

What would you say to a client who was struggling with the same thing? How would you say it?

What do you notice about how you speak to yourself and how you would talk to a friend or client. Is it different? How helpful is it to you? What could you do to increase your self-acceptance?

Self-acceptance is about learning how to respond in a compassionate way to our own shortcomings rather than being harshly judgmental and self critical. We need to learn to be kind to ourselves in the same way as we would be kind to someone else who faced the same kind of setbacks.

Environmental mastery

Environmental mastery is about a person's sense of his or her ability to make decisions and to manage these decisions in the world around them. It is about whether we feel that we are able to act on our own behalf or not.

Environmental mastery is a state of mind. It is not about actually being in control of things. It is about a person's belief in their ability, attributes and knowledge to deal with life stressors. The more a person feels they have influence on events in their lives, the less helpless they feel. They are less afraid of change and uncertainty.

DECIDING WHAT TO EAT

WORKING IN PAIRS

How much choice do you feel you have in deciding what to eat?
Who buys the food? Who prepares the food? Who dishes the food? Who decides when it is time to eat?
How does your degree of choice and control affect how you feel about eating?

4

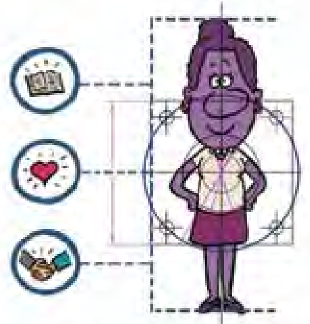
You are likely to have discovered that amongst you there are different levels of choice and control over eating. Also, the importance of mastery over making food choices will be different where a person wants to lose weight or needs to change what they eat due to their health condition. In terms of well-being, it will also differ by age. We often neglect children's need to develop mastery in making choices around food. We underestimate the importance of food in old people's need to feel mastery over their environment.

Positive relationships

RELATIONSHIPS GOOD AND BAD

WORKING IN PAIRS

Talk to each other about relationships.
What makes a relationship good?
What makes a relationship bad?
Talk about how good relationships make you feel and act.
Talk about how bad relationships make you feel and act.
Compare the differences in feeling and your actions.



Chances are that good relationships make you feel good about yourself. They make you feel comfortable in the world. And they give you a sense of mastery and purpose. You feel like you can do things. They make you more open and warm. And they make you want to cooperate with and help others.

Exactly the opposite happens in bad relationships. There is a good chance that they make you feel bad about yourself. They make you feel negative about others. Sometimes they lead to conflict. Sometimes they make you withdraw in order to avoid conflict.

So, we all know from personal experience that positive relationships at home, in the community and at work are good for our psychological well-being and mental health.

Mothers and babies

Positive relationships are good for every aspect of physical and mental health from the moment we enter the world until the day we die.

Mental health and well-being begins with the relationship between a baby and her or his primary care giver. This is usually a mother. It can also be a grandmother, father or other relative, or an unrelated caregiver.

Caring for baby is not just about feeding, clothing, cleaning, resting and protecting baby. Every physical interaction communicates how the person makes the baby feel and how the baby makes the person feel. Every touch, every smile, every sound they each make stimulates emotions between them. These relationships create a deep psychological sense of being in the world.

Relationships around mothers also have a very big influence on their psychological well-being. These impact on the care of their babies. This is why it is important for family members, friends and neighbours, as well as health care providers, to encourage and build positive relationships with, between and around mothers, carers and babies.

Co-workers, clients and people in the community

The people in the workplace and community also influence our psychological well being. Colleagues, clients and people in the community are often not our friends and we don't have to like them. But they matter. We need to learn to build positive relationships with them.

Cooperation

We build positive relationships at work and in the community through cooperation.

4

WHICH TEAM WINS?

WORKING IN PAIR

Lock hands with your elbows on the table. Arm wrestle with each other.
Your goal is to score as many points as possible. You will score one point each time you get your partner's wrist to touch the table for 30 seconds.

Which team wins? Is it the team where the individuals compete with, fight against or compare themselves to each other? Unlikely. People who compete with each other can't achieve a common goal. The team that wins has to be the pair of individuals who cooperates.

Although this is a game, it applies in real life too. From our own experiences in personal relationships as well as at work, we achieve more through cooperation than through competition. And this is because people relate to each other very differently when they compete and when they cooperate.

DID YOU KNOW?

Cooperation means to share an intention and an outcome. To cooperate, people need to work together to achieve their common goal.

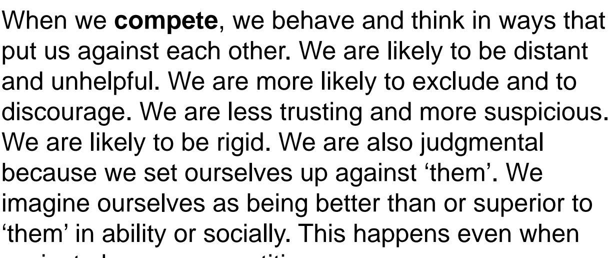
COMPETITION VERSUS COOPERATION

WORK IN GROUPS OF 4

Choose a task that the team has to do. Create a team poster. List the ways *people relate to each* other when there is competition in Column A.
List the ways people relate to each other when there there is cooperation in Column B.
Use this example to talk about what competition and cooperation mean for relationships

- ✓ in the team; and
- ✓ with clients in their homes and the community.

COMPETITION	COOPERATION
1	1
2	2
3	3



When we **compete**, we behave and think in ways that put us against each other. We are likely to be distant and unhelpful. We are more likely to exclude and to discourage. We are less trusting and more suspicious. We are likely to be rigid. We are also judgmental because we set ourselves up against ‘them’. We imagine ourselves as being better than or superior to ‘them’ in ability or socially. This happens even when we just observe competition.

When we **cooperate**, we are open. We communicate. We listen and share often, and a lot. We are interested in what other people think and feel. We are respectful. We accommodate. We adjust our thinking and our actions. We are helpful. We are also more trusting. We include more and judge less. We encourage each other. We manage differences and work to find solutions.

When we cooperate, we create the best conditions to perform a task and achieve our goals.

Having positive relationships is not only about how we deal with people when things are going well. It is also about what we do and how we respond when things are not going well and there is conflict.

Conflict is normal in relationships. Individuals have different opinions, thought processes, attitudes, interests and needs. They have to find ways to adjust to each other. Conflicts start when people don’t understand or make adjustments to each other.

Psychological well-being depends on how people resolve conflict. We can all learn to resolve conflict in a way that supports positive relationships. You use the same learning and practice techniques to solve conflicts as you do to solve other kinds of problems.

TIPS TO HELP YOU RESOLVE CONFLICTS

1. Identify the problem that is causing the conflict.
2. Say what you feel.
   - ✓ Talk about the action or the behaviour.
   - ✓ Talk about how the action or behaviour made you feel.
   - × Don't make personal remarks.
   - × Don't blame, shout, insult, abuse or hit others.
3. Actively listen to the other person.
   - ✓ Try to see their point of view.
   - × Don't interrupt.
4. Work together to find solutions.
   - ✓ Reflect on the action or the behaviour.
   - × Don't make personal remarks.
   - ✓ Reflect on feelings.
   - × Don't blame, shout, insult, abuse or hit others.
5. Decide what each person will do.
6. Put what you have decided into practice.
7. Talk again if the solution is not working.

AS A HEALTH WORKER...

you build your own health and you help other people build their health by creating and supporting positive relationships between people. You also do it by reducing the harms that come from negative relationships.

Purpose in life

Purpose in life is the meaning you give to what you do and who you are. Purpose in life comes from our relationships with and responsibilities to the people around us. It comes from the work we do. It comes from our spiritual and religious beliefs.

Purpose in life is not a fixed thing. It is shaped by changes in ourselves and by changes in the world around us. It is shaped by our own expectations and the expectations of other people.

Purpose in life contributes to mental and physical health. When we have purpose in life, we are more likely to live longer and better. We have better relationships with family and friends. We are also more resilient when we are sick. The opposite is also true. When we lose purpose in life, we live shorter lives. We don't manage our health or control disease well.

FIVE STRATEGIES TO PUT PURPOSE IN LIFE

1. **Try to keep people in your life to support and encourage you**

   Purpose in life comes from the relationships we have.
   - ✓ Keep or make contact with family members.
   - ✓ Keep or make a few close friends.
   - ✓ Meet new people at work, church, clubs or the community.

2. **Try to be physically active**

   Exercise is good for health and the management of disease. Everyone should be physically active.
   - ✓ Walk, stretch or move in any other way.
   - ✓ Do it regularly – at least three times a week. Start slowly and build up your stamina.
   - ✓ Do it for as long as you find reasonable. Between 10 and 30 minutes exercise at a time is good enough to improve your mood and sense of well-being.

3. **Try to be socially engaged**

Psychological well-being is stimulated when people engage with and keep an interest in the world. There are many ways of being curious.

- ✓ Listen, watch or read about events.
- ✓ Deliberately pay attention to the natural and social sounds and smells around you and how they make you feel.
- ✓ Take part in cultural activities, church groups, clubs, picnics, concerts, choirs, etc.

4. **Try to keep learning**

Learning as an adult helps people set goals. It increases their motivation. It improves their self-confidence and it creates purpose.

- ✓ Learn something new.
- ✓ Develop and improve a skill.
- ✓ Build on your interests.

5. **Try to be kind**

Kindness is one of the most powerful interpersonal tools that people have to connect with one another. Kindness is a practice. It is about doing things for other people, not because you have to, but because you want to. An act of kindness increases the psychological well-being of the person who gives and the person who receives.

There are many ways to act in kindness. We act in kindness when we

- ✓ do more for people than what is expected of us;
- ✓ do something for someone without being asked;
- ✓ actively listen to what people say and feel;
- ✓ speak respectfully; and
- ✓ express appreciation.

Autonomy

TWO THOUGHTS ON YOUR ACTIONS

INDIVIDUALLY

1. Think of a chore that you did this morning before you came here. Which of the following reasons best describes why you did it.
   - i. Someone told me to do it, or I would get some kind of reward, or to avoid punishment.
   - ii. People around me would approve of me doing it, or I would feel guilty, ashamed, or anxious if I did not do it.
   - iii. I personally believe that it is important and worthwhile to do.
   - iv. I feel free in choosing and doing it. I feel responsible for the outcomes.
2. Now think of the first interaction with someone that you had this morning at work. Which of the following reasons best describes why you did it.
   - i. Someone told me to do it, or I would get some kind of reward, or to avoid punishment.
   - ii. People around me would approve of me doing it, or I would feel guilty, ashamed, or anxious if I did not do it.
   - iii. I personally believe that it is important and worthwhile to do.
   - iv. I feel free in choosing and doing it. I feel responsible for the outcomes.

WORK IN GROUPS

Compare your responses to the two tasks. Talk about the differences in your motivation, how your actions relate to your values and your interests and desires, and how you feel.

Autonomy is about the human desire *to feel like* we direct our own lives. It is about how much we experience our actions and interactions with people as something that we want to do and that we value. It is also about how much we feel we have initiative and can stand by what we do or say. The opposite of autonomy is being under the control of someone or something else and being forced to behave in a way that is not in keeping with our values or in our own interest.

There are many things that people do autonomously. For example, people often autonomously support children, family members or friends. There are also many things that people do that they feel they have no say in or control over. This is especially when they are told to do things without an understanding of what or why they should do them.

A person with a high level of autonomy will be more willing to do a task or activity, ask for guidance or help. The opposite is also true. A person with a low level of autonomy is less motivated to do something or ask for assistance.

AS A HEALTH WORKER...

you support autonomy when you..

- ✓ listen and respect people's views and concerns.
- ✓ provide information and techniques to help people make choices.
- ✓ minimise pressure.
- ✓ maximise trust.

Personal Growth

Personal growth is about our belief in our ability to respond and adapt to changes in ourselves and in the people and things around us. It is also about how we feel about and experience our effectiveness in living. We perceive personal growth through our mastery of everyday things that are part of becoming an adult, like when we buy our own clothes, run a household, manage a bank account, take care of our families, etc. We also perceive that we are growing when meet goals that we have set ourselves. These can be anything, including, getting and keeping a job, learning to drive, keeping to a personal plan to exercise, control weight or manage substance use, developing a skill, making new friends, etc. And we perceive ourselves to personally grow when we are able to cope with challenging situations or get through traumatic experiences.

Personal growth is about people's commitment to self-improvement. Their levels of psychological wellbeing increase when they feel like they are making an effort to find and keep a meaningful place in the world. People feel like they are realizing their own potential when they try to adapt and adjust to challenges, respond to new environments or change their roles in the family and the community.

AS A HEALTH WORKER...

you can support personal growth.

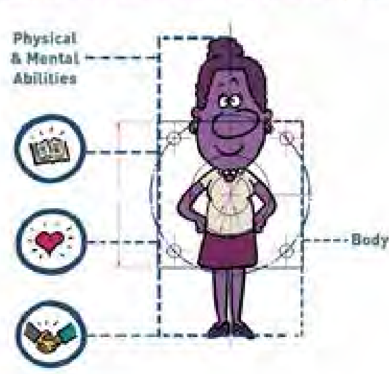
- ✓ Help people work out what is important for them. This is especially when they feel they can't do things they were able to do in the past because of changes in their health, age or social situation.
- ✓ Help people commit to one or two goals.
- ✓ Guide people to try and achieve their goals.
- ✓ Help people to persevere and find other ways when they don't succeed.

5.6 Mental Illness

5.6.1 Understanding Mental Illness

Mental illness is a health condition or disorder. Mental illnesses significantly affect people's thinking, emotional regulation and behavior. They occur when the psychological, biological or developmental processes that support mental functioning are disrupted or stop working.

Mental illnesses are grouped by the signs and symptoms associated with people's patterns of thought, expression and behavior. Our understanding of them starts from the concept of a person as an integrated whole.



DID YOU KNOW?

Other medical conditions and diseases are grouped in one of three ways. Some are grouped by organs or systems of the body, for example, the heart or the respiratory system. Some are grouped by what we know or think causes them, for example, HIV and TB. Some are grouped by the medical system created to respond to them, for example, pregnancy, childbirth and care of the mother and child after delivery (called obstetrics).

Mental illnesses are like illnesses in other parts of the body.

- There are many of them.
- They are different in how they affect people's ability to function.
- The same illness or condition affects people differently, because individuals are different.
- Some mental illnesses are episodic. This means that they happen from time to time and the person functions well when they are not ill.
- Some mental illnesses are chronic.

Mental illnesses, like other illnesses, can be less or more serious. Diagnosed mental illnesses are considered to be serious when a condition lasts for longer than a year and has very powerful symptoms that make it difficult for the person to function. Serious mental illnesses include schizophrenia, bi-polar disorder, depression and anxiety disorders.

Mental illnesses are disabling. They can make it hard for a person to function in daily life. Working, shopping, cooking, cleaning, eating, personal hygiene and other, everyday things can become hard for them to do. They can make it hard for people to care, respond or interact with the people around them.

Mental and physical illnesses are interwoven. Mental disorders and illnesses have clear physical symptoms, like tiredness, pain, changes in appetite and changes in sleep patterns. Mental health problems can also lead to physical illness. Physical conditions and illnesses have strong emotional or psychological components. These interact with one another.

Depression is a good example of the interaction between mental and physical illness.

- Depression is a risk for mothers during pregnancy and after giving birth. In Khayelitsha (Western Cape), for example, about one in three pregnant women are depressed.
- Serious depression, for example, significantly increases the risk of death from heart disease, diabetes and cancer.
- Severe depression is a risk for people on medication. For example, there is a direct link between treatment adherence and depression among people living with HIV, TB and diabetes. People with severe depression don't take their medicines properly. They also stop taking them before they should, for example, when they have TB.
- Depression, anxiety and other mental health problems increase people's risk of getting TB and TB is a risk for becoming depressed. Research in South Africa shows that about half of the people diagnosed with TB have depression, anxiety or other mental health problems.

Mental illnesses are common in South Africa and around the world. In any year, about one in six adults have a serious mental health problem. About 30 in 100 (30%) adults have a lifetime risk of mental illness.

Mental illnesses can occur at any time in a person's life. This means they affect children and adults. About half (50%) of all mental illnesses show first signs before the age of 14. Three quarters (75%) of mental health disorders begin before the age of 24.

Mental illnesses can be caused by physical, psychological and social factors. These usually interact with each other.

- Physical factors are things you inherit from your parents (also called genetic makeup). They can also be physiological changes that come with puberty and menopause (called maturation), brain injury (from violence, road or other accidents), disease and illness, or the treatment of disease.
- Psychological factors are about our emotional and mental state and our levels of psychological wellbeing.
- Social factors are the living and working conditions and the relationships we have with family, friends, colleagues and people in the community as well as the environment around us.

Mental illnesses can be treated. There are different ways to help people to reduce the harms of mental illness and restore mental health. Treatments include providing health and care services to communities, families and individuals to promote psychological wellbeing as well as medical and psychological therapy. They also include developing mental and general health literacy.

Mental illness is a neglected part of the health care system. Most people with mental illness do not get professional medical and psychological help. Many people are not diagnosed. Most people who are diagnosed go untreated. Most people with mental illness depend on family members, especially the women in their homes, to care for them. When they don't have family support they often have no one to care for them. The people and families who do the caring don't get the support they need.

AS A HEALTH WORKER...

Every illness or condition is both a physical and a mental disorder. This is because everyone's health involves the whole person in all his or her dimensions. It is helpful if you know how to reduce the harms and help people and families manage mental illness.

Mental health problems affect

1. The way a person feels.
2. The way a person thinks.
3. The way a person behaves.
4. A person's ability to work, study or do everyday things.
5. A person's ability to manage their health.
6. The way they live with other people.
7. The way other people interact with them.

Mental illness is terrifying and exhausting for the person diagnosed and for the people who stand beside them. It can create feelings of helplessness for everyone involved.

Depression and anxiety are the most common mental health problems in our communities. They are separate conditions. We look at each one separately, although they do occur together often. Also we look at mental health emergencies.

5.6.2 Depression

Everyone has times when they feel sad and miserable about life. These feelings usually don't stop us from going about our lives. And they don't last long. They are a normal part of the flow of psychological wellbeing.

But when feeling down or having a low mood interferes with a person's daily activities and it lasts for weeks, or keeps coming back for a few days at a time, the person could be experiencing depression.

Depression is a mood disorder. People with depression tend to experience their symptoms for most of the day for most days of the week.

Depression is a low mood that lasts for a long time and it affects a person's everyday life.

The signs of depression are the things that trained professionals observe and use to diagnose the condition. These can differ from person to person. But there are some common feelings that signal that a person may be depressed. These are called symptoms. Often they can be picked up by the people around them or who care for them.

People with depression are often extremely sad, tearful and express feeling hopeless and worthless. At times people suffering with depression begin to start thinking of ways to harm themselves or other people in their lives.

COMMON SYMPTOMS OF DEPRESSION:

How a person may feel

- down, upset or tearful
- restless, agitated or irritable
- guilty, worthless
- empty and numb
- isolated and unable to relate to other people
- find no pleasure in life
- a sense of unreality
- no self-confidence or self-esteem
- hopeless and despairing
- suicidal

These symptoms affect how a person behaves. They make it difficult for the person to work or concentrate at school. The person may not want to do the things he or she usually enjoys. He or she finds it hard to be around friends and family.

DEFINITION: To ruminate means to go over and over events or things in your head without insight into what these mean in the bigger picture of things.

Common behaviors with depression

A person *may*

- ruminate
- avoid social events and activities he or she usually enjoys
- self-harm or show suicidal behavior
- find it difficult to speak or think clearly
- lose interest in sex
- find it hard to concentrate or in remember
- use tobacco, alcohol or other drugs more than usual
- have sleep problems
- feel tired all the time
- lose appetite
- lose weight
- eat a lot or have food cravings
- have aches and pains with no obvious physical cause
- move more slowly than usual (e.g. because they have no energy, loose motivation etc.)
- be restless and agitated

AS A HEALTH WORKER...

remember you are not *diagnosing* depression and other mental health problems. **But** you can work out that a person may be depressed in order to think of ways to get them support. You do this by asking questions. *With their permission*, you ask them and other people who usually interact with them, if their behavior and feelings are *noticeably different from usual*. Or, even if they are behaving and feeling the same, you ask them if they experienced low mood and other symptoms of depression for a long time.

4

Factors that trigger depression

Often, depression does not have a single cause. For most people depression is triggered by a number of factors. These physical, psychological, social and environmental factors often interact with one another in different ways. Some people can become depressed without any obvious trigger.

There are five factors that are known to increase the risk of depression.

1. Childhood experiences

These are things like physical, sexual or emotional abuse, neglect, loss of someone close, traumatic events and family instability.
There is good evidence to show that

- ✓ Difficult experiences in childhood can make a person vulnerable to experiencing depression later in life.
- ✓ Lots of smaller challenging experiences can have a bigger impact on a person's vulnerability to depression than experiencing one major traumatic event.

- ✓ Difficult experiences during childhood can have a big impact on self-esteem and how a person learns to cope with difficult emotions and situations.
- ✓ A child or adolescent who has seven or more violence-related trauma experiences is 50 times more likely to attempt suicide compared to a child without experience of violence related trauma.

2. Life events

Life events are core experiences. They change or disrupt how we feel about ourselves. They are things like changing a job, moving house, falling pregnant or having a baby. They are also things like being unemployed, losing a job, being cheated on, ending a relationship, death of a loved one, being physically or sexually assaulted, being bullied or being abused.

- ✓ Life events can be positive or negative. When they are negative or they are experienced as negative, they bring down our mood and our self-confidence. They create uncertainty. This happens to everyone.
- ✓ Low mood can develop into depression when people don't know how to deal with the emotions that come from grief, loss, trauma or other events that have disrupted them.
- ✓ Low mood can develop into depression when people don't have support to help them cope.

3. Physical and other mental health problems

Any physical or mental illness or condition can lead to depression. This is because

- ✓ They can be life threatening.
- ✓ They often cause pain and discomfort.
- ✓ They disrupt people's ability to function physically and socially.
- ✓ They are often difficult to manage
- ✓ They impact on the mood of the person with the condition AND the mood of the people managing their condition.
- ✓ Living with a family member who has depression increases a person's chances of becoming depressed.

4. Medication, drugs and alcohol

- Depression can be a side effect of prescription medication, alcohol and street drugs.
- Prescription medications often have side effects. Sometimes they cause depression and other mood disorders.

- ✓ Always ask about the side effects of any medication that you take.

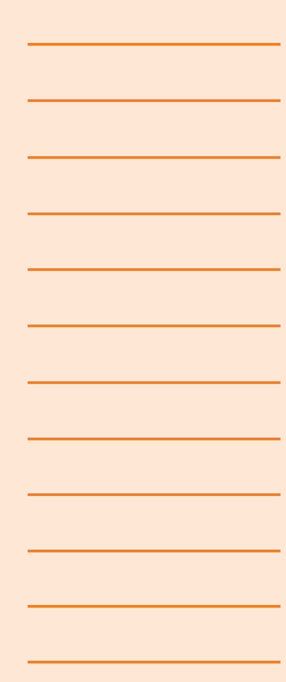
- ✓ Always check the information leaflet of any medicine you take for side effects.
- ✓ Get medical help if a prescription drug or medicine is causing depression.

- People often use alcohol or street drugs to feel better or distract themselves when they health or social problems.
  - ✓ Both alcohol and street drugs can cause depression.

5. Sleep, diet and exercise

Sleep, diet and exercise influence our mood and psychological wellbeing.

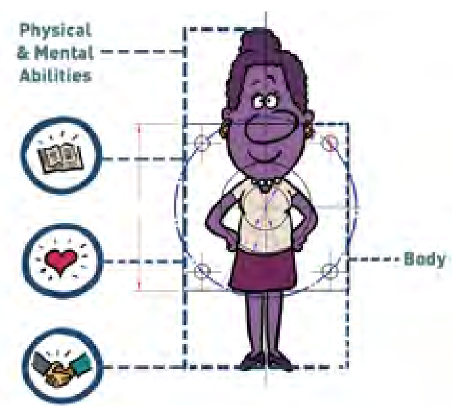
- ✓ Sleep problems and depression feed each other. People who find it hard to fall asleep and to stay asleep are at high risk of depression. People with depression find it hard to fall asleep or they sleep too much. This is especially true in children and teenagers with depression.
- ✓ Diet is about the food people eat and how often they eat. People in poorer households tend to eat more foods that are high in sugar and low in iron. They also eat less frequently and experience food insecurity more often. As a result they are often overweight but undernourished. This experience of nutritional deprivation increases the risk for depression in adults. Child hunger is a predictor of depression and thoughts of suicide in adolescence and young adulthood.
- ✓ Exercise or physical activity is closely linked to mood and how people feel about themselves. People who can't move about or are not physically active generally experience poorer psychological wellbeing and mental health. They are also at greater risk for depression. Exercise improves psychological wellbeing. It reduces the risk for depression. It also helps people manage and control depression and anxiety.



AS A HEALTH WORKER...

remember that the combination of factors that can cause of depression vary a lot from person to person. Depression is often triggered by lots of small challenges rather than one big event. Depression can creep up on a person.

Responding to depression



Depression is hard to prevent because it is complex. We also don't now enough about all the dimensions of the people we provide health care for. And there are too few people who have the health literacy and support skills that are needed to prevent depression. But we can begin to change this picture. There are things that we know help prevent depression and help people manage depressive episodes once they start.

AS A HEALTH WORKER...

remember depression is an illness. A person can't "snap out" or "get over" it. You have to understand the condition in order to be able to help the person and the people around them understand and manage it.

Preventing and managing depression takes teamwork. It requires the active involvement of the person who is at risk for depression or who possibly is having a depressive episode as well as family and close friends. It requires health care workers, clinicians and other professionals, like social workers, to treat and to support treatment. And it requires the involvement of people and organisations in the community to create a social environment that supports mental health and psychological wellbeing.

The table below describes possible actions to identify, treat and support the management of depression.

IDENTIFYING AND MANAGING DEPRESSION –WHAT TO DO AND WHO SHOULD BE INVOLVED						
ACTIVITY		Individual	Individual client or patient	CHW	Clinician psychologist	Community support clubs organisations
Help Identify Problem		✓	✓	✓	✓	✓
CLINICAL TREATMENT						
Talk Therapy	Diagnosis	✓			✓	
	Treatment	✓			✓	
	Adherence Support	✓	✓	✓	✓	✓
Medication	Diagnoses	✓			✓	
	Treatment	✓			✓	
	Adherence support	✓	✓	✓	✓	✓
NON-CLINICAL MANAGEMENT						
Promote psychological well being	Raise mental health literacy	✓	✓	✓	✓	✓
	✓ Improve self care	✓	✓	✓		
	✓ Reduce substance use	✓	✓	✓		✓
	✓ Get Active	✓	✓	✓		✓
	✓ Get Social	✓	✓	✓		✓
	✓ Change Sleeping habits	✓	✓	✓		
	✓ Change eating habits	✓	✓	✓		
	✓ Increase self understanding	✓	✓	✓		

Identifying symptoms of depression

Sometimes people notice for themselves that things are not okay. Sometimes it is family or friends who first notice that a person is possibly depressed. In fact anyone can observe that a person is possibly suffering from depression.

Clinical Treatment

The two approaches to treating depression clinically are psychological therapy and medication. These can be used on their own or together.

Psychotherapy is mental health treatment through talking and thinking. There are different kinds of therapies or treatments, but they all share a common purpose – to help people heal psychologically so that they can function better in everyday life. Therapy involves listening and talking. Professionals are trained to guide a person to find ways of resolving personal, social, or psychological problems and difficulties.

Medication is the use of medicines to improve the symptoms of depression and other mental illnesses. They can help people manage their feelings and behavior so that they can rebuild and improve their lives. Medicines for depression and other mental health problems are given by doctors and other clinicians qualified to prescribe them.

Depression is usually treated with medicines called antidepressants. Like all medicines, people need to know what they do and how they work. They also need to know about the side effects of medicines.

FACTS ABOUT ANTIDEPRESSANTS

1. Antidepressants are prescribed by doctors.
2. Anitdepressants take time to work.
   - ✓ They often first improve a person's energy levels, stomach problems and sleep.
   - ✓ They may take 4-6 weeks to improve a person's mood.
3. Antidepressants can have **side effects**.
   Side effects include
   - Nausea
   - Increased appetite and weight gain
   - Loss of sexual desire and other sexual problems, such as erectile dysfunction and decreased orgasm
   - Tiredness and drowsiness
   - Problems with sleep (Insomnia)
   - Dry mouth
   - Blurred vision
   - Constipation
   - Dizziness
   - Restlessness (Agitation)
   - Irritability
   - Anxiety
4. Antidepressants are not addictive **but** there can be a withdrawal if they are stopped too suddenly.
   - ✓ It is important not to stop taking anti-depressant medicines suddenly. Withdrawal symptoms can be difficult to cope with and may be dangerous.
5. Antidepressants treat some of the symptoms of depression not the factors that cause depression.
   - ✓ A person still needs help to manage their emotions, thoughts and actions so that they can restore balance in their psychological wellbeing.

AS A HEALTH WORKER...

your role is to support clinical treatment. You are there to help the person keep to their treatment plans. You are there to encourage and assist the people who support them to play a positive role in keeping to treatment plans.

Non-clinical Management

Promoting and restoring balance in psychological wellbeing is at the heart of non-clinical management of depression and other mental illnesses. These are things that people can learn to do or be supported to do to manage their conditions. They are activities that can help improve people's ability to cope with depression. They can also help decrease the severity and the length of symptoms. They are not a substitute for clinical treatment.

Raising mental health literacy.

One way to promote psychological wellbeing is to raise health literacy. Health literacy is about understanding health, including mental health. And it is about being able to respond to disease, illness and health related conditions. A practical way to do this is to help people plan how they can respond to a health problem.

Making a plan about what to do is as important for the person with the mental health condition as it is for the people who support them.

This is because a plan of action

- ✓ gets everybody to acknowledge the condition,
- ✓ helps people talk about how it makes them feel and act,
- ✓ gives everyone some control over and certainty about what can be done,

- ✓ helps individuals understand and identify the parts they feel they can play,
- ✓ helps everyone support each other,
- ✓ creates shared goals,
- ✓ gives people hope through practical actions.

The plan is a guide to action. It can address some or all the things that we know are disrupted by depression and that need to change in order to restore psychological wellbeing

1. Self-care

1.1 This is about eating regularly, sleeping enough and restfully, and maintaining general personal hygiene.

- Practicing self-care is as important for the person with the mental health problem and as it is for the people who support them.

1.2 Self-care is also about helping people learn to understand themselves better and to be kind to themselves. This includes

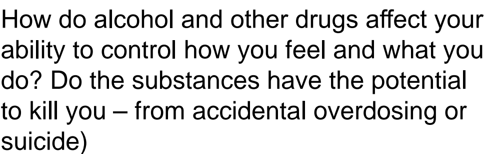
- Recognising and accepting our own individual limitations.
- Becoming conscious of the activities, places or people that affect our mood.
- Being kind to ourselves in the same way that we are kind to others.
- Learning how to put negative experiences and thoughts in perspective.
- Practicing how to focus on the positive things about ourselves, and the good things about the people around us.

2. Substance use

2.1 People often use or increase their use of alcohol and drugs to try and cope with how they are feeling. However, substances that are not prescribed to treat a condition, can make depression, anxiety and other mental health conditions worse. They can reduce people's ability to manage their health and restore their psychological wellbeing.

2.2 Although we know it is better not to use alcohol and drugs when people are having a depressive episode, it is *what they think and feel that really matters*. So it is wiser to use a harm reduction approach in order to help them make better choices. To do this you need to work out three things.

- *The benefits* they feel they get from using the substances. (What's the overall effect of alcohol or substance on you? What do you enjoy most about using them? What do you get from their use?)
- *The risks* of using the substances. (Are their possible interactions with your condition or the medicines you are taking to manage depression?



How do alcohol and other drugs affect your ability to control how you feel and what you do? Do the substances have the potential to kill you – from accidental overdosing or suicide)

- *Other ways to self medicate*. (Are there other things that you like to do that reduce your stress and negative emotions? What other things can you think of that will give you similar benefits without the risks ? What about playing some sport, volunteering to help a person or an organization?

3. Physical activity

3.1 Getting physically active is a simple way of improving a person's mood. It is often also a social activity. It increases a person's sense of belonging and involvement in the world around them.

3.2 The aims of physical activity are

3.2.1 to help a person build up to at least 30 minutes of moderate-intensity physical activity on most or all days of the week. To do this it is important that you

- ✓ Start from where people are at.
- ✓ Agree on small achievable goals.
- ✓ Help people find the kind of exercises that they feel comfortable doing. These can be simple activities like walking to the shop or to the end of the street and back.
- ✓ Help them schedule some physical activity every day.
- ✓ Set a date to review what the plan.

3.2.2 to help a person engage with other people through physical activity

- ✓ Walk with another person or group.
- ✓ Take part in other group initiatives that include exercise (communal gardening, dance or exercise classes etc).

4. Social Activity

4.1 Social activity restores people's self-confidence. It helps make them feel better. It also can increase their network of support.

4.2 People with depression and their family members need help.

4.2.1 Keep talking and listening.

- ✓ They need to be encouraged to talk about their feelings and their experiences.
- ✓ They need to be listened to with empathy and without judgment.
- ✓ They need to be included in everyday communication about family, friends and the usual activities going on around them.

4.2.2 Keep up with or go back to the social activities they used to enjoy. This can includes things like

- ✓ taking part in family gatherings,
- ✓ going out with friends,
- ✓ visiting neighbors,
- ✓ participating in local activities in the community.

4.2.3 Make contact with organizations in the community that can provide them with support for their condition.These include

- ✓ joining groups that provide counseling, occupational therapy or other kinds of resources to individuals and families with the same or similar challenges.

4.2.4 Try new things. This can include

- ✓ starting a new hobby,
- ✓ joining a choir, music, dance or theatre group
- ✓ volunteering at a local church
- ✓ joining a community based organisation.

AS A HEALTH WORKER...

you can play a very important role in helping individuals and families manage their mental health and restore psychological wellbeing. You do this by taking the techniques of learning to create capability and applying what you know about health and psychological wellbeing to the mental health problem.

5.6.3 Anxiety Disorders

Anxiety is feeling worried, tense, nervous or afraid in the face of danger or uncertainty. We feel anxious when we face stressful events. This can be something like being diagnosed with an illness, having a death in the family or among friends, having a baby, sitting an exam, going to a new school or starting in a new job. We also usually feel anxious when we have to make a big or difficult decision about something. This can be something like leaving home, getting married, breaking up or getting divorced, deciding to have an operation etc. Anxiety prepares us to pay attention and it makes us aware of danger. Anxiety is a normal human reaction to stress.

Normal anxiety...

- Is related to a specific situation or problem.
- Lasts only as long as the situation or problem.
- Is proportional to the situation or problem.
- Is a realistic response to a realistic problem or situation.
- Also, it means you know what is causing the feelings.
- The situation would make most people feel stressed.
- Feeling anxious does not change the way you act.
- Anxiety stops when the situation is over.

Anxiety is a mental health problem when a person becomes *excessively fearful* or worried in a way that is *out of proportion* to the situation and she or he finds it *hard to function normally* in day-to-day life.

4

DID YOU KNOW?

People with mental health problems like depression and anxiety, often have unhelpful, unrealistic and inaccurate thoughts about themselves, other people and the situations they find themselves in. These thoughts are usually negative. And they lead to unpleasant emotions and negative behaviors that reinforce unhelpful ways of thinking. They get trapped in a vicious cycle of thinking, feeling and doing.

An anxiety disorder is when

- Anxiety comes up unexpectedly, for seemingly no reason.
- The person's response to a situation or problem may be much stronger that they would expect.
- A person experiences a lot of unrealistic anxiety, such as fear of a situation that likely will never happen.
- Anxiety lasts for a long time, even when the situation or problem has been resolved.
- Anxiety feels impossible to control or manage.
- A person avoids situations or things that he or she believes may trigger anxiety symptoms.

Physical and Psychological Symptoms Associated with Anxiety Disorders

There are several kinds of anxiety disorders (Go to 4: Appendix 6: Anxiety Disorders). They all have physical and psychological symptoms. The actual symptoms that people experience differ by the kind of anxiety disorder. They differ from person to person. And everyone does not experience all of them.

PHYSICAL AND PSYCHOLOGICAL SYMPTOMS ASSOCIATED WITH ANXIETY DISORDERS

Physical Symptoms

- nausea (wanting to vomit)
- tense muscles and headaches
- pins and needles
- feeling light headed or dizzy
- faster breathing
- sweating or hot flushes
- a fast, thumping or irregular heart beat
- raised blood pressure
- difficulty sleeping
- needing the toilet more or less often
- churning in the pit of your stomach
- panic

Psychological symptoms

- feeling tense, nervous and on edge
- having a sense of dread, or fearing the worst
- feeling like the world is speeding up or slowing down
- feeling like other people can see you're anxious and are looking at you
- feeling your mind is really busy with thoughts
- dwelling on negative experiences,
- thinking over a situation again and again (this is called rumination)
- feeling restless and not being able to concentrate
- feeling numb

Causes and Risks for Anxiety Disorders

We don't know what causes anxiety disorders. What we do know is that there are a number of risk factors for anxiety disorders. They often come together also to cause depression and other mental health problems.

Anxiety disorders are associated with

- ✓ age
- ✓ gender
- ✓ physical health problems and conditions
- ✓ mental health problems
- ✓ social and environmental stressors
- ✓ medicines, street drugs and alcohol

AS A HEALTH WORKER...

you know where to look when you know what puts people at risk for anxiety disorders and who is at risk for mental health problems. This way you can identify and help them respond to possible mental health care.

Age

Anxiety disorders most often appear in children, adolescents and young adults. They occur in both boys and girls, but girls are more vulnerable than boys.

Gender

Women are two times more likely as men to be diagnosed with anxiety disorders in their lifetime. Women are particularly vulnerable during pregnancy and after giving birth.

Physical and mental health problems

People who have HIV, TB, diabetes, cancer or other physical illnesses or suffer from depression and other mental health problems worry about their condition. They also worry about the effect the illness has on their lives. And they worry about the effect their illness

has on the lives of the people around them. This constant worry sometimes leads to the development of an anxiety disorder.

We know that TB patients, for example, need help to manage psychological distress for the whole treatment period, especially when they have previously treated for TB, are on MDR-TB treatment and are economically deprived.

Treatment of health problems

The medicines that are used to treat physical health problems often have mental health side effects. Depression and anxiety, for example, are common side effects of many medicines, including some of those used to treat cancer, MDR TB and HIV.

Social and environmental stressors

Social and environmental stressors are the problems that come from the things going on around us in our daily lives.

Stressors may come from problems in our personal, family and social relationships.

- ☹ Interpersonal violence and violence in the home from partners, parents or caregivers seriously impact on the mental health of women, children and old people.
- ☹ Domestic conflict and the breakdown of personal relationships affects children, adolescents and parents.

Stressors may come from problems that are caused by our economic circumstances. This includes things like

- ☹ Being homeless,
- ☹ Being unemployed,
- ☹ Being food insecure,
- ☹ Being poor relative to the people around us.

Stressors may come from our social environment. This includes

- ☹ Gang and neighborhood violence are stressors, especially for adolescents and care givers in communities.
- ☹ Problems with the police and the law. These are stressors, especially for young people, people who use illegal substances, people who work in the sex industry, and family members who are affected by parents, children or partners who have problems with the law
- ☹ Services and infrastructure that are inadequate or don’t respond to people’s needs, like not having easy and regular access to water, uncertainty about grant payments or medication stock-outs. These are stressors that cause anxiety, particularly for the people who do most of the caring in the community.

Stressors may come from our occupation.

☹ People who work in emergency and security services are particularly at risk for anxiety because of the work they do.

Care and Treatment

Anxiety disorders are treated in the same way as depression and other mental health conditions. The disorder has to be identified. It can be treated clinically with talk therapy or medicines. It can also be treated non-clinically through the development of skills and understanding to build people's ability to manage and control their anxiety.

AS A HEALTH WORKER...

- ✓ you support clinical therapy
- ✓ you provide, support or help people access non-clinicial therapy
- ✓ you build individual and family mental health literacy by facilitating learning
- ✓ you work in a team

The best therapies for anxiety disorders are clinical and non-clinical talk and behavior therapies.

Cognitive behavior therapy or CBT is a clinical talk therapy. It focuses on patients' thoughts about a situation and the way their thoughts affect how they feel emotionally and physically and how they behave. In CBT, trained professionals help patients recognize and challenge negative thinking patterns and behaviors. They help patients learn to change the way they think so that they can reduce the likelihood and intensity of anxiety symptoms and change what they do with their symptoms. Many people with anxiety disorders benefit from CBT.

4

CBT applies a capability approach to help people learn to manage depression, anxiety disorders and other mental health problems.

Learning to relax is a non clinical therapy. It is important for physical and mental health and psychological wellbeing. Relaxing the body and mind produces physical and emotional changes. It helps us

- ✓ keep calm and take control of thoughts and feelings,
- ✓ increase energy and focus,
- ✓ combat illness,
- ✓ relieve aches and pains,
- ✓ improve our ability to solve problems, and
- ✓ increase motivation.

Deep breathing, progressive muscle relaxation and simple visualization are three relaxation techniques that people can learn to do to relax and manage stress. (Go to 4: Appendix 7 - Three Relaxation Techniques to Reduce Anxiety and Manage Stress)

They are simple. Everyone can learn them. They do not need any special equipment or tools or classes. People can do them in their own time and space. And they are effective on their own, and in combination with one another.

Deep Breathing

The way you breathe affects your whole body. Deep breathing is one of the best ways to lower stress and reduce anxiety. This is because when you breathe deeply, it sends a message to your brain to calm down and relax. The brain then sends this message to your body. There are different breathing exercises that you can learn to do.

Progressive relaxation

Progressive relaxation is a two-step process of systematically tensing and relaxing different parts of your body. As you tense and relax each group of muscles you learn to recognize what being tense and being completely relaxed feels like. This can help you respond to the first signs of physical tension that accompanies stress. Also as you can consciously learn to relax your body in order to help you relax your mind.

Visualization

Visualization is a technique that is used to help people take their minds off worries and negative feelings. Through visualization people can learn to actively picture positive places, people and events that make them feel relaxed and assist reduce their anxiety. Visualization can also be used to

help people imagine a topic in order to “practice by thinking” how they are going to feel and react. For example, they can visualize “what it feels like to be free of anxiety” or “what I will do to get myself free from anxiety”.
People can do visualization exercises on their own or they can be guided through them. This can happen directly, where a person takes someone through a visualization exercise. Or it can happen indirectly, for example, through a recording.
Visualization is really effective when people focus on the positive and have specific goals.

4

Medication

Anxiety disorders can also be treated with medicines. Sometimes doctors prescribe antidepressants and benzodiazepines for anxiety. They calm the brain and reduce anxiety. Benzodiazepines work very quickly. They can also be used in sleep disorders, before surgery and to help with withdrawal from substances like alcohol and street drugs.

Benzodiazepines have several side-effects. The most common are

- ✓ Addiction.
- ✓ Sleepiness.
- ✓ Dizziness.
- ✓ Weakness.
- ✓ Poor balance.

Benzodiazepines should not be used for more than 2-4 weeks.

AS A HEALTH WORKER...

- ✓ you can help identify possible mental health conditions
- ✓ you can refer people for clinical care

5.6.4 Understanding psychosis

Psychosis is a mental state where people lose touch with reality. They see, hear and believe things that are not real. They have strange persistent thoughts, emotions and behaviors that are confusing and often very scary.

Psychosis generally happens in episodes. These can be once off or they can occur for short periods throughout people's lives or they can happen most of the time.

Psychosis is not a disease or disorder. It is usually a sign of a disease or disorder. Different people may have different symptoms of psychosis. This is because they depend a lot on the disease or condition causing the psychosis.

In psychosis, people most often experience hallucinations and delusions. **Hallucinations** are hearing, feeling or seeing things are not there. People who are hallucinating often

- ✓ hear voices (auditory hallucinations);
- ✓ experience strange sensations or unexplainable feelings;
- ✓ see glimpses of objects or people that are not there.

Delusions are strong beliefs that are not consistent with a person's culture, are unlikely to be true and may seem irrational to others. People who are experiencing delusions often think that:

- ✓ external forces are controlling their thoughts, feelings and behaviors;
- ✓ trivial remarks, events or objects have personal meaning or significance; and
- ✓ they have special powers, are on a special mission or even that they are God.

Changes in speech, concentration and movement. During a psychotic episode people may experience jumbled thinking. Their speech may be hard to make sense of or it may be illogical. They may have difficulty completing tasks. Their movements may become very fast or very slow, awkward or rigid.
Family members are often the first people to see early signs of psychosis. These include

- ✓ A drop in performance at school or work;
- ✓ Trouble thinking clearly or concentrating;
- ✓ Being suspicious or uneasy with people;
- ✓ A decline in self-care or personal hygiene;
- ✓ Spending a lot more time alone than usual;
- ✓ Strong, inappropriate emotions;
- ✓ Showing no feelings at all.

Psychosis can be treated. Treatment for psychosis usually includes medication and psychotherapy. Research shows that detecting and treating people experiencing psychosis **early** reduces their chances of having further psychotic episodes and gives them better long-term quality of life.

AS A HEALTH WORKER...

you have an important role to play. You can teach people to recognize the warning signs of psychosis. You can help them get treatment. And you can support them to manage psychosis.

5.6.5 Mental health emergencies

Mental health emergencies are situations where people need urgent and immediate health care because their mental state puts them and other people in danger of serious physical harm.

There are two main kinds of mental health emergencies, psychomotor agitation and self-destructive or suicidal behavior.

Psychomotor agitation

Psychomotor agitation is extreme emotional excitement with increased verbal and motor activity that is self-fueling. People with psychomotor agitation can't stay still or remain calm. They talk and move about to try release tension and anxiety. But their talking and moving about actually increases their tension and agitation. They can go very quickly from problematic low levels of agitation, like repeating sentences, foot tapping, hand-wringing or pacing up and down to the extreme of physically harming themselves and other people.

Psychomotor agitation is a mental health condition that is associated with many diseases, treatments and health problems.

Self-destructive or suicidal behavior

Self-destructive behavior is when a person intentionally and repeatedly physically injures herself or himself without intending to commit suicide. But this relationship is complicated and there is always a suicide risk. Although people who self-injure usually do not intend to kill themselves, they may injure themselves in a way that could result in medical complications or death. Also people may become desperate about their lack of control over the behavior and its addictive nature, which may lead them to attempt suicide.

FACTS ABOUT SELF-INJURY

People who practice self-injury can hurt themselves in many ways. Usually they use more than one method. The most common self-harming methods are skin cutting, hitting or banging their heads, and burning. Other methods include excessive scratching to the point of drawing blood, punching themselves or objects, intentionally infecting themselves, inserting objects into body openings, drinking known harmful substances like bleach or detergent, and intentionally breaking bones.

People who practice self-injury say they do it to cope with or relieve emotional pain or feelings that they find hard to express. They often say they feel empty inside, lonely or not understood by other people. They also often are afraid of intimate relationships and adult responsibilities. The relief they feel is always temporary, so self-harm practices often become a compelling cycle of addictive behavior.

Self-injury behaviors can be a symptom of depression, anxiety disorders and other mental health conditions. People who practice self-injury need professional help. Their condition can be treated using a combination of medication and talk therapy.
Adapted from: *http://www.mentalhealthamerica.net/self-injury* 20-04-2018

Suicidal behavior is the thoughts and actions of people who want to take their own lives. Suicidal behavior **should always be treated as a serious threat** to a person's life and a medical emergency.

Facts about suicidal behavior

Suicidal behavior is usually divided into three activities – thinking about suicide, planning suicide and attempting suicide.

Thinking about suicide

A person who is actively thinking about suicide may say things like "I want to kill myself" or "I want to die". A person who is passively thinking about suicide may say things like "I would be better off dead", "I hope I go to sleep and never wake up", "everyone would be better off if I was dead", "I can't bear to be alive anymore" etc.
For a number of reasons, many people who think about suicide do not go onto to plan or attempt suicide.

Planning suicide.

A person who is planning suicide may make preparations for death. They may unexpectedly want to make a will or payoff debts. They may start giving away personal things that they value or are precious. They may start doing customary death rituals. They also may prepare or get things to help them kill themselves. Planning suicide is a serious and deliberate step towards action.

Committing suicide.

When people commit suicide they put their thoughts and plans about killing themselves into action. They intentionally injure themselves in a way to lead to death. Sometimes their attempts at suicide do not succeed. This does not mean that they were not serious about ending their lives. People who have tried committing suicide once are at much greater risk of trying again and of succeeding.

Risks for Suicide

There are a number of circumstances and conditions that increase people's risks for suicide. These include

Mental health and treatment problems

- Previous suicidal behavior – especially recent attempts at suicide.

4

Physical illness and treatment problems

- depression, anxiety disorders and other conditions
- medication side effects
- Combining prescribed medicine and other substances (like antianxiety medication and alcohol)

Trauma

- Injury
- Disability
- Violence and abuse, like physical or sexual assault, child abuse, family violence, bullying etc.

Social and environmental problems

In older people:

- loneliness
- loss of a partner
- social isolation
- changing home or involuntary living in an institutional setting (old age home)
- loss of independence and autonomy

In younger people:

- relationship difficulties, loneliness
- experiencing a humiliating or shameful event
- problematic use of alcohol and illicit drugs - overdosing
- family conflict, instability, disruption
- unemployment and poverty
- homelessness
- being in prison or a mental hospital

Responding to mental health emergencies

Safety first – the person's behavior is unpredictable, their strength is unknown.

- See to your own safety.
- See to the safety of other people.
  – family, neighbors, team members.
- See to the person's safety.

Remove dangerous objects

Create a safe space

Tell the person what you expect of them.

- Communicate clearly.
- Be firm.
- Be goal oriented.

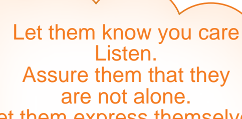
Ask if they intend to kill themselves. Say why you are there.

Calm the person down

- Speak in a friendly way
- Speak in an even tone
- Keep conversational contact (keep talking)

Create a personal relationship.

- Show empathy.
- Be friendly.
- Be kind.
- Be understanding.
- Be respectful.



Get help from trained professionals.

- To assess for any underlying disease or condition.
- To treat with medicines.

AS A HEALTH WORKER...

every success you have depends on building relationships. Your relationship with the person and family, the health care team, the clinic and other partners necessary to service the needs of your client are all important. Your skills for this job include being able to actively listen, create connections and communicate effectively.

5.7 Substance Use Harm Reduction

Harm reduction

Harm means to injure, to hurt or to cause pain, suffering, distress, anguish, trauma, torment or grief to someone or something. Reduction means the actions to make something smaller or less in size, impact or effect.

DEFINITION:	Harm reduction is an intentional practice and approach to keep or bring down injury, hurt and pain or the chances of such harm.

We all practice harm reduction in everyday life.

HARM REDUCTION

WORK IN GROUPS OF 4

How many ways are there to prevent a person from being run over by a car on the road?

Talk about

1. The things you do when you cross a busy road on foot.
2. The systems or supports that you rely on to reduce the risks
3. The things you would say or do to help other people they cross the road.

For you to be safely here, you probably looked and listened to see if there was oncoming traffic. You probably waited until you thought it was safe to cross the road or until the robot turned green. You probably hoped that drivers are in control of their vehicles and know how to stop them when necessary. You probably did all this automatically. You did not think about the person who taught you how to cross the road safely. You did not think about the people who put systems in place to reduce the risks of road accidents.

One thing for sure is that if you need or want to get to the other side, you will try cross the road, even though you are aware of the risks. You also do not think that to do it, cars or other vehicles need to be banned. In other words, to cross a road you have to practice harm reduction. And there are also social and system supports to reduce the risks of crossing a road without removing vehicles or preventing you from crossing.

Harm reduction is also part of general health care practice. We brush our teeth to prevent food and drink from harming our teeth. We encourage people not to drink and drive to reduce the harms they can cause to themselves and others in road accidents. We encourage people on medical treatment to take their medicines in particular ways to minimize the harms of them not working properly or having side effects. We keep things like medicines, paraffin, candles, matches and household cleaning materials out of the reach of children.

Harm reduction also is a specific health and social care approach to substance use and mental health. It focuses on limiting and making smaller the unwelcome and unintended physical and social effects of substance use, alcohol use and mental illness.

AS A HEALTH WORKER...

your goal is to provide the best available standards of care to all people.
One standard of care is to reduce the health-related harms people suffer due to their personal and social circumstances or choices.

Understanding Substance Use

Street substances, pharmaceutical substances taken for reasons other than as intended by the doctor and alcohol are the substances we are talking about. People take them to relax, for enjoyment, to be sociable and to be socially accepted. In many communities children and adolescents take them as a rite of passage into adulthood. Substances are also taken by people when they find it difficult to cope with themselves or the people around them and their personal, social and economic circumstances.

Everyone has a view on substance use.

TWO THOUGHTS ON YOUR ACTIONS

INDIVIDUALLY

Which substances are the most harmful to individual users and society?

1. Put these substances in order of the harm you think they they do to the people who use them. “1” is the most harmful. “6” is the least harmful.

1	Cannabis	1	2	3	4	5	6
2	Alcohol	1	2	3	4	5	6
3	Tobacco	1	2	3	4	5	6
4	Heroin	1	2	3	4	5	6
5	LSD	1	2	3	4	5	6
6	Cocaine	1	2	3	4	5	6

2. Put these substances in order of the amount of harm you think they they do to families, communities and society. “1” is the most harmful. 6” is the least harmful.

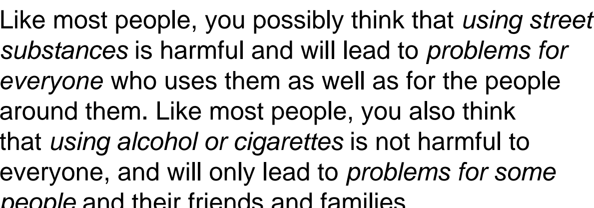
1	Cannabis	1	2	3	4	5	6
2	Alcohol	1	2	3	4	5	6
3	Tobacco	1	2	3	4	5	6
4	Heroin	1	2	3	4	5	6
5	LSD	1	2	3	4	5	6
6	Cocaine	1	2	3	4	5	6

GROUPS

Share and compare your ideas

Why do you think each of the substances

- are more or less harmful to individual users?
- are more or less harmful to families, communities and society?



Like most people, you possibly think that *using street substances* is harmful and will lead to *problems for everyone* who uses them as well as for the people around them. Like most people, you also think that *using alcohol or cigarettes* is not harmful to everyone, and will only lead to *problems for some people* and their friends and families.

Most of us have false beliefs about the dangers of substances. This is because our views on alcohol, cigarettes and street substances are often based on social norms. Especially, we are influenced by whether substances are regarded as legal or illegal and what people in the community feel about them. Our beliefs are also based on our own level of experience or inexperience with them.

What you think and believe are likely to be quite different from the facts about substances and their risks.

DID YOU KNOW?

Alcohol, followed by heroin, crack, cocaine, cigarettes and cannabis are the top five substances that cause the greatest harms to users and to society.

We know that about 16% of people who try alcohol develop some sort of problem, including alcohol dependence, as a direct result of drinking. About 10% of people who try street substances develop a substance use problem. This means that most people who try a substance do not become substance dependent.

Legal and Illegal Substances

- ✓ **Legal substances for recreational and self-medication purposes.** These are things like nicotine and alcohol. They also include over-the-counter medicines. People can buy and use them. Their use is often legally restricted by age and sometimes by the places where they can be bought or used.
- ✓ **Legal substances for medical purposes.** These are substances used to treat medical conditions. Laws control how they are used and who can give them out. They are prescribed by people, like doctors, pharmacists and qualified practitioners. They are professionally accountable and licensed to give them our or sell them.
- ✓ **Illegal substances are substances that it is against the law to have or supply to other people.** Most street and recreational substances are illegal. Controlled medicines that are scheduled and are sold by people who are not licensed to sell them are also illegal.

Why people use substances

People use substances for different reasons. Many people use substances for positive reasons – to control pain, to manage health conditions, for pleasure and to be sociable.

Many people also use substances to help them cope with emotional and social situations that they find hard to deal with.

They may use substances to numb the pain of trauma, loss or the harsh realities of their lives.

- The substance is often their way of making their pain bearable.
- It can become a substitute for the relationship they have lost.
- It can become a way of avoiding findng other ways to work through the issues that drive them into substance abuse.

People use substances to make them feel connected and part of a community.

- Substances let them into a group of substance users that is supportive. Joining the group also reinforces the reasons why they feel excluded by others.

People continue to use substances because

- They do not have opportunities to broaden their horizons.
- They find themselves with few choices.
- Substances are often a person’s “quick-fix” response.

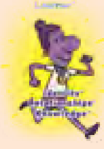
People who are arrested for possessing or using substances are not deterred from using them in the future. In fact, going to prison exposes them to criminals and prison gangs who are involved in substance use and distribution.

The effects of taking a drug

Everything that we take into our bodies affects us physically and mentally. The food we eat, the liquids we drink, the tablets we swallow, the smoke and vapors we inhale or the things we insert into our bodies can help or harm us. The same is also true for street drugs, alcohol and other substances. This is because they are all made up of chemical compounds that interact with our body systems in different ways.

How they affect us depends on number of things, like

- what they are made of,
- how they are taken in,
- how they interact with each other,
- how our bodies respond to them; and
- our emotional and psychological state.



AS A HEALTH WORKER...

it is important to recognize that a number of factors

…make substance use more or less harmful

…make substance use more or less dangerous.

What happens to people and how they feel when they take a substance is not the same for everyone. Also, people can feel and act differently each time they use a substance, even when they take the same amount of the same substance.

There are three things that make a substance less or more harmful.

1. The substance itself –
   - ☹ how much,
   - ☹ how often; and
   - ☹ the way it is used – smoked, sniffed or injected;
2. The mind-set or the way someone thinks about something and how vulnerable or sensitive they are to the substance –
   - ☹ their biology,
   - ☹ their state of health,
   - ☹ their psychological wellbeing,
   - ☹ their understanding of the substance; and
   - ☹ their expectations of what they substance will do.
3. The setting that the substance is taken in
   - ☹ where they take the substance,
   - ☹ who they take the substance with; and
   - ☹ whether the substance is legal.

The way substances are consumed

The amount and the way people take substances can increase or reduce harms. Substances need to be absorbed into the body to have an effect. There are four common ways of using substances, and each has its own set of risks.

Eating

Substances that are swallowed are absorbed into the body through the stomach and the digestive system.

- 😐 The effects of the substances are felt more slowly
- ☺ The digestive system acts as a filter and can be protective.
- ☹ It is difficult to stop the absorption of the drug if it is poisonous or the person eats the whole dose at once.

Snorting and inserting

Substances can be sniffed, put under the tongue or inserted into the anus. These are all places where there are lots of blood vessels and moisture, so they are absorbed quickly into the bloodstream. Taking substances this way makes them act quicker and can increase their effect.

- ☹ They can damage sensitive body tissues.
- ☹ They can cause ulcers.
- ☹ They can cause holes in the boney part between the nostrils.
- ☹ They can damage sphincter muscles that control bowel movement.

Smoking

Substances can be smoked. When they are taken through the lungs, they are absorbed very quickly. The amount that is absorbed is also higher than when substances are eaten or snorted.

- 😐 people feel more effect much quicker.
- ☹ smoking damages the lungs because of the hot air and the chemicals
- ☹ smoking increases the risk of developing lung cancer.

Injecting

Injecting substances directly into the bloodstream is the fastest way to feel their effects. It is also very high risk.

- ☹ The total dose is absorbed.
- ☹ There is no system to filter impurities from the drug before it reaches the blood.
- ☹ Impurities in the drug cause a lot of harm including infections, abscesses, sepsis, heart conditions, damage to the liver and kidneys.
- ☹ Syringes that are shared are unclean. They are a very effective way of transmitting HIV, HSV, HCV and many other diseases.

Dose and frequency

The effects of substances depend on the dose. The dose is the amount that is taken. The risk of substances doing harm increases with the doses that a person takes as well their patterns of use. Taking a lot in a short space of time is called binging. Binging on *any* substance is harmful.
The dose-response is the usual effect of a particular amount of substance. So, for example, the dose effect of one glass of wine (180ml) is not the same as the dose effect of three glasses (540ml). The smaller amount of alcohol can be relaxing. The larger amount makes people drunk and when alcohol is taken in very large quantities it can be poisonous.

AS A HEALTH WORKER...

…. people often take substances without thinking about how quantities affect the experience.

...encourage people who use substances to use the least amount needed to get the desired effect.

…. advise people who are dependent on substances to take smaller amounts daily, like a medicine. This is less risky than taking large amounts less frequently.

Mental and physical health

Mental health is often an important factor in determining the effect of a substance. Some substances can have a relieving effect.

- ☺ Stimulants may benefit people with attention deficit disorder
- ☺ Heroin may ease the emotional pain of post-traumatic stress.

In these cases, access to pharmaceutical substances may reduce the use and harms of street substances.

Some substances can trigger a mental health episode. Cannabis, for example, is one of the safer substances to use. However,

- ☹ Cannabis can cause some people to lose touch with reality or become psychotic.
- ☹ Regular cannabis use can affect brain development in adolescents.

Some substances can increase the severity of an existing mental health condition. People with a mental health problem need to be very careful as substance use can make their condition worse.

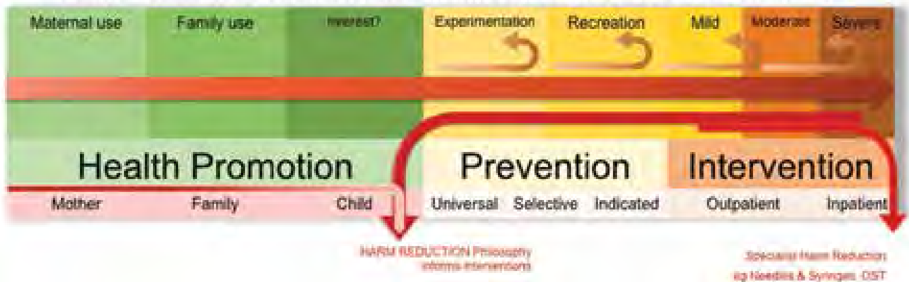
Physical health also affects the levels of harm substances can cause. So although some substances can ease pain, they also can mask serious disease. For example, heroin works to suppress coughing. Coughing is an important sign of TB. So taking heroin can mean that people may not recognize that they have TB until the disease is very advanced. Not only does this make it harder to treat, it also means they would have been infectious to other people for the whole time they were untreated

Some substances make people more vulnerable to diseases because it reduces their immunity – this is particularly harmful with people with HIV.

Social circumstances

We know that family, friends, and community all play an important positive or negative part in how people use and respond to substances. This is also why substances that are used as part of social or religious rituals have a different result compared to when they are used simply to get 'high'. As individuals, when people use substances in an environment that is supportive, they are less likely to use them in a dependent way. Also they are more likely to hide taking substances when people use them in an environment that is reactive and confrontational. They may also use more recklessly. For example, people who use heroin in a safe environment are r less likely to overdose than when when the use the same amount in a stressful environment.

Reducing the Harms of Substance Use



Harm reduction health and care activities in substance use focus on promoting and preventing and treating substance use.

There are many health-related harms associated with substance use. These include:

Serious health conditions like

- ☹ Becoming infected with HIV, TB, Hepatitis C and other STIs;
- ☹ Developing abscesses;
- ☹ Overdosing; and
- ☹ Aggravating or triggering mental health problems.

There are also serious legal and social harms of substance use, including

- ☹ Going to prison;
- ☹ Getting a police record;
- ☹ Experiencing interpersonal violence;
- ☹ Unemployment;
- ☹ Family breakdown; and
- ☹ Homelessness.

Research shows that for any condition, including substance use, it is better to find ways to reduce the harms they cause, than to do nothing.
Even while people continue to use substances, the ways they can reduce the risks of substance use include

- ☺ using less
- ☺ using smarter - sniffing instead of injecting,
- ☺ using safer – never share needles, use needles only once.
- ☺ using with a goal to be healthier or to stop.

Injecting carries significant risks. The first priority is to make sure people can access sterile syringes and then know how to inject correctly. Refer them to the nearest needle and syringe services.

AS A HEALTH WORKER...

Support people to make better rather than worse choices.

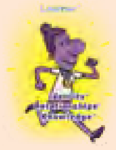
Empower people to create a better future for themselves.

The Substances

There are three main types of substances that are grouped by the main way that they make people feel.

- Stimulants make people feel awake, energized, active and confident.
- Depressants slow people down. They make them feel calm, relaxed and at peace.
- Hallucinogens change the way people see and experience things.

Some substances fall between being stimulants and hallucinogens (ecstasy) and some fall between being depressants and hallucinogens (cannabis).



AS A HEALTH WORKER...

…most substances have positive and negative effects on people.

Harm reduction for injecting

Injecting carries significant risks. The first priority is to make sure people can access sterile syringes and then know how to inject correctly. Refer them to the nearest needle and syringe services.

Depressants

Alcohol

Alcohol is a depressant and has been used since the beginning of recorded history.

The effects are different depending on what people have eaten, their build, how much they are used to drinking and their biological makeup. A person's reaction to alcohol is also affected by their emotional state and the effect they believe the alcohol will have.

When people drink alcohol, it slows down vital physical functions in their bodies. Although people drink to "loosen up" or relax, when they drink more than their bodies can handle, they start to lose coordination and control. It causes them to speak with a slur. It makes them unsteady and uncoordinated in their movements and unable to react quickly. It also disturbs their perceptions. Mentally, it affects their ability to think rationally and distorts judgment. Since alcohol is poisonous, if someone drinks too much they can get alcohol poisoning, which is life-threatening.

Alcohol can be a health and social risk
People who drink a lot usually behave inappropriately. Alcohol can make people unpredictable. They put themselves and other people in harms way.

- ☹ They often end up in arguments and fights.
- ☹ They often cause road accidents when they drink and drive.
- ☹ They are often the victims of road accidents, when they walk drunk on the road.
- ☹ They often have high-risk, unsafe, non-consensual sex.

People who drink a lot or too often put their own health at risk.

- ☹ They increase their chances of developing serious health conditions like
  - high blood pressure,
  - stroke,
  - cancer,

- depression and anxiety,
- sleep disorders,
- stomach bleeding,
- unplanned pregnancy,
- sexually transmitted infections,
- accidents and injury.

☹ They can make existing medical conditions worse.

☹ They can reduce the effectiveness of their medical treatment.

☹ They can overdose –this is when they

- vomit,
- “pass out” or fall unconsciousness,
- fall into a coma or die.

People who drink a lot or too often put other people’s health at risk.

☹ Alcohol is associated with murder, attempted murder, sexual assault, and grievous bodily harm,

☹ Alcohol is associated with violence and injury of women, children and the aged.

☹ Drinking alcohol during pregnancy harms the physical and mental development of babies.

The harms caused by alcohol can be reduced

People’s reactions to alcohol as a substance depend on how much, how quickly and how often they drink, their physical and mental health and the social environment that they drink in. This means that it is possible for people to reduce the harms of alcohol by learning to manage what they drink, when they drink and how the drink alcohol.

There are well known ways to minimize the possible harmful effects of alcohol.

Tips to Reduce the Harmful Effects of Alcohol

Have A Goal: one unit of alcohol in one hour.

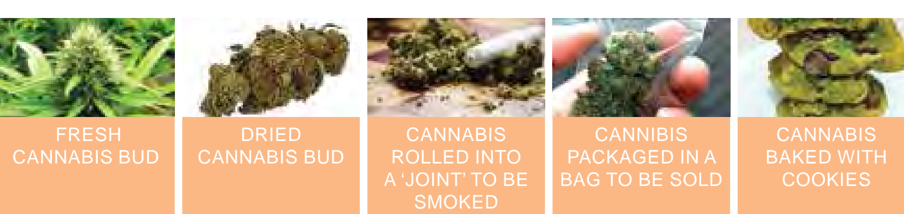
- ✓ Limit the amount of times you drink in a week. It is important to not drink alcohol every day. This way you stay in control of when and how often you drink. You give your body and liver a rest. And you save money and calories.
  - Try and have *at least* two consecutive days in a week that are alcohol free.
  - Try and have a two-week holiday from alcohol from time to time.
- ✓ Limit the amount of alcohol you drink on any one occasion. There is a rule of thumb that you can use. It takes one hour for 1 unit of alcohol to be absorbed by your body. Set yourself the goal of limiting your drinking to a *maximum of 1 unit of alcohol per hour*. And don't have more than four drinks on any occasion.
- ✓ Practice low risk drinking
  - Alternate alcohol with water, juice or a soft drink. This helps you slow down your pace of drinking. It also helps keep you hydrated. Although there is often a lot of water in alcohol, it makes you pee a lot and can cause dehydration.
  - Eat before you drink. It helps stop you from getting drunk quickly.
  - Don't mix different kinds of alcohols (spirits and wines)
  - Don't take caffeine, cocaine, ecstacy, or other stimulants with alcohol. Taken together they significantly increase the risks of dehydrating and collapsing.

Be prepared for situations or people that make you want to drink, or drink more than you want to.

AS A HEALTH WORKER...

- ✓ Help people learn how to manage and practice using it in ways that reduce or minimize the risks.
- ✓ Empower teenagers and young adults to learn to drink safely.
- ✓ Get clinical support for people who are or may be addicted to alcohol.
- ✓ Help them manage their addiction. It can be dangerous for them to suddenly stop drinking.

Cannabis



FRESH CANNABIS BUD | DRIED CANNABIS BUD | CANNABIS ROLLED INTO A 'JOINT' TO BE SMOKED | CANNIBIS PACKAGED IN A BAG TO BE SOLD | CANNABIS BAKED WITH COOKIES

Cannabis grows all over Africa. It grows easily, like a weed. It is goes by many names like 'weed', dagga, marijuana, hydro, skunk, zol, herb, pot, hash and many more things.

Cannabis is usually smoked as dried leaf. Less often it is smoked as a resin (hashish or hash). It can be eaten, baked into biscuits or cakes, or mixed with a liquid. It can also be made into oil. Cannabis is not toxic. It is also not possible to overdose on cannabis.

Cannabis is a depressant and an hallucinogen. Its effect depends on the type, strength and way it is used. Its effect also depends on what the person using it expects to happen. Many people say they feel relaxed, light headed, happy, aware of the things around them and often hungry. People who use cannabis may appear relaxed and laugh a lot.

Cannabis can cause psychosis, especially in people who are vulnerable to mental illness. They start seeing and hearing things, believe things that are not real and loose touch with the world.

Medical cannabis is different from the recreational cannabis used in the community. It is made up mostly of the chemical compounds in cannabis that relieve pain. The compounds that have psychoactive effects are removed.

It comes in a solid form that is eaten or a liquid that is drunk. It is used to manage pain and prevent nausea in cancer treatment.

Cannabis does not lead to the use of other substances. Most people who use cannabis do not usually go on to use other substances. People who do use other substances don't start because of the cannabis.

Tips to reduce the harms of using cannabis:

- ✓ Avoid smoking tobacco with cannabis. Use bongs or water-pipes instead.
- ✓ Reduce or stop using cannabis if you start hearing voices or having strange ideas.
- ✓ Give yourself breaks – don't use cannabis for a few days or weeks.
- ✓ Only use in safe places. Try to avoid being arrested or getting into trouble with the law.

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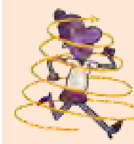


AS A HEALTH WORKER...

…encourage teenagers and adults to not smoke cannabis.

- ✓ Try motivate them to do other things for relaxation.
- ✓ Try encourage them to socialize with friends in other ways.
- ✓ To give factual information – about the effects and the risks.

…advise parents and carers

- × To not to over react, threaten or scold children and family members about their use of cannabis.
- ✓ To know about and give factual information – about the effects and the risks.

…. encourage people who smoke cannabis to smoke less.

- ✓ They can bring down the amount they smoke at any one time.
- ✓ They can try control how often they smoke.
- ✓ They can have a "cannabis break" – a holiday form cannabis.

…get clinical support for people whose use of cannabis is causing problems.

Heroin

HEROIN 'CUT' WITH STRICHNINE AND OTHER POISONOUS SUBSTANCES	HEROIN IN ITS PUREST FORM	HEROIN MELTED ON A SPOON TO BE INJECTED	HEROIN PACKAGED IN CAPSULES	HEROIN PACKAGED IN A BAD THAT IT IS SOLD IN

Heroin is in a family of substances called opioids. It is found naturally in the sap of the poppy flower. It is also artificially made in laboratories. Heroin is called different things, including nyaope, unga, whoonga, thai white, brown, gear, smack, junk, and H.

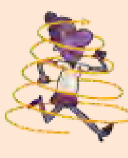
Heroin is an analgesic drug. It relieves physical and mental pain, leaving the person with a sense of wellbeing and inner warmth. Heroin effects last for around 3-4 hours.

Heroin use leads to a physical dependence when it is taken every day over a few weeks. Heroin is the drug most commonly injected, which adds to the risks of using heroin. Heroin dependent people need to use 4-6 times a day to avoid withdrawal. When the effects of heroin wear off, people who are dependent develop flu-like symptoms of withdrawal. This includes nausea, sweats, and tears running from their eyes, a running nose, and pains in their bones. They also start to feel anxious and depressed. Their need feels very urgent. They relieve these feelings by taking more heroin. Heroin users often then switch from smoking to injecting because they need to take more heroin to have the same effect.

This is a vicious cycle that makes it very hard to stop using it. People use heroin to relieve the symptoms of not having the drug. They can't stay for more than a few hours before they need more heroin to avoid withdrawing. It takes over their lives, creating a routine that can't be interrupted without medical help.

Using heroin with other depressants, like alcohol or benzodiazapines, can be life threatening. People can stop breathing and die. Using heroin after not using for a while also can lead to overdosing and death. This happens because they start reusing on the high doses they used to use before abstaining, when their bodies had become tolerant. Abstinence based treatment significantly increases the risk of death from a heroin overdose.

Doctors prescribe morphine and diamorphine. Heroin is diamorphine and both change into morphine in the body. Diamorphine is prescribed for severe pain, especially for people with cancer and for serious injuries.



AS A HEALTH WORKER...

...help people reduce the risks of heroin use by making better choices.

- ✓ Discourage them from using in a way that makes them become dependent.
  - ☺ Use occasionally.
  - ☹ Don't use every day.
- ✓ Encourage them to test the heroin for strength.
  - ☺ Use a small amount first.
- ✓ Encourage them to reduce the frequency of dependent heroin use.
  - 😐 Wait as long as possible before reusing.
  - 😐 Try to reuse only when withdrawal symptoms start, usually every 4-5 hours.
- ✓ Encourage them to do less harm.
  - ☺ Change from injecting to sniffing.
  - ☹ Warn them of the risks of overdose.
  - ☺ Start with a small amount, if they have not used for a while.
  - ☹ Never use alone.
  - ☹ Don't mix heroin with other drugs.
- ✓ Encourage them to get medical help.
  - ☺ Refer them for treatment of abscesses and other health issues.
  - ☺ Inform them of needle and syringe services.
  - ☺ Inform them about opioid substitution therapy.

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Stimulants

Stimulants are a group of substances that "stimulate" the body's central nervous system, which includes the brain and the central nervous system. They temporarily increase a person's energy levels and alertness. They also cause other physical and psychological changes. The effects of stimulants vary according to the specific drug, the amount used and how the drug is taken.

Stimulants like caffeine are found in things like coffee and tea. They are also used in prescription medicines to treat attention disorders. And they are made and used for recreational purposes. These include amphetamines, methamphetamines (TIK, Speed, work, choef), methcathinone (CAT) and newer substances like mephadrone (Mcat, meouw meouw). They are made from chemicals in a laboratory.

Amphetamine type stimulants

CRYSTALS OF METH-AMPHETAMINE | METH-AMPHETAMINE IN A BAG THAT IT IS SOLD IN | A METH PIPE OR "LOLLY" | METH IS USUALLY SMOKED, BUT CAN BE SNORTED, INJECTED OR EATEN | SMOKING FROM A LIGHTBULB

These kinds of stimulants are used by people to feel alert, to keep awake, to concentrate, to lose weight, to relieve depression, and to be able to socialize better. Some people take them to enhance their sex life (this is often called chemsex). The main effects of stimulants last for at least 1-2 hours. But some effects can continue to last for up to 12 hours.

People who use stimulants for recreational purposes often use a lot for a few days. During this time they do not sleep or eat. Then they 'crash', recover and start again. Repeated use in this way can make it hard for people to function without using the stimulant and can lead to dependency.

Methamphetamine produces physical and mental changes that can lead to serious health problems. Methamphetamine can

- ☹ It can cause rapid or irregular heartbeat and increased blood pressure. These effects can lead to a heart attack.
- ☹ It can increase body temperature. In rare cases, hyperthermia can lead to liver, kidney, and cardiovascular failure and death.
- ☹ It can cause "meth mouth" where the gums decay and teeth rot.

- ☹ It can cause memory problems and erratic behavior, especially when they are used for a long time.
- ☹ It can cause paranoia, hallucinations, and violent behavior.

Cocaine and crack

COCAINE IN ITS POWDER FORM (FREEBASE COCAINE) | COCAINE MELTED ON A SPOON TO BE INJECTED | COCAINE SNORTED WITH A ROLLED UP NOTE | COCAINE PACKAGED IN A BAG THAT ITS SOLD IN | PRESSED POWDER COCAINE ('CRACK' COCAINE)

Cocaine (coke, Charlie, snow, marching powder, shnarf) and crack (rocks, freebase) are also stimulants. Cocaine is a white powder that is extracted from the coca bush. Crack is a hard, concentrated version of cocaine. Cocaine in its powder form is sniffed or dissolved and injected. Crack is smoked.

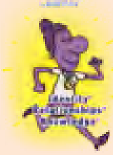
Cocaine makes people feel powerful, awake, talkative and euphoric. It has many of the effects of amphetamines. The effects of cocaine last between 1-2 hours, so people take them frequently. Crack cocaine lasts only 15-30 minutes and people tend to binge.

Sometimes doctors use cocaine as a topical anesthetic because it numbs the surface of the body and is sometimes used when they operate on the eye, mouth and nose.

There are several serious physical and mental health risks of using cocaine or crack.

- ☹ Cocaine can speed up heart rate and cause the heart to lose its natural rhythm. In rare cases, this can lead to a heart attack.
- ☹ Cocaine constricts blood vessels, which forces the heart to work harder to pump blood.
- ☹ Cocaine can cause chest pain and difficulty breathing.
- ☹ Cocaine can cause a potentially dangerous increase in body temperature.
- ☹ Regularly snorting cocaine can lead to loss of sense of smell, nosebleeds, and problems with swallowing. The overall irritation can lead to a chronically inflamed, runny nose.
- ☹ Repeated use or high doses of cocaine can cause irritability, restlessness, panic attacks, and paranoia.

The basic risks and principles of safer use are the same for all stimulants.



AS A HEALTH WORKER...

get clinical advice if the person seems to have lost touch with reality. Also you help reduce the harms of stimulants by encouraging people who use and the people who care for them to follow the safer use tips.

Harm Reduction Health Care Best Practice

Best practice to reduce the harms of substance use means applying the principles of COPC.

AS A HEALTH WORKER...

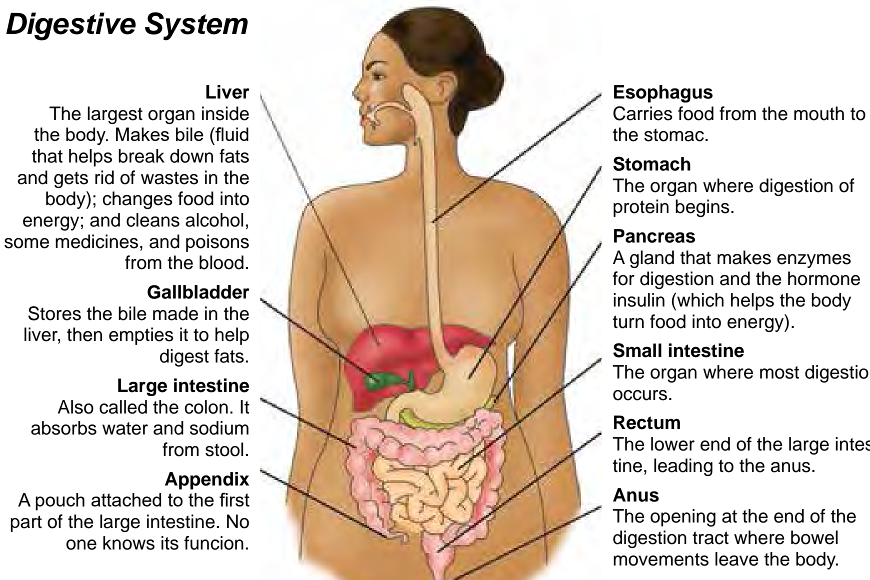
your role is to promote health and prevent and treat or support the treatment of disease, including *conditions that cause or are caused by harmful substance* use. Wherever you are in the health care system, it is important to practice health care in a way that makes it possible for you to fulfill your role.

- ✓ Help people think about and make decisions around the way they use substances.
- ✓ Believe in people's ability and desire to act for themselves.
- ✓ Include and respond to the health care of people who use substances according to their need.
- ✓ Build a good relationship with people who use substances. A good experience with health care services, over time, is the surest way to produce positive outcomes for people who use substances.
- ✓ Make sure they receive quality comprehensive health care.

FOOD FACTS

Food is one of the most important ways to create and maintain health and prevent and reduce disease. In this sense food is a form of medicine because the nutrients in food give our bodies instructions about how to function and keep healthy.

FACT: 80% of the human immune system is contained in the digestive system.



When we do not eat enough food or when we don't eat well (too much food, the wrong kinds of food), food causes the body to stop functioning properly. This happens because the combination of foods we eat every day (our diet) is unbalanced and lacks the nutrients needed to keep us healthy.

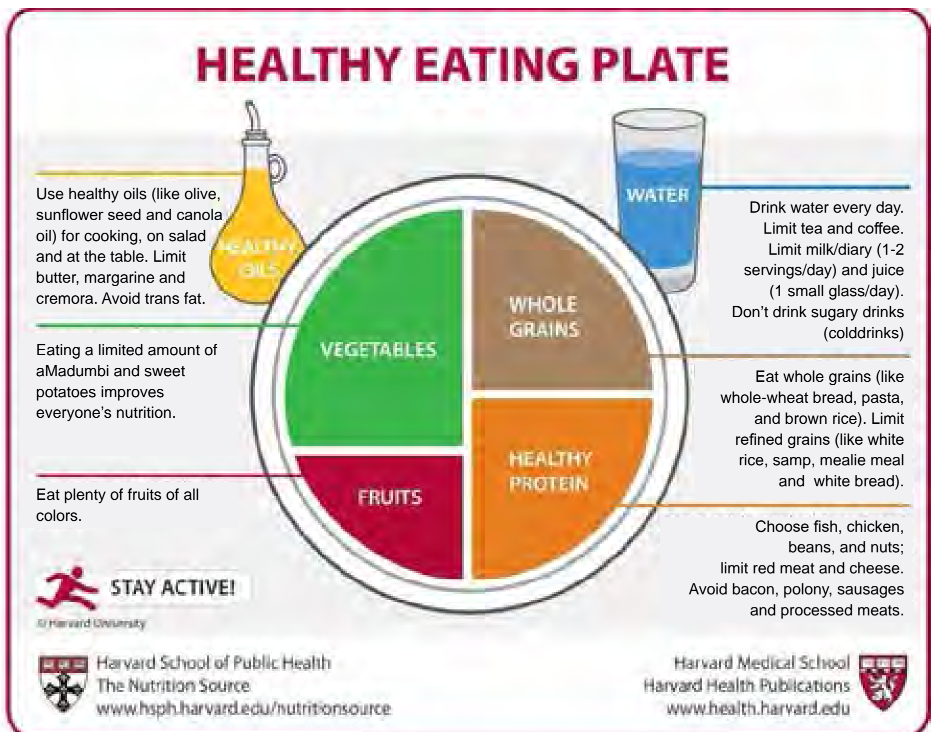
An unbalanced diet:

☹ Has too few or too many calories.
☹ Does not combine all the nutrients the body needs to stay healthy.
☹ Is not taken in at the right intervals (eating all the time or eating after long intervals).

An unbalanced diet affects our immune and other systems and can lead to chronic diseases like diabetes, heart and vascular disease.

To sustain a health body
☺ Eat enough food;
☺ Combine carbohydrates, protein, fat, fiber, vitamins, and minerals; and
☺ Eat at regular intervals (small portions every three to six hours).

The healthy eating plate shows the kinds of food and the amounts of each kind of food you should eat at a meal. It also shows the importance of water and points out the need to reduce the amounts of sugar and salt that is added to food.



Reference:
http://www.health.harvard.edu/healthy-eating-plate 2015/06/30

You can get food poisoning if you eat something that has been **contaminated with germs.**

This can happen if food:

- isn't cooked or reheated thoroughly
- isn't stored correctly – for example, it's not been frozen or chilled
- is left out for too long
- is handled by someone who's ill or hasn't washed their hands
- is eaten after its "use by" date

Any type of food can cause food poisoning

SYMPTOMS OF FOOD POISONING

Symptoms of food poisoning include:

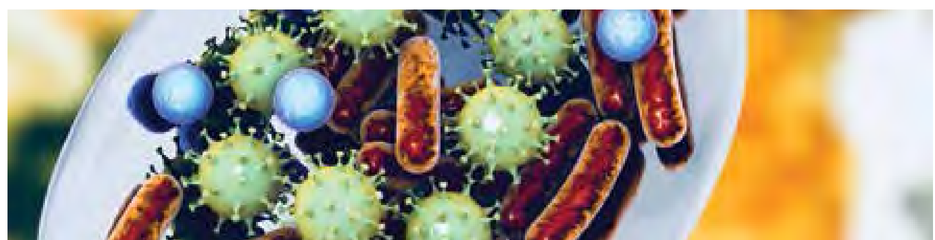
- feeling sick (nausea)
- diarrhoea
- being sick (vomiting)
- stomach cramps
- a high temperature of 38C or above
- feeling generally unwell – such as feeling tired or having aches and chills

The symptoms usually start within a few days of eating the food that caused the infection.

PREVENTING FOOD POISONING

Wash your hands with soap and water (warm or cold)

- ✓ before handling food,
- ✓ after handling raw food – including meat, fish, eggs and vegetables –
- ✓ after touching the bin,
- ✓ after going to the toilet,
- ✓ after blowing your nose;
- ✓ after touching animals



Wash worktops with hot soapy water

- ✓ before preparing food
- ✓ after preparing food

Wash dishcloths and tea towels regularly,

- ✓ let them dry before you use them again. Dirty, damp cloths are the perfect place for germs to spread.

Use separate chopping boards

- ✓ Use one chopping board to prepare uncooked meat, chicken or fish.
- ✓ Use another, different chopping board for ready to eat foods like salad, vegetables and cooked food

Keep and store raw and ready to eat food separately

- ✓ Always cover raw meat and chicken separately
- ✓ Always store raw meat and chicken on the bottom shelf of the fridge, where it can't touch or drip onto other foods.
- ✓ Always store ready to eat foods on a separate shelf above raw meat.

Cook food thoroughly

- ✓ Make sure chicken, pork, burgers, sausages and kebabs are cooked until steaming hot, with no pink meat inside.
- ✓ Don't wash raw meat ,including chicken and turkey, before cooking, as this can spread bacteria around your kitchen.

Keep the fridge at the right temperature below 5C

- ✓ Keep the temperature below 5C to stop harmful germs from growing and multiplying.
- ✓ Don't overfill the fridge – it can make the temperature go up.
- ✓ Cool leftovers quickly
- ✓ Put cooked food that is left over inthe fridge or freezer as soon as it is cool.

Respect time and 'use-by' dates

- ✓ Use any leftovers that you keep in the fridge within 2 days.
- ✓ Don't eat food that is past its use-by date, even if it looks and smells okay.

Sleep is like eating – it is a life sustaining activity.

- The body regulates sleep in much the same way that it regulates eating, drinking, and breathing. This means that it is natural and healthy to sleep
- Sleep contributes to brain functioning. Sleep plays a critical role in brain development. Infants spend about 13 to 14 hours a day sleeping. About half of that time is spent in REM sleep. The period when most dreaming occurs.
- Sleep is important for learning, growth and development, A good nights sleep allows you to rest so that when you are awake you are more alert and can concentrate better. It also makes you more energetic, happier, and better able to function.

Just as eating relieves hunger, sleeping relieves sleepiness.

The effects of tobacco smoking on the human body?	
BRAIN	• Nicotine, the drug that makes tobacco addictive, goes to your brain very quickly. • Nicotine makes you feel good when you are smoking, but it can make you anxious, nervous, moody, and depressed after you smoke. • Using tobacco can cause headaches and dizziness.
MOUTH	• Tobacco stains your teeth and gives you bad breath. • Tobacco ruins some of your taste buds, so you won't be able to taste your favorite foods as well. • Tobacco causes bleeding gums (gum disease) and cancers of the mouth and throat.
HEART	• Smoking increases your heart rate and blood pressure and causes heart disease and heart attacks. • If you try to do activities like exercise or play sports, your heart has to work harder to keep up.
LUNGS	• Smokers have trouble breathing because smoking damages the lungs. • If you have asthma, you can have more frequent and more serious attacks. • Smoking causes a lot of coughing with phlegm (mucous). • Tobacco can cause emphysema (lung disease) and lung cancer.
SKIN	• Smoking causes dry, yellow skin and wrinkles. • The smell sticks to your skin.
MUSCLES	• Less blood and oxygen flows to your muscles, which causes them to hurt more when you exercise or play sports."

http://www.girlshealth.gov/substance/smoking/tobaccotext.cfm 2013/02/15

SMOKING DURING PREGNANCY

Smoking during pregnancy affects the mother and the baby directly.
It can cause:

- Miscarriage
- Low birth weight and other complications with fetal development
- Premature birth
- Stillborn birth
- Neonatal problems, including respiratory problems and being more susceptible to Sudden Infant Death Syndrome

http://www.dassa.sa.gov.au/site/page.cfm?u=119#passive 2013/02/15

HEALTH CONSEQUENCES OF SMOKING

Summary of health consequences of smoking:

- Blindness
- Infertility and impotence
- Stroke
- Cardiovascular disease and other diseases of the arteries
- Gangrene, often resulting in the loss of limbs
- Various cancers, especially lung cancer
- Less oxygen to the brain and heart
- Shortness of breath
- Increased blood pressure
- Gum disease
- Smelly breath and stained teeth

SECOND-HAND TOBACCO SMOKE OR PASSIVE SMOKING

Passive smoking can cause many of the same health problems as active smoking. It can also cause short-term problems like:

- Sore and/or watery eyes
- Sneezing and coughing
- Respiratory distress, particularly for people with asthma

Children exposed to passive smoking are more at risk of:

- Respiratory infections
- Ear infections
- Slower lung growth and decreased lung function

http://www.dassa.sa.gov.au/site/page.cfm?u=119#passive 2013/02/15

When people know their own bodies, they are able to pick up and respond to changes. Some cancers have no symptoms to warn of possible disease. Other cancers do have early warning signs. If people respond to these early warning signs it is possible to prevent or successfully treat the cancer.

Adult *Cancer Warning Signs*

C Change in bowel or bladder habits

A A sore that does not heal

U Unusual discharge or abnormal bleeding

T Thickening or lump in the breast, testicles or elsewhere.

I Indigestion or difficulty swallowing

O Obvious changes in the size, colour, shape or thickness of a mole, wart or mouth sore

N Noticeable weight loss and loss of appetite

C Change in a wart or mole

A Any continued fever

N Nagging cough or continuous hoarseness

C Chronic pain in bones or any other area of the body

E Enduring (ongoing) fatigue, nausea or vomiting

R Repeated infection and or inflammation

Childhood Cancer Warning Signs

C Continued unexplained weight loss

H Headaches, often with vomiting early night/early morning

I Increased swelling or pain in bones, joints, back or legs

L Lump - e.g. in abdomen, neck, chest, pelvis, armpits

D Development of excessive bruising, bleeding or rash

C Constant infections

A A whitish colour behind the pupil (in the eye)

N Nausea that does not go away or vomiting without nausea

C Constant tiredness or noticeable paleness

E Eye or vision changes – these occur suddenly and don't go away

R Recurring fevers

REMEMBER:

Any of these symptoms could be caused by another health problem.
If they don't go away or the person is worried encourage them to get checked early. This way you can get the right treatment – for cancer or the condition.

Early detection of cancer saves lives!

Reference:
CANSA *www.cansa.org.za;*
CHOC Childhood Cancer Foundation *www.choc.org.za*

ANXIETY DISORDERS

Author: Canadian Mental Health Association, BC Division
http://www.heretohelp.bc.ca/factsheet/anxiety-disorders 26-04-2018

Generalized anxiety disorder	**Generalized anxiety disorder is when someone has unusually high levels of anxiety and worry about aspects of daily life like health and well-being, finances, family or work.**
Panic disorder	**Panic disorder is when a person has panic attacks and is afraid of having more panic attacks. A panic attack is a sudden, unexpected rush of intense anxiety symptoms that can last anywhere from a few seconds to several minutes. Not everyone who has panic attacks has panic disorder.**
Post-traumatic stress disorder (PTSD)	**PTSD is when someone is a part of or witnesses one or more traumatic events. In addition to other symptoms, a person suffering from post-traumatic stress disorder can relive these events long after they're over, through nightmares and flashbacks. Examples of traumatic events are assault and murder, road accidents and natural disasters and war.**
Social anxiety disorder	**Social anxiety disorder is when a person is terrified of social settings because they feel other people are judging them and they fear they'll embarrass themselves. This is also known as social phobia.**
Separation anxiety	**Separation anxiety is when a child or teenager experiences extreme anxiety when they are separated or expecting to be separated from their parents or caregivers.**
Phobias	**Specific phobias is when a person experiences extreme or unreasonable terror when confronted with a certain object, situation or activity. This terror can lead to a strong need to avoid that object or situation. Phobias can develop around common things as well as fear of dogs, flying, enclosed spaces, water, and blood among others.**
Obsessive-compulsive disorder (OCD)	**OCD is when a person has recurring, unpleasant thoughts (these are called obsessions), like thinking their hands are always dirty or worrying about germs. As a result, they may develop repetitive and time-consuming behaviors to try and reduce anxiety or distress (these are called compulsions), like washing their hands or cleaning their house or yard hundreds of times a day.**

1. Deep Breathing Exercises for Stress Management

https://www.uofmhealth.org/health-library/uz2255

Belly breathing

Belly breathing is easy to do and very relaxing.

1. Sit or lie flat in a comfortable position.
2. Put one hand on your belly just below your ribs and the other hand on your chest.
3. Take a deep breath in through your nose, and let your belly push your hand out. Your chest should not move.
4. Breathe out through pursed lips as if you were whistling. Feel the hand on your belly go in, and use it to push all the air out.
5. Do this breathing 3 to 10 times. Take your time with each breath.
6. Notice how you feel at the end of the exercise.

There are three more advanced breathing exercises- 4-7-8 breathing, roll breathing and morning breathing. See which one works best for you:

4-7-8 breathing

This exercise also uses belly breathing to help you relax. You can do this exercise either sitting or lying down.

1. To start, put one hand on your belly and the other on your chest as in the belly breathing exercise.
2. Take a deep, slow breath from your belly, and silently count to 4 as you breathe in.
3. Hold your breath, and silently count from 1 to 7.
4. Breathe out completely as you silently count from 1 to 8. Try to get all the air out of your lungs by the time you count to 8.
5. Repeat 3 to 7 times or until you feel calm.
6. Notice how you feel at the end of the exercise.

Roll breathing

Roll breathing helps you to develop full use of your lungs and to focus on the rhythm of your breathing. You can do it in any position. But while you are learning, it is best to lie on your back with your knees bent.

1. Put your left hand on your belly and your right hand on your chest. Notice how your hands move as you breathe in and out.
2. Practice filling your lower lungs by breathing so that your “belly” (left) hand goes up when you inhale and your “chest” (right) hand remains still. Always breathe in through your nose and breathe out through your mouth. Do this 8 to 10 times.

3. When you have filled and emptied your lower lungs 8 to 10 times, add the second step to your breathing: inhale first into your lower lungs as before, and then continue inhaling into your upper chest. Breathe slowly and regularly. As you do so, your right hand will rise and your left hand will fall a little as your belly falls.
4. As you exhale slowly through your mouth, make a quiet, whooshing sound as first your left hand and then your right hand fall. As you exhale, feel the tension leaving your body as you become more and more relaxed.
5. Practice breathing in and out in this way for 3 to 5 minutes. Notice that the movement of your belly and chest rises and falls like the motion of rolling waves.
6. Notice how you feel at the end of the exercise.

Practice roll breathing daily for several weeks until you can do it almost anywhere. You can use it as an instant relaxation tool anytime you need one.
Caution: Some people get dizzy the first few times they try roll breathing. If you begin to breathe too fast or feel lightheaded, slow your breathing. Get up slowly.

Morning breathing

Try this exercise when you first get up in the morning to relieve muscle stiffness and clear clogged breathing passages. Then use it throughout the day to relieve back tension.
1. From a standing position, bend forward from the waist with your knees slightly bent, letting your arms dangle close to the floor.
2. As you inhale slowly and deeply, return to a standing position by rolling up slowing, lifting your head last.
3. Hold your breath for just a few seconds in this standing position.
4. Exhale slowly as you return to the original position, bending forward from the waist.
5. Notice how you feel at the end of the exercise.

2. Progressive Muscle Relaxation

https://www.helpguide.org/articles/stress/relaxation-techniques-for-stress-relief.htm

Start at your feet and work your way up to your face. Trying to tense only those muscles you are focusing on at each point in the sequence.

Practice the exercise in the following order

1. Right foot, then left foot
2. Right calf, then left calf
3. Right thigh, then left thigh
4. Hips and buttocks
5. Stomach
6. Chest
7. Back
8. Right arm and hand, then left arm and hand
9. Neck and shoulders
10. Face

How to practice progressive muscle relaxation

1. Loosen clothing, take off your shoes, and get comfortable.
2. Take a few minutes to breathe in and out in slow, deep breaths.
3. When you're ready, shift your attention to your right foot. Take a moment to focus on the way it feels.
4. Slowly tense the muscles in your right foot, squeezing as tightly as you can. Hold for a count of 10.
5. Relax your foot. Focus on the tension flowing away and how your foot feels as it becomes limp and loose.
6. Stay in this relaxed state for a moment, breathing deeply and slowly.
7. Shift your attention to your left foot. Follow the same sequence of muscle tension and release.
8. Move slowly up through your body, contracting and relaxing the different muscle groups.
9. It may take some practice at first, but try not to tense muscles other than those intended.

3. Simple Visualisation

Water Boiling visualization

Picture a pot with water. Put it on the heat. Soon bubbles form. Then the water boils. Then the water boils wildly. Now take it off heat. See how the water calms down. The water now stops boiling. It is still too hot to touch. Soon it won't be. Soon it will be cool. So will you.

Eric R Maisel
https://www.psychologytoday.com/us/blog/rethinking-mentalhealth/201501/day-9-reducing-your-anxiety-using-one-simplevisualization

We all need to know what to look for when someone is in a suicidal crisis.

Suicide is often the result of a combination of factors. Risk factors are internal or external conditions that increase the chance that someone will attempt suicide. Nearly all people who die by suicide show at least one warning sign.

HEALTH FACTORS

Mental health conditions

- Depression
- Substance use problems
- Bipolar disorder
- Schizophrenia
- Conduct disorder
- Anxiety disorder

Physical Health Conditions

- Chronic pain
- Traumatic brain injury

ENVIRONMENTAL FACTORS

- Access to lethal means
- Prolonged stress
- Stressful life events
- Major life changes
- Exposure to suicide (including loss of a loved one or graphic portrayal in media).

Look for these warning signs. Call for help.

TIPS ON TAKING PRESCRIPTION MEDICINES

When your health care worker writes you a new prescription or gives new medicine to manage a symptom or treat a health condition, use the opportunity to ask questions about the medicine, what its expected benefits are, and what potential risks, side effects or drug interactions you should be on the lookout for.

5 medicine DO'S…

- DO take each medication exactly as it has been prescribed.
- DO make sure that all your health care workers know about all your medications.
- DO let your health care workers know about any other over-the-counter medications, vitamins and supplements, or traditional medicines that you use.
- DO try to use the same pharmacy to fill all your prescriptions, if you go to a private pharmacy, so that they can help you keep track of everything you're taking.
- DO keep medications out of the reach of children and pets.

5 medicine DON'Ts...

- DON'T change your medication dose or schedule without talking with your doctor.
- DON'T use medication prescribed for someone else.
- DON'T crush or break pills unless your doctor instructs you to do so.
- DON'T use medication that has passed its expiration date.
- DON'T store your medications in locations that are humid, too hot or too cold. For example, the bathroom cabinet may not be the best place for your medication.

Prescription medication: Safe use tips

1. **Keep an updated list of all your medications.** The list should include all the medicines you take, including prescriptions, non-prescription medicines, vitamins and supplements. In case of an accident or emergency, make sure a loved one has an up-to-date copy of your medicine list too.
2. **Read labels carefully.** It is important to follow medication directions correctly. The best way to ensure you use your medicines correctly is to read and follow the label.
3. **Get organised.** Ask your health care worker to set up a medication-taking calendar, especially if you are on several daily medicines. Ask for help to write down all the instructions for each medication that you are taking. This must include the times of day that you need to take the medication, as well as other dosing instructions, such as whether or not you must take the medication with food.

Five Tips for Taking Medicine

1. **Read and follow the label every time you take or give a medicine.**
   - ✓ Ask if you are not sure about the purpose of the medicine.
   - ✓ Check in the insert or ask about the active ingredients.

2. **Find medicines that only treat the problem or symptom.**
   - ☺ Only take or give a medicine that treats the specific symptoms.
   - ☹ Never use cough, cold, or allergy medicines to make you or your child sleepy.
   - ☹ Never give children or teenagers **aspirin-containing products** for flu-like symptoms, chickenpox, and other viral illnesses.
   - ☹ Never give oral **cough and cold medicines** to children younger than 4 years.
   - ☺ Be careful not to double dose – check the ingredients of every medicine you take, every time.

3. **Check the warnings.**
   The warnings will tell you
   - 😐 How the medicine can make a person feel.
   - 😐 When the medicine should not be used.
   - 😐 If the medicine is safe for children to use.
   - 😐 When to check with a health professional **before** taking.
   - 😐 To always keep the medicine out of reach of children.

4. **Follow directions.**
   The directions tell you
   - 😐 How to use the medicine.
   - ✓ Don't break pills.
   - ✓ If you need to take before food or after food.
   - 😐 How much to take or give at one time.
   - ✓ **Always take** the exact amount that it says.
   - ✓ **Always** use a **child's age or weight** to work out how much is **the right amount**.
   - ✓ **Always** use the measuring device – don't use a kitchen spoon.

Read the label each time before you use a medicine.

Be sure it's right in 5 ways:

1. **the right MEDICINE**
2. **for the right PERSON**
3. **in the right AMOUNT**
4. **at the right TIME**
5. **in the right WAY (swallow, chew, apply to skin)**

- 😐 How long it is safe to keep taking the medicine.
- ✓ Don't keep taking medicine just because you can get it without going to see a nurse or a doctor.
- ✓ Check the leaflet.
- ✓ Ask for advice.

5. **Store Medicine Safely, Dispose of Medicine Safely**.
   It is important for medicines to be stored safely and to be thrown away safely so that they do not do anyone any harm.

- 😐 Keep medicines **out of reach of children.**
- ✓ Lock the child safety cap every time.
- ✓ Don't tell children medicines are sweets.
- ✓ Always supervise children when they are taking medicine.
- 😐 Check the date when the medicine expires.
- ✓ Don't use medicine that is past its expiry date.
- ✓ Don't use medicine that has not been stored in the recommended way – it is has been left open or left in the sun or heat.
- ✓ Safely throw away old medicine.
- 😐 Never share medicine.

APPENDIX 10 TIPS ON TAKING OVER-THE-COUNTER MEDICINES

Most medicine cabinets contain a growing choice of over-the-counter (OTC) medications to treat many health problems. Over-the-counter drugs are sold directly without a prescription, as compared to prescription drugs, which you can only get if it has been prescribed to you. Common OTC medications include pain relievers, laxatives, cough and cold products, and antacids.

Some OTC medications however, can affect the way prescription medicines work or are used by the body. Always talk with your doctor and pharmacist about all OTC medicines you take.

Here are some important tips to remember:

- **Always start by reading the label–all of it.**
  OTC medication labels give you all the information you need to take the medicine the right way and tell you:
  - Active and inactive ingredients,
  - What the medicine is used for,
  - Interactions or side effects that could happen,
  - How and when (or when not) to take the medicine,
  - Other warnings.

  Reading the label will help you decide if you have selected the right product for your symptoms, and for you to understand the dosing instructions and be aware of any warning that may apply to you.
- **Look for an OTC medicine that will treat only the symptoms you have.**
  Some products are for one symptom (i.e., cough medicine) and some are for multiple symptoms (i.e., cold medicines that can treat headache, stuffy nose and cough). “More” does not necessarily mean better if the medicine is treating conditions you don’t have. Select a medicine that treats your specific symptoms.
- **Know what to avoid while taking an OTC medicine.**
  Like prescription medicines, all OTC drugs can cause side effects or reactions. Read the label to see what to avoid while you are taking an OTC drug.
- **When in doubt, ask before you buy or use an OTC medicine.**
  Taking an OTC medicine safely is too important for guesswork. If you have questions, ask your pharmacist or doctor.
- **Take the medicine EXACTLY as stated on the label.**
  When it comes to OTC medicines, more is not better! Taking too much of a non-prescription medicine can be harmful. Only take the recommended amount and at the exact intervals stated on the label.

- **Use extra caution when taking more than one OTC drug product at a time.**
  Many OTC medicines contain the same active ingredients, (i.e., the same pain reliever you take for a backache may also be in cold medicine), which means you may be getting more than the recommended dose without even knowing it. Always compare active ingredients before taking more than one OTC medicine at the same time.

- **Don't combine prescription medicines and OTC drugs without talking to a health care professional first.**
  Sometimes combining drugs can cause adverse reactions or one drug can interfere with the other drug's effectiveness. Always ask your doctor or pharmacist to play it safe.

- **Be aware of drug interaction**
  When medicines are used together (whether prescription or OTC) the ways they affect the body can change. This is called a drug interaction which may increase the chance that you will have side effects.

  If you see more than 1 doctor, tell each of them about the medicines you take, even if you take something for just a short time. Include any traditional medicines, herbal supplements, vitamins, and minerals you take.

- **Keep a list of all the OTC medicines, prescription drugs, dietary supplements and traditional medicines you take,** listing the active ingredient(s), and reason for taking each one. Share this list with your health care workers at each visit so they can check for any possible drug interactions or side effects. In case of an accident or emergency, make sure a loved one has an up-to-date copy of your medicine list too.

- **Always give infants and children OTC medicines that are specifically indicated for their age and weight.**
  Unless labelled otherwise, adult-strength products should not be given to children under age 12; doing so could result in accidental overdosing. Never cut adult tablets in half or estimate a child's dose of an adult-strength liquid product. When giving paediatric liquid OTC medicines to children, always use the calibrated measuring cup or dosing syringe that is provided with the medicine. Do not use a kitchen spoon, which come in many different sizes and measures and are never reliable for dosing medicines.

- **Don't use OTC medicines after their expiration date.**
  Dispose of all medicines promptly and safely after their expiration date and be careful not to throw them away where children or pets may find them.

- **Check for package tampering and the expiration date.**
  Don't buy medicines if the packaging has been broken or if the expiration date has passed. The expiration date tells you the date after which the product may not be as effective.

- **Talk to your doctor if taking an OTC medicine becomes a regular habit.** Most OTC medicines are only to be used for a short time.

Read the label each time before you use a medicine.

Be sure it's right in 5 ways:

1. the right MEDICINE
2. for the right PERSON
3. in the right AMOUNT
4. at the right TIME
5. in the right WAY
   (swallow, chew, apply to skin)

Women who are pregnant or breastfeeding should talk to their provider before taking any new medicine.

Medicines affect children and older adults differently. People in these age groups should take special care when taking over-the-counter medicines.

Check with your provider before taking an over-the-counter medicine if:

- Your symptoms are very bad.
- You are not sure what is wrong with you.
- You have a long-term medical problem or you are taking prescription medicines.

OTC medications can be risky if not taken properly or as prescribed on a drug label. Make sure to follow the above tips to avoid adverse effects of using OTC medications.

1. **Assessment and collection of accurate clinical data using Clinical Measures /Clinical Scoring Tools**

Medical scores, criteria and classification systems support health care and clinical decision-making and management. They enable the health care team assess conditions and diagnose diseases accurately, understand social context, stratify risk identify levels of service requirements and predict the outcome. They also help us know if we are making a meaningful difference by measuring the healthcare system as a whole.

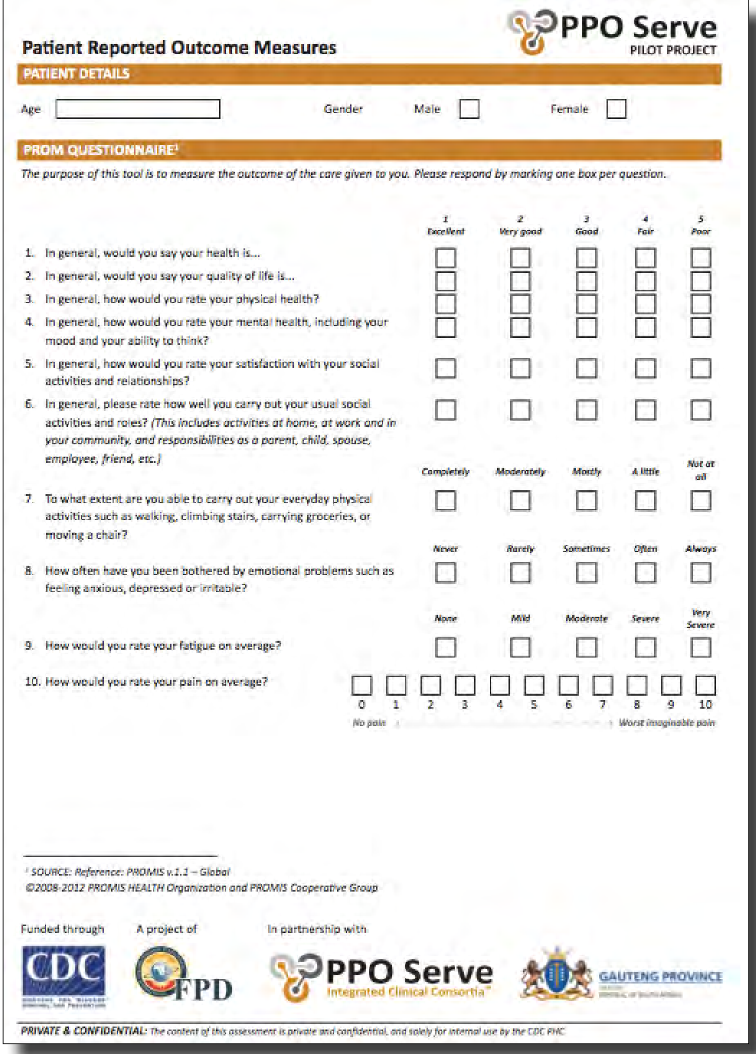
There are several scoring tools to assess risk. They provide us with a standardized and systematic way of measuring physiological variables, quality of life and other psychosocial measures, healthcare processes, health outcomes, service user perceptions, patient engagements and organizational structures etc. Measuring and reporting on these scores help to ensure that our health care system is delivering effective, safe, efficient, patient-centered, equitable, and timely care.
Below is a table of some widely used scoring tools and the things that they are useful for:

Kind	Score	Useful for?
General		
	PROMs (Patient reported outcome measures)	General view, can includes Bio-psycho-social aspects
Biological		
	BMI	Obesity, Cardiovascular risk
	Barthel	Activities of Daily Living. All complex patients
	Pre-test probability score	Angina pain
	Disability Assessment in Dementia (DAD)	Dementia
	Charlston Index	Screening for complexity
Psychological		
	PHQ- 9	Depression
	MMSE	Dementia
	Clock Drawing Test	Dementia
	Geriatric depression score	Depression
Social		
	LSNS (lubben social network score)	Psychological wellbeing, management of chronic conditions, ANC & PNC, complex conditions etc.

2. PROMs

Patient-reported outcome measures (PROMs) are measurement instruments that patients complete to provide information on aspects of their health status that are relevant to their quality of life, including symptoms, functionality and physical, mental and social health.

Many PROMs instruments are available. PROMs tools are categorized as generic (applied across different populations) or condition-specific (used to assess outcomes that are characteristic of or unique to particular diseases or sectors of care). Typically, generic and condition-specific instruments are administered concurrently, as they provide complementary information.



PPO Serve
PILOT PROJECT

Patient Reported Outcome Measures

PATIENT DETAILS

Age ☐ Gender Male ☐ Female ☐

PROM QUESTIONNAIRE[1]

The purpose of this tool is to measure the outcome of the care given to you. Please respond by marking one box per question.

	1 *Excellent*	2 *Very good*	3 *Good*	4 *Fair*	5 *Poor*
1. In general, would you say your health is...	☐	☐	☐	☐	☐
2. In general, would you say your quality of life is...	☐	☐	☐	☐	☐
3. In general, how would you rate your physical health?	☐	☐	☐	☐	☐
4. In general, how would you rate your mental health, including your mood and your ability to think?	☐	☐	☐	☐	☐
5. In general, how would you rate your satisfaction with your social activities and relationships?	☐	☐	☐	☐	☐
6. In general, please rate how well you carry out your usual social activities and roles? *(This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)*	☐	☐	☐	☐	☐
	Completely	*Moderately*	*Mostly*	*A little*	*Not at all*
7. To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	☐	☐	☐	☐	☐
	Never	*Rarely*	*Sometimes*	*Often*	*Always*
8. How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	☐	☐	☐	☐	☐
	None	*Mild*	*Moderate*	*Severe*	*Very Severe*
9. How would you rate your fatigue on average?	☐	☐	☐	☐	☐

10. How would you rate your pain on average?

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10

No pain → *Worst imaginable pain*

[1] *SOURCE: Reference: PROMIS v.1.1 – Global*
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Funded through CDC
A project of FPD
In partnership with PPO Serve Integrated Clinical Consortia™ GAUTENG PROVINCE

PRIVATE & CONFIDENTIAL: *The content of this assessment is private and confidential, and solely for internal use by the CDC PHC*

Patient-reported outcomes are essential to understanding whether health care services and procedures make a difference to patients' health status and quality of life. PROMs provide insight on the effectiveness of care from the users' perspective. It complements existing information on the quality of care and services provided. Ii is used enrich existing information and to better inform practice and decision making.

3. The Barthel Index to measures activities of daily living

THE BARTHEL INDEX

Patient Name: ____________________

Rater Name: ____________________

Date: ____________________

Activity	Score
FEEDING 0 = unable 5 = needs help cutting, spreading butter, etc., or requires modified diet 10 = independent	______
BATHING 0 = dependent 5 = independent (or in shower)	______
GROOMING 0 = needs to help with personal care 5 = independent face/hair/teeth/shaving (implements provided)	______
DRESSING 0 = dependent 5 = needs help but can do about half unaided 10 = independent (including buttons, zips, laces, etc.)	______
BOWELS 0 = incontinent (or needs to be given enemas) 5 = occasional accident 10 = continent	______
BLADDER 0 = incontinent, or catheterized and unable to manage alone 5 = occasional accident 10 = continent	______
TOILET USE 0 = dependent 5 = needs some help, but can do something alone 10 = independent (on and off, dressing, wiping)	______
TRANSFERS (BED TO CHAIR AND BACK) 0 = unable, no sitting balance 5 = major help (one or two people, physical), can sit 10 = minor help (verbal or physical) 15 = independent	______
MOBILITY (ON LEVEL SURFACES) 0 = immobile or < 50 yards 5 = wheelchair independent, including corners, > 50 yards 10 = walks with help of one person (verbal or physical) > 50 yards 15 = independent (but may use any aid; for example, stick) > 50 yards	______
STAIRS 0 = unable 5 = needs help (verbal, physical, carrying aid) 10 = independent	______
TOTAL (0–100):	______

Provided by the Internet Stroke Center — www.strokecenter.org

The Barthel ADL index is an ordinal scale used to measure performance in activities of daily living (ADL). It uses ten variables that describe the activities of daily living and mobility. Each activity is rated on this scale with a given number of points assigned to each level or ranking. In a hospital setting, for example, it helps determine the likelihood of person being able to live at home following discharge with a degree of independence. The amount of time and physical assistance support a person needs to perform each item are used to give a value (score) to each item. External factors within the environment affect the score of each item. If adaptations outside the standard home environment are met during assessment, the participant's score will be lower if these conditions are not available.
If adaptations to the environment are made, they should be described in detail and attached to the Barthel index.

The scale was introduced in 1965, and yielded a score of 0–100.
It has been used extensively to monitor functional changes in individuals receiving in-patient rehabilitation, mainly in predicting the functional outcomes related to stroke. The Barthel index has been used in 16 major diagnostic conditions. The Barthel index has demonstrated high inter-rater reliability (0.95) and test–retest reliability (0.89) as well as high correlations (0.74–0.8) with other measures of physical disability.

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4. **Lubben Social Network Scale (LSNS)**

Social ties have a significant influence on health and well-being as well as disease management and condition outcomes. Recognizing the relationship between social support networks and physical and mental health outcomes of especially the elderly, has led to the creation of scoring tools to help flag these people during a comprehensive assessment of the elderly client. The Lubben scale was created to provide relevant quality information to ensure effective holistic health care.

The Lubben Social Network Scale

The Lubben Social Network Scale	
1 How many relatives do you see or hear from at least once a month.	
0	0
1	1
2	2
3 to 4	3
5 to 8	4
≥ 9	5
2 Tell me about the relative with whom you have the most contact. How often do you see or hear from that person?	
less than monthly	0
monthly	1
a few times a month	2
weekly	3
a few times a week	4
daily	5
3 How many relatives do you feel close to? That is, how many of them do you feel at ease with to talk about private matters or can call for help?	
0	0
1	1
2	2
3 to 4	3
5 to 8	4
≥ 9	5
4 Do you have any close friends? That is do you have any friends with whom you feel at ease and can talk about private matters or can call on for help? If so, how many?	
0	0
1	1
2	2
3 to 4	3
5 to 8	4
≥ 9	5
5 How many of these friends do you see or hear from at least once a month?	
0	0
1	1
2	2
3 to 4	3
5 to 8	4
≥ 9	5

The Lubben Social Network Scale	
6 Tell me about the friend with whom you have the most contact. How often do you see or hear from that person?	
less than monthly	0
monthly	1
a few times a month	2
weekly	3
a few times a week	4
daily	5
7 When you have an important decision to make, do you have someone you can talk to about it	
never	0
seldom	1
sometimes	2
often	3
very often	4
always	5
8 When other people you know have an important decision to make, do they talk to you about it?	
never	0
seldom	1
sometimes	2
often	3
very often	4
always	5
9 Does anybody rely on you to do something for them each day?	
Yes	5
No (if so go to 9(b))	
9b Do you help anybody with something each day?	
very often 4	4
often 3	3
sometimes 2	2
seldom 1	1
never 0	0
10 Do you live alone or with other people?	
live with spouse	5
live with other relatives or friends	4
live with other unrelated individuals (paid help etc.)	1
live alone	0

5. PHQ-9

The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression:

- The PHQ-9 incorporates DSM-IV depression diagnostic criteria with other leading major depressive symptoms into a brief self-report tool.
- The tool rates the frequency of the symptoms which factors into the scoring severity index.
- Question 9 on the PHQ-9 screens for the presence and duration of suicide ideation.

Patient Health Questionnaire (PHQ-9)

Patient name: ______________________ Date: ____________

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
a. Little interest or pleasure in doing things.	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless.	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much.	☐	☐	☐	☐
d. Feeling tired or having little energy.	☐	☐	☐	☐
e. Poor appetite or overeating.	☐	☐	☐	☐
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down.	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching TV.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

TOTAL SCORE ____________

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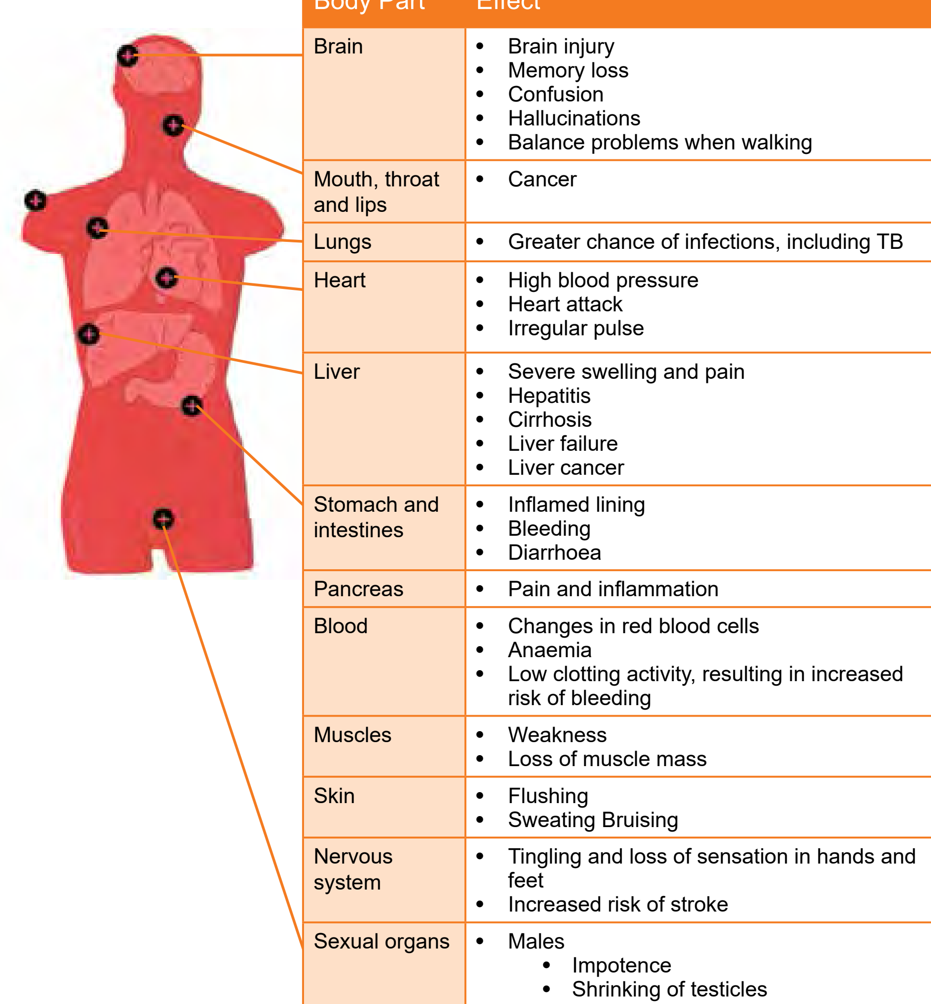
PRIME-MD ® is a trademark of Pfizer Inc.

The PHQ-9 is brief and useful in clinical practice. The PHQ-9 is completed by the patient in minutes and is rapidly scored by the clinician. The PHQ-9 can also be administered repeatedly, which can reflect improvement or worsening of depression in response to treatment.

APPENDIX 12 SUBSTANCES AND THEIR PHYSICAL EFFECTS

The physical health effects of alcohol on the human body.



Body Part	Effect
Brain	• Brain injury • Memory loss • Confusion • Hallucinations • Balance problems when walking
Mouth, throat and lips	• Cancer
Lungs	• Greater chance of infections, including TB
Heart	• High blood pressure • Heart attack • Irregular pulse
Liver	• Severe swelling and pain • Hepatitis • Cirrhosis • Liver failure • Liver cancer
Stomach and intestines	• Inflamed lining • Bleeding • Diarrhoea
Pancreas	• Pain and inflammation
Blood	• Changes in red blood cells • Anaemia • Low clotting activity, resulting in increased risk of bleeding
Muscles	• Weakness • Loss of muscle mass
Skin	• Flushing • Sweating Bruising
Nervous system	• Tingling and loss of sensation in hands and feet • Increased risk of stroke

Sexual organs	• Males
	    • Impotence
	    • Shrinking of testicles
	    • Damaged/ less sperm
	• Females
	    • Irregular menstrual periods
	    • Infertility
	    • Damage to unborn baby
	    • Increased risk of breast cancer

DAGGA

Dagga
- Ghanja
- Zol
- Marijuana
- Grass
- Weed
- Dope
- Spliff
- Dube
- Boom
- Skyf

Can be smoked
- Cigarette (joint)
- Pipe
- Hubbly bubbly

Can be used in food
- dagga muffin
- space cookies

HIGH:
- Relaxed, feelings of happiness, talkative
- Tired, no energy
- Increased appetite
- Giggling
- Mood swings
- Dry mouth
- Lazy

AFTER HIGH:
- Nausea and vomiting (sometimes)
- Seeing and hearing things that do not exist (sometimes)
- Red eyes, large pupils
- Unsteady, increasing risk of accidents
- Forgetful
- Doing 'funny things'

HEROIN

Also called:
- H
- Thai (refers to Thai White, a type of heroin)
- Nyope (dagga and heroin)

Injected ('spiking')

Smoked or inhaled ('chasing the dragon')

HIGH:
- Excitement
- Calmness
- Slow reflexes
- Narrowing of pupils
- Drooping of eyelids
- Trouble breathing

AFTER HIGH:
- Poor concentration
- Sweating
- No feelings of pain, fear, hunger, stress, anxiety
- Sleepy, tired, lazy, slurred speech
- Little interest in school, work, relationships
- Mood swings, withdrawn argumentative
- Nausea
- Death (due to overdose)

LONG TERM:
- Psychosis/ ufufunyane
- Personality changes
- Health problems
- Severe weight loss
- Loss of appetite
- Addiction

LONG TERM:
- Mental deterioration
- Tolerance toward drug
- Poor immunity
- Convulsions
- Coma
- Death from overdose

COCAINE / CRACK

Also called:

Cocaine

- Coke
- Powder
- Snow

Sniffing or snorting a a 'line', through small tube, such as rolled up money

Crack

- Rocks
- Gafief
- Zoom

Pieces smoked by heating and inhaling fumes through glass or metal tube

HIGH:

- Feelings of well-being, happiness, excitement
- Increases self-confidence
- Improves mood
- Sexual interest
- High energy levels, alert, wakeful a not feeling tired
- Improves thinking, concentration
- Seeing and hearing things that do not exist (with high doses)

PREGNANCY EFFECTS

- bleeding
- spontaneous abortion
- birth defects
- children born with dependency
- increased risk of still birth

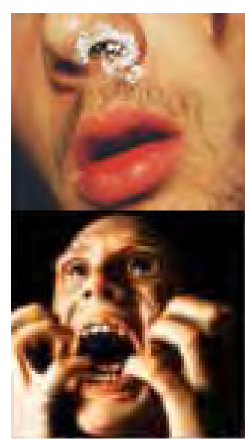
LONG TERM:

- Frequent nosebleeds and sinus problems
- Increased temperature, heart rate, blood pressure, breathing
- Large pupils
- Seizures, strokes, heart attacks, death
- Increased irritability and restlessness
- Psychosis/ufufunyane; confused, disorganised behaviour, fear, paranoia, seeing and hearing things that do not exist
- Anti-social, violent behaviour; aggression
- Anxiety, depression
- Tremors, muscle twitching,
- nausea, cold sweats, mood swings
- Crawling itching sensations ('cocaine bugs')
- Strong psychological dependence
- Overdosing and death

CAT

CAT

- CAT
- Snorting or inhaling powder



SHORT TERM:

- Not feeling tired or hungry
- Impulsive, erratic behaviour
- Increases self-confi dence
- Paranoia,irritability, severe depression
- Increased heart rate, breathing, temperature
- Feeling of excitement
- Increased alertness
- Large pupils, jerky eye movement, blurred vision
- Not being able to sleep
- Seeing and hearing things that do not exist
- Rage psychosis

LONG TERM:

- Paranoia
- Aggression, violent behaviour
- Fixed beliefs that do not change, when presented with conflicting evidence;
- Seeing and hearing things that do not exist
- Weight loss, loss of appetite
- Sleep disturbances
- 'Cocaine bugs'
- Tolerance
- Addiction
- Profuse sweating and dehydration
- Increased heart rate, temperature
- Uncontrolled shaking
- Irritability, anxiety, depression
- Suicidal ideation
- Overdose, death

METHAMPHETAMINES

Methamphetamines

- Tik
- Crystal Meth
- Tik-Tik
- Speed
- Globes
- Straws

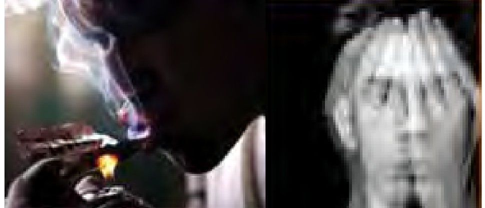
Inhale smoke which is created by heating up crystals in light bulbs.

HIGH

- Increased heart rate, blood pressure, breathing rate, temperature
- Large pupils
- Poor appetite, severe weight loss
- Increased activity
- Feelings of increased alertness, aggression, violence, agitation
- Feelings of well-being, Palpitations
- Depression, restlessness, severely tired
- Inability to sleep
- Continuous talking
- Seeing and hearing things that do not exist, psychosis
- Seizures and stroke
- Death
- exhilaration, excitement

AFTER HIGH

- Paranoia, intense anxiety or panic
- Agitation, violent behaviour



MANDRAX

Mandrax

- Buttons
- Pille
- Drugs
- Five Star
- VW

Smoked

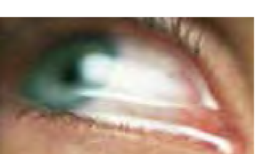
- In broken glass bottle neck ('bottle-kop')
- In cigarette form
- with dagga

HIGH/AFTER

- Tired, sleepy, sleeping for many hours
- Nightmares
- Mood changes
- Restlessness
- Rapid weight loss
- Slurring of words

HIGH/AFTER

- Headaches
- Aggression
- Poor co-ordination
- Person not bothering how they look, poor hygiene
- Emotional problems

INHALANTS	
Called different names depending on the substance and equipment used Breathe in fumes through nose or mouth, usually by 'sniffng', 'snorting', 'bagging' or 'huffing' 	HIGH/AFTER HIGH • Coughing, runny nose • Watery eyes • Large pupils and double vision • Buzzing/ ringing ears • Excitement • Confusion • Drunk and off-balance • Aggressive, emotional outbursts • Risk-taking behaviour • Nausea • Perceptual distortion • Short-term memory loss

New South Wales Health. Alcohol and Drug Fact sheets https://yourroom.health.nsw.gov.au/a-z-of-drugs/Pages/alcohol.aspx. Accessed on 4 April 2018

South African National Council on Alcoholism and Drug Dependence. Drug Information. http://www.sancanational.info/drug-information Accessed on 9 April 2018

National Institutes of Health, National Institute on Drug Abuse. Drug Facts. Inhalants. https://www.drugabuse.gov/publications/drugfacts/inhalants Accessed on 11 April 2018

TIPS TO HELP REDUCE THE HARMS OF SUBSTANCES

1. Keep taking all prescribed medicines.

☺ Take HIV, TB, hypertension, diabetes, psychosis or any other medicine.

☺ Take prescribed medicines at the right time and in the right amount.

2. Choose the less harmful way of taking a substance

☺ Take a small amount first to test each batch.

☺ Eat or drink rather than snort substances.

☺ Snort rather than smoke substances.

☺ Smoke rather than inject substances.

- ☺ Don't use large amounts everyday.
- ☹ Don't binge.
- ☹ Don't mix with alcohol.

3. Get sleep or rest

☹ Lack of sleep is very bad for anyone's health.

😐 Even if the person can't sleep, they should lie down lie down in a dark room for a minimum of 4 – 6 hours out of every 24.

☺ Rest and sleep helps restore calm and reduces excitement.

☺ Rest and sleep helps physical recovery.

4. Eat food and drink water.

5. Practice safe sex

☺ Use a condom every time.

6. Make safer choices when to use

☺ Make a choice about the days or times when you use.

☺ Make a choice about the circumstances when you use.

☹ Never use alone.

☹ Stop use if the person start hearing voices that aren't there.

☹ Stop use if the person has been taken to hospital for paranoia.

HARMFUL SUBSTANCE USE SCORING TOOL

Here are a few questions about drugs. Please answer as correctly and honestly as possible by indicating which answer is right for you.

		Man ☐	Woman ☐			Age ☐☐
1.	How often do you use drugs other than alcohol? (See list of drugs on back side.)	Never ☐	Once a month or less often ☐	2-4 times a month ☐	2-3 times a week ☐	4 times a week or more often ☐
2.	Do you use more than one type of drug on the same occasion?	Never ☐	Once a month or less often ☐	2-4 times a month ☐	2-3 times a week ☐	4 times a week or more often ☐
3.	How many times do you take drugs on a typical day when you use drugs?	0 ☐	1-2 ☐	3-4 ☐	5-6 ☐	7 or more ☐
4.	How often are you influenced heavily by drugs?	Never ☐	Less often than once a month ☐	Every week ☐	Every week ☐	Daily or almost every day ☐
5.	Over the past year, have you felt that your longing for drugs was so strong that you could not resist it?	Never ☐	Less often than once a month ☐	Every week ☐	Every week ☐	Daily or almost every day ☐
6.	Has it happened, over the past year, that you have not been able to stop taking drugs once you started?	Never ☐	Less often than once a month ☐	Every week ☐	Every week ☐	Daily or almost every day ☐
7.	How often over the past year have you taken drugs and then neglected to do something you should have done?	Never ☐	Less often than once a month ☐	Every week ☐	Every week ☐	Daily or almost every day ☐
8.	How often over the past year have you needed to take a drug the morning after heavy drug use the day before?	Never ☐	Less often than once a month ☐	Every week ☐	Every week ☐	Daily or almost every day ☐
9.	9. How often over the past year have you had guilt feelings or a bad conscience because you used drugs?	Never ☐	Less often than once a month ☐	Every week ☐	Every week ☐	Daily or almost every day ☐
10.	Have you or anyone else been hurt (mentally or physically) because you used drugs?	No ☐	Yes, but not over the past year ☐	Yes, over the past year ☐		
11.	Has a relative or a friend, a doctor or a nurse, or anyone else, been worried about your drug use or said to you that you should stop using drugs?	No ☐	Yes, but not over the past year ☐	Yes, over the past year ☐		

LIST OF DRUGS (Note! Not alcohol!)

CANNABIS	AMPHETAMINES	COCAINE	OPIODS
Cannabis Marijuana Hash Hash oil	Methamphetamine Phenmetraline Khat Betel nut Ritaline (Methylphenidate	Crack Freebase Coca leaves	Smoked heroin Heroin Opium
HALLUCINOGENS	**SOLVENTS / INHALANTS**	**GHB AND OTHERS**	
Ecstasy LSD (Lisergic acid) Mescaline Peyote PCP, angel dust (Phencyclidine) Psilocybin DMT (Dimethyltryptamine)	Thinner Trichlorethylene Gasoline/petrol Gas Solution Glue	GHB Anabolic steroids Laughing gas (Halothane) Amyl nitrate (Poppers) Anticholinergic compounds	

PILLS – MEDICINES

Pills DO NOT count as drugs when

- they are taken for a health condition that is DIAGNOSED by a doctor or registered health professional.
- they are taken as they are PRESCRIBED by the health professional.

Pills count as drugs when you take

- more of them or take them more often than the doctor has prescribed for you.
- pills because you want to have fun, feel good, get ”high”, or wonder what sort of effect they have on you.
- pills that you have received from a relative or a friend.
- pills that you have bought on the ”black market” or stolen.

SLEEPING PILLS/SEDATIVES		
Alprazolam Amobarbital Apodorm Apozepam Aprobarbital Butabarbital Butalbital Chloral hydrate Diazepam Dormicum Ethcholorvynol Fenemal Flunitrazepam Fluscand	Glutethimide Halcion Heminevrin Iktorivil Imovane Mephobarbital Meprobamate Methaqualone Methohexital Mogadon Nitrazepam Oxascand Pentobarbital Phenobarbital	Rohypnol Secobarbital Sobril Sonata Stesolid Stilnoct Talbutal Temesta Thiamyal Thiopental Triazolam Xanor Zopiklon

PAINKILLERS		
Actiq Coccilana-Etyfin Citodon Citodon forte Dexodon Depolan Dexofen Dilaudid Distalgesic Dolcontin Doleron Dolotard Doloxene	Durogesic Fentanyl Ketodur Ketogan Kodein Maxidon Metadon Morfin Nobligan Norflex Norgesic Opidol OxyContin	OxyNorm Panocod Panocod forte Paraflex comp Somadril Spasmofen Subutex Temgesic Tiparol Tradolan Tramadul Treo comp

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5.1 Maternal Mortality and Infant and Child Death and Illness

Maternal mortality and infant and child death and illness are considered to be the second of the four epidemics gripping South Africa.

Maternal death is when a woman dies from any cause related to or aggravated by the pregnancy or its management while she is pregnant or in the 42 days after she has given birth or her pregnancy has ended. (WHO: International Classification of Disease, 2010)

For much of human history, the death of women during pregnancy and childbirth and the death of infants and young children were "facts of life". They were thought of as natural hazards that came with pregnancy and early life.

There are three factors that have changed the risk for women of death during pregnancy and childbirth over the past two hundred years are:

1. **Improved health care standards**
   - Skilled and well trained health attendants.
   - Access to emergency care.
   - Improved abortion care (safe legal abortion).
   - Early detection and treatment of HIV and TB.

2. **Advances in medical science**
   - Availability of antibiotics and other new drugs.
   - Improved hand washing and infection control methods among health care providers.
   - Better blood transfusion.
   - Affordable Anti-retroviral therapy to control HIV.

3. **A decline in number of pregnancies per woman and change in women's age of pregnancy.**
   - Improved fertility control (contraception) and fewer pregnancies (family planning).
     - The safest age for pregnancy is 20-39. The risk of death in pregnancy is higher in younger and older women.
     - The safest number of pregnancies for a woman is four or fewer.

DID YOU KNOW?

Each year in South Africa at least 4452 mothers died due to complications of pregnancy and childbirth from 2011 to 2013.

National Department of Health. **Saving Mothers 2011-2013: Sixth report on the Confidential Enquiries into Maternal Deaths in South Africa**

In 2016 more than 95% of HIV-positive pregnant women were receiving ART for the Prevention of Mother-to-Child Transmission of HIV (PMTCT).

UNAIDS. AIDSInfo. **South Africa; Country factsheets**. *2016*

Infant and child death is defined as the death of a child from the time of birth until the age of 5 years from any cause.

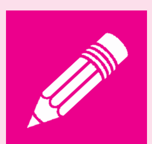
The risk of death is greatest at birth and in the first five years of life. Infants are totally dependent on their carers for food, warmth, love, comfort and protection. This is why when health care practices and social conditions improve the high risks of death and disease in infancy and early childhood go down.

There are three factors that have influenced the risk for infant and child death.

1. Care Practices during Pregnancy, Labour, Birth and in the First Month of Life.

There are a number of conditions during pregnancy, delivery and in the first 28 days that contribute to newborn and infant illness and death. A lot of death and disease in infancy and early childhood can be avoided or addressed by taking practical action, including:

- Improved maternal care during pregnancy.
- Preventing mother to child transmission of HIV.
- Treating HIV positive children.
- Detecting and responding to high risk pregnancies during labour and birthing.
- Helping newborns initiate and sustain breathing at birth.
- Kangaroo Mother Care to support low birth weight, pre-term baby survival.
- Supporting mothers to initiate breastfeeding.



In 2016 in South Africa

- Over 14 000 babies died before the first month of life.
- 34 out of every 1 000 children died before their first birthday.
- About 50 000 children died before their fifth birthday

This death toll is a result complications during pregnancy and childbirth, newborn illness, childhood illness, HIV & AIDS. At least half of these lives could be saved with improved services and better care in facilities. Most of the remaining lives could be saved with improved health literacy and health care support in the community

UNICEF. **Country-specific Child mortality Estimates.** *2017*

5

2. Public Health and Medical Science

HIV and AIDS

HIV in Africa was first identified in 1983. 90% of children infected with HIV live in sub-Saharan Africa, the epicenter of the global AIDS pandemic. Historically 95% of HIV infection in children is transmitted from mother to child.

- With anti-retroviral drug therapy and improved treatment guidelines HIV can be prevented, managed and controlled.
- Through **PMTCT** (prevention of mother to child transmission of HIV) HIV transmission from mother to child has gone down from 33 in 100 in 1995 to less than 2 in 100 in 2015.
- All HIV+ children, of any age, are given lifelong ART
- All HIV/TB co-infected children of any age are given ART.

Malnutrition

- **Malnutrition** is an underlying factor in about one-third of all child deaths because it makes children vulnerable to severe diseases. Malnutrition in the first two years of life causes irreversible damage to a child's growth, health and development. Malnutrition ranges from starvation from too little food (marasmus) to malnutrition caused by a diet of starch but low or no protein (kwashiorkor). Both lead to and aggravate micronutrient deficiency, the hidden hunger of essential vitamins and minerals like iron, iodine, zinc and Vitamin A .

  There are two main causes of malnutrition in infants and children. One is not exclusive breastfeeding in the first six months of life. The other is inadequate and insufficient diet in the next 60 months.

  Malnutrition can be prevented by
  - Exclusively breastfeeding for the first six months.
  - Effective complimentary feeding.
  - Effective crèche and school feeding schemes.
  - Improved family and community understanding of infant and child nutrition and development.
  - Micro-nutrient supplementation (Vitamin A, iron) and a diet rich in fresh green leafy vegetables and fruit.

Childhood diseases

Children are very vulnerable to diarrhea, pneumonia and other lower respiratory tract infections as well as infectious diseases like measles, TB, HIV, mumps.

Illness and death caused by childhood diseases can largely be prevented through effective public and community health, good clinical practices and medical science. These are things like

- Breastfeeding with complementary feeding.
- Improved access to safe water.
- Improved sanitation.
- Hand washing.
- Oral rehydration salts combined with zinc supplements.
- Immunization (vaccination).
- Vitamin A supplementation.
- Nutrition support.

3. Approaches to health and disease

Specialisation and professionalization has led to two disconnects in maternal and child health care and disease management.

The one disconnect is the separation of maternal and child health into distinct and separate realms of practice and knowledge. The link between mother and child

is important (but different) in all societies. Although it seems "obvious", for many decades the focus of global policy, research and programming was on infant and child health. Maternal health only began to be treated as an important part of national and international health care in the second half of the 1980s. This refocusing has led to a positive change in understanding maternal and child health.

- The health of **both the mother and the child** during pregnancy, birthing, infancy and early childhood is critical to long term individual survival, social wellbeing and happiness as well as societal well-being and development.

The second disconnect is between health care professionals and families and communities. This disconnect happens because of the way pregnancy and childbirth is managed, where it is practiced and the relationships that both of these create between health care providers and mothers, children and their families.

- In most parts of the world, including South Africa, pregnancy and birthing is seen as a medical condition. It is guided by policy and managed under professional and specialist medical care in hospitals and clinics. Professional medical care has reduced many of the risks to mothers and babies.

The medicalization of pregnancy and childbirth and the move to hospitals and facilities also has created several challenges. The *Every Death Counts* Working Group describe what they call modifiable factors that lead to unnecessary and avoidable deaths in mothers, babies and children. A significant proportion of these fixable problems occur in people's homes and families, in the community.

AS A HEALTH WORKER...

You can help save almost half of the lives lost by helping women and their families understand and respond to pregnancy and infant and child care.

Nearly half of all maternal deaths (44%) could be prevented if women

- were more knowledgeable about their bodies and reproduction.
- managed and planned their fertility.
- understood ante-natal care and the importance of getting health care early on during pregnancy.
- knew about and responded quickly to danger signs in pregnancy.

Nearly four in ten (38%) stillbirths and infant deaths in the first 28 days of life could be prevented if mothers and their families

- better understood ante-natal care.
- prepared for and had plans in place for labour.
- prepared for and had plans in place for new born and infant care, including how best to feed and care for the new born.
- better understood and knew how to respond to the danger signs in infancy.

One in four deaths in children (1-5 years) could be prevented if mothers, carers and families were empowered to

- recognize and practiced good complementary feeding.
- manage infection control and hazards in the home.
- respond to severe illness early and quickly.
- use the Road to Health Card to monitor infant and child growth and development.
- practice first aid and what to do in an emergency.

AS A HEALTH WORKER...

It is important for everyone to wash his or her hands with soap and water

- Before and after caring for a baby.
- Before and after eating.
- Before and after preparing food.
- After going to the toilet.
- After touching pets or animals.
- After playing (with toys, equipment, sand etc.).
- Before and after treating and caring for a sick person.
- Before and after treating a cut or a sore or any other injury.

DID YOU KNOW?

Keeping hands clean is one of the most important ways that people can keep themselves healthy and stop germs from spreading.

Hand washing

- Reduces the number of people who get sick with diarrhea by 31%
- Reduces diarrheal illness in people with weakened immune systems by 58%
- Reduces respiratory illnesses, like colds, in the general population by 21%

5.2 Pregnancy and The Journey Into Life

We need to know about the journey into life of a human being and the huge changes that women undergo to make this possible. This helps us understand the importance of antenatal and postnatal care in the lives of mothers and babies.

THE JOURNEY INTO LIFE

WORK IN GROUPS

Share what you know about the human journey into life.

- Conception
- Pregnancy
- Being born
- Surviving and thriving

INDIVIDUALLY

Write down the one thing that you are most uncertain about for each of the topics (conception, pregnancy, being born, surviving and thriving).

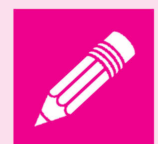
Like most people, you probably know quite a lot about some aspects of the journey into life, and not so much about others. You probably focus on the mother (possibly the father too) when you talk about conception and pregnancy. And you probably focus on the baby when you talk about being born and surviving and thriving. What we all need to be clear about is that the journey into life goes from total dependence to independence along a continuum of biological, physical, psychological and social interdependence.

There is no such thing as a baby on its own. Also, although women can become mothers by different routes, there is also no such thing as a baby without a woman. What this means is that the journey into life always has to be understood in two ways. The preborn story is the story of the transformation of the possibility of human life into the growth and development of human beings. The pregnancy story is the story of the female half of humanity who have the ability to change physically, psychologically and socially to carry and produce human life.

The preborn story

In nature, the journey into human life starts in the same time and space for everyone. Life begins as a possibility when a male sperm fertilises a female egg. This fertilised egg is called a zygote. Usually, the zygote is formed in the bottom third of a woman's fallopian tube. The zygote then travels for up to seven days

along the fallopian tube into the uterus. There it takes about 72 hours to plant itself into the uterus wall. This is called implantation. When it does this, it becomes an embryo. The formation of the embryo is the official start of pregnancy because the fertilized egg can stay and grow in the uterus. At 10 weeks the embryo has grown into a foetus and is about the size of four paper clips.

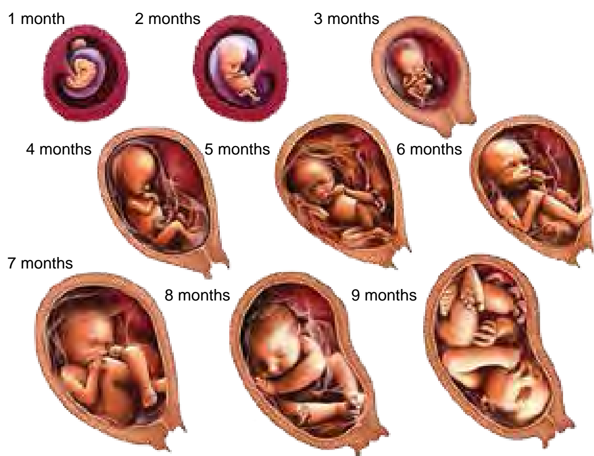


DID YOU KNOW?

The first trimester is the most crucial in the preborn story. During this time the body structure and organ systems develop as the embryo develops into a foetus. Because of this it is also the period of most risk for birth defects and when most miscarriages happen.

Over the next 14 weeks, the foetus develops all its human features. It also grows, getting longer and taller and wider, forcing the uterus to grow and the mother's abdomen to expand. At 24 weeks the baby weighs about half a kilogram and it is about 30 cm long. It continues to develop and grow, acquiring protective fat and greater physiological function. In the last 10 weeks before birth, the baby responds to internal and external noises, such as the mother's heartbeat or a loud bang, as well as light.

Stages of Foetal Development



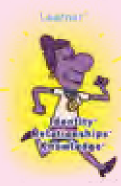
https://anatomydiagramclass.com

All along, the foetus has been influenced by the space it has been occupying. We 'know' being in the uterus is a different space from being out of the uterus. The uterus is a protective space where a number of factors put the baby into a sleep-like state that keeps brain activity low. The baby is not consciously aware of its environment or of pain until it is born.

The last part of the preborn story is giving birth. This part of the journey is called labour. In natural birth, labour lasts anything from a few hours to 12 or more hours. It is a physical process where the mother's body works to transport the baby out of the uterus through the birth canal into the world. With its first breath of air, the baby becomes conscious in the world. It is immediately capable of feeling and experiencing things like touch, heat, cold, sound, pain, smell, taste and motion.

Human beginnings start off as a *mostly biological* story that *always is connected* to *both parents* genetically and to mothers physically, psychologically and socially.

At birth, the social and psychological story of human beings as persons and individuals *in society* is added to their story of physical development.



AS A HEALTH WORKER...

You know that there is no such thing as a baby on its own. Human health and well-being is always connected to people's genetic and biological origins as well as the family, community and society they live in.

The Pregnancy Story

Pregnancy changes the whole way a woman's body functions. It does this in order to support the growth and development of the baby. This is why every pregnancy is unique. Every woman's experience of pregnancy is particular.

Pregnancy is a natural part of the way human beings reproduce. It lasts for between 37 and 42 weeks or about nine months. Throughout the pregnancy the health of the baby and the health of the mother are interconnected.

By convention, the nine months of pregnancy is divided into three parts. Each part is called a trimester. Each trimester lasts about 12 to 14 weeks. There are fairly distinct sets of physical and emotional changes that happen to the pregnant woman and the developing baby in each trimester.

First trimester (0 to 13 weeks)

The possibility of pregnancy begins when a man's sperm fertilizes a woman's egg cell. This can happen up to six days after men and women have unprotected sex.
Pregnancy officially begins when the fertilized egg (zygote) plants itself in the wall of the uterus. This is called implantation and the fertilized egg becomes an embryo. Implantation triggers the release of a number of pregnancy hormones that change the way a woman's body functions and how she feels.

These hormones

- stop her body from rejecting the embryo as an invader; and
- stop her period so that the embryo is not flushed out with the lining of the uterus during a menstrual cycle.

These hormones also change the way she feels physically and emotionally. They can cause things like

- Mood swings
- Nausea and vomiting
- The need to urinate often
- Fatigue and difficulty sleeping
- Tender or swollen breasts
- A metallic taste in the mouth
- Sensitivity to smells
- Cravings for certain foods
- Dislike of certain foods

Not everyone has all these symptoms. Most women have at least one.

Second trimester (14 to 26 weeks)

Many of the unpleasant effects of early pregnancy disappear for most women in the second trimester. During this period women often have more energy. They experience less nausea. Their sleep patterns get better. However, some can start to experience back or abdominal pain, leg cramps, constipation and heartburn. Somewhere between 16 weeks and 20 weeks, a woman may feel her baby's first fluttering movements.

5

Third trimester (27 to 40 Weeks)

The last trimester of pregnancy is often a mixture of excitement, impatience and anxiety. Because baby's growth has caused her uterus to expand significantly, a woman can develop shortness of breath, haemorrhoids, urinary incontinence, varicose veins and sleeping problems.

5.3 Choices in Pregnancy

Confirming pregnancy

The only way for a woman to know she is pregnant early on is to take a pregnancy test. This test checks her blood or urine for a hormone called HCG (human chorionic gonadotropin). HCG is released into the blood and urine when a fertilized egg implants in the wall of the uterus. This is when pregnancy begins. She is pregnant if the test result is positive. She is not pregnant if the test result is negative.

The least invasive, least costly and easiest way to check for pregnancy is to test urine. Urine tests are safe to use. They are also accurate, especially if the test is done with the first urine passed in the morning, because it has the most HCG. Some women, especially if they have irregular periods, may need to test for pregnancy more than once, a few days apart.

Confirming pregnancy is easy to do.

- ✓ Women can ask for a free pregnancy test at any government clinic.
- ✓ Women can get free pregnancy tests at non-government organisations, like Marie Stopes and Planned Parenthood.
- ✓ Women can buy pregnancy test kits over the counter from supermarkets and pharmacies.

Why women delay testing for pregnancy

There are different kinds of reasons why girls and women delay finding out they are pregnant. Some of them are probably familiar to you.

Sometimes women delay because they may not know much about sexual reproduction. For example, they may not know when a girl or woman can fall pregnant.

A girl or woman can fall pregnant

- The first time she has sex.
- If she has sex while she is menstruating.
- If her periods are irregular.
- If the man withdraws before he ejaculates.
- Until she reaches menopause.

Sometimes girls and women delay for personal reasons. Women, especially when they are young, feel shy, ashamed or scared to let other people know that they are sexually active. Also the kinds of relationships they have with their sexual partners can make them hesitant or afraid to find out if they are pregnant. Sometimes, they delay because they want to wish the pregnancy away, especially if it is unplanned and they feel ambiguous about the idea of it.

Sometimes women delay it because of system reason. Some say they delay testing for pregnancy because of the long waiting times as well as the lack of privacy at clinics. Sometimes, when women go to test early on in their pregnancies, they are instructed to return in a month or two. Some are even told to come in the second trimester. This happens for several reasons.

- The antenatal care schedule begins at 14 weeks, so it does not encourage ***early testing*** for pregnancy.
- There may be are no pregnancy test kits at the clinic. Women are encouraged to come in when their pregnancy is visible and can be confirmed by palpation.
- The nurses may have negative views on abortion, especially a woman's right to choose to terminate.
- The nurses may be judgemental of the women who are pregnant – especially if they are young or are foreign.

5

AS A HEALTH WORKER...

- Know where women can get a pregnancy test in your area.
- Encourage women to test AS SOON as they think they could be pregnant.
- Support women's right to choose.
- Encourage women who self-test to get booked for ANC early.
- Remember ANC only begins at 14 weeks.

EARLY PREGNANCY DETECTION

WORK IN GROUPS

Share ideas about why women should test for pregnancy as early as possible.

Pregnancy is life changing, so you probably can think of many good reasons why a woman should know if she is pregnant or not. And you are right. Women's personal and social circumstances are very different. Many pregnancies are unplanned. So, the first and most important reason for a woman to find out if she is pregnant as early as possible is to empower her. The earlier she knows her pregnancy status, the more she can make informed choices about her body, her health and her future.

Her choices depend on her pregnancy status.

How can a negative pregnancy test become a way to empower a woman to take charge of her body and her health?

Not pregnant

If a girl or a woman tests negative she is not pregnant. But she still needs health care support. The fact that she thought she might be pregnant suggests that she had unprotected sex. She also had unsafe sex. She may also not know enough about her body. She may not know enough about her health.

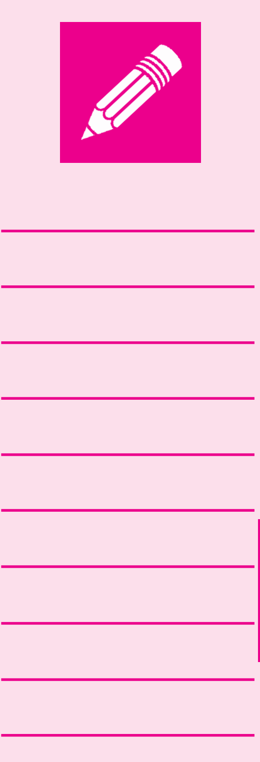
Pregnant

If she tests positive and finds that she is pregnant early, she has the greatest amount of choice. This applies whether she decides to stop the pregnancy or to keep the pregnancy.

Termination of pregnancy

Termination of pregnancy (ToP) means to intentionally bring a pregnancy to an end by medical means. Pregnancies can also end unintentionally. When this happens, it is called a miscarriage. Both ToP and miscarriage are forms of abortion. Abortion is the loss of pregnancy 'through the premature exit of the foetus, foetal membranes, and placenta (the products of conception) from the uterus'.

In South Africa, a woman can **choose to safely and legally bring an end to a pregnancy medically** if she does not want to have a baby. The law is there to support a woman's right to choose. It is there to reduce the harms of illegal and unsafe abortion. And it is there to protect the life and health of the child.



The conditions and rules for termination depend on how far along the pregnancy is.

DID YOU KNOW?

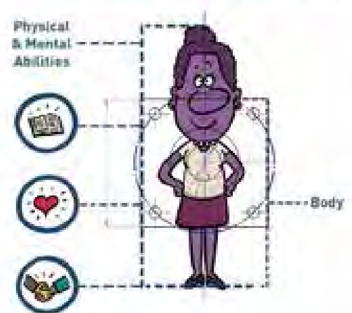
Termination of pregnancy
(Choice on Termination of Pregnancy Act [1996, amended 2008]).

Between 0–12 weeks of pregnancy – a woman can terminate her pregnancy for any reason. The person responsible for the termination must be a registered nurse or midwife or other qualified health professional.

Between 12–20 weeks of pregnancy – a woman is only allowed to terminate a pregnancy if it was the result of rape, incest or if her health is at risk. This abortion has to be carried out by medical doctor.

After 20 weeks – termination is only allowed if the women's health is at risk. The termination must be done at a designated government hospital.

In South Africa about 90,000 women a year end their pregnancies safely and legally. However, about 90,000 women also have unsafe, illegal abortions every year. There are several reasons why about half of all women who end their pregnancies have unsafe and high risk illegal abortions. Many decide to end the pregnancy late, after the period permitted by law. Many are afraid to be seen in official clinics that provide these services. Many do not know how to recognise dangerous, illegal and unsafe providers. Many women do not get the help and support they need in time to make an informed choice.



Illegal abortions can end very badly for women, often causing infertility, infection and even death.

They can also end in very serious outcomes for the babies, especially when the termination fails.

Danger signs after an abortion or ToP

A woman needs to get immediate medical help if she has any of the following signs

- Increased bleeding (not light flow or spotting)
- Continued bleeding for two days
- Fever, feeling ill
- Dizziness or fainting
- Abdominal pain;
- Backache
- Nausea or vomiting
- Foul-smelling vaginal discharge.

Trained medical professionals do legal and safe ToP in two ways. They either prescribe medication (pills or tablets) or they do a surgical procedure.

✓ Medication is used ONLY when women are between 4 to 9 weeks pregnant.
  - Two different pills are taken within 24 hours.
  - The process of expelling the content of the uterus can take a few days. It can feel like a miscarriage.
  - It has a very low failure rate.

✓ Surgical removal is used for ToPs between 9 to 20 weeks. A trained health care professional inserts certain instruments through the vagina into the uterus. These gently suck out the contents without doing any harm to a woman's reproductive system. In addition, depending on how far along the pregnancy is, medication and some tools will be used to soften and open the cervix.
  - The ToP process takes a day at a clinic or hospital.
  - The procedure itself does not take long. But it is longer and more painful the more advanced the pregnancy.
  - It has a very high success rate.
  - There are some risks, like excessive bleeding and infection, but these do not happen often.

Trained medical professionals also follow strict and clear professional health care practices for both methods.

✓ They always do pre-care counseling. They do this to ensure that the person is making an informed choice and is aware of the whole procedure and the risks.

- ✓ They always do a clinical examination. They do this to determine how far along the pregnancy is and to check if there is any medical issues that they must be aware of, like high blood pressure.
- ✓ They always book a post-procedure appointment. They do this to check that the procedure worked well, and that there are no complications (like excessive bleeding).

DID YOU KNOW?

The three rules to help women recognise professional, safe and legal ToP service providers.

1. **A trusted name** – like Marie Stopes or a clinic or general practitioner approved by the Department of Health.
2. **A fixed address and a landline in a clinic or medical practice** – not a street corner, flat or house; not just a website and a cell number.
3. ToP services offered are within the law and follow professional standards.

Women choose to end a pregnancy for a number of personal, social and economic reasons. These are things like:

- She did not plan the pregnancy.
- She does not feel personally ready or economically able to raise a child.
- Her own health is poor.
- There are risks to the baby.
- She has completed her family and does not want any more children.

AS A HEALTH WORKER...

Respect a woman's right to choose to legally terminate a pregnancy with little danger to her health.

- ✓ Help her know about her pregnancy as early as possible
- ✓ Support a woman's choice to terminate a pregnancy.
- ✓ Assist her to get safe, legal and professional help as early as possible.

Whatever the reason, it is important for everyone to know that the decision to end a pregnancy is always hard for the woman. It affects all the dimensions of her as a person. She needs support before, during and after the procedure.

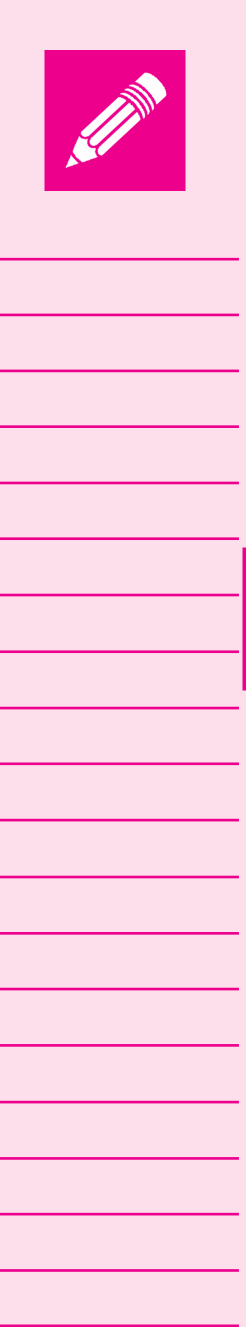
AS A HEALTH WORKER...

- ✓ Support a woman before, during and after the ToP
- ✓ Show empathy. This means being present, listening, guiding, offering a general feeling of being cared for.
- ✓ Know the facts.
    - Know when and how to test.
    - Know who can provide counselling and ToP services
    - Know what ToP is and when to do it.
    - Know how to provide after care and support.
- ✓ Do not judge. Remember a health care worker is there to provide the best available care to a girl or a woman who can make decisions for herself.
- ✓ Encourage physical self-care. This means bed rest, safe sex, no insertions, effective contraception.
- ✓ Help restore psychological well-being. This means supporting self-acceptance, self-kindness, self-esteem and creating quality relationships.

Continuation of pregnancy

Testing for pregnancy gives a girl or a woman the choice to make a decision to continue with the pregnancy. She chooses to be pregnant because she planned it. Or, more often, she decides she wants the baby now that she knows she is pregnant. Her decision to keep the pregnancy sets in motion other kinds of actions and choices that she can make. When she knows about her pregnancy early on, she is able to ensure her own and her baby's health throughout the pregnancy, during delivery and after the baby is born.

Most women have healthy pregnancies. Most women also give birth to healthy babies. But being pregnant and developing from an embryo into a human being has health risks for both the woman and the unborn baby. This is because of all the changes that they are both experiencing separately and together. It is also because newborn babies and infants are totally dependent on the people who care for them once they are in the world.



5.4 Risks to Women, Mothers and Babies.

There are risks for women and babies in the journey into life, motherhood and childhood. When we know the risks that they face, we can act, with them, to prevent the danger or reduce any possible harm.

Risks in health and health care are the things that put a person's health and well-being in danger. In order to do something about these risks, we need to identify what they are. We need to work out where they come from and if they can be prevented or controlled. And then we have to find ways to manage, control or prevent them.

Risks to the mother and baby during and after pregnancy come from three sources.

1. Risks can come from the pregnancy and delivery process itself.
2. Risks can come from other health conditions that affect the woman and the baby before, during and after the pregnancy.
3. Risks can come from the way people behave and relate with one another in society at all points along life's journey.

Pregnancy risks to health

There are well known risks that are related to the pregnancy itself. They are sometimes called complications of pregnancy. Some of these can be prevented. Some cannot be prevented. All of them need to be managed to try and ensure the best possible health outcomes for everyone.

Below are some common complications of pregnancy that every health care worker and pregnant woman should know about.

Anaemia

Anaemia in pregnancy is when a woman's body does not produce the amount of red blood cells it needs to support the growth of her baby. Anaemia can become a serious problem for her and the baby if it is severe, untreated or lasts a long time. Anaemia can be prevented and managed through diet and supplements.
During pregnancy every woman should

- Try to eat iron rich foods regularly, like beetroot, red meat, spinach, sweet potatoes, madumbi, etc.
- Take iron and folic acid supplements.

Gestational diabetes

Gestational diabetes is diabetes that first develops when a woman is pregnant. The pregnancy causes an imbalance between the body's blood sugar levels and the hormone insulin. It usually develops in the second half of the pregnancy. Gestational diabetes is a very serious condition. It can lead to the baby being preterm. It can also cause the woman to develop high blood pressure and preeclampsia.

Gestational diabetes can be controlled. The first step is to help a pregnant woman get and keep her blood sugar level normal. She can do this by changing her eating patterns and what she eats.

To control gestational diabetes a pregnant woman needs to eat often (about every 3-4 hours). She needs to control the amount of carbohydrates she eats. And she needs to change the kinds of carbohydrates she eats.

Most women with well-controlled blood sugar levels deliver healthy babies without any complications.

AS A HEALTH WORKER...

- ✓ Help and support a pregnant woman to know and choose good, high value carbohydrates.
  - ☺ Eat brown rice, brown bread, beans, lentils, madumbi, sweet potatoes, yoghurt, and milk.
  - 😐 Limit fresh fruit and sweet vegetables like butternut and beetroot, because they have high levels of natural sugar
  - ☹ Avoid sugar, honey, syrup, sweets, puddings, cakes, biscuits, Oros, sodas including diet sodas, fruit juice, canned fruit, and chakalaka.
- ✓ Help and support her to plan her eating
  - ☺ Create a daily eating routine and learn about portions.

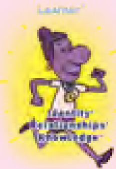
- ✓ Help and support her to keep track of the amount of carbohydrates she eats and drinks every day.
- ✓ Help and support her family to understand the importance of managing diabetes through healthy diet.

Urinary tract infection (UTI)

A UTI is a bacterial infection in the kidneys, bladder or the passage through which a person passes urine (pee). UTIs are common in pregnancy, especially during the first and second trimester.

A woman may have a UTI

- if she has pain or burning when she passes urine (wee).
- if she feels tired, shaky or have a fever.
- if she needs to use the bathroom often.
- if she feels pressure in the lower belly.
- if she feels nausea or back pain.
- if she notices her urine smells bad or looks cloudy or reddish.



AS A HEALTH WORKER...

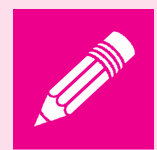
- If a woman thinks she has a UTI, it is important for her to see a health care professional to get tested and treated.
- If it is a UTI she will need to take an antibiotic.
- Remind her to take the medicine every day until the tablets are finished in order to control the infection.

Perinatal depression and anxiety

The biological, physical and social changes that are part and parcel of pregnancy and childbirth affect the psychological well-being and mental health of all women. They cause all women to experience emotional ups and downs. Sometimes, however, they can cause mental health problems. They can also trigger new episodes of existing mental health conditions.

Two common mental health problems that girls and women can experience during pregnancy and in the months after giving birth are depression and anxiety. About one in five women experience depression or anxiety during pregnancy in South Africa. Depression and anxiety often go together.

Perinatal depression is depression in the period around the pregnancy. There are some important facts that everyone should know.



- ✓ Women can become depressed during pregnancy as well as postpartum, which means after giving birth.
- ✓ Postpartum depression usually develops within six weeks of giving birth. It can develop slowly or suddenly. It can go on for a year or more after giving birth. It is not the same as 'baby blues'.
- ✓ 'Baby blues' is a brief period of feeling emotional and tearful. It happens to most women as their bodies readjust to not being pregnant. Baby blues usually happen around three to 10 days after giving birth. It usually lasts for a few days and it is generally quite manageable.
- ✓ Women who have perinatal depression may feel sad, down, tearful for no apparent reason, worthless, hopeless about the future, tired, unable to cope, irritable, angry or guilty.
- ✓ Women who have perinatal depression may not be able to concentrate. They may have difficulty sleeping, have no appetite or show no interest in or are hostile to the baby. They may show no interest in or are hostile to their partner or other people around them. They may also feel hopeless and have thoughts of death.

AS A HEALTH WORKER...

you must

- ✓ be well informed about psychological well-being and ways to respond to depression and other mental health conditions (go to 4.5 and 4.6).
- ✓ support women to learn to take care of themselves and their babies.
- ✓ encourage the people around the women to recognize their condition and support their recovery.
- ✓ get professional mental health support for the women.

5

Perinatal anxiety is anxiety experienced during pregnancy and for up to one year after giving birth. Feeling anxious during pregnancy or after giving birth is not unusual. However, when anxiety affects a woman's ability to do everyday things, it may be a mental health problem.

Some pregnancy related anxiety disorders that may be not well understood by women or the people around them are obsessive-compulsive disorder (OCD) and post traumatic stress disorder (PTSD).

Perinatal obsessive-compulsive disorder is OCD during pregnancy or in the year after giving birth. OCD has two parts:

1. Intrusive thoughts, repeated ideas or urges are called obsessions.
2. Repetitive activities that are compulsive, which means that the person feels they have to do them.

Women with perinatal OCD can have intrusive or disturbing thoughts about many things, like accidently hurting the baby in some way, being responsible for the baby contracting a disease, making wrong decisions, worrying about germs, etc. They respond to these worries by doing the same things over and over again. For example, a pregnant woman or mother who has obsessive thoughts about germs and causing the infant or baby to get sick may repeatedly wash and clean clothes, the house, the yard or even the baby. She may avoid people and places in pregnancy that she thinks will make her or the baby sick. She may make her partner, family members or other people go through cleaning rituals or even change their clothes before they can hold the baby. She may even not let them touch the infant or she may not take the infant out.

AS A HEALTH WORKER...

You must be well informed about psychological well-being and ways to respond to anxiety and other mental health conditions.

- ✓ Support women to learn to take care of themselves and their babies.
- ✓ Encourage the people around the women to recognize their condition and support their recovery.
- ✓ Get them professional mental health support.

Post-traumatic stress disorder (PTSD) is an anxiety disorder that is the result of a traumatic experience. In pregnancy, PTSD is a shocking, unexpected or traumatic experience before, during or after being pregnant.

PTSD can be triggered by any form of trauma including:

- ☹ Rape, abuse or interpersonal violence of any kind.
- ☹ Miscarriage, stillbirth or infant death.
- ☹ Long and painful birth or any emergency treatment.
- ☹ Unexpected and inappropriate behaviours from health care workers during delivery.
- ☹ Unexpected outcomes in her own or the baby's health.

There are several symptoms of PTSD including:

- Flashbacks or nightmares that cause the woman to re-experience the trauma.
- Avoiding thoughts, feelings, people, places and facts associated with the traumatic event.
- Irritability, difficulty sleeping, hypervigilance and extreme nervousness
- Anxiety and panic attacks.
- Feeling a sense of unreality and detachment.

PTSD in the period around pregnancy and childbirth is strongly associated with preterm delivery, preeclampsia, poor infant health and development, and poor maternal-infant attachment.
PTSD can impair a woman's relationship with the people who she needs to help and support her recovery.

AS A HEALTH WORKER...

- ✓ Let women know that it is not their fault.
- ✓ Help family and friends to recognize PTSD and encourage them to support their recovery.
- ✓ Get women professional mental health support.
- ✓ Be well informed about psychological well-being and ways to respond to depression and other mental health conditions.

5

Ectopic pregnancy

An ectopic pregnancy is when the fertilized egg cell implants itself and grows outside the uterus, usually in the fallopian tube. Ectopic pregnancy puts a woman's health in danger and it cannot support foetal growth. Although it is not always easy to know if a pregnancy is ectopic, there are some common danger signs.

A woman needs **urgent medical attention if thinks she might be pregnant** and

- She feels generally unwell, faint or dizzy.
- She has sharp or stabbing pain in the abdomen, at the tip of the shoulder where it meets the arm, or when going to the toilet.
- She has vaginal bleeding that does not stop (heavy and light bleeding).

Miscarriage

Miscarriage is spontaneous abortion. More than half of the time, miscarriages happen because of genetic defects and other biological reasons, including hormonal problems and abnormalities of the uterus. These mostly happen in the 1st trimester of pregnancy, because these kinds of defects in nature would prevent a baby from being able to survive.
The main social risks for miscarriage are drinking alcohol, undiagnosed or poorly managed health conditions, infection, lifting heavy things and working. These often cause miscarriage in the 2nd trimester or stillbirth in the 3rd trimester.

AS A HEALTH WORKER...

- Know that miscarriages and stillbirths are especially hard emotionally and physically for mothers and their families.
- Support mothers to recover physically and emotionally.
- Encourage partners, family members and friends to support them.
- Use the same techniques you learnt to support women after ToPs.
- Help women reduce the social risks of miscarriage.

Preeclampsia

Preeclampsia is a very serious complication of pregnancy. It can develop anytime between the 20th week in pregnancy until the end of the first week after delivery. It happens when a pregnant woman has high blood pressure AND a high level of protein in her urine (proteinuria).

Preeclampsia can cause a baby to be delivered before the foetus is fully grown. These babies are four to five times more likely to have problems soon after birth. Preeclampsia can cause the mother to have seizures as well as liver and kidney damage. It can also cause her death.

There are several symptoms of preeclampsia.

- Vision problems, including blurred vision or being oversensitive to light.
- Severe headache that won't go away.
- Swelling, especially around the ankles and feet, and in the hands and face.
- Pain in the upper right abdomen where the liver is located.
- Difficulty breathing.
- Sudden nausea or vomiting.
- Confusion.

Symptoms of preeclampsia can come on gradually or they can flare up suddenly.

There are both natural and social risks for preeclampsia. A woman is more at risk for eclampsia:

- If she is younger than 17 or older than 35.
- If she is pregnant for the first time.
- If she is carrying more than one baby (multiple births).
- If she has diabetes or develops diabetes during pregnancy.
- If she has high blood pressure.

AS A HEALTH WORKER...

- ✓ Be aware of women who may be at risk for preeclampsia.
- ✓ Be aware that preeclampsia symptoms can become very severe or combine with seizures. This is a medical emergency. **Get immediate medical help to save the lives of the mother and the baby.**
- ✓ Make women and their families aware of preeclampsia.
- ✓ Make sure women with preeclampsia are monitored and managed by health care professionals. The goals are to prevent the condition from getting worse, to prevent preterm delivery, to keep the mother healthy, and to keep the baby healthy.

Health risks during and after pregnancy

The health of women, mothers and babies is vulnerable to any infection, health condition or disorder that exists before or develops in the period around pregnancy and after giving birth.

Everything you know about these conditions and how to manage them has to take into account the pregnancy and the health care of mother and baby after delivery.

In South Africa there are well known infectious diseases and chronic conditions that cause complications in pregnancy. They are things like HIV, syphilis and other STIs, TB, diabetes, high blood pressure and heart disease. (Go to section 4)

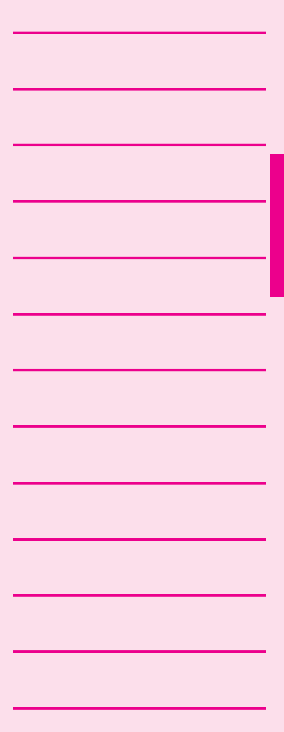
Asthma and epilepsy are also common serious medical conditions that can complicate pregnancy. Everyone needs to know about these conditions.

Asthma

Asthma is caused by an inflammation of the airways. People with asthma often make a whistling or squeaky sound when they breathe out. This is called wheezing. They also feel short of breath and 'tightness' in their chest. In pregnancy when a woman has trouble breathing it affects the amount of oxygen she and the baby get. The intensity of asthma can change from day to day, month to month and season to season. The pregnancy can make the asthma worse for some women. This often happens in the third trimester (24 to 36 weeks) but mostly not during delivery. When asthma is severe, it can increase the risk of certain complications with the baby. Asthma can be controlled through preventative measures, like avoiding the things that trigger asthma attacks and getting vaccinated for flu. It can also be controlled with asthma medications.

AS A HEALTH WORKER...

- ✓ Inform women and their families about asthma and the importance of managing and controlling it.
- ✓ Help women reduce the stress and anxiety that comes with having an asthma attack or fear of having one.
- ✓ Get clinical support to help her manage and control asthma.



Epilepsy

Epilepsy is when a sudden rush of electricity to the brain causes it to seize. It is a chronic disorder. Pregnancy may complicate epilepsy. Epilepsy that is well controlled for nine months before pregnancy usually stays controlled during pregnancy. But pregnancy can change the pattern and nature of seizures. This can be because of the kind of epilepsy a woman has. It can also be because pregnancy can affect the levels of epilepsy medicine in the bloodstream. It can also be because of increased poor sleep or stress. The baby may be at risk during pregnancy if a seizure causes a pregnant woman to fall and injure her abdomen. A baby may also be at risk after birth if the mother does not learn to practice care giving techniques that take account of her risk of a seizure.

There are important ways to reduce the risks of harm from epilepsy during and after pregnancy that women and girls can follow.

AS A HEALTH WORKER...

- ✓ Know that women with epilepsy need extra care and support during pregnancy and after giving birth.
- ✓ Follow and share the advice in "Managing epilepsy during pregnancy" and "Managing epilepsy after giving birth'.

Tips for managing epilepsy during pregnancy.

If a woman is thinking about having a pregnancy:

1. She should start taking folic acid. This is a vitamin that all women should take before and during pregnancy. It can help prevent baby having a neural tube defect. Women with epilepsy and diabetes need to take higher doses (5 milligrams) because of the medications they take.
2. She should take folic acid for the first 12 weeks of pregnancy or longer.
3. She should get her epilepsy and treatment assessed as soon as she has a positive pregnancy test.
4. She should go for ANC at 14 weeks. It is good if she has someone who knows her epilepsy with her to support her. She should let the professional health care worker know she has epilepsy. She should provide him or her with a description of her seizures and the dates of the last three seizures. She should show the health professional her antiepileptic drugs (AEDs) and repeat prescription.
5. She must not stop her medication. Suddenly stopping or reducing AED doses may cause an increase in seizures and be a risk to her life.
6. She must get urgent advice from a doctor if vomiting is causing her to have problems taking AEDs. Vomiting and diarrhoea can affect the absorption of AEDs and can cause seizures.
7. She must let you and the health team know if she has a seizure.
8. She must be asked about any infection. It is important that she takes extra safety precautions to prevent infection because infection can trigger seizures.
9. She needs help to manage her rest and sleep. Lack of sleep can trigger seizures.
10. She needs help to manage stress, depression, anxiety or more serious mental health conditions.

Tips for managing epilepsy after giving birth.

1. Advise new mothers about Vitamin K for baby to reduce the risk of haemorrhagic disease.
2. Help new mothers avoid the things that can trigger seizures. These are things like forgetting to take epilepsy medicines, not getting enough sleep, not eating regularly, getting overtired, getting overstressed.
3. Support a new mother to get her AEDs assessed. They may need to be adjusted after pregnancy.
4. Encourage her to bath, change or dress baby on the floor to prevent injury if she has a seizure.
5. Encourage her to feed baby on the floor or a low surface.

6. Encourage family members to help a new mother keep track of infant feeds, changing and taking her medicines. Her medicines and the pregnancy may make her memory poor.
7. Help a new mother to make a care plan with family members and friends for the times when she has a seizure.
8. Help new mothers get long acting reversible contraception (implants or IUDs).

Individual and social risks during and after pregnancy

Many of the risks to women and babies during pregnancy and after birth come from people's behaviour and the social environment in which they live. These are the things we do to ourselves. They are also the things we do to each other individually and collectively as a society. Many of these risks are modifiable. This means that they can be reduced or even taken away altogether by changing what everyone does, through learning and practice.

We know that nearly everything that enters a women's body is shared directly or indirectly with the baby from the time it starts the journey into life right up until she stops breastfeeding.

Substances

There are several kinds of substances that people take for health, leisure or pleasure that can be a health risk to both the woman and the baby during and after pregnancy.

Prescription medicines

Prescription medicines are medicines that are given by doctors to women because they have a diagnosed medical condition (like HIV, TB, diabetes, hypertension, depression, epilepsy, asthma, etc.). They are meant for a particular purpose. Women with chronic conditions and some infections have to take medicines during pregnancy to manage their health problems. But not all prescribed medicines are safe during pregnancy. This is why it is important that pregnant women know how to manage prescription medicines during pregnancy.

- ✓ Pregnant women should always tell a health professional that they are pregnant.
- ✓ Pregnant women should always ask a health professional about taking any prescribed medication during pregnancy.
- ✓ Pregnant women should not stop taking medicine for any chronic condition during pregnancy without professional advice.

Over-the-counter medications including herbal remedies

Many women take over-the-counter (OTC) medicines. They use them to treat things like pain, coughs, or headaches. Not all OTC medicines are safe during pregnancy.

- ✗ Many medicines that you can buy in a supermarket or a chemist have not been tested for safe use during pregnancy and breastfeeding.
- ✗ Many medicines that you can buy in a supermarket or a chemist are not safe for infants and children under six years of age. This includes anything containing aspirin like ‘grandpas’, cough syrups, flu and cold medicines, etc.

Many women also take vitamins, supplements, teas, herbs and other concoctions. Herbal remedies come in tablets, powders, tinctures, teas, capsules, etc. They are also often marketed as ‘natural’. These herbal and other remedies are often taken because people have heard through advertising or believe that they can help them be or become healthy. Many of these remedies are not effective. Many of these remedies are not safe in pregnancy.

- ☺ Some vitamins and supplements are safe and are known to support the health of the mother and baby during pregnancy. These are things like **folic acid, iron, and multivitamins.**
- 😐 Many vitamins and herbs have no particular value to pregnancy or their value is not known.
- ☹ There are some herbs and supplements that can be dangerous in pregnancy.
- ☹ Even when the herbs used may not be dangerous, the things that they are mixed with, the way they are made and the way they are stored, can make them unsafe for women, mothers and babies.

AS A HEALTH WORKER...

- Encourage everyone to always ask about the safety of any medicine for pregnant women, feeding mothers, infants and children.
- Encourage everyone to always read the labels of any tablet, syrup or remedy to find out if it is safe for pregnant women, feeding mothers, infants and children.
- Encourage everyone to avoid taking anything that they do not need.

Alcohol

Drinking alcohol is a serious risk to pregnancy.

- ☹ It can affect a woman's ability to fall pregnant.
- ☹ It can cause miscarriage, stillbirth and infant death.
- ☹ It can cause birth defects, growth restriction and disability for the baby.

Drinking alcohol is unsafe throughout the pregnancy and after delivery.

- ☹ Alcohol crosses the placenta. This means when a woman drinks during pregnancy, baby drinks.
- ☹ Alcohol enters into breast milk. This means when a woman drinks after delivery, baby drinks.
- ☹ In the first trimester alcohol affects crucial physical development of the foetus.
- ☹ During the second and third trimester alcohol affects babies' brain development.
- ☹ Babies of women who binge drink or drink regularly during pregnancy may be born with foetal alcohol syndrome (FAS). FAS will affect their physical and mental development and health throughout their lives.
- ☹ Alcohol in breast milk affects babies' sleep patterns. It makes them sleep less. It also slows baby's weight gain and decreases their gross motor skills.

Street drugs

Street drugs can directly affect the health of women (go to 4.7). They also directly affect infant and child growth and development during and after pregnancy.

- ☹ Exposure to any street drug during pregnancy increases the risks of premature birth and low birth weight.
- ☹ At birth, babies can be irritable, lethargic, unresponsive, and/or easily over-stimulated.
- ☹ Babies exposed to opioids can also suffer from withdrawal.
- ☹ Harmful use of substances after delivery disrupts caregiving. It can lead to insufficient feeding, inadequate feeding and emotional neglect as well as poor attention to infant health problems.

AS A HEALTH WORKER…

- ✓ Be aware that people often use different substances together and that this increases the health risks to mother and child.
- ✓ Treat babies as high risk when they live in environments where there is harmful use of alcohol and other substances.
- ✓ Help mothers find ways to reduce substance use harms to their own health and the health of their babies.

Smoking cigarettes

The chemicals in cigarette smoke are harmful to the health of ANYONE who inhales it (go to 4: Appendix 4 Facts About Smoking). This is true whether mothers smoke themselves or they and their babies are exposed to smoke in the air around them. Inhaling cigarette smoke during pregnancy affects foetal growth and can lead to premature birth.

Smoking also influences breastfeeding. Women who smoke are less likely to breastfeed. If they breastfeed, they also are more likely to breastfeed for a shorter period than women who don't smoke. Babies of mothers who smoke are often fussy at the breast. This is because nicotine influences the flavour of the milk and suppresses baby's appetite. Infants exposed to passive cigarette smoke are sick more often. They are likely to develop colic, middle ear infections, and breathing and digestive problems. And they are at greater risk of sudden infant death syndrome (SIDS).

The issues around cigarette smoking are complex for the individual and for the people around her. Many women who smoke try to stop during pregnancy. Even women who stop during pregnancy often go back to smoking after delivery. If they live with people who smoke, it makes it harder not to smoke. Also, they and their babies are exposed to the poisons from cigarette smoke in the air around them throughout the journey into life and through infancy and childhood. This is why it is important to try and reduce the harms of cigarette smoking in maternal and child health.

Seven tips to reduce the harms to mothers and babies caused by smoking cigarettes.

1. Cut down on the number of cigarettes smoked a day.
2. Try change the brand to one with less nicotine.
3. Breastfeed. It is not ideal to smoke and breastfeed, but it is worse to smoke and not breastfeed.
4. Try to smoke AFTER breastfeeding. Don't smoke before or during breastfeeding.

5. Try not to allow smoking around you and the baby. Don’t take baby into any enclosed area inside or outside the house where there is smoking.
6. Cover hair and clothing while smoking with something that can be taken off and left outside while attending to baby.
7. Wash hands and face after smoking.

AS A HEALTH WORKER...

- Use these seven tips to support women to reduce the harms of cigarette smoking on their own and their babies’ health.

Infections

HIV and other sexually transmitted infections (STIs), TB and Hepatitis are common and well-known risks to the health of everyone (go to 3.1 and 3.2). STIs and other infections during pregnancy, delivery or after giving birth can cause illness and serious health complications for the mother and the baby.

HIV

The risk of a woman being infected with the HI virus during pregnancy and after giving birth is three to four times higher than normal. This is because hormonal changes during and after pregnancy increase her physical risk for HIV infection. It is also because she often does not use a condom when she has sex during and after pregnancy. This happens even though many women worry about being infected with HIV by their partners.

There are several reasons why women have unprotected sex in the period around pregnancy. Many women did not use contraception and were not able to practice safe sex before becoming pregnant. In the period around pregnancy they often find it even harder to negotiate condom use with their partners. Also many women have mistaken beliefs about unprotected sex in pregnancy. They think things like ‘sperm makes the baby grow’, ‘hardens the fontanel’, or ‘makes the baby

look like him'. Many girls and women also feel more vulnerable in their relationships during this time. They want their partners to stay AND they don't want to be accused of not trusting them.

In pregnancy the baby is protected in a fluid filled sac inside the uterus. During vaginal sex the penis cannot touch the sac. The cervix (opening of the uterus) is closed. Sperm cannot enter the uterus. The baby does not experience sex.

During oral sex, blowing air into the vagina can be life threatening to the woman and the baby. Also, it is not safe to perform oral sex on genitals when a person has active cold sores (herpes or HSV). Unsafe anal sex is very high risk at all times. This form of sex carries the highest risk of transmitting HIV.

A woman who is newly infected in the period around pregnancy also increases the chances of her baby becoming HIV+. This is because she and her baby miss out on being treated with ARVs.

AS A HEALTH WORKER...

- ✓ HIV-negative pregnant and postpartum women are at high risk of HIV infection.
- ✓ Encourage them to ask for a second HIV test before they give birth.
- ✓ Help them to negotiate safer sex during pregnancy.
- ✓ Help them to negotiate safer sex after the baby is born.
- ✓ Encourage them to use a condom whenever they have sex.
- ✓ Help them plan for contraception to prevent future pregnancy.
- ✓ Help them get onto and stay on contraception immediately after delivery.

There are other common STI infections that are important to know about. Some of these are described below.

Herpes (HSV) is a virus that causes sores near the mouth ('fever blisters') or on the genitals. It is a very common virus in all populations around the world.

- ✗ Sexually transmitted HSV significantly increases a person's risk of becoming HIV+ and getting syphilis.
- ✗ Pregnant women who get infected with genital herpes late in pregnancy have a high risk of infecting baby with HSV during pregnancy or delivery.

- ✗ People who have active oral herpes can infect newborn babies and infants.
- ✗ Herpes in newborn babies is a serious and potentially life-threatening infection.
  - ☹ Symptoms of neonatal herpes include blisters on the skin, fever, tiredness, irritability, or lack of appetite.
  - ☹ HSV in babies can lead to brain damage, blindness, and damage to other organs.
- ✓ Get medical help immediately.
- ✓ Tell the clinician that you had herpes during pregnancy.

AS A HEALTH WORKER...

Get immediate help for a baby with symptoms of neonatal herpes.

Help women prevent HSV during and after pregnancy.

- ☺ Encourage them to ALWAYS use a condom.
- ☺ Encourage them not to let someone perform oral sex on their genitals if he/ she has an active cold sore on the mouth.

Help women learn to prevent babies and children from getting HSV.

- ☺ Encourage everyone to kiss babies on the forehead.
- ☹ Discourage mothers or carers from kissing baby on or near the mouth.

Bacterial Vaginosis (BV) is an infection that harms the normal (healthy) bacteria in the vagina.

- BV is common in women of reproductive age.
- Symptoms of BV can be vaginal discharge, fishy odour, itching, burning, or pain inside or around the vagina, especially when urinating or after engaging in sex. Sometimes there are no symptoms.

- There is an increased risk of getting BV by
  - ☹ Not using a condom during sex
  - ☹ Douching or 'cleaning' the vagina with a 'solution' (water mixed with other chemicals).
- BV increases a woman's risks of getting an STI.
- BV increases the risk of preterm delivery.
- BV increases the chances of full-term babies developing breathing problems and other health conditions.

Age

Being a teenager or a young adult increases the health risks for young girls and women and their babies.

Teenage and young adult pregnancy is common in South Africa. About one in five sexually active adolescent girls at school say they have been pregnant (22,2%) and have children (18%). At the time of pregnancy, about half of the girls and young women did not want to have a child.

The period between the ages of 10 and 19 is the second most critical period of physical growth in humans after infancy. During this time girls and boys achieve about 20% to 25% of their full adult height if they have proper nutrition. Becoming pregnant during this important growth period can lead to undernutrition that may cause girls to stop growing taller, especially if the baby is competing physically for essential nutrients.

Girls and young women are exposed to HIV, HSV and other STIs that affect their own and their baby's health. In terms of HIV

- 30 in 100 pregnant women of all ages who attend public health antenatal clinics in South Africa are HIV+.
- 12 in 100 pregnant teenagers (15 to 19 years old) are HIV+.
- 23 in 100 pregnant young women (20 to 24 years old) are HIV+.

Teen and young adult pregnancy also increases the risks for babies. Teenagers are more likely to deliver pre-term, low birth weight babies that can lead to neonatal death. The rate of neonatal death is nearly two times higher among teenage girls than among older women. In 2009, for example, 6.5 in every 100 babies died among teenage mothers under 18. This compares to 3.5 deaths per 100 babies born to all women.

Problems and Risks of Teenage and Young Adult Pregnancy	
Girls and young women who fall pregnant are	
PROBLEM	**RISK**
More likely to have started being sexually active before or around the age of 14.	• Physically immature • Emotionally immature • Socially immature
More exposed to assault and harmful substance use, especially if they are under 17.	• Socially vulnerable • Psychologically vulnerable • Physically vulnerable
More likely to drop out of school.	• Socially vulnerable
More likely to have had more than one partner in the previous year.	• Multiple partnering increases risk of HIV and STI infections
Less likely to have ever used contraception.	• Poor understanding of their bodies and reproductive health • Unplanned pregnancy
Less likely to know about the need for dual protection.	• Exposed to HSV, HIV, syphilis, and other STIs • Unable to negotiate safe sex
Less likely to have intended to become pregnant.	• Unprepared for pregnancy • Unprepared to use ANC
Less likely to want the baby	• Reluctant to care for infant • Poor understanding of basic infant care • Unaware of danger signs to newborn and children • Less likely to breastfeed • More likely to introduce inappropriate complementary food

5.5 Antenatal and Postnatal Self Care, Social Care and Service Care

Every person can learn to practice and support self-care, social care and service care to improve the health and well-being of women and babies before and after childbirth.

Self-care

Self-care is about the everyday things that a woman can do to support her physical and psychological well-being. It is also about the things she can do to reduce or prevent harm coming to herself or the baby while she is pregnant and after the baby is born.

Healthy eating

Healthy eating means taking in food and drinks that have enough nutrients to support your own and the baby's health through all the stages of life. Healthy eating from birth lays the foundation of a child's growth and development (go to 5.6).

Healthy eating in childhood reduces the risks of disease in adulthood. Research shows that girls and boys who were obese at four to eight years of age are 42 times (girls) and 19 times (boys) more likely to be obese at 16 to 18 years of age when compared with children who were not obese.

Healthy eating in adulthood means adapting to changes in the body. It means responding to being pregnant. It also means eating to prevent or help manage existing conditions like high blood pressure, diabetes and obesity. Many pregnant women are overweight or obese at the start of pregnancy. Because of this a number of them have anaemia and some develop gestational diabetes.

Maternal obesity and excessive weight gain during pregnancy increase the risk of gestational diabetes mellitus (GDM) and pre-eclampsia. They also increase the risk of pre-term birth, stillbirth and larger-than-average babies (birth weight >4 kg). All of these carry health risks for both mothers and babies during and after birth.

RECOMMENDED WEIGHT GAIN DURING PREGNANCY (US Institute of Medicine)				
Women's Body Weight (BMI)	Total Pregnancy – suggested weight gain	Trimester		
		1: Kgs per month	2: Kgs per month	3: Kgs per month
Underweight (<18.5 BMI)	12.5−18.0 kg	0,25– 1,00	1,75–3,50	1,75–3,50
Normal (18.5–25 BMI)	11.5−16.0 kg	0,25– 1,00	1,40– 2,00	1,40–2,00
Overweight (25–30 BMI)	7.0−11.5 kg	0,25–1,00	0,90–1,30	0,90–1,30
Obese (>30 BMI)	5.0−9.0 kg	0,00–0,50	0,68–1,00	0,68–1,00

Healthy eating is not about buying expensive things or following food fashions. Rather it is about being informed andmaking better rather than worse eating choices. There are seven good eating practices that

There are seven good eating practices.

1. Try eating enough of the right kinds of foods (see the healthy eating plate on page 250).
2. Try eating available and affordable fresh fruit, green leafy vegetables, grains, dairy and meat.
3. Try eating regularly. Take some food in small amounts, three to five times a day, every day.
4. Try eating things that have been properly cooked, properly heated and safely stored.
    - Food poisoning can be life threatening at any time in a person's life.
    - It is particularly dangerous during pregnancy, in infancy and early childhood.
    - It can cause miscarriage or infant death.
5. Try using iodized salt. You need iodine, but only small amounts of salt.
6. Try eating only small amounts of sugar.
    - Try eating fresh fruit rather than sweets, chocolates and cakes.
    - Cut down on the amount of sugar you take with tea and coffee.
7. Try taking micronutrient supplements every day in the period around pregnancy.
    - Many women need iron, Vitamin B12, calcium and folic acid.
    - Although we live in a sunny country, many women also need to take Vitamin D supplements, especially if they have dark skin or if they have fair skin but don't go into the sun.

There are also seven things to try and avoid during pregnancy.

1. Try not to lose weight during pregnancy.
    - Losing weight will affect the growth of the baby.
    - It will affect your health.
2. Try not to gain too much weight during pregnancy (See page 323 for the Recommended Weight Gain During Pregnancy).
    - Weight gain during pregnancy is necessary and normal.
    - The amount a woman should gain depends on her weight in kilograms (kg) divided by her height in metres squared (m2) (your height multiplied by your height: m2 = m x m) (or body mass index [BMI]) before she became pregnant.
    - Excessive weight gain during pregnancy is bad for the health of the mother and the baby before and after birth.
3. Don't eat liver or any raw, undercooked or half-warmed food.
    - Underprepared food can cause food poisoning.
    - Liver contains Vitamin A that can cause deformity in the foetus.
4. Try not to eat and drink things that can do you harm.
    - Cut down or avoid caffeine (coffee, soft drinks and energy drinks). Caffeine from these drinks pass through the placenta. It can affect the growth of the foetus and cause spontaneous abortion or stillbirth.
5. Try not to eat and drink things that have little or no nutritional value.
    - These are things like sweets, cold drinks, diet sodas, chewing gum, NikNaks, popcorn, deep fried foods, etc.
    - They cause weight gain without any benefits.
6. Try not to eat medicinal herbs and plants.
    - These can be dangerous to your health and the health of the baby.
7. Try not to eat soil, clay, ash or other non-foods.
    - They carry worms, parasites, bacteria and fungi that can cause serious health problems.
    - Eating these kinds of non-foods can be a sign of iron and other mineral deficiencies that are common in pregnant women and breastfeeding mothers.
    - Rather take supplements or eat food that contains iron or minerals.

Safe substance use

Safe substance use is about knowing about the effect ANY substance can have on your body and on the baby during and after pregnancy.

Prescribed and over-the-counter (OTC) medicines

TEN TIPS FOR TAKING MEDICINES.

Everyone needs to know the following.

1. The name of the medication.
2. How much to take at a time.
3. How often and for how long the medicine should be taken.
4. How to take the medicine – should it be swallowed; breathed into the lungs; inserted into the ears, eyes, or rectum; applied to the skin; injected; etc.
5. Any special instructions, like should the medicine be taken before food, with food or after food.
6. How the medicine should be stored (e.g. in the fridge, outside the fridge, in a cool place).
7. How long the medicine can be safely stored for before it needs to be discarded.
8. Common side effects or reactions that occur with the medicine.
9. Interactions the medicines can have with other medications the person needs or wants to take.
10. What to do if a dose is missed.

AS A HEALTH WORKER...

you can help women and the people around them

- ✓ by encouraging them to only use medications that are essential for their health.
- ✓ by enabling them to use medication safely.

Cigarettes, alcohol and street drugs

All substances, especially cigarettes and alcohol, are unsafe for the baby, so the less you use the better.

Cigarettes

Try to follow the 'Seven tips to reduce the harms to mothers and babies caused by smoking cigarettes'.

Alcohol

Alcohol use during pregnancy *puts HIV negative women* at high risk of practicing unsafe sex and getting infected with HIV and other STIs.
Alcohol use after pregnancy *puts ALL women* at risk of practicing unsafe sex that can lead to unwanted pregnancy.

There is *no amount of alcohol* that is known to be safe for baby during pregnancy.

- The same amount of alcohol that is in your bloodstream goes to the baby. The difference is that it stays there longer. That is why it is so dangerous!

There is *no kind of alcohol* that is known to be better than any other during pregnancy.

- Alcohol is alcohol.

There is *no time* during pregnancy that alcohol is known to be safe for baby.

- Alcohol is unsafe in all three trimesters.

There is *no time after* pregnancy that alcohol is safe for the baby or growing child.

- Alcohol passes through breastmilk to baby during feeding.

AS A HEALTH WORKER...

you can help women and the people around them

- by encouraging them to try not to DRINK AT ALL during pregnancy.
- by encouraging them to try not to DRINK AT ALL after giving birth.
- by *working with them* to reduce the harms of alcohol. Encourage them to
  - ✓ Ask for help and advice.
  - ✓ Find other ways to relieve stress and worry.
  - ✓ Limit any drinking to one glass a week.
  - ✓ Avoid binge drinking.
  - ✓ Avoid drinking regularly or routinely.

5

Street drugs

If you take street drugs, the risks for your health and your baby's health depend on the

- ☹ type of drug you use;
- ☹ its quality;
- ☹ how much you use;
- ☹ how often you use it;
- ☹ your lifestyle; and
- ☹ your health.

You can reduce the harms of substance use by reducing the amount you use, practicing safer ways of using, using alternatives and trying not to use some at all.

If you use ‘downs’ like morphine, codeine or heroin:

1. Try not to just quit – talk to a health person you trust.
2. Ask about methadone – it is safe for you and baby.
3. It is better to take tablets rather than to inject – this way you can prevent abscesses and infections. Also, it reduces the risk of HIV and Hepatitis C infection from needles.
4. Tell the health care provider you are using substances.

If you use ‘ups’ like crack, meths, cocaine and ecstasy:

1. Try not to use at all – these drugs are all cut with other things, which means baby is getting more than just the drug.
2. Try to cut down – they can cause miscarriage and preterm labour.
3. Try and eat well and rest and sleep enough – these drugs can make you forget to sleep and eat.

AS A HEALTH WORKER...

encourage women to disclose that they are using substances during pregnancy to their health care providers.

- ✓ This way they can get the right health care during labour and after giving birth for themselves and their babies.

Encourage women to ask for help with baby before they are overcome by stress.

- × Asking for help reduces the risks to her and her baby.

Help women have some sort of safety plan when they start feeling stressed. This can include

- ✓ calling someone to give her a break for a few hours;
- ✓ asking someone to check on her and the baby every day; and
- ✓ having a place to go that is safe for her and baby.

Safe sex

It is very common for women to have sex during pregnancy and after giving birth. It is also very common for women to **practice unsafe sex** during this time.

Unsafe sex in the period around pregnancy increases the risk of getting sexually transmitted infections, including HIV, for women who tested negative and for their babies. After pregnancy, it also increases women’s chances of unplanned pregnancy.

Safe sex means looking after your sexual health and learning how to stay safe.

To be sexually healthy you need to learn to take care of your health. You also need to learn to make safer decisions about sex.

SAFE SEX BEFORE, DURING AND AFTER PREGNANCY

<u>Before pregnancy:</u> safe sex means preventing infection and preventing pregnancy.

- ✓ Use dual protection – that is, it is safest to always use a condom and other forms of contraceptives (the pill, the injection, an IUD, or a patch).
- ✓ Condoms are used during these periods to control for infection, but they also control fertility.
- ✓ Other contraceptives are used to control fertility, but they do not prevent infections.

<u>During pregnancy:</u> safe sex means preventing the mother and the baby from contracting HIV, syphilis and other STIs.

- ✓ Condoms are used during this period to control for infection.
- ✓ Use condoms for vaginal sex.
- ✓ Use condoms for anal sex.
- ✓ Do not have oral sex if you have cold sores (HSV infection) on the mouth.

<u>After pregnancy:</u> safe sex means preventing infection and preventing pregnancy.

- ✓ Use dual protection – it is safest to always use a condom to protect yourself and baby from HIV and other STIs.
- ✓ Protect yourself from unwanted pregnancy.
    - There should be at least a two-year gap between pregnancies for your own and baby's health.
    - Long acting reversible contraception (LARC) like a contraceptive implant or an IUD is easiest to manage and the most effective way of preventing pregnancy.
    - Use contraception that is safe for baby while breastfeeding.

Contraceptives that Women can Control

DID YOU KNOW?

First line contraceptives

Implants, Hormonal IUDs and Copper IUDs are long acting reversible contraceptives (LARCs)

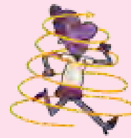
LARCs are first line contraceptives because they are the most effective and they can be used by all women, in all contexts. They are especially good for first time users, teenagers and young women, after abortion or termination of pregnancy and immediately after delivery (implants).
All three methods are 99% effective. This means that they prevent pregnancy 99 times out of every 100 times that they are used. This means that they work better at preventing pregnancy than the pill, the injection or condoms.
All three methods stop having any effect as soon as they are removed. This means the contraception is reversible.
All three methods can be stopped if a woman wants to become pregnant or if she experiences side effects that she can't manage.

Second line contraceptives

Hormonal pills and injections are second line contraceptives. They are still very effective, but there are more risks of pregnancy. Pills rely on women remembering to take them every day in a particular period of time. They also must be renewed in time to continue to be effective. The injection is not reversible for three months and it can take up to a year to fall pregnant after stopping it.

Third line contraception

Male condoms, female condoms and the diaphragm are third line contraceptives. They work but their effectiveness is reduced because they depend on continuous proper use to prevent pregnancy. They depend on women successfully negotiating with their male partners.



AS A HEALTH WORKER...

help women make better choices to prevent unwanted pregnancy.
Focus on the effectiveness of the method.
Use a 'LARC first' approach to contraception.

- ✓ Explain and encourage using an implant or an IUD before discussing injections and pills.
- ✓ Prepare girls and women for possible bleeding changes if they use an implant.
- ✓ Actively follow up on contraceptive use.
  - Intervene as soon as a woman has a problem or concern with her contraceptive.
  - This way you help women protect themselves from unplanned and unwanted pregnancy.
- ✓ Strongly encourage users to return to the clinic for advice, reassurance, treatment of side-effects or removal, if necessary.

Remind girls and women that only condoms protect against HIV and other STIs.

Sleep and rest

Sleep and rest are essential for human health. In the period around pregnancy, sleep and rest becomes even more important for women's physical and psychological well-being. Sleep helps them adjust to the many changes going on inside their bodies. Sleep helps them respond well to the caring demands that come from looking after a baby that is totally dependent on them.

During the first trimester of pregnancy it is normal for many women to sleep more than usual. Their bodies are working very hard to support growth of the embryo into a foetus and to create the placenta (the organ that nourishes the foetus until birth). During the second and third trimester, many women start to have trouble getting enough deep, uninterrupted sleep. There are several reasons why this happens.

The physical growth of the foetus can make it hard for them to find a comfortable sleeping position.

- ☹ Changing to sleeping on the left side (as doctors recommend) can be hard to get used to.

- ☹ Shifting around in bed becomes more difficult as the pregnancy progresses and the mother gets bigger.

Their need to pee increases.

- ☺ This is because the kidneys create more urine because more blood moves through a woman's body.
- 😐 Also, the pressure on the bladder (the sac that holds urine) increases as the baby grows and the uterus gets bigger.
- ☹ This means the number of night-time trips to the toilet may be greater if baby is particularly active at night.

Their heart rate increases.

- ☺ This is because the heart has to pump more blood.
- ☺ Also, the heart has to work harder to get blood to the rest of her body, as more blood goes to the uterus.

They experience shortness of breath.

- ☺ The increase of pregnancy hormones makes them feel like they need to breathe deeply.
- ☹ Breathing can feel more difficult as the uterus takes up more space and puts pressure against the diaphragm (the muscle just below your lungs).

They often experience leg cramps and backaches.

- 😐 The extra weight of the growing foetus can contribute to leg and back pain.

They often have heartburn and constipation.

- 😐 During pregnancy, the entire digestive system slows down. Food stays in the stomach and intestines longer. This may cause heartburn or constipation. Heartburn is when the stomach contents come back up into the oesophagus. Constipation is when it is difficult to pass stool.
- 😐 These can both get worse later on in the pregnancy when the growing uterus presses on the stomach or the large intestine.

Stress can interfere with sleep.

- ☹ During pregnancy, women often have vivid dreams or nightmares.
- ☹ They often start to focus on their worries when they are trying to sleep.

TEN TIPS FOR SLEEPING BETTER.

1. Try to get into the habit of sleeping on the left side with your knees bent from early on in the pregnancy.
   - ☹ This is likely to be the most comfortable position as your pregnancy progresses.
   - ☹ It makes your heart's job easier.
2. Try not to drink sweet drinks, coffee and tea. These often have caffeine. If you drink them, try drink as little as possible in the morning or early afternoon.
3. Don't drink alcohol or use street or over-the-counter medicines. These can make it harder to sleep.
4. Try to eat and drink a few hours before you sleep.
5. Try to get into a good sleep routine. Try go to sleep and wake up at the same time. Try to switch off lights, the TV, radio, and cell phone.
6. Don't do vigorous physical exercise just before going to bed.
7. Try to practice deep breathing to relax.

AS A HEALTH WORKER...

let women know that it is normal to have disrupted sleep during pregnancy.

- ✓ Short naps are better than no sleep.
- ✓ Encourage them to find ways to relax and rest, even when they can't sleep.

5

Physical exercise

Physical exercise is important for human health from earliest childhood through to old age. Some form of exercise is good for all pregnant women *as long as they don't* have a health condition that makes physical activity dangerous for them. Exercise helps reduce stress and maintain mental and emotional health. Exercise also helps manage weight gain during and after pregnancy, which is especially important for women who were overweight before becoming pregnant.

About half of all South Africans who are 15 years of age or older are not physically active. This means people do no or very little physical activity at work, at home, for transport or during discretionary time. Most people who are physically active do exercise because they have no transport or they have to do chores. What this means is that, for many people, including pregnant women, most of the things that they do in a day does not involve sustained physical activity.

Although most women believe that it is healthy to be physically active in pregnancy, many women are not. Also, among the women who do exercise, many reduce the amount of exercise they do as their pregnancy progresses. There are several reasons why women do little or no exercise during and after pregnancy. These include:

- 😐 They are tired, have little or no energy and find it difficult to move, especially during the last trimester.
- ☹ They don't know enough about exercising in pregnancy.
- ☹ They don't have people around them who exercise.
- ☹ They are discouraged from doing physical activities by family members and friends.
- ☹ They are not given advice about exercise during ANC visits.
- ☹ They can't afford to pay for exercise.
- ☹ There is no community based group exercise activities for pregnant women.

Pregnant women should try and do activities that are sensible, affordable and take account of their pregnancy. There are two rules of thumb:

1. The activity must be ***safe***. There should be minimum risk to both mother and foetus from falling or injury to the abdomen.
2. The activity must feel *comfortable* – especially as the pregnancy progresses.

DID YOU KNOW?

Walking is easy.

1. Set a goal – how long and how far. For example, if you have not been walking regularly, choose to walk for 20 minutes at a moderately brisk pace around a block, a field or a park.
2. Walk to see how many blocks or streets you can cover, during this time.
3. Repeat this activity over three or four days.
4. After that add a couple of minutes every week, pick up the pace a bit, and eventually add hills to the route.
5. Always take a few minutes to warm up and cool down.

5

The Dos and Don'ts of Exercise in Pregnancy

DO	DON'T
✓ Exercise when the weather is warm or cool.	× Exercise when it is hot and humid.
✓ Exercise regularly, most days a week.	× Exercise in intense bursts, followed by long periods of no exercise.
✓ Breathe properly while you exercise.	× Hold your breath while you exercise.
✓ Moderately intense exercise for 20 to 30 minutes at a time. Walk as fast as you can, swim up and down. Do it hard and long enough to start sweating. (Washing windows, mopping, and doing heavy laundry also count.)	× Exercise to exhaustion.
✓ Drink water before, during and after exercising	× Drink sweetened cold or warm drinks before, during or after exercising.

Pregnant women should avoid

- ✗ team sports;
- ✗ jumping, hopping, skipping, or bouncing;
- ✗ waist twisting movements and jarring motions; and
- ✗ bouncing and stretching.

Regular moderate exercise *during pregnancy* has several benefits.

- ✓ It can help reduce backache, constipation, bloating and swelling.
- ✓ It can *help prevent* or *help treat* diabetes.
- ✓ It helps increase a woman's energy levels.
- ✓ It helps improve mood.
- ✓ It helps improve posture, muscle tone, strength and endurance.
- ✓ It helps improve sleep.

After delivery, it is important to take into account how women delivered before they begin exercising.

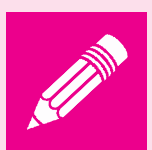
- ☺ Women can start exercising as soon as they feel comfortable.
- It may be a few days after uncomplicated vaginal delivery.
- It may be a few weeks after a difficult birth, complicated vaginal delivery or a c-section.
- Exercising should not hurt. If a woman feels pain or has any other symptoms she should stop the activity she is doing immediately and get help.
- ☺ Women should start slowly.
- Begin with gentle exercise, like walking and doing abdominal and pelvic floor exercises.
- It is important to take extra care of lower back and abdomen muscles. These areas are weaker than they were before pregnancy.
- Avoid team sports and contact exercises.
- Practice at any time.
- Ten minutes of exercise is better than none.

Regular moderate exercise *after pregnancy* has many benefits.

- ✓ It can help women feel less tired because it increases their energy levels.
- ✓ It can help improve mood and relieve stress.
- ✓ It can help improve sleep.
- ✓ It can help with weight loss.
- ✓ It helps women restore muscle tone.
- ✓ It helps build strength and endurance.

AS A HEALTH WORKER...

- ✓ Encourage women to be physically active before, during and after pregnancy.
- ✓ Encourage family and friends to be involved in regular exercise with pregnant women, new mothers and children.
- ✓ Help pregnant women and mothers get advice and support to be physically active.
- ✓ Initiate ANC and PNC exercise classes in the community.
- ✓ Initiate exercise and sporting activities for children in the community.



5

Social care

Pregnancy is an intensely personal, life changing experience for a woman. It changes her physically and emotionally. It also changes her socially because it changes her needs and relationships with the people around her.

Social care is the care and support that people, especially partners, family and friends, give to women in the period around pregnancy and childbirth. Social care is very important. It makes a significant difference to a woman's psychological well-being, her experiences of pregnancy and to the outcomes of the pregnancy. It also makes a significant difference to the health and well-being of the baby.

Women who have social support have better experiences of pregnancy and motherhood. They worry less about things and feel less distressed. Women who have little social support often feel hurt, uncared for, unheard and socially isolated. They find it harder to meet their practical, material, emotional and social needs.

Partners

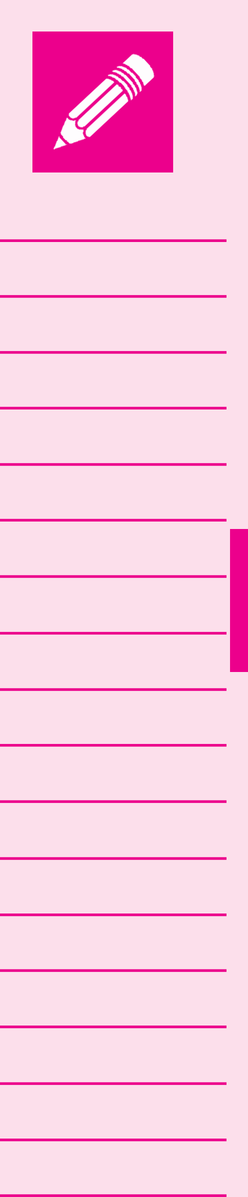
Most women hope to be supported by their partners when they fall pregnant and decide to continue the pregnancy. They feel this way even though the pregnancy is usually not planned or intended. They also feel this way even though their relationships with their partners are often not stable, steady or longstanding. Women hope for emotional support from men for themselves. They also hope for emotional and material support for their children. Mothers often need material and financial support, but they also want men to build bonds of love and affection with their children. They want men to be fathers who acknowledge and give their children a place in the world.

Men who commit to being fathers have the pleasure of receiving and giving love through a fundamental human relationship between a parent and child. They make women feel more valued and worthy in their role as mothers. They also help children develop self-worth, better psychological well-being and a greater sense of place in the world.

AS A HEALTH WORKER...

you can support men to be fathers.

- Encourage men to become involved in the care of their partners during pregnancy.
    - ✓ Help them understand the need to support women emotionally during pregnancy.
- Help men define their role as fathers after the child is born.
    - ✓ Encourage them to keep in touch. Children want to know their fathers. They want to hear from their fathers, even when they do not live with them.
    - ✓ Encourage fathers to show interest and to be kind and loving. Being a father is not about providing material things. Poor men are good fathers when they protect, guide, play and care for their children.
- Help women cope with challenges in their relationships during pregnancy and after giving birth.
    - ✓ Support them to cope with men's responses to fatherhood.
    - ✓ Encourage them to find ways to act in the best interest of the child.



Family

People's relationships with their families are complex. All women need their families for emotional, physical and material support during pregnancy and after giving birth. This need increases when they do not have a strong, secure or stable relationship with their partners.

Often women get support from family. Usually this support comes from their families of birth, although they can also get help from members of their partners' families. Mostly, they get help from female family members, like sisters, aunts, mothers, cousins or grandmothers. These women support them in practical and day-to-day things, as well as emotionally and materially. When male family members support them, they mostly provide financial help.

Unplanned and unintended pregnancy can also cause conflict between the pregnant girl or woman and her family. Sometimes she can find herself unsupported by her own and/or her partner's families.

These kinds of situations are often very stressful emotionally and financially. They can add strain to women's relationships with their partners. Also, they directly affect the quality of care mothers provide to infants in their first months and years of life. This is because family members often are the main source of information mothers have on child development and what is expected of them. It is also because social support from family (and close friends) gives mothers confidence about the way they are performing as mothers. This is especially important for women in their teens and early twenties.

AS A HEALTH WORKER...

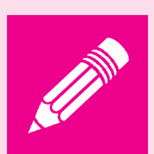
- ✓ Encourage women to talk about their need for support from family members.
- ✓ Help women find ways to develop or manage their relationships with family members.
- ✓ Help women find other sources of support when family members are not able or willing to assist.

Friends

Friends, like family, can be an important part of the social support to women when they are pregnant or become mothers. Women often talk to and get advice from their friends. Friends become especially important when women can't depend on their partners or family members for help. Sometimes they take on the emotional and practical support roles that family members often play. However, not all women have friends who they can depend on in this way.

AS A HEALTH WORKER...

- ✓ Encourage women to talk about the role they think their friends can play.
- ✓ Help women find ways to develop or manage their relationships with friends.
- ✓ Help women find other sources of support when friends are not able or willing to assist.



Community based organisations

Women are often part of churches, savings clubs and other organisations in their communities. During pregnancy many stop participating in events and meetings hosted by these clubs and organisations. Sometimes they do this because they are not allowed to attend or because they don't want to be judged or embarrassed because they are pregnant and not married. Sometimes they do this because they feel too tired or physically uncomfortable. Sometimes they don't have the money or the time to attend.
Even when this happens, often women from their churches and clubs provide them with support, especially older women. They visit and give them advice.

AS A HEALTH WORKER...

- ✓ Help women find ways to overcome feelings of rejection and isolation.
- ✓ Encourage women to be active in their clubs and churches during and after pregnancy.
- ✓ Talk to local churches, clubs and other social organisations about the role they can play in supporting women through pregnancy and motherhood.

Service care

Antenatal care and postnatal care are specific health care services. They are created by governments and health care providers to support women, children and their families. This is because

- pregnancy and childbirth are major events in the lives of women and families;
- pregnancy and childbirth are times of intense vulnerability that requires special attention; and
- pregnancy and childbirth are valued by all communities and all cultures around the world.

During this period all women of childbearing age or who care for children have the right to expect and to receive respectful care. All health care providers have the duty to provide respectful care.

RESPECTFUL MATERNITY CARE

The Universal Rights Of Childbearing Women

In seeking and receiving maternity care before, during, and after childbirth:

1. Every woman has the right to be free from harm and ill treatment.
2. Every woman has the right to information, informed consent and refusal, and respect for her choices and preferences, including the right to her choice of companionship during maternity care, whenever possible.
3. Every woman has the right to privacy and confidentiality.
4. Every woman has the right to be treated with dignity and respect.
5. Every woman has the right to equality, freedom from discrimination, and equitable care.
6. Every woman has the right to healthcare and to the highest attainable level of health.
7. Every woman has the right to liberty, autonomy, self-determination, and freedom from coercion.

AS A HEALTH WORKER...

- ✓ Make respectful care your practice in every interaction with women, babies and their families.
- ✓ Make sure that all women and family members involved in their maternal and child care know their rights to respectful care.

Antenatal health care (ANC)

The purpose of antenatal health care (ANC) services is to ensure the health of a pregnant woman and the growing baby during pregnancy. ANC services are designed to prevent and manage pregnancy-related risks to health and health-related risks to pregnancy. They are also meant to help women and the people who support them control and reduce the harms of the individual and social risks to themselves and their infants.

There are seven objectives of ANC health care services at facilities.

1. Check the status and progress of a woman's pregnancy.
2. Check the status of a woman's general health.
3. Check the status and progress of the foetus and unborn baby.
4. Check and treat any problems. These can already be present or they can develop during the pregnancy.
5. Promote and support the general health of women.
6. Promote and support the psychological well-being of women.
7. Provide information about pregnancy, labour and delivery, and new born and infant childcare.

ANC services are mostly provided directly to women when they attend at clinics and other health care facilities, including hospitals and private doctor practices. Community based services add extra value to facility ANC because they provide direct services to women and the people who will support them before, during and after delivery.

In the current schedule of visits to clinics, women are encouraged to go for eight ANC visits. Women who have high-risk pregnancies, may have to go to facilities more often. The first ANC visit is at week 14 of the pregnancy.

AS A HEALTH WORKER...

- ✓ Help women understand the difference between confirming pregnancy and starting ANC.
- ✓ Encourage women to test for pregnancy as soon as they think they might be pregnant. This gives them the chance to make an informed choice about their future.
- ✓ Advise women not to wait to confirm their pregnancy until they start ANC visits at 14 weeks or later.

Each antenatal clinic visit involves activities, including check-ups and tests, and information such as advice for the mother during and after she has given birth. These services all support the objectives of antenatal care.

What to expect at a first antenatal check-up.

The first antenatal visit

During a woman's first antenatal visit, the nurse or doctor will:

SCHEDULE OF ANTENATAL CARE VISITS FROM 1 APRIL 2017

Improved Antenatal Care visit schedule:

Week 14	Week 20	Week 26	Week 30
Week 34	Week 36	Week 38	Week 40

- ✓ Tell her how far she is in her pregnancy.
- ✓ Talk to her about how to keep herself and her unborn baby healthy. This should include a discussion on good nutrition; alcohol, smoking and substance use; safe sex and general self-care.
- ✓ Give her vitamin and mineral supplements.
- ✓ Check to make sure that she is generally healthy.
- ✓ Check for and treat infections, especially HIV and other sexually transmitted diseases.
- ✓ Find out if she is at risk of diabetes or anaemia so that these conditions can be managed.

Preparing for the birth also includes learning practical things. Carers need to be shown how to safely bathe and feed a baby. They need to be shown how to protect a baby from possible hazards or infections in the environment. And they need to know how to recognise and respond to signs that the baby's health is in danger.

AS A HEALTH WORKER...

- ✓ Encourage women to attend ANC early and frequently.
- ✓ Help women know what services to expect at different times during the course of a pregnancy.
- ✓ Help women and their families understand what they can do to keep the pregnancy safe.
- ✓ Help women and their families prepare for delivery.
- ✓ Help women and their families prepare for safe infant care and feeding.
- ✓ Help women and their families prepare to restore and retain their health and psychological well-being.
- ✓ Help women and their families know their right to respectful care.

Care during and immediately after delivery (Intrapartum Care)

Intrapartum care is the health care services women get during the process of delivery. This is the last part of the pregnancy and the first part of baby's journey into independent life. It is a very physical and emotional process that often is long and involves considerable pain and a lot of hard work.

Understanding delivery

The process of delivery usually follows three stages. Every woman is different. Every pregnancy is different. Every delivery is different, but most often it is a very hard and long physical process. It is always an emotional process.

Stage 1 lasts from the time contractions start until the cervix is fully dilated (open).

- The baby drops closer to the cervix.
- The cervix gets softer and thinner and eventually starts to open. The opening up of the cervix is called dilation. The cervix is fully dilated when the opening is 10 cm wide. This process can last a long time.
- The baby, the placenta and fluids can then start to move down the birth canal.
- Contractions can feel like aching in the lower back, period pain and pressure in the pelvic area. In the beginning they can be unnoticeable or mild. They can become very intense and painful.
- The labour is progressing when the contractions become stronger, follow a pattern, last longer and start coming closer together.
- The waters (the sac of fluid around the baby in the uterus) can break at any point.

Stage 2 is when the baby is pushed by contractions down the birth canal and out through the vagina into the world.

- Women can find the pain of each contraction very hard to bear.
- Women can also find it hard to manage not having time to recover between contractions.
- When the baby comes out, he or she should be put on the mother's tummy or next to her breast, skin-to-skin, as soon as possible.
- The cord that connects the baby to the placenta may be allowed to throb for a few minutes. This way baby receives more blood from the placenta, which boosts his/her oxygen supply and blood volume. The cord is then clamped in two places, about 1 cm and 4 cm from the baby's belly. Then it is cut with scissors between the clamps.

Stage 3 is the delivery of membranes (the amniotic bag that surrounded the baby during the pregnancy) and the placenta.

- The baby is born.
- The umbilical cord is cut.
- The uterus contracts again to push the placenta out.
- This is a very important part of the delivery. The whole placenta must come out. This prevents very heavy bleeding that can put the mother's life at risk.
- Stage 3 delivery can be done naturally – usually it takes about an hour and will require the woman to push.
- Stage 3 can be done actively with the assistance of a trained nurse or doctor. She will put her hand above the pubic bone to prevent the uterus from being pulled downward when the cord is pulled. With her other hand, she will then gently pull on the cord to help deliver the membranes and placenta. This is known as 'controlled cord traction' (CCT).

Delivery is a time when the woman and the baby need to be the centre of attention.

- The care they get has to respect their every need and wish.
- They need a lot of support.
- They need to be kept informed about the progress of the labour and what to expect.
- They need to be informed, comforted and communicated with in a way that is respectful.
- They need to be involved in any decisions about their care.

AS A HEALTH WORKER...

- ✓ Help pregnant women and the people who support them to know what to expect during and immediately after delivery.
- ✓ Remember very heavy bleeding after delivery is a medical emergency.
- ✓ Make sure that the people around the new baby and mother know the danger signs to mother and baby after delivery.

Quality care to reduce the risk of death and disability

When women do not receive the basic standards of health care at facilities before, during and after delivery they and their babies are at risk of disability or even death.

Health care professionals can reduce these risks by **following quality foetal and infant care** practices.

- ✓ Diagnose multiple pregnancy (twins +).
- ✓ Estimate foetal size accurately.
- ✓ Respond properly to poor uterine growth.
- ✓ Respond properly to poor foetal movement before and during delivery.
- ✓ Respond properly to baby's breathing after birth.
- ✓ Make sure baby is dry and warm.
- ✓ Be attentive and support mother–baby interaction.

Health care professionals can reduce these risks by providing **quality care practices to support women** during and after pregnancy.

- ✓ Check for syphilis, HSV, HIV, TB and other infections.
- ✓ Check for glycosuria (excess sugar in the urine associated with diabetes and kidney disease).
- ✓ Check for hypertension.
- ✓ Be aware of and responsive to the age of the mother.
- ✓ Be aware of and responsive to any pre-existing health conditions (like HIV, diabetes, depression, epilepsy, etc.).
- ✓ Be open and attentive to the mother's questions and concerns.
- ✓ Build a relationship of care and support.

When there are danger signs, everyone needs to act quickly. The passing of hours or days can mean the difference between life and death for the woman and the baby.

AS A HEALTH WORKER...

prepare women and the people who support them to become mothers and carers to the infant.

- ✓ Help them understand the physical and emotional changes that women experience after giving birth;
- ✓ Help them recognise changes in the womens' own health that may need attention; and
- ✓ Help them understand the importance of emotional and physical interaction between mothers and babies.

Postnatal care (PNC)

The postnatal period starts from when the mother gives birth and the baby is born. It lasts for about six weeks.

The postnatal period is a time of very big changes for the mother, the baby and all the people around them. It is a time of excitement, uncertainty and new learning.

- ✓ It is the beginning of baby's independent life, when it has to be supported to survive and thrive.
- ✓ It is the time when women go through very big physical and emotional changes as their bodies go back to the way they worked before pregnancy.
- ✓ It is the time when mothers, partners and families learn to care for the new baby.
- ✓ It is the time mothers, babies and families learn to interact with each other and the society around them in a new way.

But the hours, days and weeks immediately after being born and giving birth are also *a time of particular high risk* for both babies and mothers. It is a time when *mothers and babies* need support to survive and adjust to the changes in themselves, each other and the people around them.

Most often, mothers are the primary carers of their babies. There are times when this is not the case. Then, another person takes primary responsibility for the new-born, infant or child. She (sometimes he) becomes the surrogate parent.

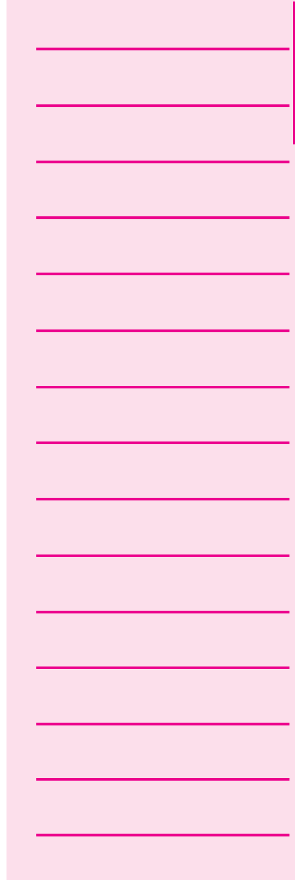
AS A HEALTH WORKER...

The postnatal period is when you can make the most difference to the health and life chances of mothers and new-borns. This is why health care providers are expected to provide specific postnatal care (PNC) services.

New-born and infant care

In health and care, we make a distinction between children by age and stage of development in the first five years of childhood. New-borns (or neonates in medical language) are babies under one month of age. Infants are babies between one and 12 months of age. Toddlers are babies between one and three years of age. Children from three to five years are pre-schoolers. After that, we think of children's health care both in terms of where they are in the schooling system as well as physical, mental and social development.

The first 28 days of life is critical to a baby's physical survival. In this phase, a mother or carer has to take great care to ensure that the baby is breathing properly and is being kept warm. It is also important to make sure that he or she is feeding well. Breastmilk is best because it is always ready made, safe and easy to get. It is very important that the mother or carer keeps the baby's umbilical cord clean and free of infection.



Babies are geared for human contact and communication because they are so dependent on care to survive. From the first moment of life they pay attention to human gestures, voices and faces. They express simple emotions through their movements and facial expressions. These emotions are the cues babies' give to their caregivers. Cues are their way of asking carers for help to calm, comfort, feed, sleep, play and respond to their needs. These cues also help create a bond of emotional commitment and physical responsibility.

By the second month after birth, the mother and infant know each other better. The baby has developed a routine. The mother or primary carer is also more confident in care-giving and understands her/his infant's needs and cues. But baby still needs 24-hour care and close attention. Carers still have to watch for and respond urgently to any changes in how the infant behaves or interacts. (See Appendix: Danger Signs in New-born Babies and Children.)

In fact, babies need care and protection throughout their childhood, even when they can walk and talk (toddlers) and start going to school (young children).

AS A HEALTH WORKER...

help make sure that babies and children:

- ☺ get the food that is right for their age;
- ☺ are played with, cuddled and comforted;
- ☺ are spoken and sung to;
- ☺ are loved and cared for; and
- ☺ are kept safe from harm.

Preventing and controlling infection

New-borns and infants are at high risk of infection because they have not developed resistance to many things that are around them. This means that **their health can change very quickly**. Four in ten babies who die before the age of five are new-borns. Most die in the first weeks of their lives.

Tips for preventing new-born and infant infection.

Every mother, carer or person who supports the care of baby should

- ✓ Wash their hands
  - after going to the toilet;
  - before and after touching food;
  - before breastfeeding; and
  - after changing soiled nappies.
- ✓ Keep baby clean –
  - Change nappies as soon as baby poos.
  - Sponge-bath baby until the cord has fallen off.
  - Change wet nappies often.
  - Put fresh clothes on baby.
  - Wash the blanket where she/he lies.
- ✓ Keep baby warm –
  - Avoid drafts.
  - Cover baby's head and feet.
  - Put on layers of loose clothes for baby.
  - Don't bath baby in cold weather.
  - Use warm water and bathe quickly.
  - Feed baby skin-to-skin but covered.

AS A HEALTH WORKER...

Everyone in the home must know to get urgent medical attention if baby is:

- ☹ very hot to the touch;
- ☹ cold to the touch;
- ☹ floppy and becomes inactive;
- ☹ having a fit; or
- ☹ yellow all over.

Everyone who provides postnatal care needs to understand and respond to a few common things that mothers and carers worry a lot about in the first weeks and months of the baby's life.

Umbilical cord care

The umbilical stump on baby's belly button is the part that is left after the umbilical cord is clamped and cut. It will dry up and fall off on its own. This can take anything from one to three weeks. Until baby's umbilical cord stump falls off it is important to keep it *clean and dry*. It must be cared for like any cut or wound on the skin that is healing.

Tips for infant cord stump care.

- ✓ Fold the nappy away from the stump. This way you prevent the stump from getting into contact with urine.
- ✓ Sponge-bath baby. Do not put baby's tummy under water until the cord has fallen off.
- ✓ If the weather is warm, leave the cord uncovered. Fresh air will speed up the drying process. Lift the baby's shirt or dress baby in loose fitting clothes.
- ✗ Never put salt, ashes, animal droppings (isiwasho), stuips (or any liquid) on or near the stump. These can cause serious infection and be life threatening.
- ✗ Never do cuts, incisions and mohlabelo. These can cause serious infection and can be life threatening.
- ✗ Never try to pull off the stump, even if it seems to be hanging by a thread. Pulling can tear the skin and cause infection.

Tips for infant cord stump care.

- ✓ Get medical help if there are signs of cord infection –
  - Baby cries when you touch the cord or the skin next to it.
  - The skin around the base of the cord is red.
  - The stump smells bad.
  - The stump has a yellowish discharge.

AS A HEALTH WORKER...

help mothers and carers

- ✓ practice good cord care;
- ✓ know the signs of cord infection; and
- ✓ get medical advice and help if they are worried about the cord.

Constipation

Many mothers and carers think a baby is constipated when he or she does not poo as often as they think babies should, (see Best food for babies op page 240). Constipation is not about how often baby poos (passes stool). Rather, constipation is when passing stool causes pain or bleeding and the poo is hard (and dry). The baby will groan or strain when trying to pass stool.

Tips to help new-borns and infants poo (pass stool)

- ✓ Breastfeed baby on demand.
- ✓ Make sure you prepare formula exactly – measure the amount of formula and add it to the recommended amount of boiled water that has been left to cool down. Do not add extra formula.
- ✗ Do not mix feed. Mixed feeding harms a baby's digestive system.

- ✓ Try moving baby's legs gently in the air as if she or he is riding a bicycle.
- ✓ Massage baby's abdomen in gentle large circles.
- ✗ Do not give baby an enema ('spuit'). It can make the baby sick and can even cause the baby's death.

Enema
An enema is the administration of water or liquid concoctions (like sunlight soap and water, or traditional medicines and water) through the anus.

Mothers or carers are sometimes advised to give their babies enemas 'to make them clean', for constipation, 'to treat internal wounds' thought to be caused by severance of the umbilical cord, for stomach pains and to protect baby against evil spirits.

Giving enemas to babies can be dangerous. They can cause floppiness, difficulty breathing, swelling of the body, dry mouth, diarrhoea, vomiting, jaundice, collapsed veins, inability to pass urine and intestinal obstruction. Enemas have caused babies to die from liver and kidney damage, intestinal perforation, brain damage, and lung and heart failure.

DID YOU KNOW?

New-born babies who are exclusively breastfed are hardly ever very constipated. Constipation is more common in formula fed babies and babies who are mixed-fed.

New-born and infant bowel movement – what to expect

A new-born baby usually first poos a dark green or black, tarry substance called meconium. Around the third day or so, the new-born baby should poo more often, especially if she/he is breastfeeding.
Breastfeeding new-born and infant babies

- ✓ may poo from one to four times a day.
- ✓ It is normal for them sometimes not to poo for one or two days.
- ✓ Their poo becomes a lighter brown, tan, or yellow colour.
- ✓ It is relatively soft or like curds.

Formula fed babies
- ✓ may poo one or two times a day.
- ✓ The colour and the consistency of baby's bowel movements are different.

The fontanelle

Mothers or carers sometimes worry about the soft spot on new-born baby's head. These soft spots are called fontanelles. They are where baby's skull bones have not yet come together. Normally they only join after being born. The fontanelle in front is on top of the head. It usually closes completely when baby is between seven and 18 months old. The smaller fontanelle is at the back of the head. It usually closes completely when baby is about two months old.

AS A HEALTH WORKER...

let carers know that

- the fontanelle should feel firm with a slight inward curve. It may bulge when baby cries, but it should go back to normal when baby is not crying and is being held with its head up.
- a **sunken fontanelle** *can* be a sign that the new-born or infant is severely dehydrated. BUT a **sunken fontanelle** *comes after other signs* of dehydration.
- to **prevent dehydration**, carers should
  - ✓ *watch for* fewer wet nappies;
  - ✓ *watch for* baby being less alert;
  - ✓ *watch for* baby not feeding;
  - ✓ *watch for* baby losing fluid through vomiting or diarrhoea;
  - ✓ *keep* breastfeeding or cup feeding little and often;
  - ✓ *not give* enemas ('spuit'); and
  - ✓ *not cause* vomiting.
- a bulging fontanelle that does not return to normal may be a sign of infection or another serious condition. If this happens, the baby needs medical help.

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Colour patches on the skin (birthmarks)

Colour patches on the skin are birthmarks. About one in three babies are born with a birthmark. Some are due to a stretching of blood vessels that make a patch of skin appear to be red. Some are due to changes in the pigment (colour) of the skin. Birthmarks often occur on the head and neck, but they can appear anywhere on the baby's body. The mark can become darker when baby cries or the temperature changes. It can fade when pressure is put on it. Some types of birthmarks will fade over time. Some need to be medically treated.

AS A HEALTH WORKER...

let carers know that

- ✓ most birthmarks are harmless.
- ✓ most birthmarks do not need to be treated. Many will fade on their own after a few months or years.
- ✓ some birthmarks, like port wine stains, do not fade.
- ✓ they should ask a health care professional if they are worried. A few birthmarks need to be treated by a doctor if they block a baby's airways or affect their vision.
- ✓ birthmarks **should not be treated** with mohlabelo (powders, ointments), stuips (mhuthi wenyoni, druppels, dutch medicine) and incisions.
  - × They have no effect on birthmarks.
  - × They are bad for baby's health.
  - × They can cause infection.
  - × They can make baby sick.

Sores and nappy rashes

It is very common for baby to develop a rash or a sore on the parts of his or her body covered by a nappy.

- Rashes around the anus are common during bouts of diarrhoea. This is because diarrhoea poo contains enzymes that irritate the skin.
- Rashes and sores around the anus can come from poo that is left on the skin. This is because it contains bacteria. Stool rash is also common on the scrotum or anywhere that poo can hide.
- Rashes and sores can be caused by soap or other irritants used to clean nappies. Rashes from irritants can get infected with yeast. Yeast infections are bright red and can be sore and weepy. These rashes can be sore and will make baby cry.

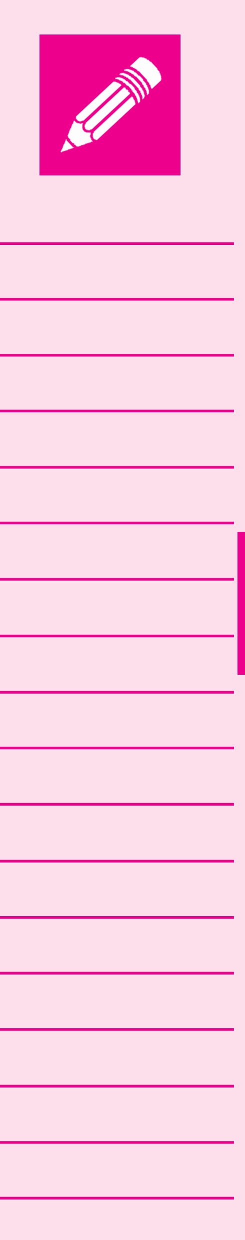
AS A HEALTH WORKER...

encourage mothers and carers to prevent and treat nappy rash.

- ✓ Change nappies often. Don't 'save' by using disposal nappies for too long.
- ✓ Rinse baby's skin with warm water after a poo. Clean the folds of skin carefully. Dry baby's skin properly.
- ✗ Don't use perfumed soap or cream on baby's skin.
- ✓ Rinse and dry cloth nappies thoroughly.
- ✗ Don't give baby an enema. It can irritate the sore and make the sore worse.
- ✗ Don't put toothpaste on sores by the anus or rashes.
- ✓ Get medical help for a yeast infection. It is a stubborn rash that can go onto baby's genitals, abdomen and thighs. It needs to be treated with a special cream.

Encourage mothers and carers to get urgent medical help if baby

- has a fever and the skin looks infected (spreading redness) or is coming off in sheets;
- is less than one month old with tiny water blisters or pimples in a group;
- or is less than one month old and the skin looks infected (yellow scabs, spreading redness).



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Women and mothers and carers

We all know that being pregnant and giving birth is very demanding on women physically, psychologically and socially. Women also need a lot of care in order to keep and restore their own health and well-being. And they need a lot of support to be able to take care of their babies.

Postnatal care is the health services that women are entitled to after childbirth and as mothers. Postnatal care should be a continuation of the care women received through pregnancy, labour and birth. It should take into account their individual needs and preferences.

The South African national health guidelines recommend two early PNC visits to clinics – one within six days post–delivery and the other at six weeks. These are intended to check the physical health of the mother and infant. They are also there to provide general and reproductive health as well as infant and mother care services.

Postnatal danger signs for women

Get medical help immediately if a woman experiences.

- Heavy vaginal bleeding,
- Fever or difficulty getting out of bed,
- Severe headache with blurred vision,
- Fast or difficult breathing,
- Severe abdominal pain,
- Pain, redness or swelling in her lower legs.

Go to the clinic as soon as possible if she has any of the following signs.

- Swollen, red or tender breasts or nipples,
- Problems urinating, or leaking,
- Increased pain or infection in the perineum,
- Infection in the area of the wound (redness, swelling, pain, or pus in the wound site),
- smelly vaginal discharge,
- severe depression or suicidal behaviour (ideas, plans or attempts).

Women should get medical help if they notice any signs that put their own health or the health of the baby in danger.

PNC visits should

- ✓ Check on women's physical and mental health.
- ✓ Advise and offer contraception.
- ✓ Provide vitamin supplementation.
- ✓ Support breastfeeding.
- ✓ Advise on nutrition and self-care.
- ✓ Provide immunizations.
- ✓ Raise awareness of danger signs.

PNC visits to support women at home are important. They provide the necessary extra guidance and support many individuals and families need.

AS A HEALTH WORKER...

- ✓ Encourage mothers to rest, eat well and drink lots of water. This way they can support their own health and meet the extra physical demands on their bodies of breastfeeding and looking after baby.
- ✓ Support exclusive breastfeeding and help prevent mixed feeding. This means helping mothers manage the initial discomfort and pain of breastfeeding.
- ✓ Check for risks to the health of the mother and the baby in the home.
- ✓ Make everyone aware of the importance of getting urgent medical attention if there are signs of danger to mother and baby.
- ✓ Inform mothers about what to expect at PNC clinic visits.

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5.6 Newborn and Infant Feeding

One of the most important decisions every mother or caregiver makes is about what to feed her newborn baby. This is because infant feeding is the start and the heart of health care and attention. It is the foundation of a baby's physical, mental and emotional growth and development.

Mothers (or carers) of a newborn baby have to make choices about infant feeding. There are four important things that influence their decisions:

- their own experiences and what they know about infant feeding;
- the infant feeding practices they see around them;
- their social and economic circumstances; and
- the support they are given by health care workers and the health care system.

It is hard to always know what to do in a world of change. There seem to be so many choices. And people live in circumstances that vary a lot.

So what does a mother (or carer) need to think about when deciding what to feed her new baby?

The most important thing that must guide her decision is the health and well being of the baby.

UNDERSTANDING INFANT FEEDING

WORK IN GROUPS

1. What's your experience of infant feeding?
2. Where do you go for advice and information about infant feeding?
3. Who is influences your decisions about infant feeding the most ?

Breast milk is best for baby's health.

What we know is that breast milk is the best available food for babies. It is made up of at least 200 ingredients including protein, fats, carbohydrates, minerals and other bio-active elements. These are designed by nature specifically for the needs of human infants. Breast milk is food, water and medicine. It is the only food babies need from the minute they are born and for the next 6 months. It is also the best food for babies during the first two years of life, even after they have started to eat solid food.

There are seven good reasons why breast milk is best for babies

1. **Breast milk is easiest for baby to digest.**
   The physiology of babies is immature when they are born. Their internal organs and systems still need to develop. They need food that is easiest to take in (swallow) They need food that gives them the best available nutrients and that can be broken down and used by the body. Human breast milk is the normal food for babies and that is why it is easiest for them to digest[i].

2. **Breast milk helps baby grow and develop.**
   A baby does an enormous amount of growing in the first two years of life. A baby will double in length and weight in the first six months. In fact babies grow faster during this period than at any other time in their lives. During this time, its brain and other systems also become mature. To grow and develop so fast, babies need the right kind of food. Breast milk gives babies the best available nutrients, minerals and bioactive factors it needs.

3. **Breast milk protects babies from infection and disease.**
   In addition to providing baby with nutrients, breast milk contains other things including hormones, growth and other bioactive factors. These form a biological system to protect them. This is why breast milk is like medicine. It protects babies from infection and disease. So even when babies get sick, breast milk helps them get better faster.

4. **Breast milk adapts to babies' needs.**[ii]
   Breast milk adapts in two ways to babies' needs. It changes to help a newborn survive

5

DID YOU KNOW?

Adapting to survive

The composition of breast milk goes through four phases. It changes three times during the first few weeks of a baby's life. Then it changes at the end, when a mother stops breast-feeding altogether and baby is weaned[iii]. The first milk that comes from a new mother's breast is thick and yellowy-cream in color. It is called colostrum and it is there in the first 2-5 days. Transitional breast milk comes in after colostrum and before mature breast milk. This milk gives baby a boost. From about two to three weeks onwards a mother produces mature breast milk until she stops nursing.

Breast milk also adapts to baby's needs during each feed.

DID YOU KNOW?

Mature breast milk changes during each feeding session. The milk that comes in the beginning (also called foremilk) is thinner. It is high in lactose and quenches baby's thirst. Hind milk, or the milk that comes after foremilk, is creamier and is much higher in fat. When a mother allows baby to properly empty a breast before changing to the other side baby gets the right mix of fore and hind milk. This way she helps baby digest at the same time as she makes sure that he or she gets the right amount of fat content. Hormones in breast milk stimulate both wakefulness and sleep in the baby. In this way breast milk helps mothers establish a routine of wakefulness and sleep with baby.

5. Breast milk is free.

Making breast milk costs nothing. The amount of milk babies take increases very quickly only in the first few weeks. After that, the amount of breast milk that exclusively breastfed babies take in does not change even though they grow bigger and heavier as they get older.

Exclusively breast fed babies take in between 84 and 135 litres of milk in the first 6 months of life. All this food is made by their mothers for free!

The amount of milk consumed by a baby in the first 6 months of exclusive breastfeeding.

Age of Baby	**Milk a day**		**Milk a month**		**Milk in 6 Month**	
Period	average	range	average	range	average	range
1-6 months	750 millilitres	560-900 millilitres	22,5 litres	16,8-27 litres	112,5 litres	84-135 litres

6. **Breast milk comes properly prepared and ready for each feed.**
The composition of breast milk is just right for babies, especially when they suckle until the breast is empty. This means that every mother makes good quality milk to feed her baby, including women who are poorly nourished[vi]. A breastfeeding mother does not need a special diet. What she needs is to eat a variety of locally available food AND she needs to eat enough to keep herself healthy.

Breast milk is delivered to baby at the right temperature, making it easy to digest. Breast milk is made on demand. This means that it is never "old" and does not have to be stored anywhere.

It is also mostly safe. Breast milk only becomes unsafe when breastfeeding mothers
- take drugs;
- drink alcohol;
- eat food that is contaminated;
- take some prescribed medicines that interfere with the composition of breast milk;
- or take herbs, muthi, over-the-counter or other concoctions or 'remedies'

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7. **Breast milk is safe for babies of HIV negative and HIV positive mothers on ART, breast milk is safe for mothers on preventative TB treatment (IPT or Isoniazid Preventative Therapy) or TB treatment**
A mother must know her HIV status so that she can breastfeed safely. If she is HIV negative her baby cannot be exposed to HIV through breastfeeding. If she is HIV positive, she needs to go on antiretroviral treatment (ART). By taking ART she also can safely breastfeed. She will not infect her baby as long as she takes her ART medicines and only (exclusively) feeds baby breast milk.

An HIV positive woman who is not on ART should start with ART medicine at 28 weeks in her pregnancy. When she delivers, baby should be given some medicine (mouth drops) immediately after it is born. This is given to protect him/her from HIV infection. While she breastfeeds the mother must continue to take her ART medicine to prevent giving her baby HIV and to make sure that her HIV infection does not become AIDS. It is very important that she only feeds baby breast milk.

Pregnant mothers who are HIV negative but show signs of TB will be put on IPT. If they have TB, they will be put on TB treatment. Pregnant mothers who are HIV positive will be put on IPT even if they don't show signs of TB, because HIV makes them more vulnerable to TB infection. If they show signs they will be tested and put on TB treatment once they are on ART.

Breastfeeding is good for a mother's physical and mental health.

A mother's decision about what she feeds her baby (0-6 months) also needs to take her own health into account. Breast milk is not only the best baby food, but also because it is made by women naturally, making breast milk is also really good for the health of mothers.

Five Good Mental and Physical Health Reasons for Mothers to Breastfeed

1. **Breastfeeding helps a woman bond with her baby**
   When a mother breastfeeds she releases hormones that help her bond with baby. The hormone prolactin produces a peaceful nurturing sensation. Prolactin allows her to relax and focus on baby. Another hormone, oxytocin stimulates a strong sense of love and attachment between mother and baby.

2. **Breastfeeding helps a woman's uterus return to its original size and reduces bleeding after giving birth.**
   The hormone oxytocin helps a mother's uterus (womb) return to the size it was before she fell pregnant. It also helps lower the amount she bleeds after giving birth. This is important for her health and for the well being of the baby, because when a woman bleeds a lot she increases her risk of getting anemia. Most often anemia is caused by low stores of iron, the essential nutrient that helps the body make the oxygen-carrying part of a red blood cell, hemoglobin. Mothers who develop iron-deficiency anemia after giving birth are more likely to be depressed and stressed. They also have difficulty concentrating and have low levels of energy. These effects of anemia can make it difficult for mothers to care for and bond with baby.

3. **Breastfeeding can lower a woman's chances of developing breast, uterine and ovarian cancer.**
   Breast and cervical cancer are the most common cancers affecting women in South Africa. Generally, about 1 in 35 women are at risk of developing breast cancer and 1 in 40 women are at risk of developing cervical cancer in their lifetimes. There is a very strong association between being HIV+ and the risk of cervical cancer.

   The only known association between HIV and the development of breast cancer is that HIV positive women diagnosed with breast cancer tend to be younger than HIV negative women.Research from 30 countries has found that women who breastfeed are less likely to get breast and ovarian cancer.

4. **Breastfeeding can help women lose pregnancy weight and lower their chances of developing diabetes.**
   Breastfeeding helps some women loose the extra weight they gained during pregnancy quicker than if they were not breastfeeding. This is especially true when they exclusively breast feed for 6 months each time they have a baby.
   More importantly, women who breastfeed for long periods during their reproductive years are less likely to get diabetes, regardless of their body mass index (weight for height).
   Breastfeeding also helps bring blood sugar levels under control if a woman develops diabetes during her pregnancy.

5. **Breastfeeding brings down the financial costs and stress of paying for infant formula.**
   Breastfeeding has direct economic benefits to the mother and her family because she makes the food her baby needs. She does not need to buy commercially manufactured formula, which costs at least R100 every 10 days (2014).

AS A HEALTH WORKER...

You should encourage and support every mother to exclusively breastfeed baby for the first six months.

- ✓ Breastfeeding is best for the health and well being of both baby and mother.
- ✓ It costs nothing and is always perfectly prepared and ready for baby.
- ✓ Breast fed babies have the lowest rates of ill health and significantly lower risks of dying from disease and infection when compared to babies who are not breastfed.

Feeding Baby Formula

There are situations where babies can't be fed breast milk. For example, when a baby's mother has died or when a baby is physically separated from its mother because of heath, economic, social or cultural reasons. In these circumstances, the best food for baby is properly prepared commercial formula.

Many mothers who can breast feed and don't face these contraints choose to feed their babies formula.

Many mothers choose not to breastfeed because:

- They think it is "easier". They say it lets them share feeding duties with their partners or other family members.
- They see it as a way of showing they are "better off"and can "afford" formula, even though it is expensive.
- They see it as helping them get back to the lifestyle they had before they had baby. They can finish school or go back to work. Or they can go out and about without being tied to the feeding needs of their babies.
- They see it as "good for baby". Babies that are not breastfed seem to get heavier, quicker.

You probably have noticed that most of the reasons that women give for "choosing" not to breastfeed are related to the needs of mothers rather than the needs of babies.

Everyone should know that commercially made ***formula is never as good as human breast milk*** that mothers make naturally, even when it is properly prepared.

The following table compares the nutrient and other values of breast milk and formula milk.

Food Values Compared: Human Breast Milk and Commercial Infant Formula		
Food Type	**Human Breast Milk**	**Commercial Infant Formula**
Protein	Best quality, quantity, easiest to digest	Right in quantity but not in quality because not made from human milk
Fat	Right amount of essential fatty acids, lipase	No lipase
Vitamins	Nearly all there except vitamin D and K sometimes	Vitamins added
Mineral	Right amount at the right times	Partly corrected
Anti-infective properties	Yes, present	No, missing
Growth factors	Yes, present	No, missing
Digestive enzymes	Yes, present	No, missing
Hormones	Yes, present	No, missing

No mother should make a decision about infant feeding without being properly informed about the importance and value of breastfeeding to baby and herself.

Remember, the most important question that a mother or carer should ask is how her infant feeding food choices affect the baby's health.

For carers who can't breast feed and mothers who decide not to breastfeed for good reasons, the only alternative food for a baby is commercially manufactured infant formula. Commercially manufactured infant formula is good food for babies only when it is **properly prepared and safely stored**.

The decision to feed baby formula, for whatever reason, comes with risks to their baby's health that every mother or carer needs to know about.

The Risks of Formula Feeding

Formula is not as good for babies' health as human breast milk.

- It does not have the variety of nutrients that protect babies against infection.
- It does not adapt to babies' nutritional needs like breast milk.
- It is often not prepared properly. Either too little powder or too much powder is mixed with water. This puts babies at risk of getting too little food or food that is too concentrated.
- It often is not safely prepared and stored. This increases baby's chances of infection and illness. For example, bottles and teats are not sterilized. Formula is not kept at the right temperature or it is reheated and kept until the bottle is empty. All of these practices increase the chances of infection and illness.
- Formula is not sterile, even when it is properly manufactured. This means that it can contain contaminants that may cause diarrhea and food poisoning.

Feeding baby infant formula also means that mothers miss out on the health benefits of breastfeeding.

Mixed feeding is not good for baby

Mixed feeding is feeding babies under 6 months breast and formula, or breast milk, formula and other food and drink. Mixed feeding is bad for the health of babies under 6 months of age because foods other than breast milk (or properly prepared formula) are not suitable for their needs. Mixed feeding can lead to babies becoming sick or even dying. It also can cause babies to develop life long health problems.

Babies (0-16 months) do not need

- ✗ soft porridge, sour porridge, sorghum, cereal
- ✗ samp water, water, rooibos, sugar water, juice or tea
- ✗ muthi, herbs, supplements, immuneboosters

They do not need these foods because they get all the fluids, proteins and minerals they need from breast milk and properly prepared commercially manufactured formula.

Babies should be fed only breast milk or only infant formula from the time they are born until they are 6 months of age. Exclusive feeding is best for babies in the first 6 months. Remember breast milk or properly prepared infant formula must continue to be the main food until babies are 12 months old, even though they have started to eat other foods.

AS A HEALTH WORKER...

The best food for baby is breast milk!

Where there is no alternative, the next best food for baby is properly prepared formula.

Formula it is not as good, safe or cheap as breast milk and should not be the food of choice where mothers can breastfeed.

It is important that mothers and carers know that successfully feeding baby formula depends on:

- buying enough to meet baby's food needs;
- preparing formula properly every time;
- storing formula safely;
- using water that is safe for drinking;
- keeping equipment clean and sterile (spoons, teats and bottles or cups).

There are foods a baby (0-6 months) should never be given

- **Coffee whitener or coffee creamer** ("cremora"). It is fat not food. A baby will starve if it is fed coffee/tea creamer. Whiteners are not recommended for children of any age.
- **Honey**. It carries bacteria that a baby can't fight. It can affect a baby's ability to move, eat and breathe. Honey should not be given to a baby under 12 months of age.
- **Fresh cow's or goat's milk.** Fresh milk from other animals has not been pasteurized and has not been changed to suit human infants.
- **Gravy or soup.** Gravy or soup from packets and tins have too much sugar and salt. A baby will be malnourished and will have digestive problems.
- **Peanut butter.** It is hard for a baby to digest and can cause babies to choke.
- **Fruit and vegetables** are hard for babies to digest and are difficult for them to swallow.
- **Yoghourt and custard** are bad for babies. They are hard to digest. They also don't have the right nutrients to help them grow and be healthy.
- **Small food pieces of any kind** like nuts, raisins, peas, beans and apple. They can cause a baby to choke.

Apart from breast milk, all other food (and drink) is bad for the health of babies because their digestive systems are not ready for them.

- They cause infection (diarrhea, pneumonia, ear infection etc) and put babies at very high risk of being sick often and of even dying.
- They cause babies discomfort and cramping and disrupt babies' sleep.
- They do not give babies the nutrients they need to develop and grow.
- They increase babies' risk of anemia (shortage of iron), skin disorders (like eczema) and food allergies.
- They increase babies chances of having health problems later in life.

AS A HEALTH WORKER...

Giving a mother advice to feed her baby things other than breast milk and properly prepared commercial infant formula is wrong advice. Although people may say things like "it worked for me", "it is our tradition" or "it is our culture" and even that "it is good for baby", any advice to mixed feed babies is bad for their health. It is also costly for mothers and carers because mixed feeding makes babies sick often.

5.7 Exclusive Feeding in Infancy (0-6 months)

EXCLUSIVE FEEDING

WORK IN GROUPS

1. What does exclusive mean. Are there other health care contexts where we use “exclusive”?
2. Can you think of something that is exclusive, select or reserved?

What’s in a word?

What’s in the word “exclusive”?
When you think about the word “exclusive’ what other words come to your mind?

- Exclusive means only.
- Exclusive means unshared.
- Exclusive means limited to.
- Exclusive means nothing else but this one thing or person.

What do we mean when we say “exclusive breast feeding”?
Exclusive breastfeeding means only feeding baby breast milk!
Exclusive has another meaning that is relevant to breastfeeding. Exclusive also means select or reserved.

Think about it!

- Breastmilk is nature’s designer food for babies! It is the BMW or Pierre Cardin of baby food! But unlike any other thing that is for sale, it is made by every mother and it is free! It has no private company brand. Rather it has the everyman stamp of human beings “perfectly made by mothers for babies!”
- Breast milk is exclusive in this way too. It is made by mothers in pregnancy so that they are ready to feed their infants the healthiest, safest and best available food and drink.

Exclusive breastfeeding means ONLY feeding baby breast milk. Breast milk is food water and medicine.It is the best food for baby. It is the only food baby needsto thrive and grow in the first six months of life.

Many mothers believe they exclusively breastfeed. But often they actually don't mean that they never give their babies things other than breast milk.

EXCLUSIVE FEEDING

WORK IN GROUPS

When you exclusively breast feed what other things have you or do you know is given to baby to eat or drink? Does this fit in the definition of exclusive meaning only.

When a baby is given other food or drink as well as breast milk it is called mixed feeding.Exclusive breastfeeding means feeding baby breast milk and breast milk only.

Women usually learn about breastfeeding while they are pregnant. Most also start breastfeeding when the baby is born. However, most women do not exclusively breastfeed for long and very few exclusively breast feed until baby is 6 months old.

Breastfeeding in South Africa

Out of every hundred babies, research shows that		
	SADHS 2003	**SADHS 2016**
Never breastfed	20 in 100	25 in 100
Exclusively breastfed 0-3 months	12 in 100	36 in 100
Exclusively breastfed 0-4 month	2 in 100	
Exclusively breastfed 0-6 months		32 in 100
Complimentary Feeding	70 in 100 (1998)	43 in 100

Most mothers and carers live in families and communities where mixed feeding is common and seen as "normal". Exclusive breast or formula feeding is not common.

There are several common reasons why mothers give other things to baby or mixed feed.

1. Mothers don't know the risks of NOT exclusively breastfeeding.

Breastfeeding is the way that human beings were built to feed human infants. That is why not exclusively breastfeeding comes with serious health risks for **all** babies and **all** mothers. The health risks are high for all babies who are not exclusively breastfed, whether their mothers are HIV positive or HIV negative.

Babies of ALL mothers (HIV- and HIV+ ART or not on ART) are at greater risk of getting sick and dying from diarrhea, pneumonia and other common childhood infections when they not exclusively breastfed. Babies that are not exclusively breastfed are at risk of HIV infection if their mother is HIV+ and NOT on ART.

DID YOU KNOW?

Babies who have never been breastfed are
- 7 times more likely to be hospitalized than babies that have never been breastfed.
- 5 times more at risk of dying from diarrhea and pneumonia than exclusive breastfed babies.

Non-exclusive breastfed (mixed feeding) babies are
- two times more at risk of dying from diarrhea and pneumonia compared to babies that are exclusively breastfed.

HIV negative mothers are
- less likely to exclusively breastfeed.
- more likely to mix feed
- more likely to introduce solid food early in infancy (before six months).

More than half the deaths of children under five are caused by malnutrition and mixed feeding.

Mothers don't know that **not exclusively breastfeeding** is the biggest risk to baby's health, development and survival.

AS A HEALTH WORKER...

- ✓ Any breastfeeding counts.
- ✓ The longer a mother breastfeeds the better it is for her and for baby.
- ✓ Exclusive breastfeeding for six months is best for baby's health.
- ✓ Continued breastfeeding for at least 12 months is critical for baby's continued survival and health.
- ✓ All mothers need to be supported to exclusively breast feed.

2. Mothers are unclear about the composition of breast milk.

Although mothers think breast milk is food, they think that baby will also often be thirsty. That is why some mothers give baby water.

Some mothers throw away colostrum and replace this essential first breast milk with water, herbs or other fluids.
When you know what breast milk contains you realize that both these practices are not necessary or good for baby.

The composition of breast milk is exactly designed to suit a baby's needs from the very moment that it comes into the world and takes its first breath until it is ready to be weaned off the breast.It gives baby good bacteria to make it strong. Although colostrum looks different from the milk a mother expects to make, it is the best food for the newborn baby.

The Composition of Breast Milk

First breast milk is called **colostrum**.
Colostrum is made during pregnancy and is ready for baby at birth for 2 to 5 days. This first milk that comes from a new mother's breast is thick and yellow in color. Colostrum has many very important things to make baby healthy.

- It is high in carbohydrates, high in protein, high in antibodies, and low in fat.
- It is very concentrated. Baby is born with a very small digestive system (throat, stomach, intestines, pancreas) and only needs to eat about ½ a teaspoon at each feed on the first day and about one teaspoon at each feed over the next two or three days.
- It has antibodies and hormones that help protect the lining (mucous membrane) of baby's throat, lungs and intestines from germs and foreign substances.

- It gives baby antibodies to help fight infection.

Transitional breast milk is the breast milk that is made in between colostrum and mature breast milk. It has high levels of fat, lactose (carbohydrates), water-soluble vitamins, and contains more calories than colostrum.

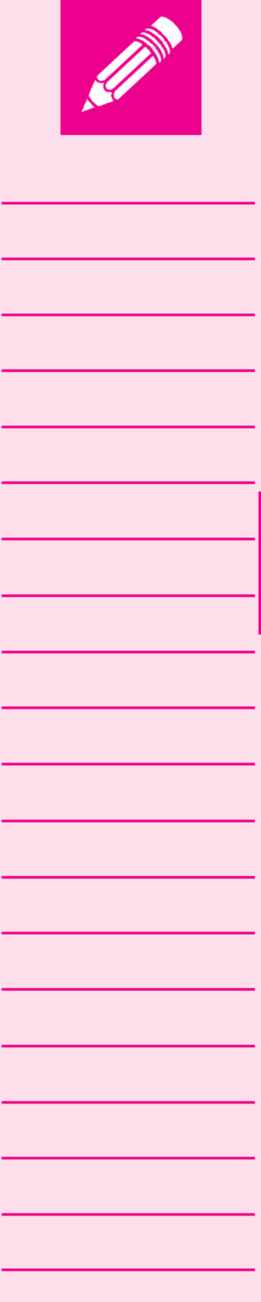
It comes in 2 to 4 days after baby is born and lasts for about 2 weeks. This milk gives baby a boost.

Mature breast milk is the milk that a mother produces from when baby is about two weeks old until baby stops breastfeeding. 90% of mature milk is water. This means that if baby is feeding well he/she will be properly hydrated and won't get thirsty. 10% of mature milk is food (protein, fats and carbohydrates). This means that baby gets the energy it needs to develop and grow. Mothers continue to produce mature milk as long as baby breastfeeds.

3. Mothers are unclear about the mechanics of breastfeeding.

Sometimes mothers do not only throw away colostrum, they also throw away the first milk at the start of each feed. It is not necessary or desirable for a breastfeeding mother to throw away "first milk" because the mechanics of breast milk is also ideally suited to baby's needs.

Colostrum or first milk is ready for baby at birth. This means that colostrum is "on tap". Also the flow of colostrum is very slow. Baby can get it even before it can coordinate suckling, breathing and swallowing. Over the next few days, as baby learns to latch, suckle, breathe and swallow, the mother starts to produce transitional milk. Her breasts will become less soft. After that, she and baby become more expert and attuned.
The mechanics of breast milk also means that the milk in a mother's breast never goes off. It is always sterile and never has to be thrown away.



4. **Mothers worry that they won't produce enough milk to satisfy their babies or for their babies to grow properly.**

With few exceptions, a mother will naturally make enough milk for baby to grow and thrive the more often and the more effectively her baby feeds at the breast.

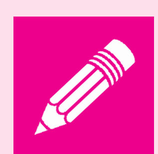
Part of the worry about not have enough milk comes from the fact that when a mother breastfeeds, she can't see how much milk she makes or the amount baby gets with each feed. In this sense breastfeeding is not like preparing food for the family or formula feeding, where it is easy to see and know the amount of food that is made and consumed.

Also, a mother is unfamiliar and unsure of her baby's needs. In the first weeks mother and baby are just getting to know each other. They both don't have a routine. Because a mother or carer does not know baby well enough,she also may think that all baby's cries are cries of hunger.

Babies cry when they are hungry, warm, cold, in need of a change, uncomfortable or just in need of a cuddle. The average six-week-old baby cries for two-and-a-half hours in 24. Crying in infants is normal and healthy. It is the only way a baby has to tell her mother or carer about her needs and how she is feeling.

A mother can tell if her infant is getting plenty of milk, without measuring each feed. She knows this if

- Baby is mostly content (does not cry constantly, sleeps and wakes well).
- Baby gains weight steadily. In the first week of life, it is common for a baby to loose some weight. After that, she/he should put on between 140-200 grams a week (seven days).
- Baby should wee (pass clear or pale yellow urine) enough. Enough wee means making 1 or 2 wet nappies a day (in the first 48 hours) and 5 or 6 wet nappies a day after that.
- Baby should poo enough. The first bowel movement (poo) usually happens within 8 hours of being born. After that baby should poo one or two times in a day (24 hours). It is also normal for baby not to poo for a few days from time to time.
- Baby's poo should be the right colour and consistency. The first poo is thick, tarry and black. On day 3 and 4 it may be green to yellow and watery. After that it should be loose and a seedy yellow colour.



- Baby should switch from periods of short sleep to being wakeful and alert over the day.
- Baby should seem satisfied and content after feeds. Remember, she/he will still squirm, grimace and wind during digestion.
- A mother's breasts should feel softer after each feed.

There are some mothers who can't produce enough breast milk on their own. They can be helped to exclusively breastfeed. One option is for them to use a breast pump, in addition to baby suckling. A second option is for them to get prescribed medicines from a doctor that safely stimulate milk production.

AS A HEALTH WORKER...

Assure a mother that she will be able to make enough breast milk for her baby to thrive. It happens naturally when baby

- is properly latched,
- feeds often and at regular intervals,
- feeds off *both* breasts and
- is not given formula or any other food, drink or concoction.

But saying this is not enough. Help her to to breast feed. Help her to check by observing her baby's behavior.

5. Mothers do not know that a baby's digestive system is immature and needs to be looked after carefully.

Mothers may not know that babies need special food from birth to 6 months because a baby's digestive system is immature and needs to be looked after carefully.

DID YOU KNOW?

Human babies are born with immature digestive systems. That is why as they digest food they grimace, pull up their legs, squeeze and even cry. This is normal. It takes the first six months of life for them to develop enough to safely eat things other than human milk. Breast milk is the only new born and infant food that is not harsh on a baby's digestive system. It also carries micronutrients and probiotics that protect baby from infection and keep baby well while the parts are all starting to work properly.

Mothers sometimes treat babies like "little adults".They think baby can be fed anything as long it is soft enough. Even though foods like yogurt, custard and porridge or drinks are "soft" they are very harsh for baby. They cause digestive and health problems. They can also be harmful to baby by increasing the risk of infection and illness as well as the chances of baby developing food allergies. Foods other than breast milk, including formula that is not properly prepared, can also cause malnutrition, because they do not provide babies with the nutrients they need. They also increase gassiness.

DID YOU KNOW?

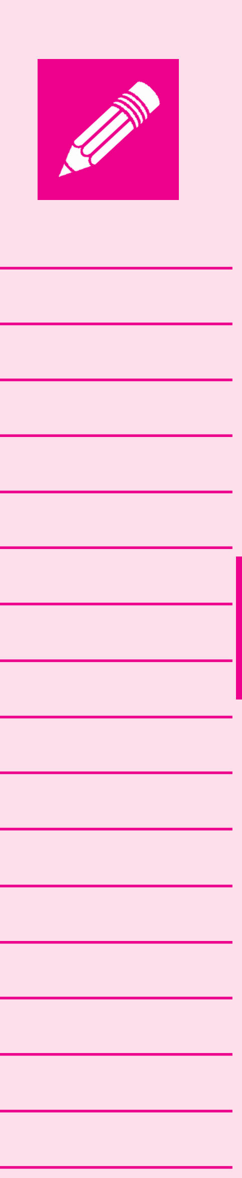
It is normal for all babies to have gas. It is also normal for some babies to have more gas than others. Gas is air that is caused by different things. It is caused by the baby's digestive system as it breaks down. It is also caused by air that baby sucks in during feeding or crying. Babies grimace, pull up their legs, squeeze and even cry after feeding until they hiccup, spit-up, burp and wind. That is how they are get rid of gas. Sometimes, when gas is trapped it makes baby's tummy bloated and is one cause of fussiness, restlessness and crying.

Many mothers don't know how to respond to baby's discomfort, as the face book thread shows (page 224). They also need to be shown how to respond safely to baby's discomfort.

None of the things that mothers and carers should do to relieve gassiness and colic involve "medicine" or money. The best remedies for colic or gassiness is "time" and "comfort" along with feeding baby only breast milk or only formula. With time, baby will pass gas (burb, hiccup, wind) and the discomfort will stop. Also, touch, motion and making soothing sounds ease the discomfort of gassiness. By rubbing, rocking, swinging, cradling and singing to her restless infant, a mother or carer signals to baby that she is safe and cared for. Over the months, as baby grows he/she will experience less and less discomfort as her/his digestive system matures.

AS A HEALTH WORKER...

Make sure that mothers and carers know that gas is a normal part of digestion. It is distressing for mothers and carers especially when baby is restless and fussy and seems to cry, arch, cramp and wind “a lot”. Reassure mothers that that baby’s body will start to manage gas more easily as baby grows.



There are things that mothers and carers do that do not relieve gassiness, may be harmful to baby and are expensive.

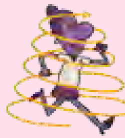
Many mothers and carers give baby concoctions like “gripe water” (e.g. MuthiWenyoni, Telament, Woodards Gripe Water). These products and other ‘traditional remedies” are not good for baby. They contain things that can even increase baby’s discomfort and especially they increase baby’s risk of infection.

Although they are sold in shops and at chemists or prepared by herbalists or “traditional chemists they should not be given to baby for several reasons.

Like most herbal, homeopathic and dietary supplements

- Many have not been tested for safety in infants and children.
- Many have not been tested to see if they claim to do.
- Some that have been tested, like Simethicone, have been shown to have no effect on reducing colic.
- Many are not sterile, increasing the risk of baby being
  exposed to harmful bacteria.
- Many contain ingredients like sucrose (sugar) that can increase gassiness and discomfort.

- Many contain ingredients that are not suitable for infants and children, causing digestive problems and even serious illness.
- Many have dosage recommendations that are untested and misleading.



AS A HEALTH WORKER...

You play a crucial role in making sure that mothers get advice and support that is based on the best available knowledge. You also peer educate family members.

- ✓ Make mothers' aware of the responsibilities that come with putting baby in the care of another person.
- ✓ Support them practically.
- ✓ Be aware that mothers may not think about or they may be afraid to ask carers about how they feed baby. They also may be reluctant to tell carers about their expectations.

DID YOU KNOW?

Giving baby anything but breast (or properly prepared) formula is a form of mixed feeding.

Gripe water, muthiwenyoni or other herbal concoctions also contain things that are harmful for baby.

They often contain alcohol, which suppresses baby's nervous system making it very sleepy. Alcohol is also addictive.

Some contain herbs like dill, ginger, peppermint, star anise etc. Although these are natural ingredients they can be harmful. Star anise is associated with seizures, vomiting, rapid eye movement and jitteriness. Peppermint oil and peppermint or spearmint tea can be dangerous if given directly to baby.

Breastfeeding mothers should also not drink mint tea because it decreases milk supply. Dill can lead to dehydration because it increases the amount baby passes urine (wee).

Face Book Page – Question and Threads 2012-2014
Downloaded 2014/08/24

Hi momies what is muthiwenyoni use for and how do you know that your baby suffer 4rm a colic. What can i use for hiccups.omagug'sGuglooGug's Thanks @cheryl got dt
KM Muthiwenyoni is for phogwana/hlogwana. And I use Gripe water for hiccups.. *November 6, 2012 at 8:10am*
·
NM @gwenk,iws also gvng mine gripe water btiactualy found out is 4 stomach cramps nt hiccups *November 6, 2012 at 8:33am*
AS Hiccups are good for babies thou *November 6, 2012 at 9:12am*
RS Mine drnkmuthiwenyoni 4 phogwana as Katlego said n grapewter 4 stmch gramps yes it also hlpkuhicupsb-thicpz are natural in babies n as 4 colic I use baba suurcz she ws crying alot
RS I jstbord it at phmcy dint go 2 Dr
MM He have to drink the whole bottle for muthiwenyoni?
CD Which herbs can I use for my 1month baby,he's got too much phlegm *May 30, 2013 at 3:48am*
TT I gv my bbymuthiwenyoni everyday bt I jstfoundout I sepose 2gv her 2 or 3 tmes a week..nd gripe water 4 not stool *June 5, 2013 at 1:49pm*
NM nna I give muthiwenyoni and gripe water *June 14, 2013 at 12:37pm*
Remove
ManananNthabiseng hi moms my bbyhs a red mark..z it gona go awy or shldigv her sumtng?
August 6, 2013 at 10:43am
LM hi mommies mi bbyhasent got dat red mark but does not sleep at night, so is it ok to use muthiwenyoni and gripw water and how many times a day? pls help urgent she is 8wks now
August 12, 2013 at 8:55am
SiB someone told me that umuthiwenyoni can help that *August 13, 2013 at 6:39pm* *Remove*
NSN Mine as well she is 8weeks now she doesnt sleep cries whole day its hurting n she has this big red spot on her head i give her everything gripe water muthiwenyoniphipps glucose
spasmopep junior bt its da same she cries n scraches me flod (Fold) her legs and scream like m not there plzppl help *August 15, 2013 at 10:43am*
ToT you use muthiwenyoni when what happens with pogwane I don't understand? *August 21, 2013 at 12:26am*
RR urbby might be cryin for her eldetsnamea try to cal her wth da name oofurgrandpatentoorur ancestors *August 28, 2013 at 7:58am* *Remove*
MD My baby is 5wiks...we started gvn him Muthiwenyoni a day ago..the leaflet says 2.5-5ml 4 babies in his age group but i feel its too much..My mum wants to follow wats on the leaflet nd that scares me..simone please give me the rite dosage nd how often it shud b taken..HEEEELP...
September 14, 2013 at 1:52am
TM my baby is 7mnths 2weeks she doesn't have a mark in her head but she's always scratching her head at the back and she rub her noise so I dntknw what to do or to use for this.I took her to one gogobt I dnt see any differents she gave her some traditional med I gave her but its still da same help plz what can I give her
MaM hey mommies my baby is 2weeks she cnt sleep @nyt, she's crying wen she's making poo nd she's making yellow nd green poo watcni use pliz help. *October 25, 2013 at 5:50am*
T Master hi, ive only strugles 2 nights with my baby crying for over 2 hours, I would loke to try muthi we nyoni is there any evidence that it helps with colic? *November 5, 2013 at 11:45pm*
MmaB @sweetness,the babies r not the same,,some cry some don't..mine was crying like yours until he was 11mnths..I had depression m nw its a heart deasesbcs of ntsleeping..its not easy but I'm telling u he/she will be fyn u won't blv..he is nw a strong he.
MNSikhweni @manana if its da red mark at da back of ur kids head,datz very dangerous,inbox me ill tell u what 2 do *November 10, 2013 at 1:00pm*
MaM hello mothers out der,plz read the ingridents of grip water,it has alcohol!!! *November 10, 2013 at 1:12pm*
TP Lets not deceive each other ladies or try to scare one another. The red mark on baby's head is Nothing at all, it's not dangerous it's just a minor tissue scarring your baby got from the pressure when his head got engaged in your pelvic bones on his way out. C-section babies have minimal ones, but natural birth babies may have larger spots. It goes away on its own. *November 29, 2013*
ZZ "a stork bite" do google it! its not dangerous @ all..black people will usually called it "ibala" nd its not something 2 worry about. *January 7 at 2:46am*
MMa hi ladies I would lyk 2 watmuthiwenyoni used 4 bcz even on de leaflet does nt explain
February 5 at 8:23am

5

6. Mothers don't know how to overcome the challenges of breastfeeding

Breastfeeding is a skill that has to be learned. It takes time and practice. While for some mothers it happens easily, nearly all mothers face one or more challenge in initiating and maintaining breastfeeding.

Most mothers need to learn the skills of feeding their babies. They need to be shown

- How to get baby to latch, so that it suckles properly and does not hurt mother's nipple.
- How to take baby off the nipple (unlatch) without hurting it.
- How to prevent nipples from cracking and becoming sore.
- How to prevent and manage engorgement.
- How to wind, comfort and soothe baby.

Mothers and carers who formula feed need to be shown

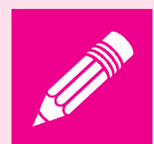
- How to sterilize feeding equipment.
- How to make formula correctly.
- How to use and store formula safely.
- How to wind, comfort and soothe baby.

Community health workers and health professionals play a crucial role in supporting mothers to sustain exclusive breastfeeding. They also play a crucial role in making sure that carers and mothers know how to properly and safely prepare formula, when breast feeding is not possible.
Health care workers are there to make sure that mothers and carers get the skills they need to properly feed babies in their care.

Feeding and caring for babies is a social activity. Mothers often do not have people around them to support their decision to breastfeed. Many times parents, partners, relatives and friends actively discourage them from exclusively breastfeeding. Or they often don't have the knowledge or skills to support a mother when she has a feeding-related problem even when they are not against exclusive breastfeeding.

Research shows that infant feeding practices improve when community health workers support mothers and families in their homes.

Often mothers don't think about or know how to sustain exclusive feeding when other people look after their babies. While grandparents, relatives, friends or helpers may be willing to help out, mothers need to make sure that they know what to do and are able to support exclusive infant feeding during their absence.



DID YOU KNOW?

Babies who are left in the care of people other than their mothers for long periods during the day are more likely to be mixed fed. This is because carers are left with insufficient infant food or because they do not know or understand the importance of exclusive feeding.

When mothers leave their babies in the care of other people she must

- make sure that there is enough food for baby for the time that she is away. She needs to take into account that she may be delayed or late getting back to her baby.

Tips to support exclusive feeding

When a breastfeeding mother leaves baby in the care or a relative, friend or day care provider she must

- express enough breastmilk to ensure that baby can feed on demand; and
- provide feeding equipment and cleaning materials.

When a formula feeding mother leaves baby in the care or a relative, friend or day care provider she must

- provide enough formula to ensure that baby can feed on demand;and
- provide feeding equipment and cleaning materials.

When mothers leave their babies in the care of other people she must make sure the person she leaves baby with knows how to feed baby and what exclusive feeding means.

Tips to support exclusive feeding

To sustain exclusive breastfeeding while she is away from baby, a mother must

- explain and show the carer how to safely store, warm and feed expressed breast milk;
- explain and make sure the carer understands the meaning of exclusive breastfeeding;
- explain and make sure the carer knows how to properly clean any feeding equipment.

To sustain exclusive formula feeding while she is away from baby, a mother must

- explain and show the carer how to prepare and feed formula properly;
- explain and show the carer how to properly clean any feeding equipment;
- explain and make sure the carer understands the meaning of exclusive formula feeding.

A mother who leaves baby in the care of another person for any length of time must always

- show how to settle and comfort baby;
- inform the carer where she is going and how she can be contacted;
- inform the carer of when she expects to return;
- inform the carer when she is delayed; and
- give the carer advice on ongoing feeding and care until she returns.

AS A HEALTH WORKER...

- Support mothers to take responsibility for exclusive infant feeding when they leave their babies in the care of others.
- Support carers to exclusively infant feed when they look after babies in the absence of their mothers.

APPENDIX 1 SEX DIFFERENCES IN REPRODUCTION

All humans go through changes that begin at puberty. The table outlines the general changes in reproduction between males and females from puberty onwards.

Males	Issue	Females
• Begins: around the age of 10 • Puberty: 10-16 • Ability to reproduce: throughout the lifespan	**Timing** is influenced by: • diet • environment • individual • general health	• Begins: between 7-11 • Puberty: 8-15 • Ability to reproduce for about 35-40 years • Ends: with menopause around the ages of 45-52
• Testicles and penis grow bigger • Grow pubic, underarm and facial hair • Has more frequent erections	**Secondary sexual characteristics at puberty**	• Breast development • Grow pubic and underarm hair
• Shoulders get broader, gains muscle and weight • Arms, legs, hands and feet grow faster than the rest of the body • Grows taller in spurts	**Physical growth during puberty**	• Grows taller in spurts • Arms, legs, hands and feet grow • Fat deposits in breast, around thighs and hips
• Voice box (larynx) grows larger, voice 'breaks' • Voice becomes much deeper	**Voice changes (over a few months) during puberty**	• Voice box (larynx) grows larger, voice changes • Changes are not noticeable
• Sperm production begins at puberty. Millions of sperm cells are made every day in the testes • From puberty an erection can lead to ejaculation or the release of sperm-containing semen	**The start of being physically able to reproduce**	• This is called menarche or the first period • It is the beginning of menstruation • It starts about a year after the growth spurt and about 2-5 years after breast development • It starts at around the age of 10-15 • Once it starts, a girl can become pregnant

Males	Issue	Females
• Does not apply. Fertility (the reproductive quality of sperm) varies from man to man	**Menstruation/ period** (400-500 times in a life time)	• Menstruation is the shedding of the lining of the uterus • t lasts between 3-7 days • It happens when the egg that is released from the ovaries is not fertilised by sperm • It looks like blood • A woman passes about 2-4 tablespoons (30-60ml) of menstrual fluid during a period
• Does not apply. Males produce sperm continuously throughout their lives as long as they are healthy. Sperm production does not follow a cyclical pattern	**Menstrual cycle** (400-500 times in a life time)	• The menstrual cycle is the process that happens each time an egg is released from the ovaries • It lasts from the first day on one period to the day before the first day of the next period • A menstrual cycle typically is about 28 days but can be anything from 21 to 45 days • It often takes a few years for an individual's menstrual cycle to develop a regular pattern
• Does not apply to men • Age is not a predictor of fertility. With age, the volume of semen remains the same although there are fewer living sperm in the fluid • With age an individual's sex drive may decrease due to decreased testosterone levels and sexual responses may be slower and less intense • An individual's general health status will affect5 his sex drive	**Peri-menopause** (the process that ends female reproductive capacity)	• This happens naturally over a period of about five years any time after 40 years of age • It is still possible to fall pregnant • It is not linked to an individual's age at first period, height or number of pregnancies • Periods become irregular (longer/shorter, heavier/ lighter, spotting, skipping months)

Males	Issue	Females
		• Hormonal changes can affect sleep patterns, mood (irritability), energy levels (fatigue), body temperature (hot flashes, night sweats), concentration and sexual interest • The experience of peri-menopause differs from individual to individual
• Does not apply to men • Age is not a predictor of fertility. With age, the volume of semen remains the same although there are fewer living sperm in the fluid • With age an individual's sex drive may decrease due to decreased testosterone levels and sexual responses may be slower and less intense • An individual's general health status will affect5 his sex drive	**Menopause** or the final menstruation or period	• This is defined as not having a period for 12 consecutive months or not having a period as a result of a surgical intervention (hysterectomy) • It happens naturally to women usually in their late forties or early fifties • It is influenced by genetics (a woman will have menopause at about the same age as her mother) • It is the endpoint of the female reproductive pathway • A woman cannot fall pregnant after menopause • Premature menopause occurs when a woman stops having periods before she is 40 • Premature menopause often happens when there is an underlying health problem

Providing women with access to safe and effective contraception is a critical element of women's health. Enabling women to make choices about their fertility is empowering and offers women better economic and social opportunities. Birth spacing also improves the opportunities for children to thrive physically and emotionally. Engaging men in sexual and reproductive health encourages shared responsibility in their roles as partners and parents.

This table outlines the types of contraception that are available at the local facilities.

Type		Description	Possible Side Effects
COMBINED ORAL CONTRACEPTIVE PILL (THE PILL)	**Short term / Hormonal**	These are pills that have low doses of female hormones (oestrogen and progestogen) which are **taken orally 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 fairly quick to reverse should she want to fall pregnant. • Safe, effective and convenient. • Available only by prescription. • Some women may not be able to use this for medical reasons. • Active pills can be used without a break.	"The Pill" has a few side effects. Some women who are on "the Pill" experience • nausea • breast tenderness or enlargement • mood changes • breakthrough bleeding • headache Other possible side effects that may occur over time include: • Skin changes including acne or brown discoloration on the face.
	NOTE: Taken every day, very good method when taken correctly, quick to reverse		
THE INJECTION	**Short term / Hormonal**	Depomedroxyprogesterone acetate (DMPA) injections (Depo-Provera® or Depo-Ralovera®) is a hormone injection that is **given every two or three months depending on the type**. The hormone prevents the woman from releasing an egg. 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.	

Type		Description	Possible Side Effects
THE INJECTION	Short term / Hormonal	• An injection in the arm that prevents pregnancy • Safe, effective and convenient • Must be administered by a health care provider • Lasts for 12 weeks	DMPA has a few side effects. • Small weight gain in some women • Bleeding changes • Headaches • Acne • Change in sexual interest • Mood changes The injection is long acting. If side effects occur they may last up to 3 months. It is not possible to reverse the effects of an injection once it is given). Some side effects (especially bleeding changes) may persist beyond 3 months.
	NOTE: Every two or three months, very good method when return visits are respected, can take a few months to reverse.		
CONDOM	Short term / Barrier	Condoms stop the sperm entering the vagina during sex. There are male condoms, for use on the penis, and female condoms, for use in the vagina. You only need one kind of condom at a time. Condoms are the most used barrier method. **They are also the only method that provides protection against HIV and other STIs as well.**	
	NOTE: Used every time you have sex, good method when used correctly, totally reversible (stops preventing pregnancy as soon as you stop using the condom), also protects against STIs including HIV		
CERVICAL CAP, DIAPHRAGM	Short term / Barrier	These less common methods prevent the sperm from meeting the egg once in the woman's body. They both fit over the opening to the uterus, called the cervix. They must be fitted to each woman by her healthcare provider. They are used each time you have sex.	
	NOTE: Used every time you have sex, good method when used correctly, immediately reversible (stops preventing pregnancy as soon as you stop using the condom)		

Type		Description	Possible Side Effects
WITHDRAWAL METHOD	**Short term**	This is when the man withdraws the penis from the vagina before ejaculation. It is not a good method to stop pregnancy as some sperm can enter the vagina even before ejaculation. It also does not protect against STIs or HIV.	
	NOTE: not a good method.		
INTRA-UTERINE CONTRACEPTIVE DEVICE (IUD)		This is a device that is inserted into the womb and prevents the fertilised egg from attaching. It lasts for 3-5 years depending on the type. Some IUCDs have hormones and some do not. It is extremely effective and difficult to use incorrectly. It must be placed and removed by a healthcare provider. It is not a common method in South Africa and is only available at some clinics. This is also known as the "loop".	
	Long term / Can be hormonal	**Levonorgestrel-releasing intrauterine device** The Mirena® intrauterine contraceptive device (IUD) or LNG-IUD is a small, t-shaped device which is fitted inside the uterus, where it releases a hormone to prevent pregnancy • Safe, effective and convenient • Available only by prescription - must be inserted by a health care provider • Lasts up to five years • Suits the majority of women • Ideal for women with heavy menstrual bleeding or pelvic pain • Fertility returns in a month of removing the IUD • A LARC (long-acting reversible contraception) – most cost-effective	Side effects are uncommon but may include: • Menstrual irregularities, • Follicular ovarian cysts – usually there are no symptoms and do not require treatment
		Copper-bearing IUD / Copper IUD, Cu-IUD • A small, plastic device (which has wire wrapped around the stem) is placed inside the uterus to prevent pregnancy • No hormones • Safe, effective and convenient • Lasts from five to ten years depending on the type	

Type		Description	Possible Side Effects
INTRA-UTERINE CONTRACEPTIVE DEVICE	**Long term / Can be hormonal**	• Suits the majority of women; less suitable for women with heavy menstrual bleeding • Fertility returns in a month of removing the IUD • A LARC (long-acting reversible contraception) – most cost-effective • Available from True Clinics, gynaecologists and some general practitioners - must be inserted by a health care provider	
	NOTE: Lasts up to 3-5 years, extremely good method, immediately reversible (hormonal IUDs may take a few months to reverse after removal)		
IMPLANON	**Long term / Hormonal**	**Contraceptive implant (Implanon NXT®)** The Implanon NXT® contraceptive implant is also known as the 'rod', the 'stick' or the Implant. The implant is a small rod inserted under the skin of the arm using local anaesthetic, and slowly releases the hormone progestogen. It can be removed any time before or replaced at three years. • A plastic, flexible rod (about the size of a matchstick) is inserted just under the skin in the inner upper arm to prevent pregnancy • Safe, effective and convenient • Must be inserted by a health care provider • Lasts up to three years • A LARC (long-acting reversible contraception) – most cost-effective	A change to the pattern of vaginal bleeding. Changes can include: • changes in bleeding frequency (about one in every five women have no bleeding at all) - talk to a health care professional if you are worried • irregular light bleeding - talk to a health care professional • prolonged and/or frequent light bleeding – talk to a health care professional • prolonged and/or frequent heavy bleeding – you may need to change contraceptive method • Headaches - talk to a health care professional • Mood changes - talk to a health care professional • Breast tenderness • New onset acne- talk to a health care professional
	NOTE: Lasts up to 4 years, extremely good method, should use condoms for the first few weeks after it is placed, takes a few weeks to reverse		

Type		Description	Possible Side Effects
FEMALE STERILISATION: TUBAL LIGATION	**Permanent**	A woman can have her tubes tied. This means the fallopian tube is cut so that the egg does not reach the uterus. The procedure can be done in a hospital. The woman can go home the same day of the surgery and carry on with her normal activities within a few days. It is important to note that this method cannot be reversed if you want to have a baby.	
	NOTE: surgical, extremely good method, **not** reversible		
MALE STERILISATION: VASECTOMY	**Permanent**	This operation is done to block the sperm from moving into the penis during ejaculation. This operation is simpler than tying a woman's tubes. The man can go home the same day. Recovery time is less than one week. After the operation, a man visits his doctor for tests to count his sperm and to make sure the sperm count has dropped to zero; this takes about 12 weeks. Another form of birth control (such as condoms) should be used until the man's sperm count has dropped to zero. After a vasectomy, a man can remain fertile for up to three months, so contraception must be used until two zero sperm counts are done and before a vasectomy prevents pregnancy.	
	NOTE: outpatient procedure, extremely good method, takes effect after 3 months, **not** reversible		
EMERGENCY CONTRACEPTIVE PILL	**Short term / Hormonal**	ECP is a high dose of hormones that prevents pregnancy. It must be taken within 72 hours of unprotected sex. It is not meant to be used as a regular form of birth control. NOTE: good method, not a regular form of birth control, immediately reversible (once you stop taking it)	

APPENDIX 3 ANTE-NATAL CLINIC VISIT SCHEDULE

All pregnant women should attend at least 8 ANC visits at the clinic during her pregnancy to make sure that both she and her baby are healthy. It is equally important for a community health worker to visit the woman throughout her pregnancy and after the baby is born.

Visit	Weeks of Pregnancy	Services at ANC clinic visits
1	14 weeks	• The nurse will: ✓ take a history of the woman's health, family history and previous pregnancies ✓ do a physical examination ✓ check the woman's blood pressure ✓ do some blood and urine tests ✓ do a Pap smear test ✓ ask questions to check if the woman may have TB ✓ look for any signs of sexually transmitted infections (STIs) ✓ counsel the woman and offer an HIV test • The woman will ✓ get a Tetanus Toxoid vaccination ✓ be given vitamins and folic acid tablets that are important to help keep her healthy during the pregnancy
2	20 weeks	
3	26 weeks	
4	30 weeks	
5	34 weeks	
6	36 weeks	
7	38 weeks	
8	40 weeks	

It is important to encourage partners, family or friends to support pregnant women during their pregnancy and after giving birth.

APPENDIX 4 POST-NATAL CLINIC VISIT SCHEDULE

Every new baby and mother must be visited at home at least four times in the first six weeks after delivery.

Teach the mother and other members of the household about danger signs to look in both the mother and the baby. If they notice any danger signs they must take them to the nearest clinic immediately.

Postnatal Care by the Community Health Worker

	VISIT 1	VISIT 2	VISIT 3	VISIT 4
When	Within 24 hours after delivery or discharge from hospital	3 days after delivery of baby	7 days after delivery of baby	14 days after delivery of baby
Task	Educate, check and support	Educate, check and support	Educate, check and support	Educate, check and support
	Mother: Basic postnatal care of the mother	Mother: Basic postnatal care of the mother. Remind mother to follow-up about birth HIV test results	Mother: Check, educate and provide guidance on postnatal care and complications	Mother: Provide PNC for complications
	Infant: Basic care of infant	Infant: Basic care of infant	Infant: Check, educate and talk to the mother and family about how to care for the baby and discuss the danger signs	Mother: Remind mother to keep her 6 week clinic visit and 10 week HIV test for the baby
	Infant: Support exclusive breastfeeding	Infant: Encourage exclusive breastfeeding	PMTCT: Follow up on ARV medications for HIV-exposed baby; Follow-up on mother's ARV medication adherence	Infant: Tell mother about danger signs for the baby
	PMTCT: Follow up on ARV medications for HIV-exposed baby; Follow-up on mother's ARV medication adherence	PMTCT: Follow up on ARV medications for HIV-exposed baby; Follow-up on mother's ARV medication adherence Remind mother to keep Day 6 clinic appointment		Continue to discuss and check exclusive breastfeeding
				PMTCT: Follow up on ARV medications for HIV-exposed baby;
				Follow-up on mother's ARV medication adherence mother's ARV medication adherence

DANGER SIGNS IN PREGNANCY

Most women will feel some discomfort during pregnancy. It is important that every woman knows the difference between normal discomfort and danger signs that need urgent medical attention.

Pregnancy can cause:

- nausea - usually during the first three months but it can go on longer
- heartburn
- a need to urinate often
- backache
- breast tenderness and swelling
- tiredness
- sensitivity to smells

Although these problems may cause a woman to be uncomfortable they do not put the mother or the baby in danger.

There are problems during pregnancy that are signs that the pregnant woman and the unborn child may be danger. She must get immediate help from a health care professional or facility if she has any of the following:

Danger Signs in Pregnancy

1. Any leaking of fluid or bleeding through the vagina
2. Pain, pressure or cramping in the belly
3. Fever or convulsions
4. Swelling of the feet, ankles, face and hands
5. Headaches
6. Blurred vision
7. Severe anemia or when the inner part of the eyelids, the tongue or the palms of a mother-to-be's hands are very pale
8. A noticeable decrease in the unborn baby's movement

These danger signs are a warning that there are complications in the pregnancy. They need to be attended to quickly so that they do not become life threatening. They can lead to premature birth or even death (miscarriage, still birth) of the baby. They can also lead to the death of the mother.

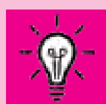
Helping a mother-to-be to check her baby's movements

Unborn babies sleep and move around during pregnancy. From about 18-25 weeks into the pregnancy a mother-to-be will begin to feel her baby's movements and will soon notice a pattern. This is good because she will then be able to know if there is a change. If a mother notices a dramatic decrease in her baby's movements she should get medical help.

You can teach a mother-to-be to count baby's "kicks". Starting at 28 weeks she can check her baby's "kick count" in the following way:

1. Find a comfortable position to sit or lie, preferably on the left side.
2. Get a piece of paper and a pen and a clock or watch.
3. Check how long it takes to feel 10 kicks, swishes, rolls or flutters. To do this she should:
   a. write down the time she feels the first movement.
   b. she should put a mark on the paper for every time she feels movement until she reaches 10;
   c. Once she has noticed 10 "kicks", she should write down the time again.

She should feel 10 kicks in 2 hours. It usually takes less time. But if it takes longer she should not panic. She can rest for a hour and do the kick test again. If she still can't feel movement after a second kick text, she should get medical help.



REMEMBER:

A baby's movement pattern is different at different times of the day and on different days.

An example of a significant change in kick counts.

Day	start	10 kicks	stop	Total time elapsed
Monday	9:00	XXXXXXXXXX	9:32	Total: 32 min
Tuesday	12:00	XXXXXXXXXX	12:45	Total: 45 min
Wednesday	9:00	XXXXXXXXXX	10:00	Total: 1 hr
Thursday	9:00	XXXXXXXXXX	11:15	Total: 2 hrs, 15 min

PELVIC FLOOR EXERCISES

Pelvic floor muscles are the muscles between the tailbone (coccyx) and the pubic bone. These muscles support the bowel, bladder, uterus (womb) and vagina. You tighten these muscles to stop weeing Childbirth can weaken these muscles.

Pelvic floor muscle exercises can be done standing, sitting or lying down. You can do them as often as you like. Aim to do them 5 or 6 times a day, everyday. Nobody can see you are doing them.

One set of pelvic floor muscle exercises.

1. Direct your attention

- Focus on the muscles that you tighten to stop urinating (weeing).
- Try to relax your abdominal muscles.
- Don't bear down.
- Breath normally. Don't hold your breath.

2. Part 1 –Repeat 10 times

- Slowly squeeze and increase the tension until you have contracted these muscles as hard as you can.
- Hold them tightly together and count to 20
- Let go slowly.

3. Part 2- Repeat 10 times

- Perform the same exercise with quick, short and hard squeezes.

4. Part 3- Repeat 3 times

- Squeeze, then clear your throat or cough lightly.

APPENDIX 7 DANGER SIGNS IN NEWBORN BABIES AND CHILDREN

A baby's and child's health can change very quickly. It important that **the mother or person caring for the infant or child** recognizes and responds to danger signs that show that he or she may be sick or have an infection.

The signs listed below mean that the baby must get help quickly from a medical professional.

General Danger Signs

The baby or child:

1. Cannot be woken or is responding less than usual to what is going on around.
2. Has glazed eyes and is not focusing on anything.
3. Seems floppy, drowsy or less alert than usual.
4. Has a convulsion or fit (arms and legs twitch or jerk).
5. Has an unusual cry (high pitched, weak or goes on for one hour or more)
6. Has severe abdominal pain.
7. Has a bulge in the groin that gets bigger with crying.

Temperature Changes that are Danger Signs

The baby or child:

1. Feels cold to the touch (body temperature falls below 35ºC) and can't be made warm.
2. Feels hot to the touch and has a fever or high temperature (above 38.3ºC).

Changes in the Eye and Skin Colour that are Danger Signs

The baby or child's:

1. eyes look yellow.
2. lips and mouth look blue.
3. skin looks pale.
4. nails go blue.
5. has redness, swelling or puss from the eyes, cord or skin.

Changes in Breathing that are Danger Signs

The baby or child:

1. Struggles to breathe or stops breathing.
2. Breathes faster than usual and in a shallow way.
3. Grunts or breathes noisily.

Changes in Feeding and Body Fluids that are Danger Signs

The baby or child:

1. Feeds or sucks poorly and does not want to feed.
2. Vomits out half of each of the last three feeds.
3. Has diarrhea or vomiting and diarrhea.
4. Has blood in the poo.
5. Has little or no wet nappies.
6. Has a bulging or swollen soft spot (fontanel).

FACT: All babies are born with "soft spots (fontanels) on their heads. These are the places where the baby's skull bones have not yet joined together. They curve inward a very little when baby is healthy.

ORAL REHYDRATION AND TREATING DIARRHEA

Diarrhoea is very serious in under-fives. A child (or adult) with diarrhoea looses a lot of body fluid. and they become dehydrated. This makes any illness worse and can even lead to death. Death and illlness from diarhoea can be prevented using oral rehydration solution (ORS). This is because it stops dehydration although it does not stop diarrhoea.

How to Make ORS

Oral rehydration solution (ORS) is easy to make.

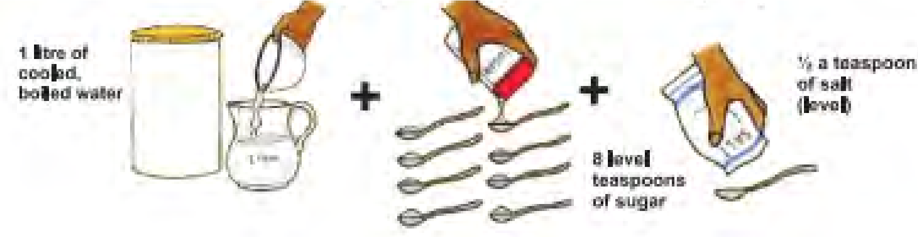
1. Wash your hands with soap and water before preparing solution
2. Take a a clean pot
3. Add
    - Eight (8) level teaspoons of sugar and
    - Half (½) level teaspoon of salt
    - One (1) litre of cooled boiled water
4. Stir the mixture till all the contents dissolve.

How to Give ORS

ORS is easy to make.

1. Wash your hands with soap and water before feeding ORS
2. Wash the child's hands with soap and water before feeding ORS
3. Give the child sips from a cup
4. Remember to give ORS in small sips often
5. Continue giving extra fluid until the diarrhoea stops.
    - Continue to breast feed
    - Give the child juice or other fluid (6months or older).
    - Continue to give solids if child is four months or older.
6. Store ORS in a cool place. Make a fres solution after 24 hours.

If diarrhoea increases and /or vomiting persists, take the child to the clinic.



APPENDIX 9 SCREENING FOR MALNUTRITION

Identify children who are undernourished or malnourished quickly.

Use the Mid-Upper Arm Circumference Malnutrition (MUAC) Screening Tool (Figure 1) to check if a child is malnourished.

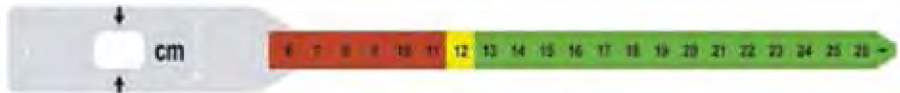


Figure 1 Mid-Upper Arm Circumference measuring tape

The MUAC is color coded. The colors help you see how well a child is nourished.

Red = Malnourished. Yellow = At risk. Green= Nourished

You need to take a MUAC measurement THREE times to be sure your results are accurate.

How to measure using MUAC

Step 1: Find out the age of the child. If the child is between six months and five years, ask permission to do a quick, safe and pain-free test to check for malnutrition.

Step 2: Find the middle point on the child's upper left arm. It is half way between the top of the shoulder and tip of the elbow. Mark the mid point with a pen or keep your finger on the mid point.

Step 3: Ask the child to relax and let the arm hang loosely. Take the coloured plastic strip and place it around the mid upper left arm of the child at the point you have marked.

Step 4: Hold the white part of the strip on the child's arm. Wrap the narrow coloured strip around the arm and thread it through the small window until the strip fits the child's arm closely.

Make sure that the MUAC strip is fitted properly around the arm. Do not pull the strip too tight. It must not pull the arm in. Do not make the strip too loose. It must not fall down.

Step 5: Look at the colour where the two arrows point. The arrows will show red, yellow or green.

- Arrows that point to green show the child is nourished.
- Arrows that point to yellow show the child is at risk of malnutrition.
- Arrows that point to red show that the child is malnourished.

REMEMBER

Step 6: Write down the result

Measurement 1	Measurement 2	Measurement 3

Take the measurement two more times. Repeat steps four and five to make sure that the result is accurate.

RESULT

Step 7: After completing the three tests:

If the child's result is either yellow or red - make sure the mother takes the child to the clinic as soon as possible.

The child is at risk of malnutrition or already malnourished. This result may also be an indication of HIV and an opportunity to screen or refer the child for HIV testing.

IMPORTANT

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

HOW TO BREAST FEED

All mothers should learn and practice how to hold and position baby during breast feeding during ANC and immediately when baby is born. Mothers who may need additional support include:

- New mothers who are breastfeeding for the first time
- Mothers who have difficulty with breastfeeding
- Mothers who formula previously and now want to breastfeed

When positioning the baby, make sure that

- Baby's whole body is held close to the breast and faces the breast
- If baby is young, the mother supports baby's whole body
- Baby's arms are not be wedged between the baby and mother's body
- Baby's head and body are in line
- Baby's bottom is supported and not resting on the mother's lap

Mothers can breastfeed in many positions. What is important is that the baby takes enough breast tissue into the mouth so that he/she can suckle effectively. The pictures show mothers breastfeeding sitting or lying down.

Figure 1: Breastfeeding positions for mother who are sitting

Underarm hold: Mother holds infant at her side, lying on his back, feet pointing to the back with his head at the level of her nipple. Mother supports infant's head with the palm of her hand under the infant's head. Mother may use a pillow to help support the baby.

The underarm hold position is useful:

- For mothers with large breasts or inverted (flat) nipples
- For mothers with twins
- If the mother is having difficulty attaching her baby
- To treat a blocked duct
- If the mother prefers it

Cradle hold: This position is comfortable for most mothers. Mother holds infant with his head on her forearm (near bend of arm) and his/her whole body facing mother. Baby's arm should be tucked under mother's arm. Mother can use pillows to help support the baby.

The cradle hold position is useful:

- For very small babies
- For sick and disabled babies
- If the mother prefers it

Figure 2: Breastfeeding positions for mother who are lying down

Lying position: The mother lies down on her side in a position in which she can sleep. A pillow under her head may help make her comfortable. She can support her baby with her lower arm. If necessary, she can support her breast with her upper arm. If she does not support her breast, she can hold her baby with her upper arm. Mother should keep baby's body straight; mother should not bend forward. Mother should bring baby as close to the breast as possible so that baby does not stretch to reach the breast.

The position is useful:

- When the mother wants to sleep
- Soon after a Caesarian section, when lying on her back or side may help her to breastfeed her baby more comfortably

All new mothers are encouraged to breastfeed their babies. If your baby is finding it difficult to breastfeed, you will be shown other ways of giving your baby breastmilk.

Expressing your breastmilk by hand, for example, will ensure a good milk supply for your baby. You can give your breastmilk using a small, one-millilitre sterilised syringe or a sterilised feeding cup, depending on the amount of milk you are giving your baby.

Cup feeding

A feeding cup should be used when your baby needs to have feeds greater than three to five millilitres.

Using a cup rather than a bottle with a teat helps baby continue breastfeeding. This is because cup feeding encourages your baby to use their tongue and lower jaw in a similar way to breastfeeding. Baby is also able to smell and enjoy the milk.

How to cup feed your baby

Wash and dry your hands thoroughly before you start, and use a pre-sterilised, once-only cup at each feed.

Sit the baby upright or semi-upright on your lap; support the baby's back, head and neck. It helps to wrap the baby firmly with in a blanket or cloth, to help support his or her back, and to keep his or her hands out of the way. Place a bib around your baby's neck.

Place the cup so that it is gently resting on your baby's lower lip. Do not press it down. The cup rests lightly on the baby's lower lip, and the edges of the cup touch the outer part of the baby's upper lip.

Tip or tilt the cup so that the milk just reaches the baby's lips.

The baby becomes alert, and opens his or her mouth and eyes.

A preterm baby starts to take the milk into his or her mouth with his or her tongue.

A full term or older baby sucks the milk, spilling some of it.

DO NOT POUR the milk into the baby's

mouth. Just hold the cup to the baby's lips and let him or her take it himself or herself.

The baby will drink at their own pace. He or she will take breaks. When the baby has had enough, the baby closes his or her mouth and will not take any more. If the baby has not taken the calculated amount, he or she may take more next time, or you may need to feed the baby more often.

Measure the baby's intake over 24 hours - not just at each feed. At the end of the feed they may close their mouth to show that they have finished.

COMPLEMENTARY FEEDING

Adequate nutrition during infancy and early childhood is essential for the growth, health, and development of children.

From six months onward an infant's diet must be gradually expanded to include complementary 'family foods'. The term 'complementary' is important. **These first foods complement breast milk.** They do not replace it. Continued breastfeeding for up to two years or beyond provides an essential source of energy and nutrients in the child's diet.

Feeding Infants 6 tot 11 months of age	
How often should I breastfeed?	Breastfeed at least 8 times, day and night, untill your child is two years old or more.
What foods should I feed my child each day?	Give soft thick porridge always enriched with: ✓ 2 or 3 colorful foods, such as orange vegetables and fruits, green leafy vegetables, eggs, beans, lentils ✓ Butter or oil each time ✓ Milk each time ✓ Small amounts of mashed chicken or fish when avaialable
How much food should I feed my child each day?	Feed 1 full cup of porridge 2 or 3 times each day, or more if your child wants In between, also give snacks 1 to 2 times each day, including: ✓ Ripe mango or papaya ✓ Carrot ✓ Banana ✓ Boiled potatoes and sweet potatoes ✓ Avocado
How should I feed my sick child?	Breastfeed your baby more often during and after illness Be patient and encourage your baby to eat during illness Give 1 extra feeding of porridge each day for 2 weeks after illness

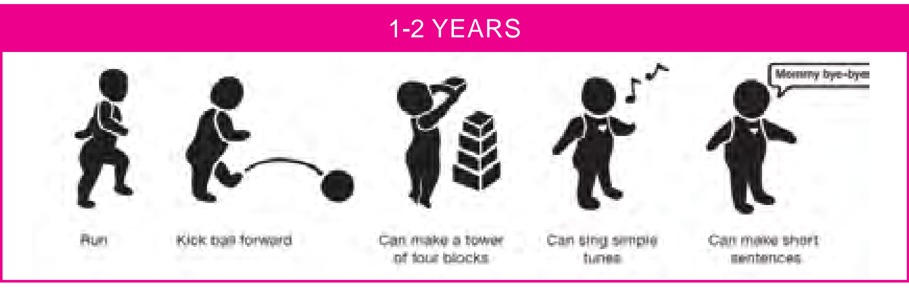
APPENDIX 13 CHILD DEVELOPMENT MILESTONES

Developmental milestones help the mother and you to check if the child is developing well. They also help you and the child's carers to stimulate and support the child's development check.

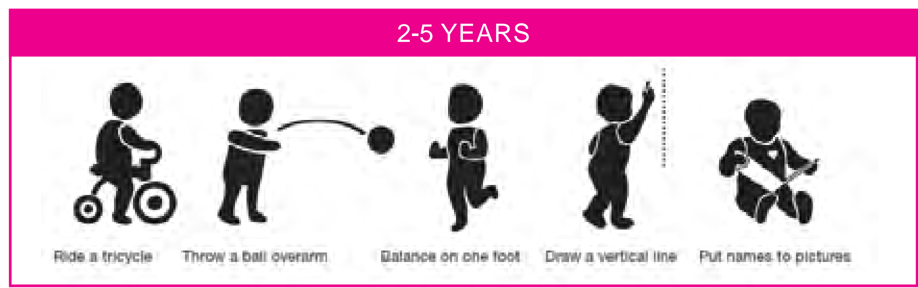
0-6 MONTHS

6-12 MONTHS

1-2 YEARS



2-5 YEARS



Play and Communicate

0-6 MONTHS

- Encourage your baby to see, hear, feel and move.
- Let your baby see and touch colourful things.
- Look into your baby's eyes and smile.
- Talk to your baby and get a conversation going with sounds or gestures.

6-12 MONTHS

- Give your baby clean household things to handle, bang and drop.
- Respond to your baby's sounds and interests.
- Tell your baby the names of things and people.
- Start reading stories to your baby.

1-2 YEARS

- Encourage your child to be active every day.
- Give your child things to stack up, put into a small box and take out.
- Ask your child simple questions.
- Respond to your child's attempts to talk.
- Play games like "bye-bye" "hello" (wave and say "goodbye", hind behind something, pop out and say "hello").
- Read stories to your child.
- Sing to your child.

2-5 YEARS

- Help your child count, name and compare things.
- Make simple toys for your child to play with.
- Talkwith your child.

Baby Teeth Facts

- A baby's first teeth begin to form in the womb.
- A baby is born with a full set of teeth in their gums. 10 on the top and 10 and on the bottom
- A baby's teeth usually appear in the mouth between 6 and 10 months of age.
- A few babies can start to teeth as early as 3 months or as late as 12 months.
- Most children will have their full set of baby teethby the time they are 3 years old

Clean Baby's Teeth

Tooth care begins even before the first tooth appears.

- Clean baby's gums and tongue using water and a clean face cloth.
- Clean baby's teeth with water usinga clean wet facecloth as soon as the first tooth appears.(You can also use o gauze or soft infant toothbrush designed for children under two years).
- Clean baby's teeth two times a day – after the first feed and after the last feed.
- Only start using toothpaste when baby is 18 months old.

Prevent tooth decay

- Feed baby aged 0-6 months only breastmilk or formula.
- Don't let baby sleep with a bottle in the mouth – the sugar in the milk can cause tooth decay, baby can also choke
- At 6 months feed baby water in addition to milk and solid foods.

Be Tooth Friendly

- Don’t give baby any sugar drinks – like sweetened rooibos, fruit juice, Oros
- Don’t dip baby’s dummy in food or sugary drinks
- Don’t give baby honey until 2 years of age
- Avoid sweet biscuits and cakes, chocolates and sweets.
- Do feed older babies (+6 months) apples, carrots and other chopped vegetables
- Do feed food and drinks that are low in sugar.
- Do let baby drink from a cup as soon as she or he can.

APPENDIX 15 VITAMIN A AND DEWORMING SCHEDULE

Deworming and Vitamin A supplementation ensure the healthy development of babies and children. It is important to keep to the deworming and Vitamin A schedule in the *Road to Health* booklet.

VITAMIN A SUPPLEMENTATION						
	At age	Date given dd/mm/yy	Signature	At age	Date given dd/mm/yy	Signature
100 000 IU	6 months	/ /				
200 000 IU every 6 months	12 months	/ /		42 months	/ /	
	18 months	/ /		48 months	/ /	
	24 months	/ /		54 months	/ /	
	30 months	/ /		60 months	/ /	
	36 months	/ /				

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 months	/ /		18 months	/ /	
	24 months	/ /		48 months	/ /	
	30 months	/ /		54 months	/ /	
	36 months	/ /		60 months	/ /	
	42 months	/ /				

VIOLENCE AND INJURY

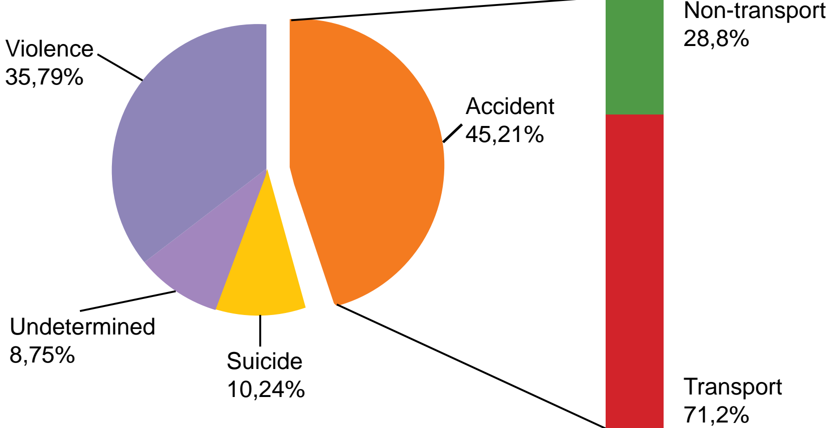
Violence and injury is a major public health issue. It is also a major individual, family and community health issue. 11,1% of deaths in 2015 were as a result of violence and injury. The health care system attends to about 3.5 million people with non-fatal injuries a year. For every person killed by violence and injury, about 30 have to be hospitalized because of the seriousness of their injuries and about 300 have to be treated and discharged. Three in four South Africans will experience a trauma or injury in their lifetimes.

DID YOU KNOW?

Injury or trauma is physical or emotional damage to a living person or animal. Physical damage involves external force of some kind. Emotional damage involves an external threat to life, bodily integrity or sanity.

Injuries are usually described by cause and intention. The primary causes of **unintentional** death or disability due to physical injury are road traffic accidents, burns, falls, poisoning, fetal alcohol syndrome and drowning. The primary **intentional** causes of death and disability due to physical injury are all forms of violence, including homicide, interpersonal violence, gender-based violence, sexual abuse, maltreatment and torture. Suicidal behavior and self-inflicted trauma is also a form of intentional violence.

Statistically, over half (54,79%) of deaths from injuries are intentional, with most being caused by violence. The remainder (45,21%) is caused unintentionally, by accidents.



National Injury Mortality Surveillance System: Manner of Death January-December 2007.

Alcohol is a common risk factor for unintentional and intentional death and injury. Harmful alcohol use significantly increases a person's risk of injury and death in road transport accidents, falls, fires and drowning. Alcohol is involved in between a quarter and a half of all intentional injury and death, injury and death from domestic violence, gang conflict and other crimes.

AS A HEALTH WORKER...

1. Physical trauma and injury always has psychological consequences that cause emotional injury, irrespective of cause and intentionality.

2. People can act to significantly reduce their own and other people's risk of death and disability from intentional and unintentional injury.

UNINTENTIONAL INJURY

INDIVIDUALLY

- Make a list of any unintentional injuries that caused you to get medical help.
- Write down what you have learned and reflect on what you need to do as a health worker in the community (think / write and plan).

UNINTENTIONAL INJURY

GROUP / CLASS

- Create a mind map of injuries that have required medical help. Organise them by cause.
- Discuss the pattern of unintentional injuries. Could they have been avoided or prevented?

DID YOU KNOW?

Alcohol is no ordinary commodity. It is a catalyst for violent and reckless behavior. Alcohol contributes significantly to death and disability. It is the most widespread substance of abuse. Based on the harm it does to drinkers and the people affected by drinkers, it is also the worst of 20 substances of abuse.

R G Matzopoulos; S Truen; B Bowman; J Corrigall "The cost of harmful alcohol use in South Africa" S. Afr. med. j. vol.104 n.2 Cape Town Feb. 2014

6.1 Violence Death and Intentional Injury

Intentional injury that leads to death and disability is widespread in South Africa. Only official crime data on murder reflects the full extent of the consequences of that crime in South Africa. All other crimes reported by the South African Police Services do not show the full extent of violence due to under-reporting. Even so, they do give a general picture of its nature and scale.

Violent crimes:

Murder per 100 000 people		Attempted Murder per 100 000 people	
2015/2016	2016/2017	2015/2016	2016/2017
33,95	34,01	32,96	32,56
	1,8% ↑		0,4% ↑
52,1 murders per day		49,9 attempted murders per day	

According to SAPS over 608,000 serious contact crimes were committed in 2016/2017. Nearly all of these involved physical assault or weapons.
5% ended in death or near death. Averaged out over the year, about 52 homicides are committed a day. The murder rate is 34/100000 and the attempted murder rates is 32,6/100000 people in the population.

Table 1: Contact Crimes (Crimes Against the Person)

	Crime Category	April 2016-2017	Crime Rate / 100 000
1	Murder	19 016	34,04
2	Attempted murder	18 205	32,56
3	Total Sexual Offences	49 660	88,82
4	Assault with the intent to inflict grievous bodily harm	170 616	305,16
5	Common assault	156 450	279,82
6	Robbery with aggravating circumstances (use or threat of use of a weapon)	140 956	252,11
7	Common robbery	53 418	95,54
TOTAL CONTACT CRIMES		608 321	Total Contact Crime Rate
			1 088,04

Violent crime is not simply a matter of policing. It is also a major public health issue because it affects the physical, mental and social well-being of individuals, families, communities and society in general. Relatively speaking, there are more murders, attempted murders, rapes and acts of sexual assault between people who know one another, who live in the same neighborhoods and who are socially and economically similar than between strangers. This is why domestic and community based violence needs to be an important focus of primary health care.

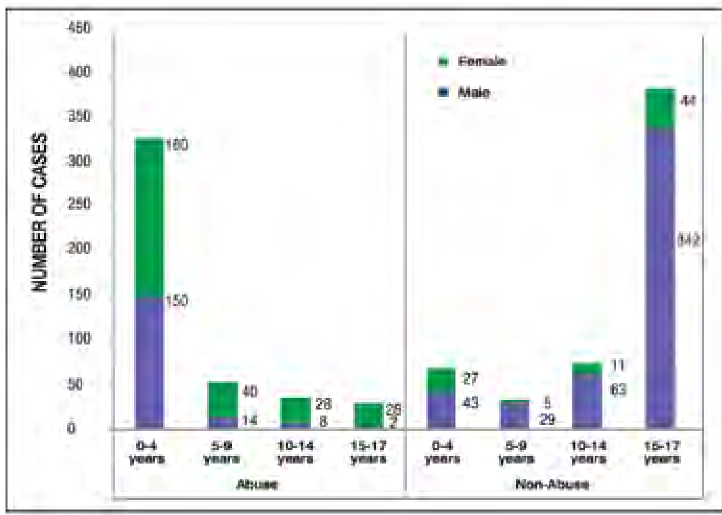
6.2 Domestic Violence

Many contact crimes occur in the context of family and interpersonal relations.

Domestic violence can happen to men and women. But most domestic violence is against women. And women are at risk of domestic violence throughout their lives. Men are likely to be more at risk during childhood and in older age. In 2009, for example, nearly 6 in 10 murdered women (57%) were killed by intimate male partners in South Africa. In 2010 about 30% of women in southern Africa experienced intimate partner violence.

Domestic violence also takes a toll on children. A Medical Research Council study of the more than 1000 children under 18 years of age who were murdered in 2009 found very distinct gender and abuse associations. (See Figure 4, below).

- Nearly half of the children (44,6%) died due to child abuse and neglect.
- Girls were significantly more likely to be victims of domestic violence:
  - ☹ A significant proportion died at the hands of their mothers.
  - ☹ Rape or sexual assault was suspected in about a quarter of girl homicides.
- Boys were more likely to be stabbed or shot, most commonly by a known person who was not related.
  - ☹ Teenage boys were at greatest risk of this kind of violence, with 53% of male homicide victims falling in the age group 15-17.



Number of child abuse-&-neglect homicides compared to non-abuse homicides by child's age and sex

AS A HEALTH WORKER...

You can impact on domestic violence. Know and understand

i) what domestic violence is;
ii) what supports exist in your community as well as in society and through the law;
iii) how to get the support a person and a family needs to help stop or get them away from domestic violence.

Although domestic violence has been a feature of South African family life for centuries, it was only made a crime in law for the first time in the new democratic dispensation.

According to the South African Domestic Violence Act (1998) domestic violence is violence that threatens the integrity (wholeness), privacy, liberty and security of a person or people in any kind of intimate and or family relationship.
In other words, it involves acts of violence against

- *intimate partners* (e.g. wives, husbands, girlfriends, boyfriends, dates);
- *siblings* (sisters and brothers);
- *children* (related, adopted or unrelated);
- *the elderly* (grandmothers, grandfathers);
- *relatives* (aunts, uncles, nieces, nephews); and
- *unrelated people* who live with or who live as if they are part of the family.

Domestic violence happens amongst all groups and classes of people in all societies. Abusers and victims of domestic violence are female and male. They can be children and adults, young or old. Victims of domestic violence are in heterosexual relationships and homosexual relationships. They come from all racial, ethnic and origin groups. They come from all socio-economic classes and occupations. They come from all religious affiliations.

Domestic violence involves four broad categories of abuse:

1.	**PHYSICAL ABUSE**
2.	**SEXUAL ABUSE**
3.	**EMOTIONAL ABUSE**
4.	**ECONOMIC ABUSE**

1. Physical abuse

Physical abuse is where a person causes pain, injury and harm to another person through intentional and unwanted contact.

Examples of physical abuse include:

- ☹ Hitting, punching, smacking, squeezing, pinching, etc.
- ☹ Scratching, biting, pulling hair, kicking, strangling, etc.
- ☹ Throwing any object at another person.
- ☹ Pushing or pulling the person around.
- ☹ Grabbing any part of a person's body to stop them from going or to force them to go somewhere.
- ☹ Using a gun, knife, stick, bat, mace or other weapon on or to threaten another person.

Physically violent abusers often don't act in mindless rage. Rather, they carefully aim their kicks and punches where bruises and marks won't show.

2. Sexual Abuse

Sexual abuse is any action that pressures or coerces a person to do something sexually that they don't want to do. Sexual abuse is also any action that takes away a person's control over their sexual activity or the circumstances in which sexual activity occurs.

Examples of sexual abuse include:

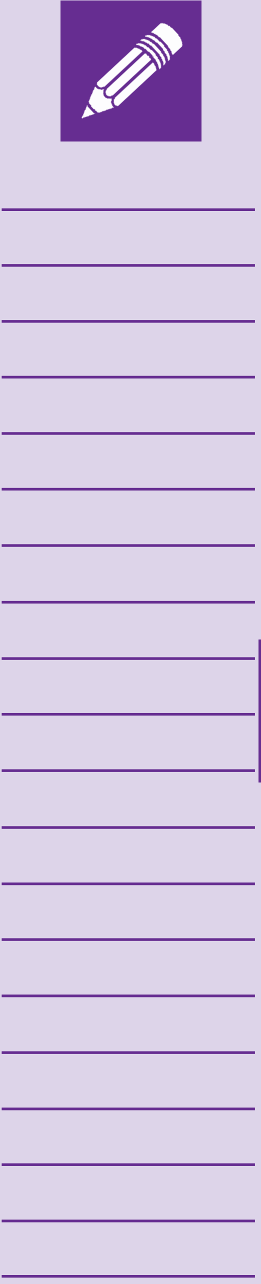
- ☹ Unwanted kissing or touching.
- ☹ Unwanted rough or violent sexual activity.
- ☹ Rape or attempted rape.

- ☹ Refusing to use or stopping a person from using birth control.
- ☹ Refusing to protect or stopping someone from protecting themselves from sexually transmitted infections (STIs).
- ☹ Having sexual contact with a person who is unable to say “yes” or “no”, because they are drunk, drugged, unconscious,too afraid or otherwise unable to respond.
- ☹ Threatening someone into unwanted sexual activity.
- ☹ Repeatedly putting pressure on someone to have sex or perform sexual acts.
- ☹ Repeatedly using sexual insults toward someone.

3. Emotional Abuse

Emotional abuse is verbal and/or psychologically manipulative behavior that is used to threaten, insult, humiliate, intimidate, undermine, isolate or prey on another person or other people.
Emotional abuse takes many forms. It includes:

- ☹ Name calling, shouting or screaming.
- ☹ Private and public humiliation, putting a person down.
- ☹ Controlling the other person’s relationships with family and friends – like who they see, talk to, spend time with, etc.
- ☹ Taking control of and/or repeatedly criticizing the other person’s appearance, choice of clothes and behavior.
- ☹ Using the internet or cell phones to control, intimidate or humiliate a person.
- ☹ Following, watching or harassing a person so that they feel unsafe and afraid.
- ☹ Blaming their abusive or unhealthy behavior on the actions of the person who is being abused.
- ☹ Threatening to harm a person, their pets or people they care about.
- ☹ Threatening self-harm, abandonment or public humiliation.



Some girls believe that if a boyfriend gets jealous or checks up on them it means he loves them. This is not true. This kind of behavior is not about love. It's about control and about a boy making a girl behave in the way he wants.

4. Economic abuse

Economic abuse is where domestic finances are used as a tool of power and control over another person or other people.
Examples of economic abuse include:

- ☹ Using money to hold power over the other person.
- ☹ Unreasonably withholding money, food, transport, rent, medicine or clothing from the other person or people who depend on them.
- ☹ Unreasonably controlling how the other person spends her own money.
- ☹ Preventing the other person from working and/or accessing their own income.

AS A HEALTH WORKER...

You need to know that domestic violence

- is a crime.
- it often involves a combination of physical, sexual, emotional and economic abuse.
- it usually involves more than one criminal act.
- it is always an individual health issue, a family health issue and a community health issue.

Preventing Domestic Violence

Preventing domestic violence requires that health care providers are able to recognize the warning signs and activate and apply all the principles of COPC.

Health care providers need to work in teams together with individuals, families, the community and relevant professionals. They need to work together to support the full spectrum of prevention.

Prevention in Health Care

In health care prevention refers to activities that are designed to protect people from actual or potential health threats, like domestic violence and their harmful consequences.

Warning Signs of Domestic Violence and Abuse

http://www.helpguide.org/articles/abuse/domestic-violence-and-abuse.htm#warning (2015/07/20)

It's impossible to know with certainty what goes on behind closed doors, but there are some telltale signs of emotional abuse and domestic violence.

General warning signs of domestic abuse

People who are being abused may:

- Seem afraid or anxious to please their partner.
- Go along with everything their partner says and does.
- Check in often with their partner to report where they are and what they're doing.
- Receive frequent, harassing phone calls from their partner.
- Talk about their partner's temper, jealousy, or possessiveness.

Warning signs of physical violence

People who are being physically abused may:

- Have frequent injuries, with the excuse of "accidents".
- Frequently miss work, school, or social occasions, without explanation.
- Dress in clothing designed to hide bruises or scars (e.g. wearing long sleeves in the summer or sunglasses indoors).

Warning signs of isolation

People who are being isolated by their abuser may:

- Be restricted from seeing family and friends.
- Rarely go out in public without their partner.
- Have limited access to money, credit cards, or the car.

The psychological warning signs of abuse

People who are being abused may:

- Have very low self-esteem, even if they used to be confident.
- Show major personality changes (e.g. an outgoing person becomes withdrawn).
- Be depressed, anxious, or suicidal.

Prevention strategies are organized along a continuum of time:

- before the problem starts (called primary prevention);
- once a problem has begun (called secondary prevention); and
- after the problem has occurred (called tertiary prevention).

Prevention strategies are also organised according to the target population:

- universal prevention (everyone benefits);
- selective prevention (people at higher than average risk benefit); and
- indicated prevention (people who are known or show signs of having the problem benefit).

The preventing domestic violence matrix shows the universal, selective and indicated actions that can be taken at each level of prevention.

Preventing Domestic Violence: A Matrix for Action

PREVENTION	UNIVERSAL	SELECTIVE	INDICATED
Primary (Knowledge and awareness)	Everyone should know about domestic violence	The people at greatest risk should know about domestic violence	The people who show signs of domestic violence should be helped to understand how it works and what they can do about it
Secondary (Organise, Support and counsel)	Set up organisations, groups and networks that can assist prevent domestic violence	Create groups and networks that support people at greatest risk for domestic violence	Assist people who are exposed to domestic violence to get help
Tertiary (Protection orders, Provide Shelter)	Know and mobilise laws, policies and services	Know and make sure people at risk have service and legal support	Provide individuals exposed to domestic violence with help (counseling, health care, shelter, policing and legal services).

Assisting a Victim of Violence

It is not ease to know when a person is a victim of domestic violence unless they tell you. It is also hard to know what to do to help them when you suspect they are being abused. There are warning signs that there may be domestic violence or abuse. And there are ways of helping victims of domestic violence.

To assist a victim of violence:

DO:

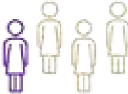
- Get assistance and support from your team.
- Ask the person if something is wrong.
  - Express concern.
  - Listen and validate.
  - Offer help.
- Support the person's decisions.
- Remember the safety of the victim comes first.

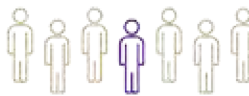
DON'T:

- Wait for the person to come to you.
- Judge or blame.
- Pressure the person.
- Give advice.
- Place conditions on support.
- Promise to do things that you can't do or honour.
- Discuss domestic violence with the victim in the presence of the perpetrator.

More than seven in ten of all unintentional deaths in

Domestic violence can affect anyone

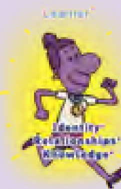




1 in 4 women 1 in 7 men

at some time in their life will experience domestic violence.

6



AS A HEALTH WORKER...

You should know that perpetrators of violence also need help if the abuse is going to be stopped.
To help abusers you need to get people with the skills to assist your team.

6.3 Road Traffic Accidents and Unintentional Injury

South Africa are caused by road traffic accidents. The remainder is caused by burns, falls, drowning and accidental poisoning etc.

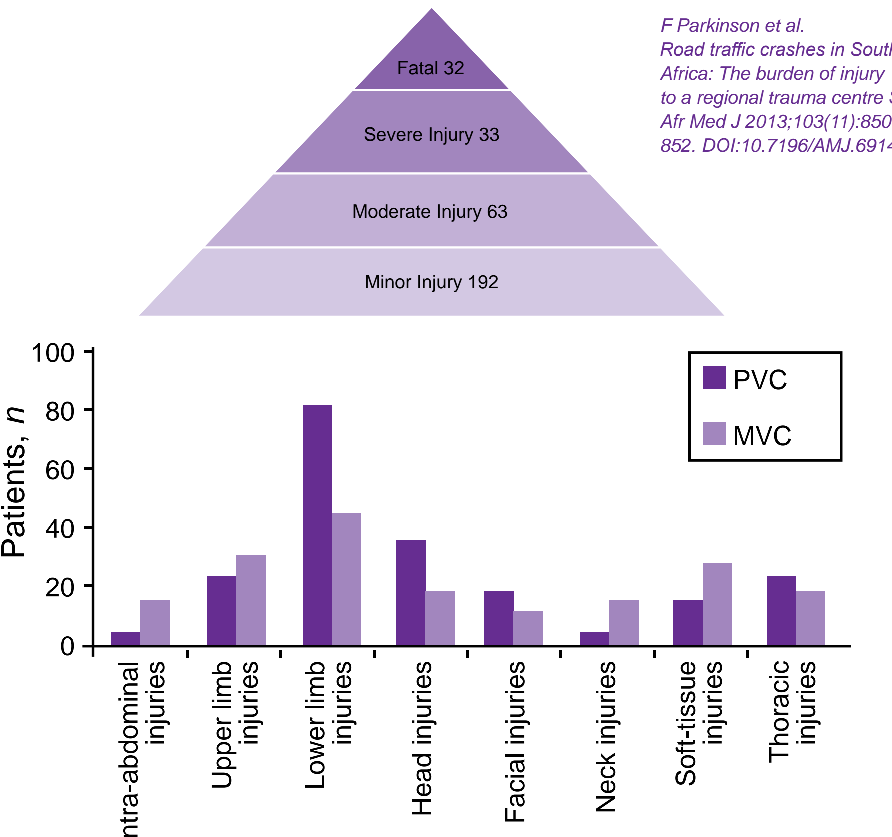
South Africa has a road accident mortality rate of 43/100,000 people in the population. Road traffic accidents lead to about 18,000 deaths a year. Road accident injuries are the leading cause of violence and injury for women and the second leading cause of death for men. They are also the leading cause of injury and death from violence and unintentional accidents for children under 15 years of age.

Road traffic accidents are very costly to public health and the public health care system as the study of one trauma centre KwaZulu-Natal shows.

2011-2012 Cost of Road Traffic Accidents in One Trauma Centre: KwaZulu Natal

ISSUE	NUMBER
Total road traffic accident patients seen at Edendale Hospital	305
Road traffic accident patients admitted	100
Road accident fatalities recorded at police mortuary (15 at scene, 17 at EH)	45
Patients who were in the motor vehicle (14 drivers, 44 passengers)	59
Total injuries for all patients	197
Total patients requiring surgery	62
Total operations	90
Total operating theatre hours	182
Total days in hospital for all patients	1859

Death and Injury Consequences of Road Transport Crashes



Distribution of injuries according to body region.

Who dies, when accidents happen and the reasons for road traffic injury and death make the cost of road traffic death and disability even more unacceptable. The fact is, **most road traffic accidents are avoidable.**

Who

Of the people who die in road accidents

- 25% are drivers;
- 35% are passengers;
- 3% are cyclists
- 37% are pedestrians

Of these pedestrian deaths:

- 16% are children under 15 years of age
- 11.5% are children under 10 years of age;

5 Facts that Make Younger Children Vulnerable to Death and Injury on the Road

1. Children are small in stature. Drivers can't always see them. They move quickly.
2. Children are fragile so their injuries are likely to be severe.
3. Children don't have the sensory skills (sound and sight) to warn them about the dangers of moving vehicles.
4. Children don't have the developmental skills to make judgments about safe road use. They move from safety to danger very quickly.
5. Children don't have the cognitive and emotional skills to manage their curiosity, impulsiveness and focus. They are both easily distracted and really focused.

When

Road accidents can happen at any time. However, we know that fatal road accidents happen more often at particular times in the week and in the day.

☹ About a quarter happen between16.00 and 22.00 hours.

☹ Three out of every five happen at weekends, between Friday and Sunday .

☹ Weekday afternoons are the most common time for road traffic fatalities amongst children.

Why

Road accidents usually happen because of a combination of human, vehicle and/or road environment factors. Between October and December 2016

☹ 75% of fatal road accidents were caused by what people do.

- ☹ 17% were caused by the poor condition of vehicles.
- ☹ 7% were caused by bad roads or the road environment.

AS A HEALTH WORKER...

Accidents and death from road accidents are unintentional. But they are avoidable. As road users, we all need to know how to stop injury and death on the roads.

There are five main factors that lead to serious injury and death in road accidents.

1. Alcohol and substance use.

- ☹ About 5 in 10 drivers who are killed on the road had blood alcohol levels above the legal limit.

- ☹ About 6 in 10 pedestrians who are killed on the road have blood alcohol levels above the legal limit.

2. Driving too fast.

- ☹ Driving above the speed limit.
- ☹ Driving too fast around a corner.
- ☹ Driving too fast in built up areas where children play.

DID YOU KNOW?

Speed Kills!
Speeding is a factor in nearly one-third of all fatal road traffic accidents.

- Speed reduces the amount of time needed to stop the vehicle.
- Speed increases the distance a vehicle travels while the driver reacts to a dangerous situation.
- Speed reduces the ability of the driver to steer safely around curves or objects on the road.
- Speed increases the likelihood of crashing.
- Speed increases the severity of a crash once it occurs.

http://www.arrivealive.co.za

3. Distracted driving.

- ☹ Loosing concentration due to fatigue (mostly not stopping often enough on longer journeys, driving in the early hours of the morning, falling asleep at the wheel).
- ☹ Manipulating instruments (mirrors, CDs, radio etc.).
- ☹ Using a mobile phone (dialing, answering, talking, texting).
- ☹ Eating, drinking or smoking.
- ☹ Grooming (shaving, doing hair, makeup etc.).
- ☹ Changing clothes.
- ☹ Attending to passenger behavior managing (children, babies, adults).
- ☹ Feeling or expressing strong emotions (anger, grief).
- ☹ Reading and writing.

4. Poor seat belt use.

☹ 41% of drivers, 23% of all front seat passengers and 98% of all rear seat passengers do not use seat belts.

It is illegal to not buckle children up when they travel in a motor vehicle.

5. Poor pedestrian visibility and use of the road.

☹ Walking drunk.

☹ Wearing dark clothing and not being visible at dusk and at night.

☹ Walking on the road or freeway.

☹ Not crossing at safe places.

☹ Not understanding and accounting for driving speed and driver behavior (e.g. thinking a moving vehicle can stop as quickly as a person can stop walking).

All the main risks for fatal and serious injury on the road are modifiable which means they can be reduced if people learn to use the road differently.

AS A HEALTH WORKER...

You can promote safe road use and prevent road injury in the community.

Do five things.

1. Help children and adults learn how to be safe when they walk and play on the road.
2. Encourage adults to take charge of the road environment where they live.
3. Help children and adults learn how to keep themselves safer when they ride in cars, taxis or buses.
4. Help adults and children know about the dangers of speedy, reckless and unsafe driving.
5. Make adults and children aware of the dangers of driving and drinking.

PEDESTRIAN ROAD SAFETY TIPS FOR CHILDREN AND ADULTS

Adapted from
https://www.arrivealive.co.za/Road-Safety-for-Children

1. **Always walk on the pavement**
   - If there is no pavement, walk facing traffic. This way you can see cars as they come towards you and you can get out of the way to avoid danger.

2. **Cross at marked intersections (like stop streets, robots, pedestrian crossings).**
   - Most pedestrian are knocked when they cross the road at places that are not intersections.

- Where there is no place marked for pedestrians to cross, find a straight part of the road where you can see and be seen clearly from both directions. There must be no bushes, hills, bends or parked cars.

3. **Pay attention to vehicles and what they are doing**
   - Look and listen.
   - Always look right, look left and look right again BEFORE and WHILE you cross a road.
   - Don't expect drivers to stop, even if they are supposed to.
   - Make eye contact with the driver when you walk across busy streets.
   - Walk quickly across the road.
   - Don't run across or onto the road.

4. **See and Be Seen**
   - Drivers need to see you to avoid you.
   - Don't cross the road between parked vehicles.
   - Wear light or bright color clothes at dawn, at dusk and in the night.

5. **Be Sober on the Road**
   - Don't walk on the road if you have been drinking or you have taken drugs.
   - If you have been drinking, get someone who has not been drinking to fetch you or sleep where you are.

6. Watch over children - yours and other people's

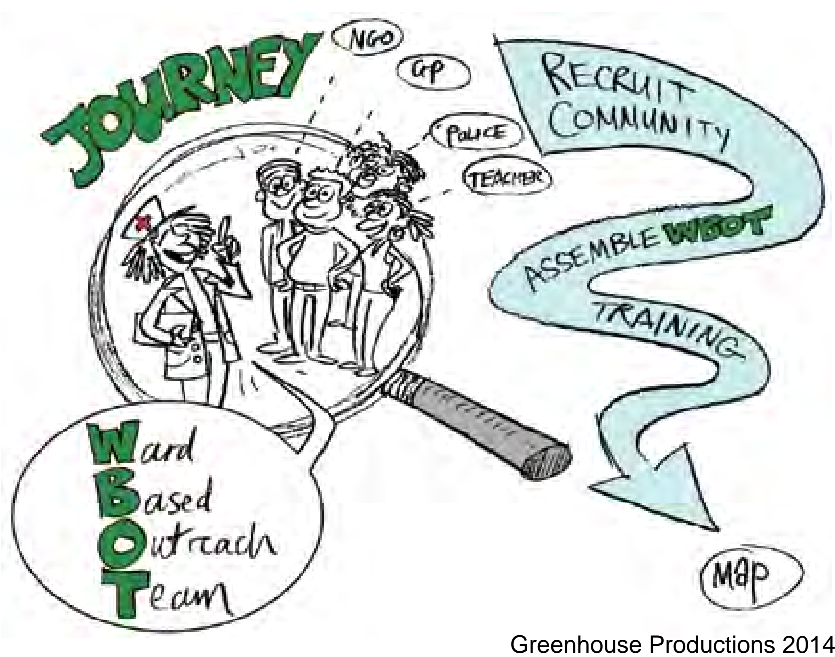
- When you walk along or across the road
  – always hold a child's hand.
  – always hold someone's hand.
- Make sure children play where it is safe.
- No child should be left alone in a vehicle.
- No child should play on the street.
- No child should play in the drive way.
- Teach children how to be safe on the road.

6

Introduction

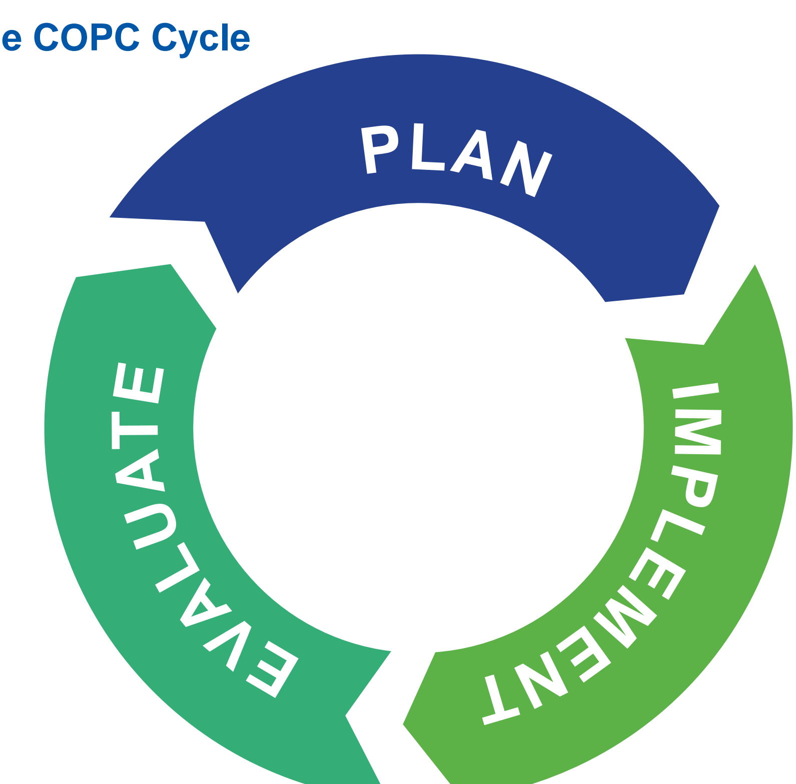
Doing community oriented primary care is a cyclical process of planning, implementing and evaluating. It begins with identifying a community and creating a team that works with people to find out about local health and health related issues. The health care team uses the information it has to develop a local action plan to provide and support quality services. The team then implements the action plans, monitoring their work to make sure that they are on track. The plans are also evaluated to see if they have the effect they are supposed to have. Using the knowledge and experience that they gain from doing COPC the team reviews their work, reprioritizing and re-planning. The close of the first cycle is also the start of the next PIE (plan-implement-evaluate) cycle.

Doing COPC becomes an ongoing and continuous cycle of improvement so that over time health service delivery leads to higher levels of health literacy, better health care practices and better health outcomes.



Greenhouse Productions 2014

The COPC Cycle



PLAN	**COPC TOOLKIT**
	• Facility catchment area
	• Resources
	  • Teams
	  • CHWs
	  • Equipment
		FACILITY ACTION PLAN
		• Management
		• Learning (Work *i* Learn)
		• Service support
		• Linkage to care
		• Partnerships (LISA)

IMPLEMENT	**FACILITY** • Management • Work *i* Learn • Clinical support • Linkage to care (District Health Team) • Partnerships, Community Health Fourm	**COMMUNITY HEALTH TEAMS** • Community entry • Mapping • Household and individual registration and assessment • Service • Work *i* Learn
EVALUATE (Monitor, Review and Revise)	**FACILITY** • Management • Learning • Clinical support • Linkage to care • Partnerships	**COMMUNITY HEALTH TEAMS** • Service • Learning • Performance

7.1 The Place

If community is the starting point of doing COPC, the first thing that we need to do is identify the place or space that we are thinking about.

In COPC, we use the term community to refer to geographical space and physical place.

WHAT IS A COMMUNITY

INDIVIDUAL

What makes a ward / village or school / college a community?

What makes a ward / village or school / college a good place to do community oriented primary care?

DID YOU KNOW?

A community is
- a specific geographical space
- a place where people live (e.g.ward, suburb, village, town, farm or hostel, prison etc.)
- a place (or institution) where people work or study (e.g. school, college, office, factory, farm etc.)

Organizationally, government plays an important role. Provincial departments and local municipalities and councils determine the larger geographical space in which COPC is practiced. In other words political-administrative boundaries (ETU) are used to define “community” in community oriented primary care.

When COPC was reintroduced as an approach to health care, Tshwane District (Gauteng Department of Health) began a nine-site pilot in 2011, concentrating on the poorest wards in priority areas in each sub-district.

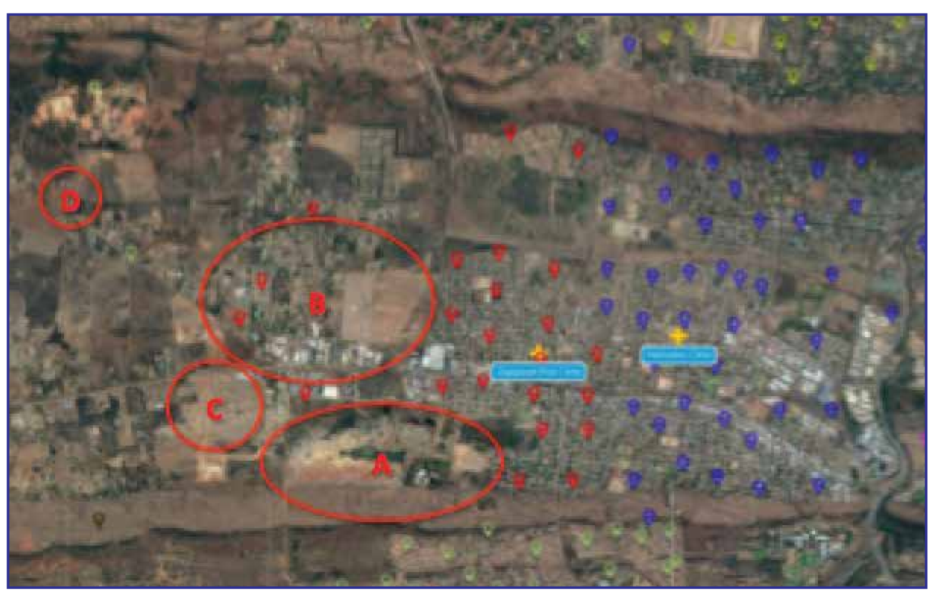
In 2013, the City of Tshwane started COPC across Mamelodi.

In 2014, the City of Tshwane and Tshwane District (GDoH) began an integration process to streamline delivery and support the expansion of COPC in Tshwane District including the City of Tshwane. Between January 2014 and May 2018, 291 WBOTs had registered 206593 households and over 600,000 people using AitaHealth.

Practically, community based health care teams do COPC in the , homes, crèches, schools and places of work that fall in the geographic catchment area of a health care facility. These are the places where people who are physically closest to a facility, live, work, learn and play.

Below is the Hercules Clinic Catchment area population (Blue) and the Daspoort Policlinic catchment area population (Red) with Melusi Informal settlement in April 2018.

Melusi Informal Settlement and Hercules and Daspoort Clinic Catchment Areas



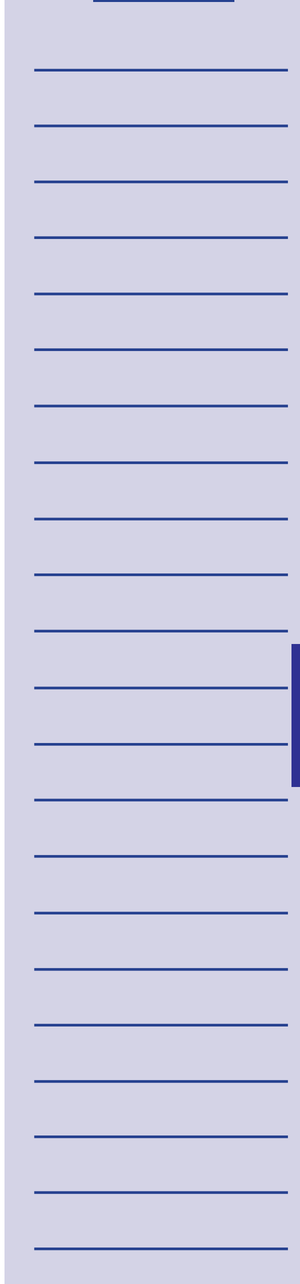
Geoff Abbott, Rod Bennett, Jannie Hugo, Tessa S. Marcus, Geoff Abbott, COPC Toolkit (2018)

Within each place, team members also work in defined physical boundaries. Through a process of physical mapping, teams and team members are assigned to particular households or individuals where they live, learn or work. In this way every team member is connected to defined people in defined places.

IDENTIFICATION AND MAPPING OF A COMMUNITY

WORK IN GROUPS OF 4

1. Physically identify a community.
2. Map the community (determine the boundary of the community and the number of stands and households.



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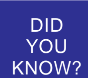
7.2 The Health Care Team

Health care teams have to be created to deliver primary care services.In South Africa (and in many other parts of the world) they are created by the Department of Health on its own or together with non-governmental and private sector health care providers. In COPC what is important is that the approach is **integrated into and part of normal service delivery.**

Health care professionals take the lead in delivering COPC for three reasons. Firstly, this service needs to be managed and provided by trained and qualified health professionals.

People want and should get the best available health care. Also, primary care should never be made into low quality care because then its impact on health is reduced and people are forced into higher levels of services. Secondly, as registered health care providers, health professionals are expected to commit to ethical practice. They are able to guide team practice at the same time as they and their teams are held accountable to their profession for what they do and say. Thirdly, they are in the best position to manage the integration of clinical care from the home into clinics and hospitals and back home again.

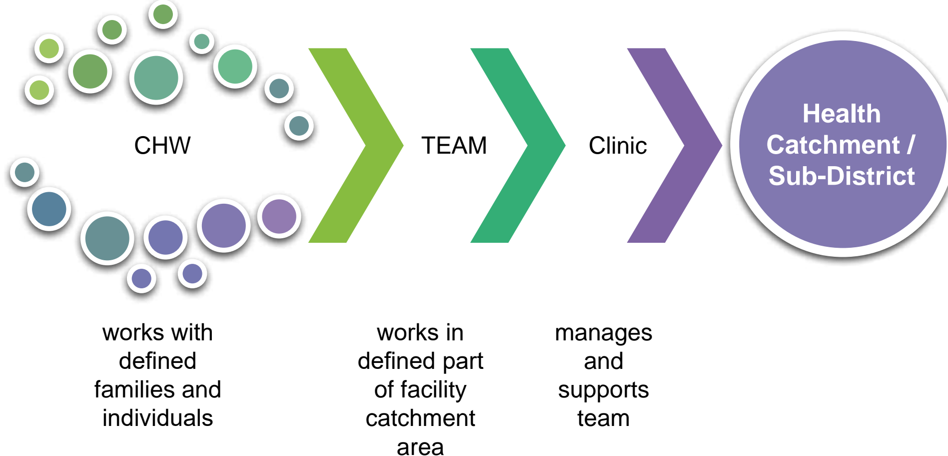
Go to 8: Appendix 4 – The Multidisciplinary Team to learn more about the team's clinical and professional role.



"In every society there are agreed rules and practices of health care that say who can diagnose disease and treat health conditions. These rules and practices are important for two reasons. First, they set the standards of education, training and behaviour that clinicians have to have to be allowed to take responsibility for and do these tasks. Second, they guide people to know what to expect from health care professionals.

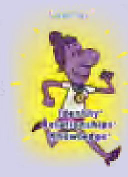
In primary health care, clinicians are responsible for assessing, diagnosing, treating and managing diseases and health-related conditions. Clinicians are health care professionals. Although there are different kinds of clinicians in South Africa, they all have one thing in common. They have all attended and completed an education and training programme for three or more years. This means that they have formal training and a formal qualification. They have also registered with and have a license to practise from a professional board."

Tessa S Marcus 2013:29



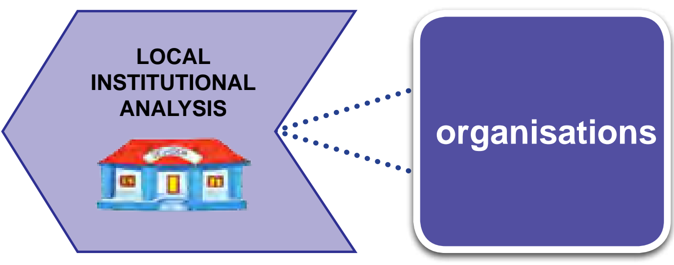
Health care and allied professionals involved in COPC include doctors, nurses, clinical associates, physiotherapists, and occupational therapists, speech and language therapists, psychologists, dentists, dieticians etc. They also work with other professionals, including social workers and auxillary social workers.

Community health workers are also part of health care teams. These are women and men who live in and come from the communities the teams serve. They do not have professional health qualifications. However, they bring valuable knowledge about the people and the communities where they work.



AS A HEALTH WORKER...

remember team work is group work.
Use the same skills in team work that you use to learn in groups.



Organisational and Institutional Partners

Identifying the team is the first step in identifying organisational partners. Because the team includes health care providers and professionals from different disciplines in health or from other service sectors, like social development or counseling, they have to link and work with their organisations.

Team members can come from

i) Government departments or divisions like the Department of Social Development or the City of Tshwane's Integrated Community Development Division.

ii) Not-for-profit organisations, like Sungardens Hospice, Abba Adoptions and Social Services, ACDiSA (Applied Counselling and Development Institute of South Africa) and many others in Pretoria.

iii) Educational organisations and departments. For example, medical, health science, psychology, theology, architecture, design and other students from the University of Pretoria are actively involved in COPC as part of their formal learning requirements.

Just as importantly, in COPC health care teams have to work with the range of organisations and institutions that are already active or based in their defined communities. Each organization has its own purpose and specific functions. Each also directly or indirectly plays a part in the health of individuals, families and communities.

To find potential local partners the health care team has to do a Local Institutional Support Assessment (LISA). LISA helps the health care team make contact with local organisations. Through it the team finds out about what each one does and if the organisation can be part of COPC. The team also finds out how it can be support the organisation. The purpose of LISA is to maximize local collaboration and resources.

Health Care and Allied Professionals and What They Do

(adapted from Marcus 2013:30-31)

Professional	Practice
Art/Music Therapist	use art, drama, music and dance to relieve symptoms and to provide, emotional, cognitive and physical integration and personal growth.
Clinical Associate	assist assess, treat and manage ill health and disease
Dental Therapist	identify and treat conditions that affect the teeth and gums
Dietician	assess and treat individuals and groups using dietary principles to control disease and promote health
Doctor/ Family Physician	assess, treat and manage ill health and disease, integrate clinical and family health
Environmental health practitioner	detect, diagnose and manage health and safety in various environments (e.g waste management, pest control, food safety etc.)
Nurse (Professional Nurse qualification)	assess, plan, deliver and evaluate comprehensive nursing care for individuals and groups, promote rehabilitation, diagnose and treat minor and common ailments, deliver safe obstetric care, manage a health care unit or facility.Apply biomedical, biotechnological and psychosocial sciences in practice. Develop, implement and evaluate population based health care.
Occupational therapist	assess and treat people with physical or mental impairment to achieve independence in all facets of their lives
Optometrist	detect, diagnose, treat and manage disease in the eye, and the rehabilitation of conditions of the visual system.
Physiotherapist	assess, treat and manage human movement disorders to manage pain, restore function, inimize dysfunction and prevent disability
Psychologist	assess, treat and manage emotional, cognitive and behavioral conditions using psychotherapeutic techniques
Social Worker	seeks to improve the quality of life and well-being of individuals, families, couples, groups, and communities by problem solving in human relationships, promoting social change and intervening where people interact with their environments.
Speech/Language/ hearing Therapist	assist identify, prevent, treat and manage a variety of developmental or acquired speech, language, oral and hearing disorders.

AS A HEALTH WORKER...

1. Find the organisations that are locally active
   - if your community is a place where people live this means organisations like schools, crèches, clinics, churches, shops, spazas, shelters;
   - if your community is a school/college this means departments, disciplines/subject groups, professional and technical service providers, partners, unions, teacher associations.
2. Find out if and how their activities link to health care.
3. Find out about potential areas of cooperation and partnership.
4. Find out about the resources they can contribute to COPC (people, time, finance, systems, skills).

7.3 Creating a Community Health Forum

The aim of community oriented primary care is to maximise the impact on health of all services in a community. This is done by encouraging cooperation in order to bring together all the people, resources and activities that contribute to health.
One way to encourage cooperation is to create a Community Health Forum that is made up of interested, relevant local organizations and people. It is a way of getting important community members to contribute to and take ownership of COPC.

In COPC, the Community Health Forum is an advisory body. It gives input and direction to COPC but it is not a decision-making authority. It also is not part of the health care team that implements the programme.

The Community Health Forum is a formal but voluntary structure that is made up of people from organizations working in the community. Forum members should be willing to contribute resources and align their activities as well as give direction to and support the work of COPC. The forum should be made up of people who come from a wide variety of organizations and experiences. This way everyone can make an input into COPC. It also gives every organization a stake in local health care.

A COPC Community Health Forum should include the following kinds of people:

- professionals (like doctors, teachers);
- public officials (ward councilors, school principals, clinic heads); civic, traditional and faith based leaders (from not for profit organisations, churches, clubs etc.);
- business people (like factory, shop or taxi owners);
- workers representatives (like trade unionists); and
- unofficial community leaders (men and women who are known and respected).

7

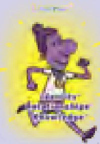
As with any organisation, it must have a purpose. In COPC, the purpose of the Community Health Forum is

- to consider the big picture (where does COPC fit in);
- to share information (what is happening in the community);
- to coordinate activities (look for opportunities to maximize collaboration and minimize duplication); and
- to identify opportunities and risks (to community health, to COPC as an approach and to partner organisations).

It is important that the Community Health Forum is functional and effective.

- Ideally it should have about 15 members. (It can't be too big as it will not work.)

- The composition of the community health forum should keep up with changes that are going on in a community. (Some people or organisations may fall away while new ones may appear because COPC itself will throw up new leaders.)
- It should meet at set intervals (e.g. two or three times a year).
- Each community health forum meeting should have a clear purpose and agenda (e.g. to build a common understanding of COPC, to report on health issues and services, to share information, to advise on challenges, to raise funds/share resources, to mobilise support etc.).
- The community health forum should be run in a way that encourages participation and inclusion. It should also be run efficiently to make the best use of people's time.



AS A HEALTH WORKER...

You need to know that the community health forum is a resource that is there to help deliver COPC. It is a vehicle for structured community input. Effective COPC is inclusive and expansive.

Developing a Shared Understanding of COPC

Things seem to be ready made. We think that cars, cell phones, computers, schools, clinics, hospitals, the internet etc. and the systems and relationships that make them happen always have been and always will be there. But everything has a beginning. Everything has to be developed into the things we now know them to be. Everything also has to be used or put into practice and to work to continue to exist, as the brainteaser example shows.

The fact is, every social activity, every initiative that is taken in society and every thing we make and use comes out of a process where people come together and develop a shared understanding of what it is they want to do and then they do it. This is as true for COPC as it is for things.

In order to do community oriented primary care people have to develop an understanding of what it is and how to go about doing it. One way to start to develop a shared understanding is to organize a workshop to introduce people to and give them information about COPC.

PLAN A COMMUNITY HEALTH FORUM INFORMATION WORKSHOP ON COPC PRINCIPLES.

WORK IN GROUPS

1. Carefully read ***How to Hold a Workshop*** (Appendix 2 (Section 8)).
2. On a blank sheet of paper, draw a table with the following plan headings:

Workshop Topic	Content	Learning Style / Activity / Approach	Materials	Venue	Person Responsible	Time

3. Fill in the Plan.

AS A HEALTH WORKER...

use the information from LISA to

- identify people and organisations who should be part of the community health forum;
- discuss with team members the reasons for their inclusion;
- invite them to join.

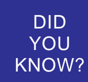
Partners and Partnerships

You have already used LISA to identify who can provide advice and direction to community oriented primary care as members of the Steering Committee.

LISA also can help teams to identify partners. When people or organisations become partners they form partnerships. (Go to 8: Appendix 1 – LISA Checklist)

LISA helps identify the organisations and people

- who contribute through their daily activities to community health;
- who can provide locally available expertise; and
- who are willing to partner to deliver COPC.



Partnerships take different forms.

In partnerships between organisations, each partner keeps its own organizational identity and purpose (e.g. the City of Tshwane and the Department of Family Medicine are partners in doing COPC in Tshwane).

In partnerships in a team, partners share a common team identity and purpose (e.g. members of a ward based outreach team work with one another as a team to deliver COPC).

In partnerships between individuals, each individual keeps his or her own identity but shares a common purpose (e.g. when two people fall in love).

There are different kinds of partnerships, but here the focus is on partnerships between organisations in and across systems.
Partnerships between organisations have the following characteristics.

1. They are cooperative relationships between two or more organisations. Practically they are a working alliance between people in organisations who know about and work with one another on a particular problem or issue.
2. They are built on a shared understanding of problems and an agreed response to them. In health care they identify and develop shared responses to health needs.
3. They are dynamic, living relationships. This means that over time they change as priorities and circumstances change in and between each partner organisation as well as in the community.

Partnerships can be formal or informal.

Informal partnerships are usually word-of-mouth agreements. They work well where collaboration is around specific and achievable issues in the short term.

Formal partnerships are written agreements (e.g. a memorandum of understanding, a memorandum of agreement or even a formal contract). They work well where the relationship is built around a range of issues and involves commitment over time.

FINDING PARTNERS

DIVIDE INTO 3 GROUPS

(GREEN, YELLOW AND ORANGE)

Identify all the organisations/departments that said they were interested in partnering with WBOTs to deliver COPC (LISA questions 14 who answered YES)

Identify all the organisations/departments that said they may be interested in partnering with WBOTs to deliver COPC (LISA question 14 who answered MAYBE)

Identify all the organisations/departments that said they were not interested in partnering with WBOTs to deliver COPC (LISA questions 14 who answered NO)

Each colour-coded-group must create a table that provides detailed information about each organisation (use responses to LISA questions 1-8, 11-13)

7.4 Building Partnerships

Identifying potential organisations is the beginning of a process of creating relationships that may lead to partnerships. There are several more steps that need to be taken in order for organisations to work together as partners.

- **Contacting**
  The next step in the process is to make contact with each individual organization/ person who expressed an interest in COPC in order to share information with one another and discover possible areas of cooperation. This means getting in touch with a potential partner
  i) Write a letter or an email;
  ii) Call by telephone; and
  iii) Go in person to make an appointment

It is important that contact is made with the head of the organization or the person who provided their contact details (e.g. on the LISA).

- **Meeting**
  Once contact is made, it is is important for partner organisations to meet one another. The main purpose of the first meeting is to share information.This meeting can involve more than two organisations.

  It should give people an opportunity to introduce themselves and their organisations to one another (who they are) as well as to explain what they do and how they work.

  Through this exchange it is possible to identify what each organization has in common. Also each organization can reflect on working together in order to decide if and how they can build a partnership.

7

- **Forming a relationship**
  Once organizations decide to become partners they have to come to a shared understanding of how the partnership will work.
  They need to agree on five main issues:

  1. The purpose of the partnership (this is a summary of the intention of the partnership in a sentence or two);
  2. The short and long term goals of the partnership (what the partnership wants to achieve or its aims);
  3. What is expected from each partner (the tasks and resources that each partner will contribute, how they approach the way they work with each other as well as in the community);
  4. The length of the partnership (how long the partnership is expected to go on); and
  5. The terms of entry and exit (how partners come in and leave).

It usually takes several meetings to reach agreement on these issues. Putting in the time and effort to get a shared framework is worthwhile. Although it is hard to put partnerships into practice, it is even harder to keep them going without thorough discussion.

- **Working together**
  Once a partnership is formed then partners have to put what they agreed to do into practice. But because a partnership is also a relationship, keeping it going also depends on how people work together.

The success of partnerships depends on several factors. These include:

- ***Respect and trust.*** This comes from civil practice, recognition of the importance and value of each person/partner, and from each partner doing what it has agreed to do).
- ***Compatible ways of working.*** The culture of partner organisations should not cause conflict or tension. All partners should be active participants in decision making. One organization or person should not dominate or manipulate others.
- ***Capable organization.*** This means good management of people, time and resources as well as effective delivery.
- ***Communication.*** This is done through regular contact and interactions, exchanges of ideas and information, as well as through clear, honest and open explanations and responses.
- ***Commitment.*** This means owning the partnership and putting in time and effort.

DID YOU KNOW?

Meetings (workshops, committees, forums, get-togethers, public meetings) are at the heart of starting and building partnerships between people and organisations.

IDENTIFICATION AND MAPPING OF A COMMUNITY

IN PAIRS OR FOURS

Arrange to meet with one organization /department or person that expressed interest (answered YES or MAYBE) in COPC.

i) Prepare for the meeting by using the information collected through LISA as well as what you know about COPC.

ii) Meet with the head or a key person from the organisation to share information about each other's activities and possible areas of cooperation. Take notes during the meeting.

iii) Discuss what you have found out (including obstacles and concerns);

iv) Determine if there are areas of cooperation and decide on the next steps to be taken.

7.5 Organisational and Institutional Resource Gaps

Mapping, LISA, networking (for example, through the Community Health Forum) and partnerships help you find out what exists. They also help you discover organizational and institutional gaps in the community.

There will always be gaps. Gaps exist for several reasons. Firstly, different communities have different levels of organization. Each community is likely to have a different set of organizational resources. Secondly, it is unlikely that any community will have **all the organizational and institutional resources** they need for health a third reason for resource gaps is that resource needs and possibilities change over time.

AS A HEALTH WORKER...

identify institutional and organisational resource gaps in your community

ask question like

"in this community what types of essential primary health services or supports are missing?" (e.g. clinic, hospital, doctor, counseling, social services, youth center, shelter, feeding scheme, physiotherapist, optician, dentist, chemist)

"…what types of essential primary health services or supports are available but are not presently willing to work in COPC?"

The case study "Audiology Screening in COPC and Preventing Hearing Loss in MDR TB patients in Tshwane" is an example of a response to a resource gap.

IDENTIFYING AND RESPONDING TO RESOURCE GAPS

GROUP OF FOUR

Read the case study carefully and answer the following questions.

1. What problem triggered the professors' responses?
2. What health care system solutions have they proposed?
3. What technical solution have they proposed?

CASE STUDY

Audiology Screening in COPC and Preventing hearing Loss in MDR TB patients in Tshwane

Background:

Hearing loss is a common disorder globally. It is caused by different things, including the side effects of drugs used to treat MDR TB. Around the world there is very limited access to ear and hearing services. In South Africax, a shortage of audiologists as well as the nature and costs of equipment has meant that hearing services are mostly available in tertiary hospitals. As a result many people with hearing loss are not diagnosed in time to prevent or contain their condition. New approaches to health care delivery as well as new technological opportunities using mobile phone applications may make it possible to accurately screen for hearing loss in communities.

> *"Dear … Colleagues,*
> *I had a meeting with …(the), speech therapist … and her assistant regarding the hearing screening for MDR TB patients. We think this can be done more effective if we do it with a district wide, integrated COPC approach, and link it to a research project.*
>
> *The idea is that we map all the MDR-TB patients, link them to WBOTs and a Community Health Center (CHC) or clinic. Then we create a district plan with a schedule to ensure that each patient gets hearing screening before the start of treatment and thereafter every month while on treatment and 3-monthly after treatment for 2 years. That will provide excellent patient care… We need to engage the other audiologists in the district, the academics at Medunsa and the colleagues at HAST.*
>
> *Through the Department of Communication Pathology a research project has been initiated to improve access to ear and hearing health by integrated screening as part of WBOT."*

Communication July 2014 : Professor Jannie Hugo, Department of Family Medicine, University of Pretoria

> *"Community health workers will conduct smartphone-based screenings in communities using software that allows for standardised testing with integrated quality control and data management. Where problems are detected people will be sent to clinics for follow-up services to diagnose and treat ear and hearing disorders. Through this project it will also be possible to monitor MDR TB patients on treatment to determine likely deterioration in their hearing ability and the possibility of adjusting their treatments and/or providing counseling and timely rehabilitation."*

Communication July 2014: De Wet Swanepoel, Department of Speech & Language Pathology and Audiology, University of Pretoria

Community Oriented Primary Care Cycle (COPC) Local Institutional Support Assessment

We all want to live in a healthy community. We believe that it is possible if we work together with all the organisations that are active here as well as with the individuals and families we serve. Our vision is to support health for all. I have come to find out more about your organisation and if you would be interested in working with us in community oriented primary care (COPC).
COPC is an approach that brings service providers and service users together. for better health and well-being in the community. We work in ward based outreach teams using the best available information and resources.

I would like to ask you some questions about your organisation. The information you give me will be shared with other community partners. It may also be used for research purposes, although your organisation's name will only be mentioned in publications and reports with you permission.

A. Organisation Details

1 Name of your Organisation	
2 Physical address	
3 Person / s in Charge	
4 Telephone Number / s	
5 Email address / web address	
6 Date of Establishment	
7 Registration number	
8 Main purpose of your organisation	

9 Type of Organisation		
	Not for profit (NPO)	
	Community (CBO)	
	Faith based (FBO)	
	Private Business	
	Government	
10 Number of People working in your organization		
	Full Time	
	Part time	
	Volunteers	
11 Target population for your services		
*11.1 **who?***		
*11.2 **where?*** *(geographical coverage)*		
*11.3 how many (number) currently **supported?***	individuals	
	families	
*11.4 **how often?***	daily	
	weekly	
	monthly	

B. Who are your main partners
(people/ organisations that you actively work with)

1.1 Name of Organisation	2.1 Name of Organisation	3.1 Name of Organisation
1.2 Person in Charge	2.2 Person in Charge	3.2 Person in Charge
1.3 Contact Number / s	2.3 Contact Number / s	3.3 Contact Number / s

C. Do you provide any of these services?

Prevention and Treatment Support	Y=yes N=No
TB	
HIV/AIDS	
Pre/post natal care	
Heart/stroke	
Diabetes	
Infant feeding	
Child and adult Nutrition	
Physical disability	
Mental disability	
Other	

Lifestyle Support	Y=yes N=No
Aftercare/education	
Violence and abuse	
Substance/alcohol abuse	
Water/sanitation	
Sports/dance/ recreation	
Family planning/safe sex	
Teen pregnancy	
Family health promotion & education	
Infection and hazard prevention	
Food and diet	
Other	

Access to Care	Y=yes N=No
Grant support	
Child headed households	
Oral and dental care	
Immunization	
Mental/physical disability	
Home based care	
Health/disability Support groups	
Other	

Would you like to be involved the community oriented primary care Ward Health Team initiative?

Yes! …. please contact me		**Maybe** …. please follow up		**No**	

Thank you for your time.

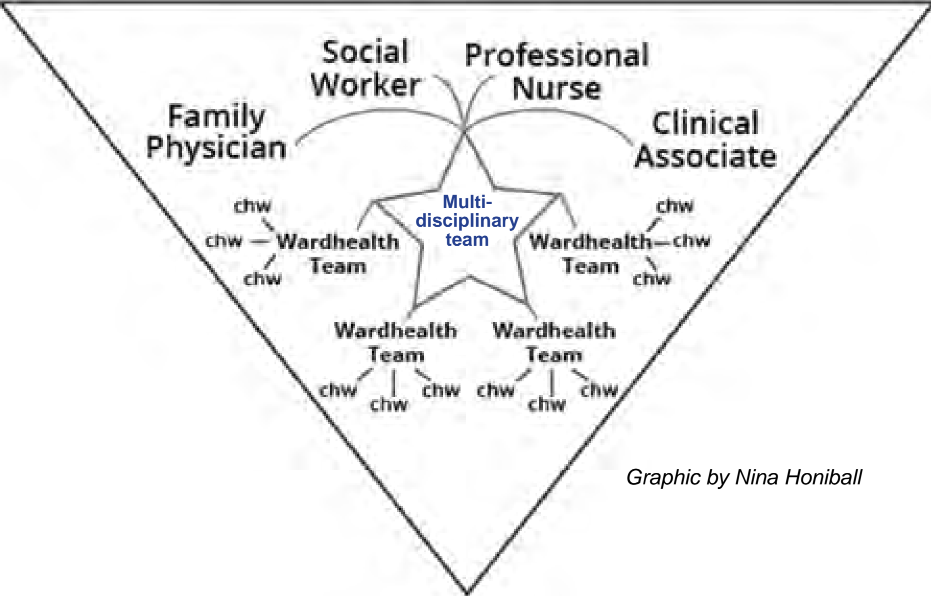
7

Health care is team work. The multidisciplinary team extends from community health workers to clinicians. it provides services to people who fall in the catchment area of a CHC or private practice consortium.

It always needs to have one or more professionals with clinical skills, like a doctor, professional nurse, or clinical associate. It can also include social workers, occupational therapists, psychologists and other health care providers when and as they are available and needed. It also includes leaders (OTLs) and health workers (CHWs) who provide community based services.

Figure 1 shows a facility catchment area multidisciplinary team with a number of community based service teams (e.g WBOTs). Together they all form part of one bigger multidisciplinary team.

Figure 1: Intergrated Health Platform

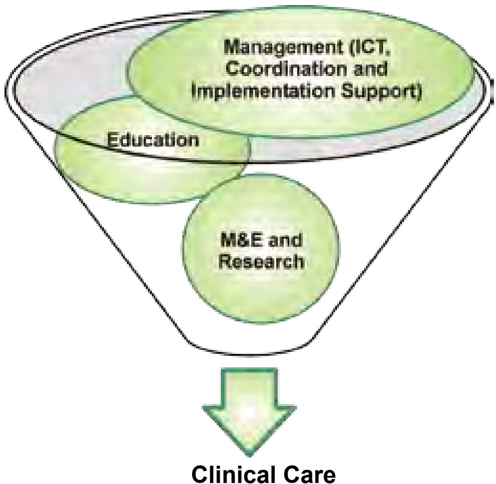


Graphic by Nina Honiball

The Purpose of Multidisciplinary team

The purpose of the Multidisciplinary team is to take responsibility for the effective functioning of all health care services provided in the catchment area.

Figure2: Effective Clinical Care



Clinical Care

1. Management

The management tasks include ensuring

- IT support
- Equipment
- Human resources
- Budgeting
- Clinicial care integration

2. Education

The education tasks are to organise and support

- Structured work integrated, peer learning (Work-*i*-Learn) that is facilitated by team leaders. The content is informed by the disease profile, action plan and the existing knowledge and skill of the CHWs.
- Structured learning and development for the multi-disciplinary team.
- Structured learning for key local stakeholders.
- The articulation of qualifications (QTCO and NC (V) programmes) into the local learning programmes.
- The mobilisation of educational resources (e.g. universities and colleges, non-governmental, faith and community based organisations, private sector etc.) to take part in quality peer learning in the community.

3. *Coordination, Integration and Co-operation*

With the integration of different health and social service programmes, the coordination, integration and cooperation tasks are to ensure

- The geographical area is covered and divided adequately.
- Each team has a team leader with an appropriate number of CHWs.
- WHTs and other health system service delivery entities cooperate and collaborate (e.g. clinics, hospitals, private GPs, traditional healers).
- WHTs and other local government, non-government, faith and community organisations coordinate, collaborate and cooperate in their work.

4. *Clinical care, support, mentoring and referrals*

The tasks are to ensure that

- Each WHT is linked to a medical doctor or other clinician.
- Each WHT is linked to a social worker as well as other health and care professionals (psychologist, physiotherapist, ECD etc.), as available and required.
- Team leaders and CHWs are mentored, assisted to solve problems and enabled to provide active patient care.
- A functioning referral system is created and managed.

5. *Planning, Implementation, Monitoring and Evaluation*

The multidisciplinary team is responsible for the data collected through the Local Institutional Support Assessment (LISA) as well as the Household Registration and Assessment (HHR) and individual Health Status Assessments (HSA).

Its key tasks are to work with WHTs

- To ensure data is collected routinely and accurately.
- To access information collected through various instruments.
- To interpret and use data to develop adaptive action plans.
- To use data to monitor implementation of WHTs at a sub-district level.
- To use data to evaluate plans and compare functioning, impact and performance.

APPENDIX 3 HOW TO HOLD A WORKSHOP

1. What is a workshop?

In general, a workshop is a short educational program
- to introduce new ideas and information;
- to plan;
- to learn practical skills/techniques; and
- to develop ways of cooperating and collaborating.

Tip: A workshop can be run from anything between 45 minutes to 2-3 days

2. Why give a workshop?

A workshop is organised to
- achieve goals. It can provide an intensive educational experience;
- bring people together to create a sense of common purpose and understanding;
- expose people simultneously to new ideas/information at the same time;
- introduce people and organisations to one another.

3. When do you run a workshop?

It is best to run workshops
- at the beginning of something new;
- as an initial training of staff and/or volunteers;
- during in-service or on-going organisational training;
- periodically to develop and support public understanding and knowledge.

4. How do you run a workshop?

A workshop is a project. Running a workshop involves three related activities – **Planning, Implementing and Evaluating (PIE)**.

Planning | Implementing | Evaluating

4.1 **Planning** means discussing and deciding on eight key elements

1. **Topic** (The title or focus of the workshop; ***What*** is the main focus?)
2. **Topic Content** (***What*** do you want people to learn about/ ***What*** information and skills will be covered.)
3. **Learning Style/Activity** (***How*** do you want to organize the way learning is done – e.g. do you want it to be participatory, inclusive, interactive)
4. **Time** (***How*** long is the workshop. ***How*** much time is needed to complete each section/activity.)

? **Tip:** Use your decisions on 1-5 to design the Workshop Programme.

5. **Participants** (***Who*** are the learners, what do they know about the topic; ***who*** are the presenters)
6. **Materials** (***What*** resources – people, things, space, funding - do you need to run the workshop)
7. **Venue** (***Where*** will the workshop be held?)
8. **Tasking** (***Who*** is responsible for each task)

Planning example:

Topic of Workshop:	Breastfeeding is best for babies!			
Venue:	UP	Time:	9:00 – 11:00	
Content	Learning Style / Activity / Approach	Person Responsible:	Time:	Materials:
Advantages	Presentation	Nurse B	15 min	projector lead speakers workbooks
Problems	Presentation	Nurse B	10 min	samples exhibit
Q & A	Groups	fascilitators (1 per 6)	20 min	workbooks extra pens

4.2 **Implementing**

Implementation involves two processes that follow on from one another. The first is ***preparing to do*** the plan, the second is ***doing*** what you planned ***(application).***

4.2.1 **Preparation**

- Each member of the planning team has to do the task that they have been given.
- The team leader/project manager makes sure that all the preparation is done, identifies and resolves problems.

Tip: Use a check list to monitor preparation – workshop programme and other materials available, invitations sent and confirmed, venue arranged and organised, presentations and activities prepared.

4.2.2 **Application**

A workshop usually involves 3 phases –

1. ***Introduction*** (introducing participants to one another, describing the purpose and programme of the workshop, the way you would like participants to interact and engage, workshop etiquette and 'housekeeping'.
2. ***Content*** (presentations, activities, skills).

Tip: Keep track of time; try to present material in a number of different ways; encourage discussion and group work; encourage reflection.

3. ***Closure*** (summing up; participant feedback on ideas, techniques, activities; individual evaluations).

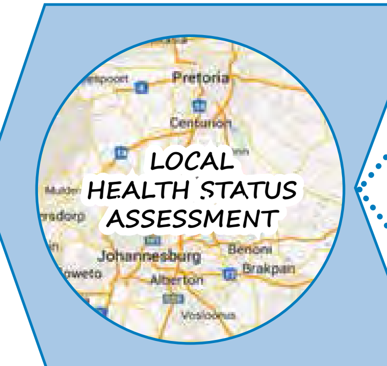
Tip: Record feedback e.g. on newsprint, audio, or through note taking. This way the team learns, improves individual and collective ability to run workshops, and provides information for future work.

4.3 **Evaluating**

Evaluating a workshop means reflecting on the whole project. Individually and collectively the team needs to ask several questions

- did the workshop meet its content, participation and process goals?
- what worked?
- what didn't work?
- what should be done differently next time?
- what impact has it had on individual/team motivation?
- what next?

ASSESSING THE HEALTH OF THE COMMUNITY



A local health analysis is based on
i) a Local Health Status Assessment (HSA) to find out about the health of people who live in a community or ward;
ii) available primary information (from clinics and hospitals, police stations, schools, etc.); and
iii) available secondary information (other research, the national census and other studies etc.)

The purpose of the local health analysis is
i) to understand local health needs;
ii) to build strong relationships between service providers and service users.

To do COPC you need to find out about the health status of the community you serve. In this section you are going to learn skills - how to identify, get and make sense of health and other social information (also called data). To practice these skills you have to learn about the norms and values that guide the collection and use of personal and other information for health care and research.

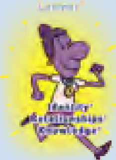
8

8.1 Information and Research Ethics in Health Care

All ethical principles come from three sources.

1. They come from people as individuals. They are virtues, like kindness or desirable morals like honesty.
2. They come from families and communities. They are virtues, duties or rules, consequences of actions.
3. They come from society. They are virtues, duties or rules like “thou shall not kill”, and the agreed rules of practice. These are set out by
   - Professional, occupational or other organizations (e.g. medical ethics)
   - National and international law (e.g. the National Health Act (RSA No. 61 of 2003)

Generally, ethics is about the standards of behavior that we expect from each other. Health workers provide services and collect information from and have information about the people they serve. Because of this society sets the standards that they are expected to follow. These create a system of norms and values to guide people’s actions around what they know and do through laws, health departments and councils as well as professional, research and other organisations.



AS A HEALTH WORKER...

Ethical practice requires you to follow seven rules:

1. **Respect human dignity**
2. **Ensure informed consent**
3. **Protect privacy**
4. **Ensure confidentiality**
5. **Practice equity**
6. **Maximize benefits**
7. **Minimize harm**

Remember:

Horizontal equity means people with the same needs should get the same attention. Vertical equity means people with greater needs should get more attention.

Civil practice is genuine respect in speech and behavior towards other people. It requires time, presence and a willingness to engage openly and honestly to seek common ground with others.

Uncivil Practice is rude, disruptive, intimidating and undesirable speech and behaviors towards other people.

These norms and values apply to all aspects of your work, including the collection and use of information for service and research. Here you are going to learn about confidentiality and informed consent.

Informed Consent

In health you have to get informed consent from people explicitly when you ask them to share information about themselves for service, care or research purposes. This is because people have the legal and ethical right to direct what happens to them. It also is because health care providers have the ethical duty to involve people in their own health care.

Just like you, people in the community need to have a picture of what community oriented primary care is all about. Therefore the first step in the process is to introduce them to the model of care.

8

CONSENT	• to agree to do something • to give permission for something to be done or to happen
INFORMED CONSENT	• a process where the health care provider shares appropriate information with a competent person • so that the person can make a voluntary choice to accept or refuse to take part in or have something done to them • a competent person is somebody who is able to understand the benefits and risks as well as the social and other implications of the procedure, treatment or activity.

ETHICAL PRACTICES

REFLECT AND WRITE

Read the Tshwane COPC flyer "Introducing ward-based primary care" (Go to 8: Appendix 1)

Write down which of the 7 ethical practices it addresses or supports.

Tip: *it can support more than one. Plan how you would go about sharing the information from the leaflet with a household member.*

Think about ...
When *you need to share the information?*
What *would you say and do?*
How *would you check the person has understood key issues?*
Why *you need them to understand and respond?*

After providing general information the next step in the process is to get informed consent to register households and do household and/or individual health status assessments.

AS A HEALTH WORKER...

Every time there is a new activity or decision, people have to agree to allow it to happen or to participate. Think about it. When you agree to let a doctor do a procedure on you (e.g. to remove your tonsils) you only give him or her permission to do that procedure. You are not agreeing for him or her to do other operations at the same time (e.g. take out your appendix). This is also true when you collect information from people. Each time you do a new thing or ask for new information you have to get informed consent.

To get informed consent to collect information for service and for research there are standard topics that you have to talk about.

You have to tell the person:

- **what** you want to do (the nature and purpose),
- **how** you will go about your work (procedure),
- **the risks** and potential discomfort (if there are any),
- **the benefits** (if there are any),
- how you will ensure **confidentiality**,
- about their **rights** as participants,
- and for research, about **ethical approval** from a recognized research ethics committee.

You also have to give your team's or other contact details (your own / your team leader).

When you have explained everything to the person, he or she then has to sign their consent.

On the following two pages is the participant information and informed consent leaflet for the Tshwane HHR.

Photo courtesy: Nina Honiball

8

Consent is captured separately for service and research. For example, in Tshwane COPC participants have to consent to be registered and assessed and they have to consent for their information to be used for research purposes. Their consent is captured in the AitaHealth app on the gadget. Who gives consent depends on what you are doing.

To register and assess households you have to get informed consent from the household head or a household member who can properly represent the household.

- ✓ He or she must live in the home in order to be able to represent the household.
- ✓ She or he must also have knowledge and authority to speak on behalf of the family.

The person should be over 18 years of age. If they are younger than 18 years old, they must be mature enough to make an informed decision. This means that they must be able to understand the benefits, risks, social and other implications of participating in the registration and assessment.

To do an individual health status assessment the individual person you are interviewing must be competent. This means that he/she must be old enough to give informed consent (18 or older).

For **research purposes** a person who is under 18 years of age also can give informed assent. Assent is a term used to express a person's willingness to participate in research but only if they are mature enough to make an informed decision. This means that they must be able to show they understand the benefits, risks, social and other implications of participating in the HSA. They also have to be over 12 years of age.

You need to get parental or guardian consent to do a health status activity for service and research purposes with all children under 12 years of age as well as with children who are over 12 but who are not mature enough to make an informed decision.

INFORMED CONSENT

GROUPS

Role play
Use the Tshwane 'Participant Information and Informed Consent' leaflet (8: Appendix 2)
The person who plays the role of the CHW must prepare (use P.I.E.)
The person who plays the role of the patient or family member must give feedback about what was said and how it was said.

8.2 Confidentiality

People tell you about their health. You also ask them for information. They often show you a problem they have. You see their personal and home circumstances. You see them going to the clinic. You see them going to see a clinician. You are often given information about them. You also often do things that are part of the health care service you provide. It does not matter where you work. It does not matter who you are. Every day when you work in health care, you see, hear and do things that involve other people's personal and private lives.

The private and personal information that people share with you as a health worker or the health care system is privileged information. Privileged information is information that is shared in confidence with a person, because of the position they occupy and the place where they work. Privileged information is confidential information.

AS A HEALTH WORKER...

you are expected to treat what you know about people as confidential. This means that

- ✓ You will not use what you know about people to embarrass them, or put them in danger or discriminate against them.
- ✓ You will be professional in your work.
- ✓ You are trustworthy and responsible.

For you to practice confidentiality, you have to learn to identify confidential information. You have to learn about the rules of confidentiality. And you have to know what it means to break confidentiality.

8

Confidential information

Confidential information is all information that can identify a patient or a person in the health care system. It can be written on paper, in a file, on a device or on a computer. It can be a photo, video, audio recording or any other image. And it can be something that is held in the memory of a health worker or professional that can be communicated.

The rules of confidentiality

CONFIDENTIALITY AND TEAM WORK

GROUPS OF FOUR

Discuss

- If health care is teamwork, what does this mean for confidentiality?
- When can a health worker share information about a person or a patient?

It should be clear from your discussion that practicing confidentiality is not about keeping secrets. People share information with health workers and the health care system because they want health care. So confidentiality is about following rules that allow you to provide people with quality care at the same time as you protect their private and personal information.

When information is confidential it means that:

- It is shared in confidence with a person or institution;
- It can only be shared with other people (or institutions) who are authorized to know about it.

In South Africa, the rules about confidentiality are set out in two laws -The National Health Act (2003) and the Children's Act (2005). They say that all information concerning a patient, including information relating to his or her health status, treatment or stay in a facility is confidential.
According to these laws, a health worker may give a person's information to another person only with their consent or when he or she can justify the purpose for sharing the information.

What this means is that health workers can share information about a person without his or her permission only under specific conditions. These are

- When the law says they must (statutory provision)
- On instruction from a court.
- When it is in the public interest.

- With the written consent have a parent or guardian for children less than 12 years of age.
- With the written consent of the next of kin when a person has died.

AS A HEALTH WORKER...

there are 6 golden rules you can follow to ensure confidentiality.

1. Get CONSENT where possible.
2. Make sure that you can JUSTIFY THE PURPOSE for sharing the information.
3. Share ONLY what is essential.
4. Share ONLY when absolutely necessary.
5. Share ONLY on a need to know basis.
6. CHECK if you are UNSURE.

These six golden rules apply to health and all information you have about the individual and families you serve.

BREAKING CONFIDENTIALITY IN THE PUBLIC INTEREST

GROUPS OF FOUR

Discuss the circumstances when it is in the public interest to break confidentiality as a health care worker?

In your discussion about public interest, it probably became clear that the rights of individuals often have to be weighed against the good of the community. When this happens, health workers have a responsibility to put the interests of the community above the rights of the individual.

In South Africa, health and care workers are obliged to report a number of conditions, diseases and events to the relevant government departments. These are:

- ✓ Notifiable medical conditions - Department of Health (8:Appendix 4 – Notifiable Medical Conditions Diseases List 2018).
- ✓ Births and deaths - Department of Home Affairs.
- ✓ Gunshot wounds – SAPS.
- ✓ Abuse of children and abuse of the elderly - Department of Social Development and SAPS.
- ✓ An emergency where the person is incapacitated/incompetent.- medical facility.
- ✓ Psychiatrically ill patient who needs to be committed to a hospital - mental health facility.

Health care workers also have some discretion when it comes to breaching confidentiality in the public interest.

- ✓ You can decide to share confidential information with other healthcare professionals in order to provide the best quality care.
- ✓ You can decide to share information where they believe a third party is at significant risk
- ✓ You can decide to share confidential information to aid in the prevention or detection of serious crime.

But even then, using your discretion is not straightforward. The example about sharing information with a sexual partner about a person's HIV status shows the steps that you would have to take to do this properly.

When can a health professional tell a person that their sexual partner is HIV positive?

Health Care Professionals have discretion when a 3rd party is at risk.

But they can't disclose unless after counseling the patient is still reluctant to disclose and the following conditions have been met:

- The sexual partner/s is known and clearly identifiable.
- The sexual partner is at real risk of being infected. In other words, the doctor believes the patient is posing a risk to the sexual partner.
- The patient is told by the health care professional that his/her duty to maintain confidentiality is going to be breached.

Sharon Kling Confidentiality in Medicine Current Allergy & Clinical Immunology, November 2010 Vole 23, No. 4

Breaching Confidentiality

Usually we breach confidentiality through gossip. Gossip is talking about other people. Through gossip we share information and make judgments about them. We also express how we feel about things when we gossip. Indirectly, when we gossip we express our values and standards by comparing ourselves to the people around us.

In health care, we gossip when we share information about individuals and families

- **Unselectively.** We give inappropriate information.
- **Casually.** When it is not part of our work, or when we are with other service providers.
- **In inappropriate places and situations.** This can be at the shops, in a taxi or while you are waiting at the clinic, health post or school. It can be at church, at a party, at suppertime etc.
- **With inappropriate people.** This includes neighbors, family and friends. It includes patients, other people who you work with or are nearby.

In health care, when we gossip we break our agreement and promise to respect the rights of people and patients. When we gossip we break people's trust. We take away their ability to exercise control over their lives, because we share information about them with people who they may not wish to inform or who do not provide them with services that will contribute to their health and well being.

Once confidential information or documents are shared, they cannot be unshared, erased or deleted. The same happens with any words you say. Once they come out of your mouth, you cannot un-say them.

We can all learn to practice confidentiality.

AS A HEALTH WORKER...

learn to do **the Four Questions Confidentiality Self-Test**

1. What are you discussing?
2. Why are you discussing it?
3. Where is the discussion taking place?
4. Who is listening?

8.3 Assessing Health and Well-Being

Collecting data

To assess health in communities we need to know about the health and well being of individuals. It can be collected about them from files, records, logs or forms as well as through questionnaires.

PRIMARY DATA is original information that is collected by you, clinicians or researchers directly. It includes questionnaires, letters, photos, records and documents.

SECONDARY DATA is systematic information about communities that has already been collected by other people.

There are a wide variety of secondary data sources including archival records (e.g. vital records, hospital discharge files, medical records, official incident reports, legal cases), ongoing monitoring systems, registration and billing systems (e.g. vehicle license or electricity accounts), management information systems (e.g. college or school registration and performance records, clinic records) and specific studies or research (e.g. medical male circumcision, deworming, HPV or HCT campaigns).

Secondary data can compliment and support COPC. Health research and facility reports, for example, provide additional information about the general health status of communities or particular segments of the population. They also provide WBOTs with information about service use and provision in the community, e.g. use of clinics, participation in campaigns, attendance register in class/school/college etc.

However, secondary data is never enough to do community oriented primary care.

- It usually does not link services and people to continuing and on-going health care in their homes and places of occupation.
- It is not likely to cover all the issues that community oriented primary care covers.
- Health related information does not cover everyone. Except for the national census, data is usually collected from sample populations (research like the Demographic and Health Survey) or selected populations (Facility records).
- It is often collected for other purposes that have little relevance to COPC.
- It is often difficult to access – it takes time to get the necessary permissions, it is often poorly stored.
- It is often 'out of date' – there are long time lags between collection and analysis.

INSTITUTIONAL AND ORGANISATIONAL RESOURCE GAPS

IN PAIRS OR FOURS

Identify institutional and organisational resource gaps in your community.

1. Choose one organization in the local community.

Tip: *Use the LISA to identify health and related organisations.*

2. Obtain secondary data from each organisation that is related to health and well being in the community.

Tip: *Amongst other things you can ask for attendance reports (e.g. from health facility, crèche, school, college, welfare groups etc.), trauma, violence and injury and other incident reports (e.g., from SAPS, NGOs), annual and any research reports that local organisations have participated in.*

3. Obtain secondary data from each organisation that is related to health and well being in the community.

Primary Information

The best way to find out about people's health status is to ask them directly. Generally, primary data is collected from people using questionnaires of some kind.

DID YOU KNOW?

A questionnaire (also sometimes called a survey) is a tool for collecting and recording information (data). It is a written, preplanned interview with questions (and often possible answers) about specific topics. Some questions are asked in a way that allow people to answer freely and in their own words. These responses have to be written down by the person doing the interview. Other questions are closed and are already part of the written document. People are asked to answer in particular ways e.g. yes or no, by degrees (very unhappy, unhappy, unsure, happy, very happy) or they are given a list of answers to choose from.

Because there are different kinds of communities (geographical places where people live,e.g. wards and institutions where people work or study, e.g. schools or colleges) there are different ways of going about the process of assessing community health in COPC.

When we do COPC in residential communities with families and households the process of assessing health has two steps. The first step is to register and assess the households. Only after we have done that do we start to do individual health status assessments with each person in the family or household.

When we do COPC in institutions there is only one step to follow. We register and assess individuals (e.g. students, workers, staff etc.).

In Tshwane, our questionnaires are developed on the AitaHealth application. This app is supported by an ICT enabled platform that makes it possible for you to read and to capture the questions on a gadget. They can be seen on a web page by team leaders, clinicians and managers.

The information that you share and the responses that you receive are sent to and stored in a central system.

They can then be used to plan and support service delivery, support research and assist with human resource management.

AS A HEALTH WORKER...

When you use a questionnaire to collect data you are expected to follow all instructions and to read the question exactly as it is written.You also need to record all information accurately. This is because you want the information to be precise and as true as possible.

There are different ways of going about the process of assessing community health in COPC. This is because there are different kinds of communities. Some are geographical places where people live. Some are places of work or learning, like clinics. crèches and schools. And sometimes people don't live in homes although they live in communities, and they don't work in buildings or companies.

Household Registration and Assessment

To register and assess households we use the HHR.
Below is the table of contents of the AitaHealth used in Tshwane. It gives you an idea of the topics covered when you register and assess households.

AitaHealth HHR Table of Contents

Household Registration		
Administrative Information		
Date of registration	Head of HH	HH municipal account number
CHW name	Ownership of property	Electricity meter number
WBOT	Address	Contact number
GIS ward	GPS data	
Clinic name	HH identifier	
Date of registration		

Household Members		
Registration of members	Relationship to head of HH	Age
		Sex

Triage		
Immediate attention	May be pregnant	Vulnerability
TB medication	ANC attendance	Home Based Care
TB diagnosis	Postnatal care	Harmful substance use
TB symptoms	U5	
Pregnancy	Chronic medication	

Household Assessment (HH)		
HH demographics		
Births	In-migration	Indigence
Deaths	Out-migration	

HH characteristics		
Dwelling type	Goods (fridge etc.)	Food security
Condition of dwelling	Means of Communication	HH safety
Number of rooms	Toilet	Business/Enterprise
Windows	Refuse (garbage)	Environment
Water	Income	Fruit & Vegetable
Energy		Keep Animals

Each topic usually involves several questions. Below is the first topic "Household Registration" to give you a sense of how the questions are asked, how the system supports the way the information is recorded and some of the reasoning behind the questions.

The first part generates administrative information.

Date of registration *[system preset]*
CHW name registering the household *[preset on CHW log in]*
WBOT (DHIS name) *[preset on CHW logon]*
GIS ward *[drop down menu]*
Clinic name *[drop down menu, according to DHIS]*
What is the household's account number? *[enter number], no account number, DK.*
What is the household's electricity meter number? *[enter number], no meter number, DK.*
Please enter contact number (s): *[enter phone number(s)]*

Then we capture the name and address of the household head.

The physical address helps CHWs and the team locate households. Although our ICT system captures GPS (geographic positional system) coordinates we also need to get manually written addresses. These help identify households in informal settlements because GIS does not work in areas where there are no plans (e.g. an "extension" or "number" or "street name").

Next we register all household members (name, age, gender).

We also get kinship or relational ties among household members. They tell us something about obligations and reciprocity.

Who is the head of the household? *[system requires Surname, Name, Date of Birth, Gender]*
Does the head of the household own the property? *Yes. No. Don't Know Refuse [CoT - indigent programme]*
Address *[manually enter address]*
Household identifier ...

Below is an illustrative table of what the CHW can see on the gadget.

Register all household members *Definition of a Household Member: Someone who usually sleeps at the household*	
Assess the relationship of each HH member to the head of household	***Immediate family member of the head of household*** *(wife, child, mother, father, sister, brother)* ***extended family member*** *(inlaws, cousins, nieces and nephews)* ***not related***
Asses the vulnerability of each member *(system generates all members and CHW chooses from pre-set drop down menu)*	*Child (<18), Pensioner (>60), Couple, Couple Parent, Single, Single Parent*

Name	...	*Age*	*Gender*	*Relation to HeadoHH*
M... N...	*...*	*[35 years]*	*female*	*Head*
M... P...	*...*	*[75 years]*	*male*	*immediate*

The question about vulnerability helps service providers, like the City of Tshwane, identify households made vulnerable by their age composition and their marital status.

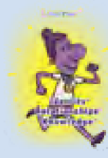
Household Triage

One of the principles of COPC is to practice equity. Household triage questions help CHWs, teams and other service providers identify and give priority to people who need urgent assessment or support.

Triage questions identify household members

- who need immediate referral (e.g. people suspected of having TB, girls or women who are pregnant, bedridden family members etc.); or
- who should be prioritised for assessments (e.g. chronic care, children under five.)

QUESTION	ANSWER	ANSWER
Does anyone in the househlod need immediate attention?	Yes, No, Don't Know, Refuse	If YES: [Documentation prompt] - see individual triage
Is anyone in the household currently taking TB medication?	Yes, No, Don't Know, Refuse	CHW [no immediate action - assess within a week]
Was anyone in the household taking TB medicine during the past 12 months?	Yes, No, Don't Know, Refuse	[no immediate action - assess within a week]
Has anyone in the household been diagnosed with TB but is not yet taking TB medicine?	Yes, No, Don't Know, Refuse	If YES [immediate referral or immediate assessment]
Does anyone in the household have: Persistant Cough; NightSweats; Weight Loss; Loss of appetite.	Yes, No, Don't Know, Refuse	If ANY YES [immediate referral or immediate assessment] Refer for / take sputum test for TB
Is there anyone in the HH who cannot get out of bed or needs help with daily living activities?	Yes, No, Don't Know, Refuse	
Does the person get home based care support?	Yes, No, Don't Know, Refuse	If NO: [immediate referral] Refer for HBC
Is there anyone in HH who is currently pregnant?	Yes, No, Don't Know, Refuse	
Has she been to the ANC clinic?	Yes, No, Don't Know, Refuse	If NO prioritise
Is there anyone in HH who is currently pregnant?	Yes, No, Don't Know, Refuse	If YES prioritise
Has anyone had a baby in the last 6 weeks in this household?	Yes, No, Don't Know, Refuse	If YES prioritise Post Natal Care
Are there any children under the age of five in the household	Yes, No, Don't Know, Refuse	If YES prioritise Under 5s
Is there anyone in the HH who takes daily medication (like ART, TB medication, diabetes medication, high blood pressure medication)	Yes, No, Don't Know, Refuse	If YES prioritise Under 5s



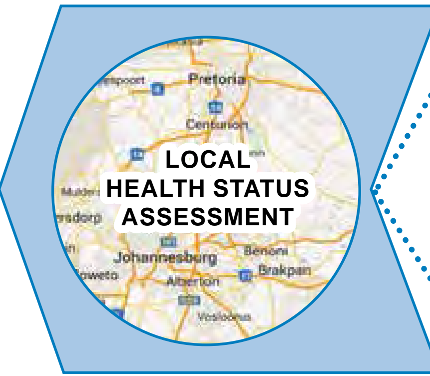
AS A HEALTH WORKER...

You need to remember that the questions that show on the screen depend on the age, sex and condition of the family members registered on the system. This means that the questions that appear are person specific.

DID YOU KNOW?

When you complete each question the answer is a stored and sent to the web. When you save and finish the information you collect is there to help you and the team provide continuity of care.

8.4 Describing the Health of the Community



A local health analysis is based on

i) a **Local Health Status Assessment** (HSA) to find out about the health of people who live in a community or ward;

ii) available primary information (from clinics and hospitals, police stations, schools, etc.); and

iii) available secondary information (other research, the national census and other studies etc.)

The purpose of the local health assessment is

i) to understand local health needs;

ii) to inform service priorities and interventions;

ii) to build strong relationships between service providers and service users.

The next step is to take the data that you have collected and make it into information.

This process involves several practical activities that help you make sense and give data meaning. To illustrate ways of describing data use Melody (Ward Number 0201) data collected using AitaHealth.

Raw Data

Raw data is the data that you collect on the gadget, on a tick sheet, or in a patient file. It is data that has not been processed in any way. You use raw data to provide a particular person or family with care. It gives you the detailed and specific information you need to provide them with a service.

9

Making Sense of Data using Tables and Charts

We have to do something with data to make it useful. We have to describe it because describing data is the starting point of making sense and giving meaning to it. Also, we have to present it in a way that makes the information user friendly.

One common way of giving meaning to data and making it accessible is to create tables. Lets begin with the demographic data that we have.

Demographic data, especially age and gender, is always important. This is why, when we register the household we capture essential details about all members of the household and identify who is the household head.

> ***Who is the head of the household?***
> *[system requires Surname, Name, Date of Birth, Gender]*

AS A HEALTH WORKER...

The family name and physical address is for the *exclusive* use of service providers. Remember people give informed consent for the information they provide to be used for research purposes, as long it does not identify them personally.

We can organize data into categories to begin to make sense of it. For example, the HHR Table below tells us about the age, gender, kin and vulnerability of the "MN Household".

> ***Note***:
> Every table has a heading

HHR Table 1: Melody (Ward Number 0201) Mrs.'s MN's Household

Name	*Age*	*Gender*	*Relation to Head of HH*	***Vulnerability***
M... N...	*[35 years]*	*Female*	*Head*	*Single Parent*
M... P...	*[75 years]*	*Male*	*Immediate*	*Pensioner*
M...Z...	*[2 years]*	*Female*	*Immediate*	*Child <5*
M...X...	*[13 years]*	*Male*	*Not*	*Child <18*

Information presented this way is useful to health care providers because "for practice, you need a micro, bite-sized focus". It gives a detailed and quick snap shot of the family in their care.

DESCRIBING DATA

REFLECT AND WRITE

Write a paragraph to describe Mrs MN's Household using the information in the HHR Table 1.

Triage Dashboard

A frequency table is a way of summarizing data. It has at least two columns, one for categories and another for frequencies (or the number of times something occurs).

Probably you have noticed that to describe data you need to break it down thematically. You then have to break each theme into its component part.

In addition to charts, common software programs on computers like Microsoft Word, Excel and Power Point let you show information using "smart art" graphics. The picture below shows macro HHR Melody (Ward Number 0201) demographic information collected using A taHealth.

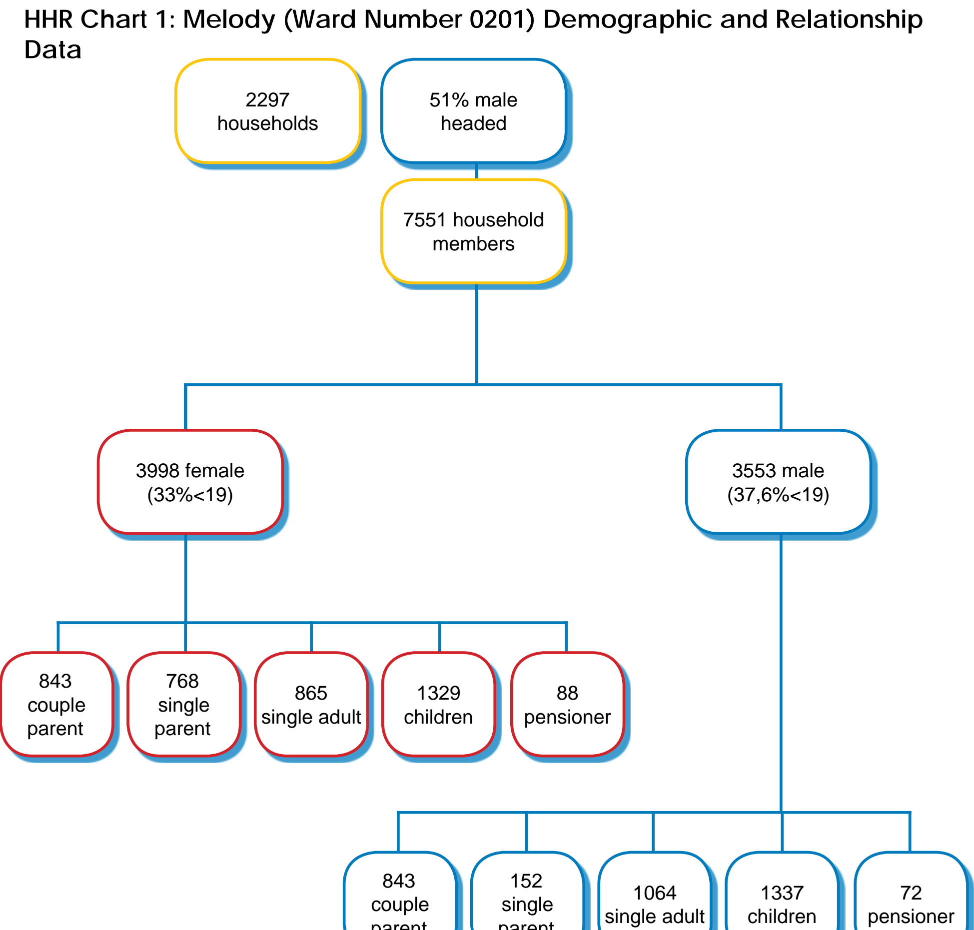
It shows the frequency of categories (or characteristics) and a way of mapping relationships. We have used it here to show relationship patterns in the community. It can also be used to show the actual relationships in households that micro information provides.

HHR Table 2: Triage Dashboard

#	Household Triage Condition	Count	Household Triage Condition - Descroption
02	TB / Rx	0	The number of household members who "are currently taking TB medication".
03	TB / 12m Hx	0	The number of household members "who was taking TB treatment during the past 12 months and has completed TB treatment".
04	TB / Dx	0	The number of household members "who in the past six months was diagnosed with TB but has not been put on or has not commenced TB treatment yet".
05	TB / Drx	0	The number of household members "who was diagnosed with TB in the past 12 months and has defauted or stopped TB treatment".
06	TB / Sx	2	The number of household members who answered "Yes" to at least 1 of the 5 TB symptom screening questions.
05	HBC	0	The number of household members who could not get out of bed and/or needed outside help with their daily living activities, thus requiring Home Based Care.
08	ANC - Pregnant	1	The number of household members who "are currently pregnant".
09	May be pregnant	0	The number of household members who "may be pregnant".
10	PNC	1	The number of household members who "had a baby in the last 6 weeks".
11	Chronic Conditions	15	The number of household members who are "taking daily medication for a chronic condition"
12	HIV - Request Test	3	The number of household members who requested an HIV test.
13	HIV - Under 18m PCR	1	The number of under 18 months children who were HIV exposed and had not received a PCR test.
14	U5 / Not Immunized	6	The number of under 5 year old children with an immunization schedule that is not up to date.

9

HHR Chart 1: Melody (Ward Number 0201) Demographic and Relationship Data



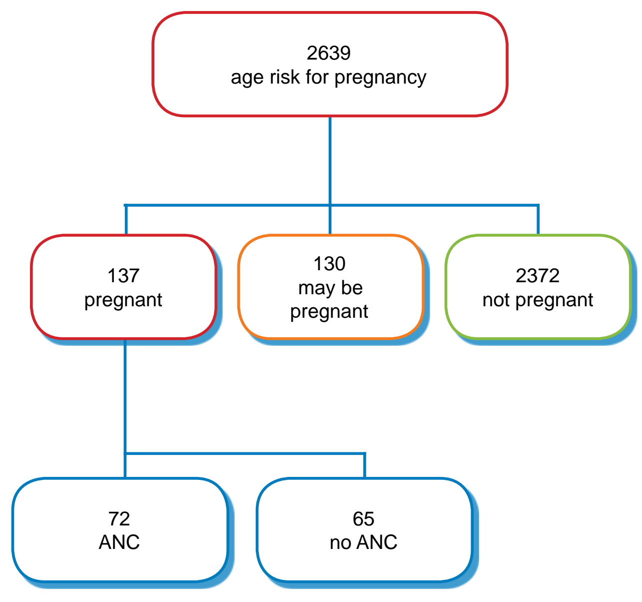
Making Sense of Data through Words

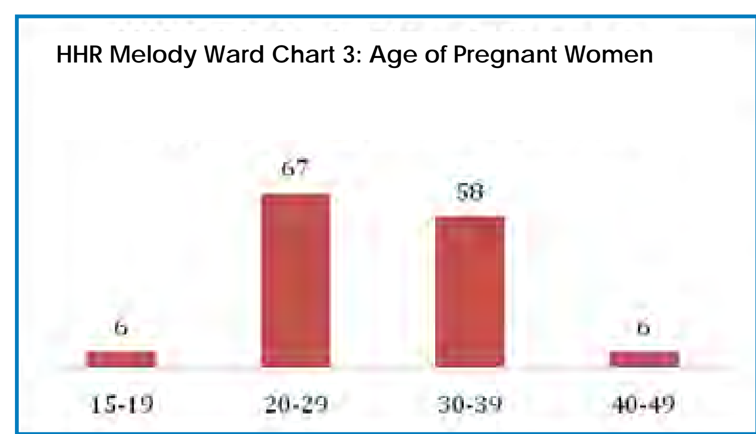
Tables and pictures (graphs, smart art) are only one part of making data into information. The other essential part is to describe it in words. Information does not "speak for itself". It has to be explained and interpreted. It does not matter if you have shown it in pictures, tables, charts or smart art graphics.

Describing information in words is a skill. You have to say exactly what is shown, nothing more or less. In other words, it demands that you use language that is accurate and precise. Writing accurately takes practice, just like working with tables and numbers.

As an example of how information can be described, lets look at HHR data. Chart 2 shows the number of pregnant or possibly pregnant women and Chart 3 shows the age of pregnant women in Melody (Ward Number 0201) households registered and assessed by January 2015.

HHR Chart 2: Melody (Ward Number 0201): Pregnant and Possibly Pregnant Women





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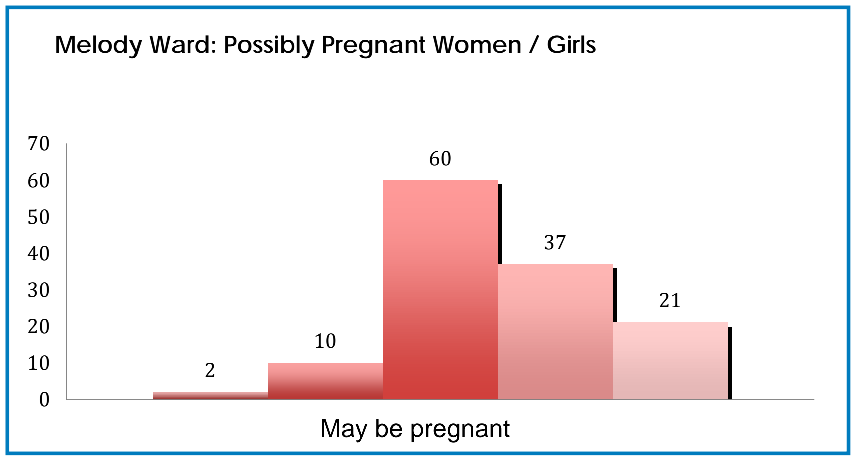


There are 3998 women in the registered households. 2639 women are in the age range of possible pregnancy. 137 women (0,5%) are reported to be pregnant. The women who are known to be pregnant range in age from 15 to 49. Six are in their teens and 6 are 40 years or older. The majority is aged between 20-29 (49%) and 30-39 (42%). 73 pregnant women (53%) are in antenatal care. The remaining 65 (47%) still have to be booked for ANC.

A further 130 women and girls (0,5%) may be pregnant. Of the possibly pregnant, 12 are teenagers and two are under 14 years of age.

AS A HEALTH WORKER...

information guides you in your work.

- It helps you understand people.
- It helps you respond to their health needs.
- It helps you see the effect of your work.

Collecting and describing information is not something we do “once off”. We do it all the time because we need it to plan. We need it to check if we are doing what we thought we would do. And we need it to see what effect we have.

Introducing ward-based primary health care:

The City of Tshwane and the Tshwane District (Gauteng Department of Health), supported by the University of Pretoria and Medunsa, have begun to implement ward-based primary health care. We have created ward-based outreach teams (WBOTs) to work with and support you towards better health.

Each WBOT is made up of a nurse and a number of community health workers (CHWs). Each team is responsible for a number of streets in a ward. Each community health worker works with about 200-250 families or households. You will get to know your community health worker by name.

HOW WARD-BASED PRIMARY HEALTH WORKS:

Step 1: Household registration - to begin ward-based primary health we need to find out who lives in your home and what your family and individual health situation is. We call this household registration.

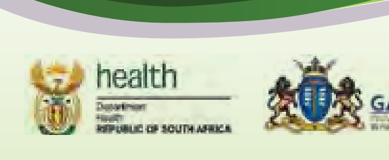
Step 2: Health status assessment - after registration, your CHW will come back and find out about each individual's health. We call this a health status assessment.

Step 3: Urgent health care needs - through their WBOT, your CHWs will also help you attend to health problems that need urgent attention.

Step 4: Planning and intervening - using all the information, the WBOT will develop and implement plans to support local health.

The registration and the individual health status information will be captured by your CHW on an app on the cell phone. It will be used to do five important things, namely -

i) to help the WBOT support your family's health care needs;
ii) to improve health and manage disease better in your neighbourhood;
iii) to improve the way the health system works;
iv) to find out about and better understand health and disease management in families and communities (research); and
v) to support learning and advance health literacy.



8

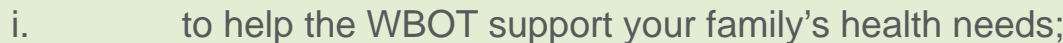
Participant Information Leaflet: Household Registration and Assessment

Tshwane District and City of Tshwane COPC

INTRODUCTION

Ward Based Outreach Teams (WBOTS) from City of Tshwane and the Gauteng Department of Health are implementing community oriented primary care across Tshwane District.

Your CHW has been asked to register and assess each household that she is responsible for. The information she collects will be used in five ways:



i. to help the WBOT support your family's health needs;

ii. to improve health and manage disease better in your neighbourhood;

iii. to improve the way the health care system works;

iv. to improve health literacy; and

v. to do research in order to support learning, services and systems.

THE PURPOSE OF THE HOUSEHOLD REGISTRATION AND ASSESSMENT (HHR)

The HHR is on the AitaHealth app that has been developed to register all households living in Tshwane District. If you agree to participate, your CHWs will ask you to answer questions about physical and service details, household members (name, relationship to household head, vulnerability), and if there are urgent health and social issues that need immediate attention (TB, Pregnancy, Children under 5, Indigent home based care).

THE PROCEDURE

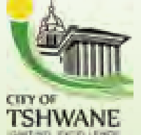
The information you share with CHWs will be captured on their cell phones.

Your CHWs may take notes in a notebook. They will do this when you give them additional information that can't be written on the AitaHealth app. These notes will be kept safely and securely as part of WBOT records.

Your CHWs will respond to issues that need attention. They must always work within their scope of practice and according to their level of training. They work as aides to health and other professionals.

RISK AND DISCOMFORT

There are no risks to you or your family in participating in the HHR. You can choose not to answer any questions that cause you discomfort. Also you will not be excluded from health care services at clinics or hospitals should you decide not to do the HHR and take part in community oriented primary care through WBOTs.



BENEFITS

By participating in the HHR you and your family will directly benefit from the services and support provided by WBOTs through your CHWs. You will not have to pay for any of the services and they may also save you time and money. HHR related research is also likely to benefit you directly and indirectly, by improving services and the quality of care you and your family receive.

PRIVACY AND CONFIDENTIALITY

CHWs can only access the cell phone app through a password or unique identifier. This means that the information you share that is captured electronically will be safely kept in a closed information system. In this system, only people who provide you with health care– that is your CHWs, WBOT leaders and other health and service providers – are allowed to link the information you give to them to you as a person or family.

Information (data) will be depersonalized before other providers, service managers or researchers can use them. This means that they may only access your information in a way that does not identify you or your household as people.

Your CHWs may take notes in a notebook where additional information is required that can't be written on the app. These notes will be kept safely and securely as part of each WBOT records.

YOUR RIGHTS

You can agree or decline to participate in the HHR and to allow the information you share with the WBOT to be used for research purposes. Your decision is entirely voluntary. Whatever you decide, it will not affect your own and your family's rights to access public and private health care services at clinics or hospitals.

ETHICAL APPROVAL

The roll out of WBOTS is government policy and part of the National Department of Health's reengineering of primary care. Research to support WBOT roll out through COPC has been approved by the University of Pretoria's Research Ethics Committee (102/2011) as well as the Tshwane District (DoH GP) Ethics Committee.

CONTACT INFORMATION

My name is .... I am a member of the WBOT led

by ……………..……(Name) …............…………… (contact number) of Team

Leader. Please contact her/him or the WBOT Cluster Manager ……….....................….………(Name)

…………..............…… (contact number) if you need any further information.

CONSENT

Your decision to participate in the HHR and research related to the HHR will be captured on the Aita app

REGISTRATION CONSENT:

I have been told about the purpose of household registration and assessment. I agree to the registration and assessment of this household.

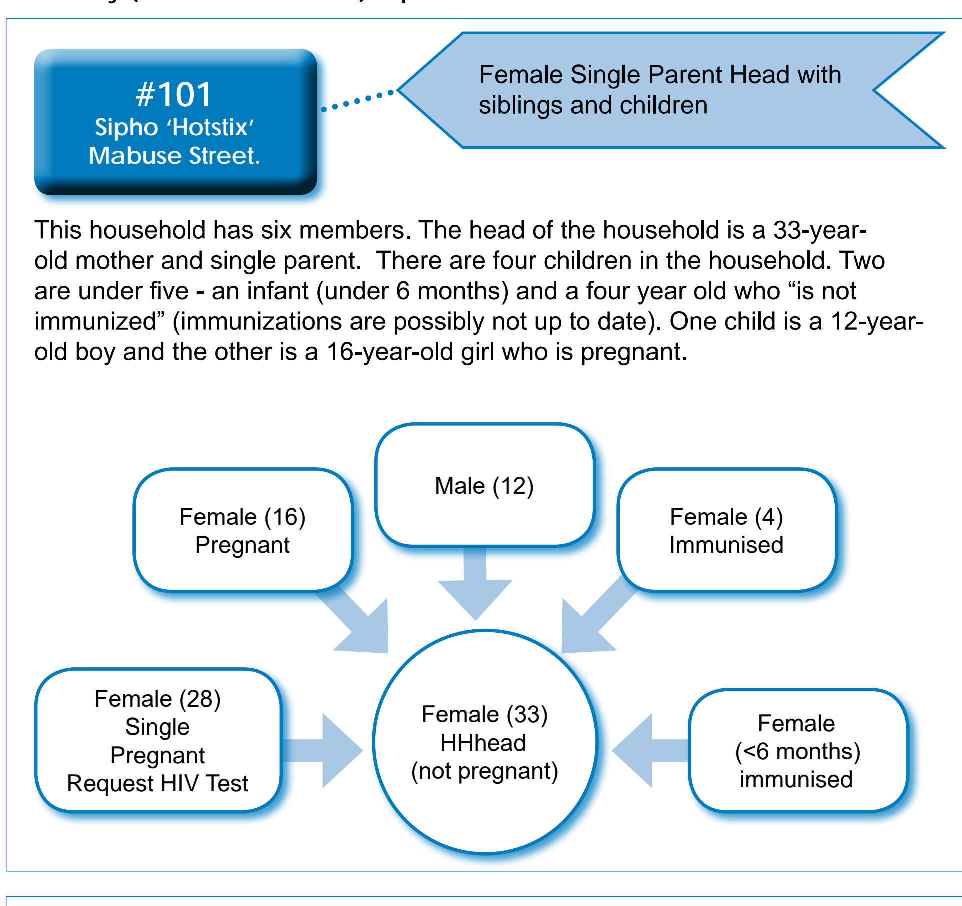
Agree | Don't Agree

RESEARCH CONSENT :

I understand that this information may be used for research purposes. I have been told that if the information is used for research it will not identify me, or any members of my household in any way. I have had time to ask questions.

Agree | Don't Agree

Melody (Ward Number 0201): Sipho 'Hotstix' Mabuse Street



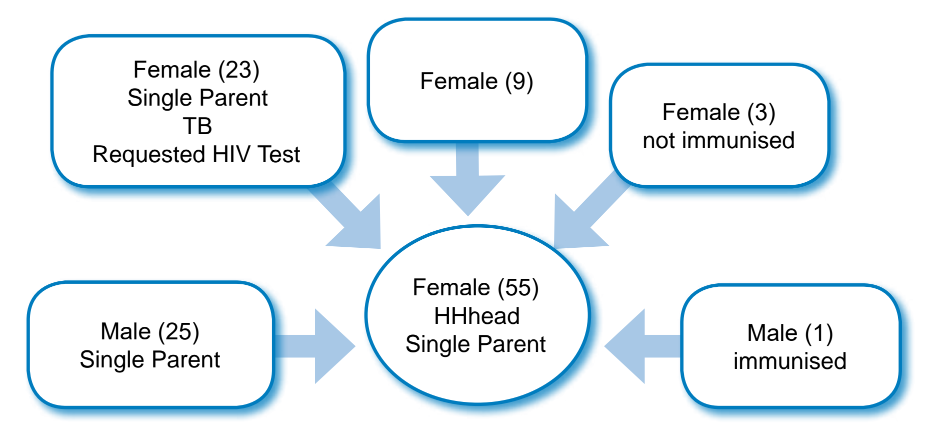
This household has six members. The head of the household is a 33-year-old mother and single parent. There are four children in the household. Two are under five - an infant (under 6 months) and a four year old who "is not immunized" (immunizations are possibly not up to date). One child is a 12-year-old boy and the other is a 16-year-old girl who is pregnant.

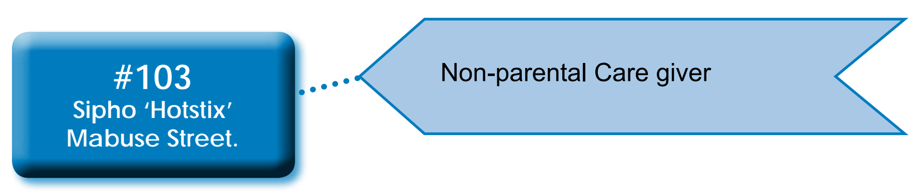
#102
Sipho 'Hotstix' Mabuse Street.

Single parent female head of 3 generational household

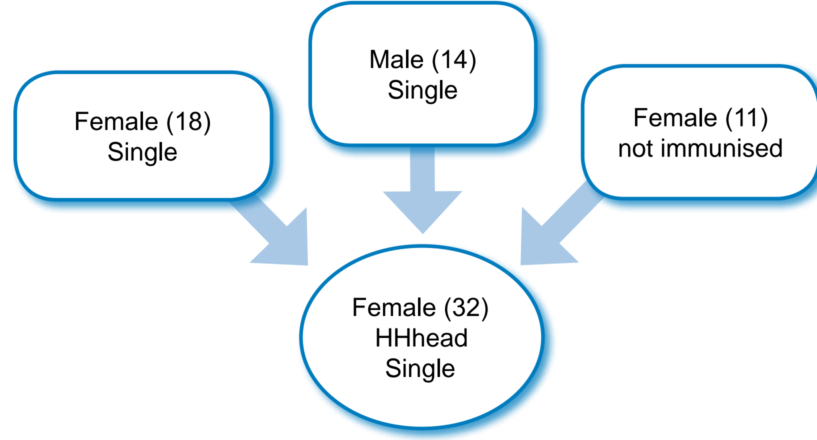
Household #102 has six members. The head of the household is a 55-year-old mother and single parent. There are three children in the household. Two are under five – a 1 year old boy and a three-year-old girl who "is not immunized" (immunizations are possibly not up to date).

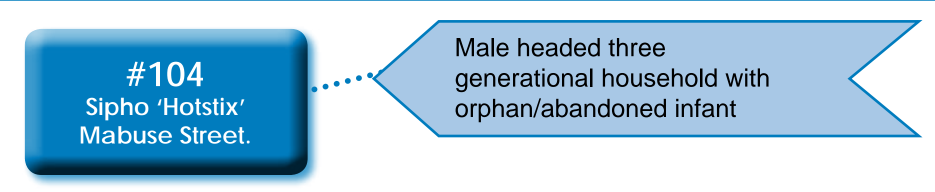
There is also a nine-year-old girl. In addition, there are two adults who are also single parents – one a father of 25 and the other a mother of 23. The 23 year old is said to have TB and there is a request for an HIV test.



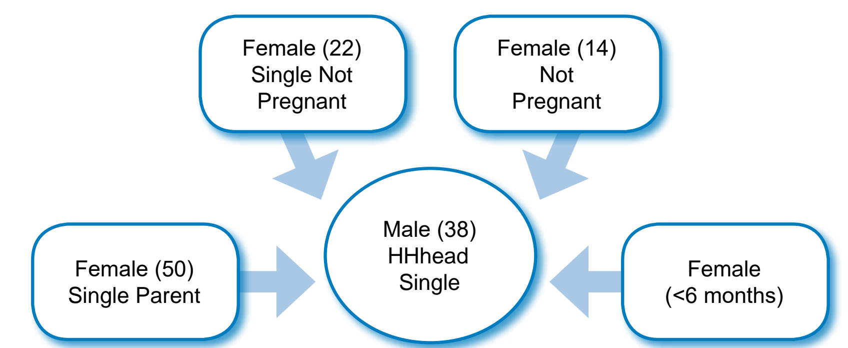


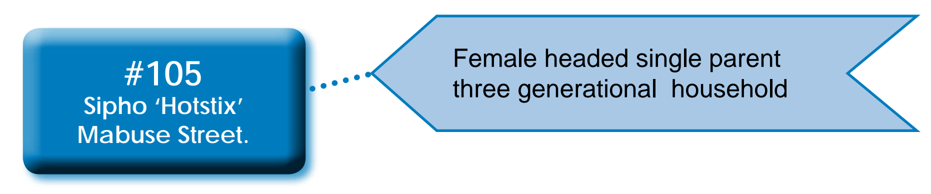
Household #103 has four members. The head of the household is a 32-year-old single woman. There are three children in the household. Two are girls aged 18 and 11 respectively and one is a boy aged fourteen.



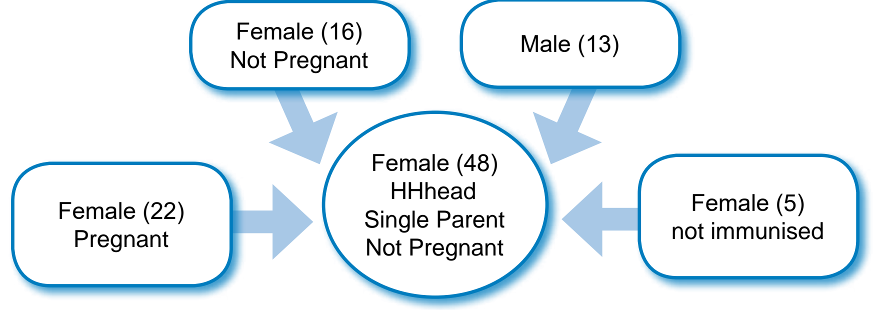


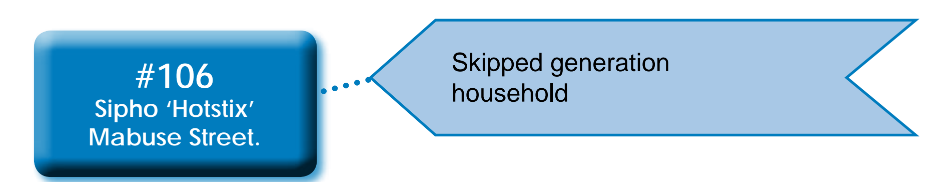
Household #104 has five members. The head of the household is a 38-year-old man who is single. There are two girl children in the household. One is an infant (under 6 months) and the other a 14-year-old teenager who is not pregnant. There is also a 50-year-old woman (and parent) and a 22-year-old single woman in the household.



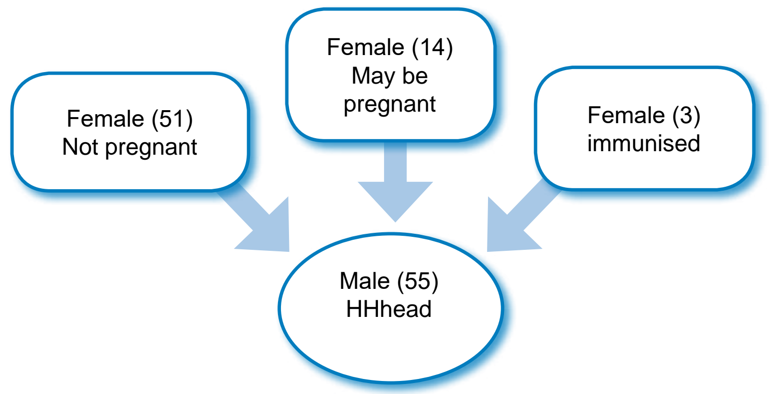


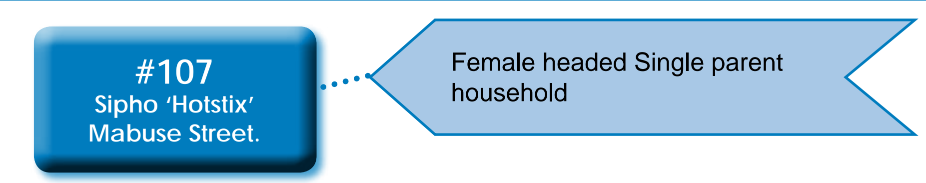
Household #105 has five members. The head of the household is a 48-year-old woman who is a single parent. There is a 22-year-old woman who is pregnant as well as three children living in the household. Two are teenagers - a 13-year-old boy and a 16-year-old girl who is not pregnant. One child is a five-year-old girl who may require immunization.



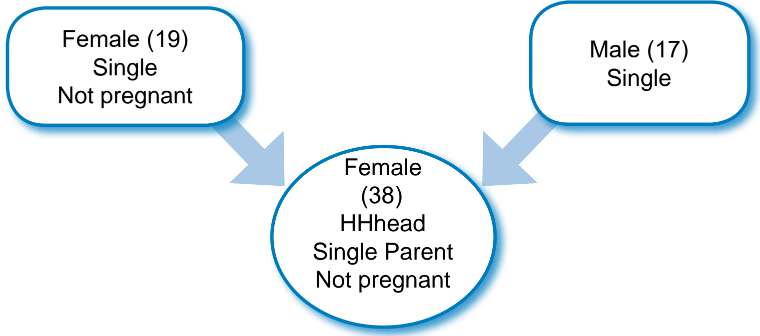


Household #106 has four members. The head of the household is a 55-year-old man who is married. There is a 51-year-old woman who is married to the HH head. There are two girl children in the household, a three year old who may require immunization and a 14 year old who may be pregnant.





Household 107 has three members. It is headed by a woman who is a single parent. There is one child, a 17-year-old boy and one young adult, a 19-year-old woman who is single and not pregnant.



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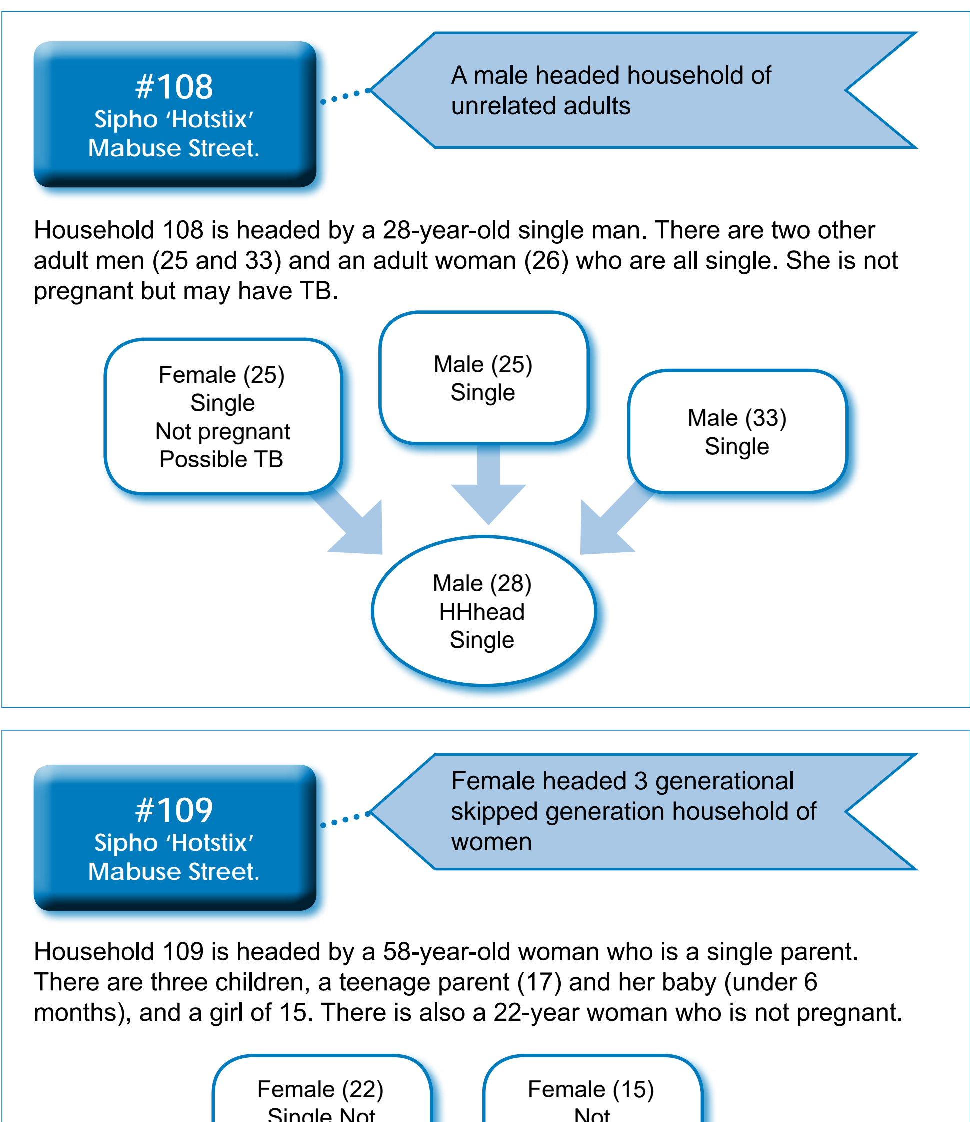


Household 108 is headed by a 28-year-old single man. There are two other adult men (25 and 33) and an adult woman (26) who are all single. She is not pregnant but may have TB.

Household 109 is headed by a 58-year-old woman who is a single parent. There are three children, a teenage parent (17) and her baby (under 6 months), and a girl of 15. There is also a 22-year woman who is not pregnant.

NOTIFIABLE MEDICAL CONDITIONS (NMC) DISEASE LIST

CATEGORY 1 NOTIFIABLE MEDICAL CONDITIONS	
Category 1 notifiable medical conditions that require immediate reporting by the most rapid means available upon diagnosis followed by a written or electronic notification to the Department of Health within 24 hours of diagnosis by health care providers, private health laboratories or public health laboratories. * Food -borne disease outbreak is the occurrence of two or more cases of a similar foodborne disease resulting from the ingestion of a common food. ** Examples of novel respiratory pathogens include novel influenza A virus and MERS coronavirus. *** Viral haemorrhagic fever diseases include Ebola or Marburg viruses, Lassa virus, Lujo virus, new world arena viruses, Crimean -Congo haemorrhagic fever or other newly identified viruses causing haemorrhagic fever.	
Acute flaccid paralysis	
Acute rheumatic fever	
Anthrax	
Botulism	
Cholera	
Diphtheria	
Enteric fever (typhoid or paratyphoid fever)	
Food borne disease outbreak*	
Haemolytic uraemic syndrome (HUS)	
Listeriosis	
Malaria	
Measles	
Meningococcal disease	
Pertussis	

Plague	
Poliomyelitis	
Rabies (human)	
Respiratory disease caused by a novel respiratory pathogen**	
Rift valley fever (human)	
Smallpox	
Viral haemorrhagic fever diseases***	
Yellow fever	

CATEGORY 2 NOTIFIABLE MEDICAL CONDITIONS	
Category 2 notifiable medical conditions to be notified through a written or electronic notification to the Department of Health within seven (7) days of clinical or laboratory diagnosis by health care providers, private health laboratories or public health laboratories.	
Agricultural or stock remedy poisoning	
Bilharzia (schistosomiasis)	
Brucellosis	
Congenital rubella syndrome	
Congenital syphilis	
Haemophilus influenzae type B	
Hepatitis A	
Hepatitis B	
Hepatitis C	
Hepatitis E	
Lead poisoning	
Legionellosis	
Leprosy	
Maternal death (pregnancy, childbirth and puerperium)	
Mercury poisoning	
Soil transmitted helminths (Ascaris Lumbricoides, Trichuris trichiuria, Ancylostoma duodenale, Necator americanus)	

Tetanus	
Tuberculosis: pulmonary	
Tuberculosis: extra-pulmonary	
Tuberculosis: multidrug-resistant (MDR-TB)	
Tuberculosis: extensively drug-resistant (XDR-TB)	

CATEGORY 3 NOTIFIABLE MEDICAL CONDITIONS	
Category 3 notifiable medical conditions to be notified through a written or electronic notification to the Department of Health within 7 days of diagnosis by private and public health laboratories.	
Ceftriaxone-resistant Neisseria gonorrhoea	
West Nile virus, Sindbis virus, Chikungunya virus	
Dengue fever virus, other imported arboviruses of medical importance	
Salmonella spp. other than S. Typhi and S. Paratyphi	
Rubella virus	
Shiga toxin-producing Escherichia coli	
Shigella spp.	

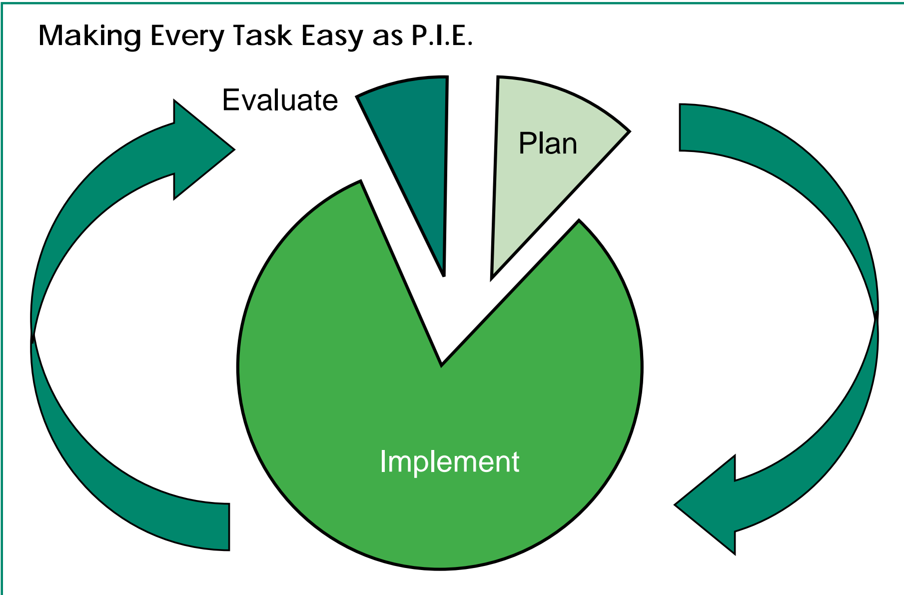
CATEGORY 4 NOTIFIABLE MEDICAL CONDITIONS		
Category 4 notifiable medical conditions to be notified through a written or electronic notification to the Department of Health within 1 month of diagnosis by private and public health laboratories.		
Healthcare-associated infections or multidrug-resistant organisms of public health importance	Carbapenemase-producing Enterobacteriaceae	
	Vancomycin-resistant enterococci	
	Staphylococcus aureus: hGISA and GISA	
	Colistin-resistant Pseudomonas aeruginosa	
	Colistin-resistant Acinetobacter baumanii	
	Clostridium difficile	

9

9.1 Prioritising and Planning

Learning and work tasks are just like everyday tasks and activities. They always involve decisions about their importance (prioritization). They also always involve some degree of preparation (planning), application (implementation) and assessment (evaluation).

This means that even if you have not consciously thought about how you go about everyday things, you already have some experience of prioritization and you have some experience of planning, implementing and evaluating or P.I.E.



By making visible the P.I.E tools you use to do everyday things, it will help you consciously think about them in order to expand and deepen the way you use them.

Health Care Prioritization and Planning

Prioritization

PRIORITIZATION

REFLECT AND WRITE

Write down 5 things that you had to do this morning before leaving home.

1. In column 1 rank them by their importance to your well-being.
2. In column 2 rank them by their importance to your work or studies.
3. In column 3 indicate if you completed/did not complete the task. If you did not complete the task write down the reasons why.

3.1.1 Five things that I had to do this morning before leaving home.	1.Importance to my well-being	2. Importance to my work/studies	3.Reasons for completing/not completing the task
	1= most important, 2= very important, 3 = important, 4= less important and 5 = least important.		1= complete 2= incomplete + reason
1.			
2.			
3.			
4.			
5.			

PRIORITIZATION

PAIRS

Discuss the differences in the way you ordered (ranked) the things you had to do and the outcome of your prioritization (i.e. the tasks you completed, the tasks you did not and the reasons why).

PRIORITIZATION

REFLECT AND WRITE

Reflect and write down what you learnt about yourself?

DID YOU KNOW?

A **priority** is something that is considered to be more important than other things.

Rationing is a system of limiting the amount of something that each person is allowed to have or do.

In health care there are always many needs and too few resources to deal with all of them equally all the time. This reality forces people and health systems to make difficult choices about what to provide and who to serve. They all do this by practicing some form of rationing. Sometimes they ration services. Sometimes they ration people. Whatever the form of rationing, health care systems have to have some way of prioritizing what they do and whom they serve. And they have to do this in a way that responds fairly, taking account of the complexity of competing interests, needs and expectations.

PRIORITIZING HEALTH IN THE COMMUNITY

GROUP

Using Information

Use the information from "Case Study at Melody' (8: Appendix 3)

Rank the households or health issues that need urgent health system services.

Tip: *First use the information (e.g. in text)*

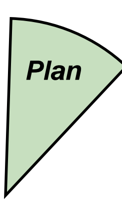
Tip: *Because there are competing priorities. The ranking order can be constructed in more than one way. Keep in mind the four epidemics as well as the fact that people/households with multiple risks also matters.*

Tip: *Use or Adapt the Melody (Ward Number O201): Sipho "Hotstix" Mabuse Street template to the issues you are considering.*

9.1 Melody (Ward Number 0201) Sipho "Hotsticks" Mabuse Street Households

Ranking
1= most important, 2= very important, 3 = important, 4= less important and 5 = least important.

Household	Child Headed	Single Parent	Pregnant	Newborns / infants	Children under five	Teenagers
.#101						
.#102						
.#103						
.#104						
.#105						
.#106						
.#107						
.#108						
.#109						



Planning

In COPC we use the principles of COPC to guide decisions on how to allocate resources, which services to provide and who to provide services for. Even then, the framework for action that the principles create is still broad. This means that choices always have to be made.

The best way to determine priorities and ration resources is to have a plan. A plan is a method of thinking through actions and activities before doing them. It is a way of preparing for a task or a process.

There are different approaches to planning and different kinds of plans. They all have one thing in common – they are all tools that people create to achieve their desired goals or outcomes.

Traditionally, planning is divided into two parts that follow one another: "strategic planning" and "action planning". A strategic plan is a "big picture" plan that people create to envisage where they want to be in the future (say in five or ten years time). Action plans are "small picture" steps that need to be taken to achieve the goals and objectives of the strategic plan.

Traditional strategic planning starts from a common set of assumptions. These are that:

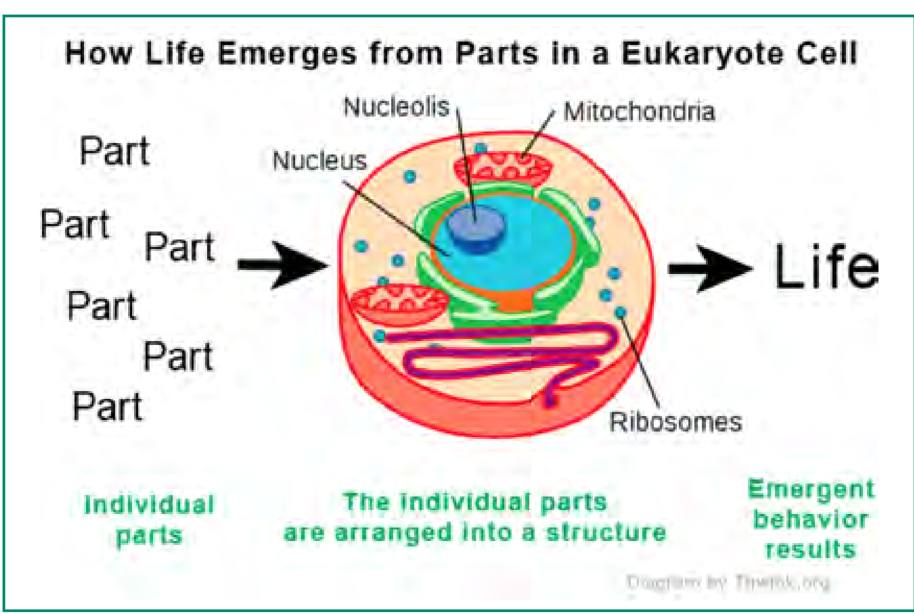
- the future is knowable;
- the future is largely predictable, because the influences on the organization, programme or project are stable and constant;
- there is only one way of accounting for the present situation, including gaps and ways to fix them;
- there is only one vision of the desired future;
- goals, objectives, roles and responsibilities are discrete organisational areas;
- people are organized by and work towards the goals that are set by the organisation;
- performance against plans is best monitored and evaluated at fixed intervals;
- action plans come after strategic goals and objectives are set.

Unfortunately, many of these assumptions about the world, organisations and people are not true. This is why many strategic plans stay on paper.

They just don't work because many physical and social systems are complex. Life is complex. Communities are complex systems. Health and welfare are complex systems. Learning is a complex system.

Complex systems are made up of many parts.. All of them are important. Breaking each part down will help you understand it. But it will not help you understand the system. What matters in a system is how the parts connect and interact with one another. These connections, interactions and relationships make the whole greater than each of the parts.

The Thwink illustration shows how life emerges when parts come together in "the cell that can do anything" - an eukaryote cell. This is a cell with a nucleus and other parts.



What all this means is that you have to make different assumptions when you plan for complexity.

"In complex systems:

- Order flows from interactions, not from central control;
- Adaptability is natural;
- Small changes may produce big effects;
- Behavior can be amplified or diminished by influencing the nature of the interactions among the parts;
- The whole is greater than the sum of the parts."

Complex systems are context specific.

http://www.plexusinstitute.org/?page=complexity 2015/03/10

Planning in complex systems means doing different things and working in a different way. Planning has to respond to the way people interact with each other in specific contexts. It has to adapt to changes in behavior in order for it to be useful.

Adaptive Action Planning

1. It works in the circumstances that people find themselves in.
2. It focuses on actions towards common goals that make a difference "here and now".
3. It produces focused action plans that can have a ripple effect on the whole system.
4. It reflects the insight and knowledge of people who work in the system every day.
5. It is responsive to change and uncertainty.
6. It works in multiple cycles of planning and evaluation to encourage adaptive change to a shifting environment.
7. It helps people identify and track the measures that are relevant to their work.
8. It encourages diverse perspectives and strategies that support on-going learning.
9. It assumes that people, conditions and contexts change all the time.
10. It focuses on the actions needed to achieve priorities, not on the priorities *per se*.

"You need macro and micro data to see patterns. But for practice, you need a micro, bite-sized focus." Ali Korkmaz

Adaptive action planning is something that you can do on your own to help you prioritize and/or do tasks. You can use it to help you do the things you had to do in the morning or a learning task.

ACTION PLANNING

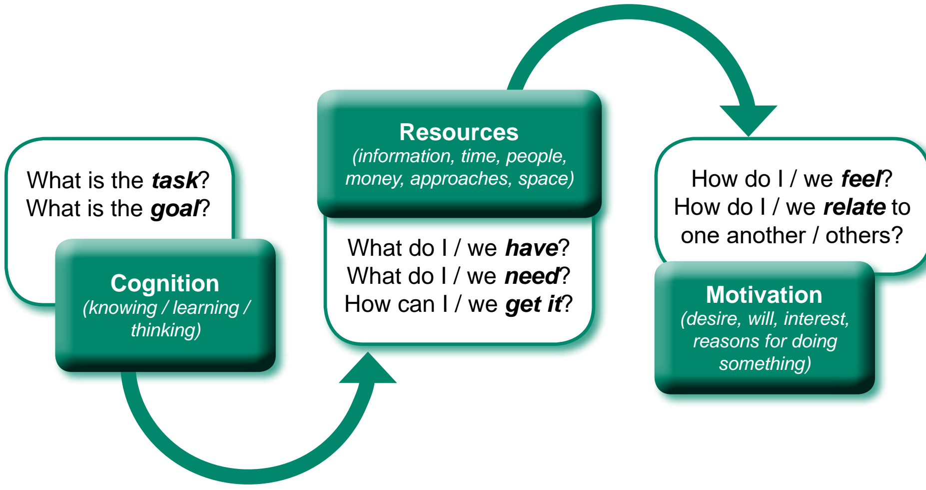
INDIVIDUALLY

Individually, write an action plan for a task that you have to do. You can choose a task you planned but failed to do this morning or something that you have to do in the next week e.g. household registration / triage follow-up.

Workings backwards, identify all the things that need to be done to meet the objective (column 1) or achieve the expected outcome (column 6). Then put each of those items in the Action Steps column and fill out the columns for that row. Make sure you break the task or objective into simple, specific action steps.

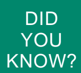
PLAN – IMPLEMENT- EVALUATE					
1	2	3	4	5	6
Name the task *(what is the task?)*	Action steps to do the task *(What has to be done?)*	Time *(How much time will it take? How much time have I got?)*	Resources: Money, People, Information, Tools Equipment *(What things, information and people are needed to do it?)*	Potential Obstacles/ barriers *(What could get in the way of completing the task? How will obstacles/barriers be overcome?)*	Result *(What is the output, or outcome?)*

Planning is an activity. It combines cognitive (or thinking) ***skills*** with motivation and self/group/organisational awareness or ***will***.



Action planning is also something that you do with other people when you work in teams or learn in groups. Now though, you have to come to a shared understanding as a group or team on seven things:

1. the task or objective;
2. the actions or steps that have to be taken;
3. the person or people who will be responsible for each task/activity;
4. the time needed to achieve each task as well as the objectives or outcomes;
5. the resources (support, technical skills, finance, tools and equipment, facilities, personnel, etc.) needed to realize the task; and
6. the things that could get in the way of completing the task and ways to avoid or overcome these obstacles;
7. the output or outcome i.e. the expected result/s.



In planning a task or activity:

Outputs are the service delivery or implementation targets you want to achieve. They tie up with your task and the steps you plan.

Outcomes are the results you expect to achieve. They tie up with your objective/s.

Impacts are the effects of the results you have achieved. They tie up with your objectives and goal.

PLAN – IMPLEMENT- EVALUATE

Ante-Natal Action Plan

1	2	3	4	5	6	7
Task / Objective *(what is the task/ objective?)*	Action steps *(What things have to be done to achieve the task..?)*	Responsible Person *(who will drive or take responsibility for doing it in the group)*	Resources *(What things, information, people, organizations, support are needed to do it?)*	Time *(How much time is needed? How much time do we have to do the task?)*	Potential Obstacles / Barriers *(What could get in the way of completing the task? How will obstacles / barriers be overcome?)*	Expected Result *(What is the output / outcome?)*
Antenatal Care	Test for Pregnancy *(possibly Pregnant)*	A Person *(CHW responsible for HH where someone possibly pregnant)*	Pregnancy Test or Knowledge of test and where to get tested	1 week	1. Person not available/not willing to go for test. 2. CHW knowledge 3. Too little time	Tested for possible pregnancy
	If pregnant – Determine reproductive intentions *(retain /terminate pregnancy)*	A Person *(CHW responsible for HH where someone pregnant)*	Knowledge about 1. keep/terminate pregnancy decision making 2. support services 3. implications 4. counseling and advice giving	1-10 weeks *(depending on stage of pregnancy)*	1. Person partner or family response *(denial, unsupportive, punitive, uncooperative)* 2. CHW authority 3. CHW knowledge and skills	Informed choice to continue or end pregnancy
	If pregnant (retained) –Initiate health promotion and disease prevention	A Person(CHW responsible for HH where someone pregnant)	Support an Information *(appropriate to the stage of pregnancy)* to individual and family on 1. ANC schedule (5 visits) 2. staying well (maternal physical and mental health); 3. ensuring baby growth and health during pregnancy 4. Preparing for newborn 5. Monitoring changes 6. Team leader / Clinic / Doctor support	42 weeks *(or remainder of the duration of the pregnancy)*	CHW knowledge; CHW time; Family interest/ support involvement;	Healthy pregnancy; Healthy mother; Informed family; Informed Mother; Supported Mother to prepare for new born

PLAN – IMPLEMENT- EVALUATE

Ante-Natal Action Plan

1	2	3	4	5	6	7
Task / Objective *(what is the task/ objective?)*	Action steps *(What things have to be done to achieve the task..?)*	Responsible Person *(who will drive or take responsibility for doing it in the group)*	Resources *(What things, information, people, organizations, support are needed to do it?)*	Time *(How much time is needed? How much time do we have to do the task?)*	Potential Obstacles / Barriers *(What could get in the way of completing the task? How will obstacles / barriers be overcome?)*	Expected Result *(What is the output / outcome?)*
	If pregnant *(termination)*	A Person *(CHW responsible for HH where someone pregnant)*	Information about ToP; Knowledge of available safe legal ToP services; Knowledge about post-ToP support *(HCT, Contraception, Safe sex, PsychologicalCounseling)* Team leader/ Clinic/ Doctor/ Psychologist support	<20 weeks	CHW time; Family interest / support involvement; Team leader / Clinic / Doctor support	Safe ToP, Well woman. Informed about safe sex. On contraception. Done HCT

ACTION PLANNING

GROUP

Working as a group, use the action plan template to create an action plan for one health priority that you have identified.
Review your action plan to check it is complete, clear and current. Make sure that each action will help your group meet it's objective and achieve the outcome you have set yourselves.

Three Cs+I to Ensure Good Action Planning

Check to make sure that the Action Plan is:

1. Complete.

Does it list all the action steps that have to be taken to meet the objective or achieve the outcome? Remember a single task or objective may need many action steps.

2. Clear.

Does every one know what they have to do? Does everybody know the amount of time available to complete their tasks, and/or the whole activity?

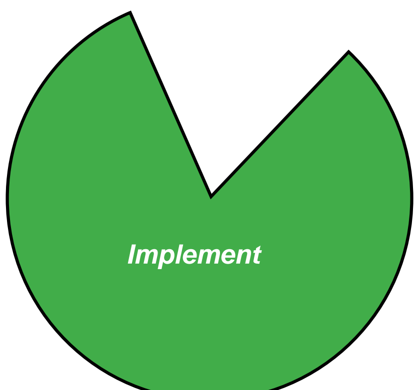
3. Current.

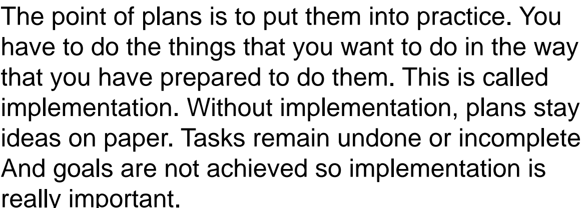
Does the action plan reflect the current work people do? Does it anticipate new or emerging opportunities? Does it anticipate barriers?

+1 Communicate

A good plan depends on good communication. Communicate well during planning. And remember to plan to communicate!

9.2 Implementation and Monitoring





The point of plans is to put them into practice. You have to do the things that you want to do in the way that you have prepared to do them. This is called implementation. Without implementation, plans stay ideas on paper. Tasks remain undone or incomplete. And goals are not achieved so implementation is really important.

Everyone has experience of not doing what he or she has planned to do. Everyone also has experience of the big or small consequences of not following through on their plans.

In health care, failing to put plans into action often carries very serious personal, individual, family and community consequences.
So how do you know if a plan really works? Sometimes, you know simply by seeing the end result. This usually happens when the activity or task is simple or familiar. But it is different when tasks or activities involve many people. The only way to know if a plan is working is to monitor actions.

Monitoring is the process of thinking about and actively watching over actions and activities while these are being done.

The best time to think about monitoring and evaluation is during the planning phase of a task, project or program.

Monitoring a task or activity means checking your plans.
- You check the things you have done against what you planned to do.
- You can also check on the results of your activities. These are called outcomes.

Monitoring is a form of management.
- It is a self-management tool that you can use to improve your work.
- It is a system management tool when it is used by a team leader, supervisor or manager to support and direct the work of others.

Self-monitoring

When you watch over your own activities, it is called self-monitoring. Everyone can check him or herself to make sure that the learning, skills or practical tasks they do are going to plan.

For example, when you register a household or do triage, there are three sets of questions that you can ask yourself to help keep you on track.

- You need to ask yourself cognitive questions or questions about your thinking, understanding or approach (e.g. Is my approach working? Am I clear enough about what I am doing?).
- You also need to ask yourself about your motivation (e.g. How do I feel? Am I paying attention?) Remember, motivation energizes, directs and sustains what you do and how you act.
- And you need to ask questions about the context (the environment and/or the relationships) around you or where you are doing the task (e.g. Is the context affecting the task? Should I move to another place?).

COGNITION

- Is my approach working?
- Am I going towards my goals

MOTIVATION

- How do I feel about what I am doing?
- Am I paying attention?

CONTEXT

- How is the context affecting the task
- What should I change or do?

Self-Check/ Self-Monitoring Questions

Four Facts about Motivation

(Adapted From: J E Omrod April 30,2014. http://www.education.com/reference/article/motivation-affects-learning-behavior)

1. It directs behavior/activities/learning towards goals.
2. It has an impact on effort and energy.
3. It affects cognition or how well people pay attention, process and remember things.
4. It impacts on consequences (performance).

Formal System Monitoring

Monitoring is also a formal activity that takes place regularly at specific times throughout the process of implementation. Every action plan describes the tasks. It identifies ways to achieve each task (steps). It identifies the person responsible for those steps or actions, a time frame and expected outputs and outcomes. These identified people, processes, outputs and outcomes become the indicators that help you monitor whether the task or activity is on track or not.

Melody (Ward Number 0201) Household Registration, Triage and Follow-Up Report is a monitoring report as much as it is planning tool.

FORMAL SYSTEM MONITORING

GROUP

Look at the Melody (Ward Number 0201) Report (Table 9.2):

1. Identify the reporting interval (s)
2. Identify the columns that show team progress in
   a. outputs
   b. outcomes
3. Draft your Action Plan

Table 9.2: Melody (Ward Number: 0201) Household Registration, Triage and Follow Up Report 0001: Jan15 -Jan31, 2015												
Team Name	Ward Number	CHW	Task: Household Registration			Task: Completed Triage Assessments		Task: Complete Household Assessments		Task: Follow Up Visits		
			Households		People					Scheduled	Completed	
			(n)	(% of total)	(n)	(n)	(% of registered)	(n)	(% of registered)	(n)	(n)	(%)
1	2	3	4	5	6	7	8	9	10	11	12	13
Melody	0201	MA	16	8,0	41	16	100,00	11	68,75	14	0	0,0
Melody	0201	MB	17	8,5	88	16	94,00	17	100,00	48	15	24,1
Melody	0201	MC	17	8,5	88	15	88,00	14	82.,35	77	17	0,0
Melody	0201	MD	20	10	61	17	85,00	20	100,00	15	0	31,3
Melody	0201	ME	20	10,0	71	19	95,00	19	95,00	25	3	12,0
Melody	0201	MF	23	11,5	91	22	95,60	20	87,00	68	14	37,3
Melody	0201	MG	23	11,5	85	23	100,00	22	95,00	15	8	22,1
Melody	0201	MH	27	13,5	83	27	100,00	27	100,00	29	7	54,2
Melody	0201	MI	28	14,0	129	27	96,40	27	96,40	107	58	0,0
Melody	0201	MJ	28	14,0	149	27	96,40	28	100,00	31	31	20,6
Melody	0201	MK	36	18,0	115	34	94,40	36	100,00	67	25	50,0
TOTAL		11	255	100	1001	243	95.29	241	94.51	496	178	35.9

AS A HEALTH WORKER...

Monitoring implementation helps you

- ✓ check progress against plan;
- ✓ identify problems and challenges; and
- ✓ make decisions and respond to problems in a systematic and informed way.

In other words, monitoring is very valuable because it helps improve performance while you or your team is doing a task, implementing a project or implementing a program.

9.3 Evaluate

Evaluation is a systematic process. It follows a specific plan or method that is designed to assess a task, project (set of tasks) or program (several projects) in terms of its efficiency, effectiveness and impact.

Efficiency, Effectiveness and Impact
Adapted from "Monitoring and Evaluation" *http://civicus.org/index.php/en/media-centre-129/toolkits/228-monitoring-and-evaluation (2015/04/18)*

Efficiency is about the relationship between input and output. When you evaluate for efficiency you are interested in finding out if the result was appropriate for the amount of resources (effort, time, money, people, equipment, etc.,) that were put into the task, project or program.

Effectiveness is about measuring the extent to which a task, project or program achieves the specific objectives it set. If, for example, you set out to improve primary health care service by linking individuals and families through WBOTs to health care facilities, in evaluating for effectiveness, you have to ask the question "did we succeed?" or "to what extent did we succeed?".

Impact is about the nature and extent of the difference that has been made to the problem by the intervention. In other words, using the above example, "did linking individuals and families to WBOTs improve primary health care delivery?" or "did linking individuals and families to WBOTs improve health in the community?"

Types of Evaluations

An evaluation can be undertaken before, during and after an intervention or an activity. The timing of the evaluation is linked to its purpose. The purpose of an evaluation is either to *improve* or *to prove* performance and effect.

A **formative evaluation** is an evaluation that is done before a task, project or program begins. A formative evaluation is usually done to help improve a service or activity that is already being done. It is done

i) to determine the focus and scope of the intervention; and
ii) to provide baseline information against which it is possible to measure the impact of an intended intervention

An evaluation that is done while a project or program is in process is called a mid-(term/milestone/ way) evaluation. Evaluations that are done during interventions can be done to both improve and prove.

A **mid-term evaluation** is an evaluation that is done while a project or program is in process. Evaluations during interventions are often linked to funding. Funders often want to know that milestones are reached. This helps them determine if the project is on track. It also helps them decide about the value of continuing to put money into it. In this sense, they are done to prove outcomes.

A **summative evaluation** is an evaluation that is done when the task, project or program is finished. . Summative evaluations are designed to demonstrate results or prove to funders or the communities the effects of the activities. There are two kinds of summative evaluations.

1. Outcome evaluations review, measure and reflect on the overall task or activity. Their purpose is to discover the extent to which plans are realized and have met expected outcomes. They are usually done at the end or shortly after the project or program has ended.
2. Impact evaluations look at the effects of the project or program more broadly. Impact evaluations are complex, costly and require the passage of time for reliable results to emerge. They often can only be done long after the project or program is finished.

Evaluation Culture

Evaluation is a good way to improve health care learning and practice. But how evaluations are approached also matters. “The evaluation culture” that we bring to managing improvement is very important. It tells us about the values we share and want to support.

In COPC, evaluation is guided by COPC principles. This means that evaluation should be:

1. **action oriented** – finding solutions to problems, testing ideas, weighing the results, revising approaches – in an endless cycle of improvement;

2. **learning oriented** – bringing evaluation techniques to every day practice in a simple, low cost, practical way;
3. **integration oriented** – ensuring that diverse views, disciplines and interests contribute to the evaluation process in order to find solutions because problems are often complex;
4. **self-critical and modest** – acknowledging limitations and recognizing that any proposed solution is always tempered by context;
5. **truth seeking and ethical** – ensuring accountability and that the evaluation results are credible (scientific) and practical (applicable).

Evaluation Methods

Any form of evaluation needs a method or systematic way of doing it. There are important methodological differences between informal (individual or group self-evaluation) and formal (internal or external) evaluations.

The method for doing an informal self-evaluation is fairly straightforward. Evaluating a task like doing an HHR, writing a test, writing a report, doing an interview, involves two steps. The first step is to put time aside and to ask yourself/ the group evaluative questions about the task and its outcome. Examples of evaluative questions include "Have I/we done what I/we said would be done?", "What went well?, "Why?", "What went badly?", "Why?".

The 'why' question is particularly important because it gives you a chance to reflect and consider the reasons for your performance or the outcome. Was it the way you thought about, prepared for and understood the task (metacognition). Was it the way you felt about the task (motivation); and/or was it the way you went about the strategies you used, what you did or the way you managed the environment?

The second step is to find solutions in order to improve your performance the next time you do the task. You need to be able to respond to the reasons for the way you performed in the past i.e. your answers to "why". In other words, individually or as a group you have to change the way you prepare for, feel about or act when you do the task.

SELF EVALUATE

PAIRS

Self-evaluate a learning or practical task that you have completed during the past week.
Remember to define the task and expected outcome. Consider what went well and what did not go well and the reasons for these outcomes. And then find solutions.

Formal evaluation is a more rigorous process. It is very similar to doing scientific research. It can be done internally by team or organization or externally, by hiring recruited experts. There are several good reasons to do formal self-evaluations in an organization, as the text box shows. There are also several disadvantages to doing an evaluation internally. These include:

- organizational vested interests;
- the danger of bias and a lack of objectivity;
- the time it takes out of working hours; and
- limited evaluation skills.

10 Reasons to Do Formal Self-Evaluation (also called "Internal" Evaluation)
http://knowhownonprofit.org/organisation/quality/mande/evaluation (2015/04/17)

1. It is done by people who are familiar with the organization's culture.
2. It can build on and complement internal reporting systems.
3. It can be more easily integrated with other work processes.
4. It can tap into internal knowledge more easily.
5. It encourages greater learning and a more reflective approach.
6. Control and use of the information stays within the organization.
7. It is less threatening.
8. It is more likely to lead to change and supports self-correction.
9. It can support the development of new skills.
10. It may be less costly or more cost effective.

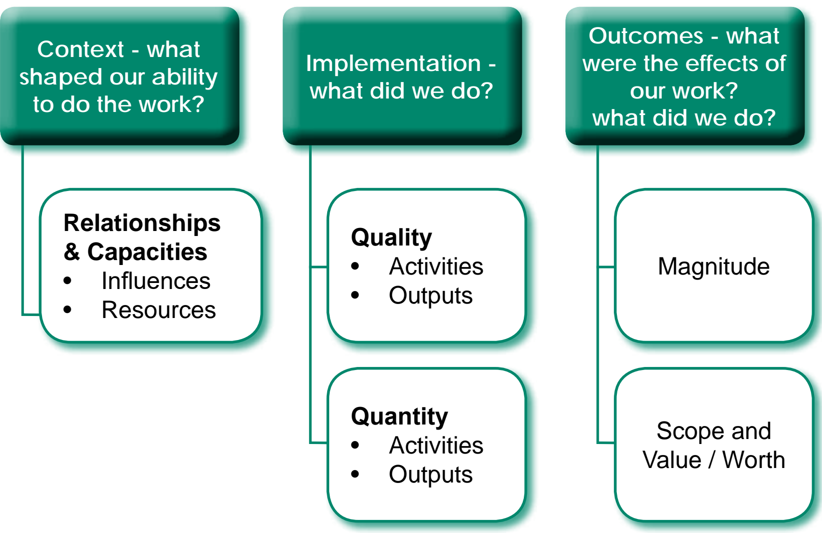
Whether conducted internally or by an external organization or expert, a formal evaluation is a process that involves several steps[iii]. Here we are only going to briefly explain three[iv], namely: determining what to evaluate, determining evaluation criteria; and determining performance criteria.

1. Determining what will be evaluated.

A summative evaluation can evaluate any or all of the following areas:

- ***the context*** of the project or program (e.g. where do WBOTs / Colleges fit in in the health care, social and political system? What resources do we have?);
- ***implementation*** (e.g. the extent to which activities were carried out according to plan); and
- ***outcomes*** or the changes that the project or program made on people, organizations, systems or conditions (e.g. service integration in municipal wards, individual and family centered care, detection and community response to the four epidemics, primary care service provider learning and organization, health literacy, etc.,)

These are summarized in the diagram below.



DID YOU KNOW?

It is often necessary to focus the evaluation on one or two sets of activities within an area because people do not have the time or resources to evaluate every thing they have done. By choosing a focus you are **prioritizing**.

2. Determining evaluation criteria. Evaluation criteria are used to decide on what exactly will be assessed. They are always project and program specific, but there are some general waysof thinking about evaluation criteria that are useful.

Evaluation criteria should:

a) ***relate to services or people*** –you have to state who or what is being assessed (e.g. CHW followups, TB, etc.,)

b) ***reflect explicit performance targets*** – you have to state what was the expected output or outcome (e.g. a CHW would visit every household known to have TB or to be at risk of TB within a specific period of time; everyone with possible TB is tested and treated)

c) ***be objective*** – they should not be based on an individual's judgment, interpretation or opinion (e.g. identified TB households visited, people with possible TB tested, people with TB on treatment, etc.,)

d) ***indicate relative achievements*** – proportion of TB households visited, proportion of possible TB referred for testing, proportion of TB treated supported, etc.,)

e) ***cover all important aspects*** (e.g. TB identification, testing, treatment adherence, infection control, integration of health care, etc.,)

f) ***be acceptable to all levels of project employees or participants.*** (e.g. TB detection and treatment support is something CHWs, team leaders and managers know and consider to be part of their work)

3. Determining performance standards for evaluation criteria.

Performance standards are explicit statements about expected work quality. Performance standards can be used to evaluate any activity (e.g. learning, health care, managing, teaching, cooking, singing etc.,). They are valuable tools because they communicate expectations about how an activity should be performed to the person doing the activity as well as to the people observing or being acted on. In other words performance standards in health care help health care workers know where to aim for when they do a task.

At the same time, people, be they patients or family members or the community, know what to expect from a particular process, service or procedure.

Continuing with the example, the performance standard for TB is for a CHW to ask about and follow through on TB in order to either rule out or to ensure TB detection and treatment adherence in every household. Specifically he or she is expected

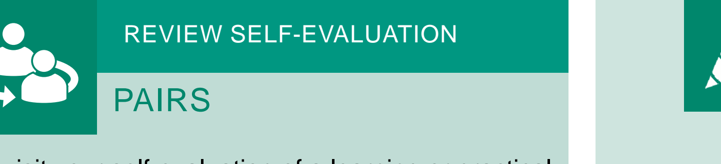
i) to ask about TB in every household;
ii) to triage the household if she or he is told that somebody in the household has TB, has had TB in the past 12 months or possibly has TB;
iii) to interview the person/ or log a follow up visit to interview the person with TB/possible TB;
iv) to complete the TB screening intervention for that person and the household. depending on their TB status or their TB diagnosis/ treatment status;
v) to be given clinical support from the team leader and relevant health care professionals;
vi) to be given learning support from the team leader and the inter-professional WBOT education and support team.

The other steps - collecting evidence[v], analyzing evidence and drawing conclusions- follow scientific methods used in research.

In Tshwane COPC, AitaHealth systematically collects information that can be used for monitoring.

Although it is also a substantial source of information for evaluation, additional sources of information are required to evaluate the outcome and impact of COPC. These are collected using specific research methods and tools.

Reporting is the final step of an evaluation. Here the evaluator presents evidence and his or her judgments to the organization and other stakeholders that requested or participated the evaluation. Evaluation is therefore different from science because evaluators directly address interested parties. They are expected to comment on the meaning and implications of their findings for the project or program.



Revisit your self-evaluation of a learning or practical task that you completed during the past week.

Identify and describe the evaluation criteria and the performance standards you used. Consider the changes you would make to your evaluation now that you have used these tools?

APPENDIX 1 ACTION PLAN TEMPLATE

PLAN – IMPLEMENT- EVALUATE				
1	2	3	4	
Task / Objective	**Action steps**	**Responsible Person**	**Resources**	
What is the task / objective?	*What things have to be done to achieve the task..?*	*Who will drive or take responsibility for doing it in the group?*	*What things, information, people, organizations, support are needed to do it?*	

	5	6	7
	Time	**Potential Obstacles / Barriers**	**Expected Result**
	How much time is needed? How much time do we have to do the task?	*What could get in the way of completing the task? How will obstacles / barriers be overcome?*	*What is the output / outcome?*

APPENDIX 2 THE HOME VISIT

A home visit is a consultation.

1 PREPARE

1.1. Know what you are going to say, learn and do.
1.2. Know how you are going to communicate and interact.

2 BE RESPECTFUL

2.1 Always knock on the door, request permission to come in and wait to be let in.

AS A HEALTH WORKER...

when you go into a home you ALWAYS need to be aware of and respect YOUR OWN SAFETY and PEOPLE' S PRIVACY. If you have any concerns DO NOT enter the house. Call your team partner and the team leader.

3 FIRST VISIT

3.1. Introduce yourself.

- ✓ My name is ….
- ✓ I am a community health worker.
- ✓ I am part of the ward based outreach team working in the area.
- ✓ We are linked to the …… (clinic name)

3.2. Establish a relationship.

3.2.1. Tell them the purpose of the day's visit.

I have come today to explain …

- ✓ what WBOTs are
  and
- ✓ to register your household
  or

3.2.2. Find out from the person their concerns or worries.

3.2.3. Give them feedback on what they are saying.

3.2.4. Get informed consent.

3.2.5. Do the tasks or activities.

3.2.6. Communicate about future contact.

- ✓ Make a next appointment.
- ✓ or tell them how to get hold of you.
- ✓ and when to expect another visit from you.

4 IN ALL VISITS

4.1. Prepare in advance for what you want to do/see/learn.

4.2. Continue to establish a relationship.

- ✓ Explain the purpose of the visit for the day.
- ✓ Communicate respectfully and clearly.
- ✓ Be aware of the language you use.
- ✓ Be sensitive to the person, family and home environment.

4.3. Find out from the person their concerns or worries.

4.4. Do the task or activity.

- ✓ Help them move towards recovery.
- ✓ Support positive change.

4.5. Communicate about future contact.

- ✓ Make a next appointment
  or
- ✓ tell them how to get hold of you
  and
- ✓ when to expect another visit from you

Report Date: 2015 January - 2015 February			
Ward: MELODY			
AitaHealth			
REGISTRATION SUMMARY			
Date	2015-01	2015-02	Cumulative Total
Households Registered	23	282	305
Household Triage Completed	23	265	288
Household Assessment Completed	23	259	282
Household Visits Completed	23	259	282
% Households Registrations Completed	100%	92%	86%
% Households Registrations not Completed	0%	9%	14%
Household Members Registered	36	493	592
Number of Community health workers	9	20	20

Follow-Up Reason	Scheduled
Unavailable	1
HIV	2
Tuberculosis	3
Antenatal Care	6
Chronic Care	6
Post -Natal Care	8
Child Under 5	10

FOLLOW-UP VISIT SUMMARY		
Year Month	2015-02	2015-03
Follow Up Scheduled	12	19
Follow Up Completed	7	2
% Follow Completed	60%	10%
Follow Up Missed	0	1
Follow Ups Rescheduled	0	2

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