

TRADITIONAL BIRTH ATTENDANTS AND HIV/AIDS IN SOUTH AFRICA: A TRAINER'S MANUAL

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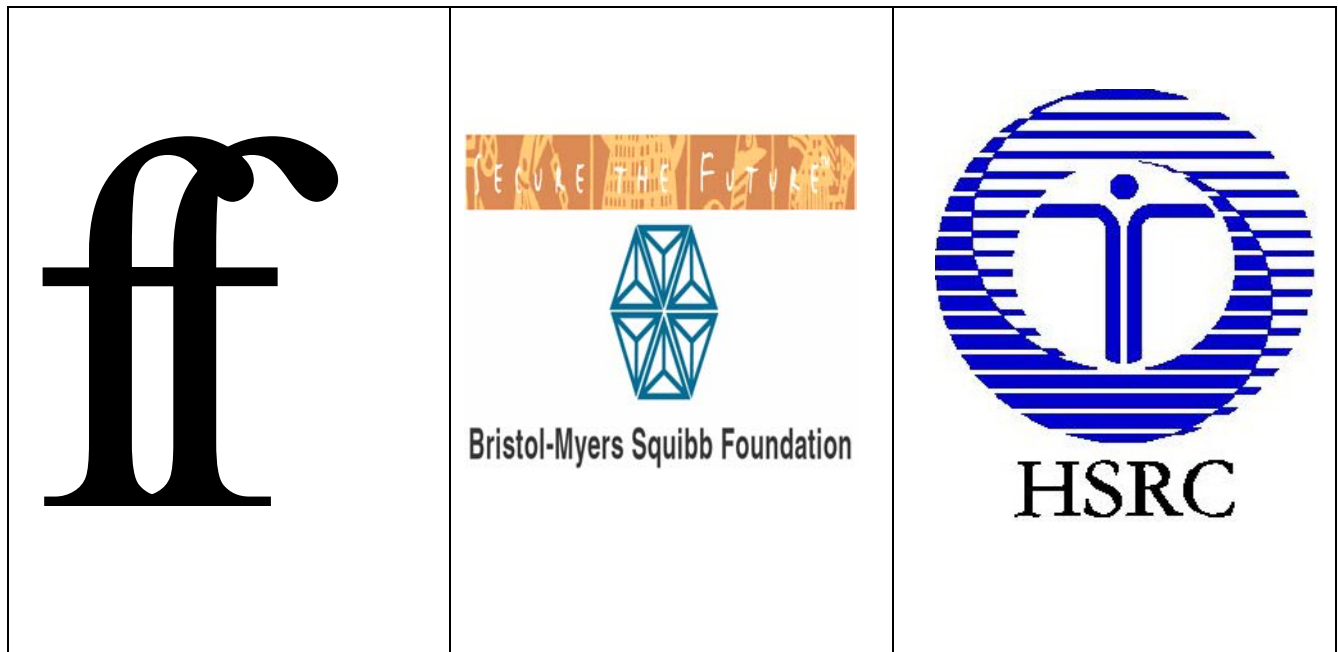


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ACRONYMS AND ABBREVIATIONS

ANC	Antenatal Care
ART	Anti-Retroviral Treatment
A B C	Abstain Be-faithful Condomise
AIDS	Acquired Immuno Deficiency Syndrome
ART	Anti-Retroviral Treatment
DoH	Department of Health
HIV	Human Immune deficiency Virus
HSRC	Human Sciences Research Council
NVP	Nevirapine
PHC	Primary Health Care
PMTCT	Prevention of HIV Transmission from Mother to Child
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
TBA	Traditional Birth Attendant
TB	Tuberculosis
THP	Traditional Health Practitioners
OIs	Opportunistic Infections
VCT	Voluntary Counselling and Testing

Introduction and contents

The Government of South Africa is a strong believer that no single sector, ministry, department or organization can in isolation be responsible for addressing the HIV/AIDS epidemic. South Africa can only succeed if we share our resource, our knowledge and our spirit of willingness. South Africa is to have an Act on Traditional Health Practitioners. It was gazette in April 2003. The South African government has formulated national policies, strategies and plans of action to sustain Primary Health Care (=PHC) as part of the comprehensive National Health System and coordination with other sectors.

A Traditional Birth Attendant (TBA) is defined, based on the South African Bill to establish the Interim Traditional Health Practitioners Council, as a person who engages in traditional health practice and is registered under this act.

Pregnancy and childbirth are natural and should be safe events in a woman's life. But even in an adequately resourced health facility under skilled workers, tragedies still do occur. Labour that can be seen as normal or low risk during antenatal care sometimes ends up being high risk or traumatic. Home deliveries are still prevalent in some parts of this country (up to 40-50%) and still contribute to a certain percentage of maternal deaths. If possible all pregnant women should attend antenatal clinic and be persuaded to deliver in a health facility. It is known that some circumstances force mothers to deliver at home. This should not be deliberate in any way.

Data from the 1998 South Africa Confidential Enquiries into Maternal Deaths suggest that main causes of maternal deaths are related **to failure to use health care facilities**, inadequacy of services and substandard care. Problems with maternity care in South Africa currently include:

- A large number of women still give birth in their homes, in unsafe conditions
- A large number of women still do not use antenatal care facilities
- Hypertension accounts for the largest number of direct maternal deaths, in many cases associated with pulmonary oedema and inappropriate management of eclampsia
- Haemorrhage remains an important cause of maternal death, associated with substandard care and poor referral systems in outlying areas
- A significant number of preventable maternal deaths are due to pregnancy-related sepsis and underlying heart disease
- AIDS has recently become the leading cause of maternal death in South Africa (DoH, 2002).

Five major causes of maternal deaths are: hypertension, HIV/AIDS, post partum haemorrhage, pregnancy related sepsis and pre-existing medical conditions. This explains fully the importance of attending antenatal care and the need to deliver in a health facility. This country is faced with a problem of HIV/AIDS; 25% of pregnant women attending antenatal care are HIV positive. Delivery involves exposure to blood and body fluids. Traditional birth attendants should be able to protect mothers, children and themselves. Knowing and understanding all issues surrounding HIV/AIDS, modes of transmission, signs and symptoms and infection control can help health workers and all traditional birth attendants to protect themselves and others. Home deliveries have been there from the past but due to the changing health trends and demographics one understands even the great need to opt for health facility delivery.

One of the Millennium Development Goals (MDGs) endorsed by all United Nations Member States (including South Africa) is to improve maternal health. The target set is to reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio. The indicators suggested to measure progress towards reaching the goal is maternal mortality ratio and proportion of births attended by skilled health personnel¹.

Traditional birth attendants have the potential for improving maternal and newborn health at community level. The role of Traditional birth attendants in caring for pregnant women and conducting deliveries is acknowledged, but generally TBAs are not trained to deal with complications. A paradigm shift from the risk approach to focus on emergency obstetric care (every pregnancy carries a risk) has occurred since 1997. The reason behind this shift is that most complications often occur in women with no ANC risk factors during labour and delivery. It is therefore essential for women to be cared for by skilled health workers if maternal mortality is to be reduced.

Hence the new role of the TBA aims at:

- 1) preparation of the mother throughout pregnancy for delivery,
- 2) to provide appropriate assistants in emergency delivery,
- 3) to provide appropriate after delivery care for mother and newborn,
- 4) collaboration with family and community and encouraging transport system for pregnant women, particularly in emergencies, and
- 5) support pregnant women to undergo VCT, PMTCT and taking Nevirapine for both mother and new born baby.

To strengthen the collaboration between traditional birth attendants and the Department of Health, we have embarked on a training curriculum on traditional birth attendants and HIV/AIDS. The training manual was piloted and evaluated in a number of trainings in the Eastern Cape. The evaluation of the training manual is available in a separate report.

The identified skills needed for the training of TBAs are safety in their practice, non-interference during perinatal care, early recognition of obstetric complications and referral, some obstetric emergency care, avoiding unsafe traditional practices, and promotion of Prevention of HIV transmission from mother-to-child (PMTCT).

The content of the manual is divided two sets of modules, as follows:

A) Modules for traditional birth attendants

- Module 1: HIV and AIDS
- Module 2: Prevention of HIV from mother to child
- Module 3: Antenatal care
- Module 4: Obstetric care
- Module 5: Postpartum care
- Module 6: Counselling on safe infant feeding

¹ “Skilled birth attendant is defined by the WHO as a health professional – such as a midwife, doctor or nurse – who has been educated and trained in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and immediate postnatal period, and in the identification, management and referral of complications in women and children” (WHO/UNFPA/UNICEF/World Bank, Reduction of maternal mortality, joint statement, World Health Organisation, Geneva, 1999).

B) Modules for traditional birth attendants and skilled birth attendants

Module 7/1: Status and role of traditional birth attendants

Module 8/2: Traditional medicine and rituals in delivery and infant care

Module 9/3: Monitoring and follow-up

How to use this manual

This manual is organised into eight modules. It only serves as a guide to trainers and introduces the trainer to various modules which can be used for the training of traditional birth attendants. It therefore, implies the application of safe methods to reach “attainable goals” meaning, to prevent the infant from contracting HIV and infant mortality. It is important that these goals should be clearly defined so that the trainer can know precisely what she is aiming at, before she sets about formulating the measures she should adopt in order to reach those goals. This will be a vitally important aspect of the training programme, in respect of each individual TBA.

The content of the manual is divided into two sets of modules, as follows:

A) Modules for traditional birth attendants

Module 1: HIV and AIDS

In this module participants are given a definition of HIV and AIDS, mode of transmission, risky sexual behaviour, and HIV prevention. It further explains the different stages of HIV, and AIDS sign and symptoms. Promotion of HIV testing is also addressed in this module.

Module 2: Prevention of HIV from mother to child

This module explains the passing of HIV from an infected mother to her infant. This module also focuses on the details of PMTCT service process and promotes all pregnant women to participate in the programme. It further mentions details of Nevirapine and ART.

Module 3: Antenatal care

This module encourages all pregnant women to understand and receive antenatal care from a public health care professional. It gives advice to pregnant women on pregnancy care, minor disorders during pregnancy and disorders that need immediate action. It also encourages all pregnant women to deliver in a health care facility by advising them to notice if signs of labour are near, preparation of mother's home and reliable transportation.

Module 4: Obstetric care (Emergency Delivery)

This module describes the health practices to be followed by TBAs when attending to pregnant women during labour. It emphasises on the use of clean and hygienic instruments to protect the practitioner as well as the client from contracting HIV. It also empowers traditional health practitioners to watch for certain signs when attending to women at labour to protect the unborn baby. Further, the TBA must play a role to remind pregnant women to take Nevirapine for herself and the baby.

Module 5: Postpartum care

In this module TBAs are encouraged to support the mother to have a post partum visit (including the baby) at health care facility and visit their clients after giving birth and what to look for when assessing the baby's condition after delivery. The TBAs are also taught to provide post partum practice information and avoid applying harmful practices that can cause illness in the child.

Module 6: New born care and counselling on safe infant feeding for a newborn from an HIV

positive mother

The TBA is empowered with knowledge about new born care, benefits of breast milk and techniques of breast feeding. Further, different safe infant feeding options and the preparation of infant formula milk for an infant born to an HIV infected mother are explained.

B) Modules for traditional birth attendants and skilled birth attendants

Module 7/1: Status and role of traditional birth attendants

This module explains the status of traditional birth attendants in South Africa and their role in antenatal care, delivery and postnatal care.

Module 8/2: Traditional medicine and rituals in delivery and infant care

This module encourages discussion and collaboration between biomedical practitioners and traditional birth attendants. It compliments the use of indigenous knowledge from generation to generation and the sharing of this knowledge. Also it commends the western knowledge that the midwives bring to the TBAs and the educational aspect of the discussion to inform those less knowledgeable on certain issues.

Module 8/2: Monitoring and follow-up

In this module the traditional health practitioners learn about the importance of record keeping. Other traditional methods of record keeping are discussed and appreciated as they show that people always have their ways of doing things successfully. This module also encourages practitioners to see where they are going and the importance of their role in our society.

THE TEACHING AND LEARNING PROCESS

1. Socialisation and communication

Socialisation and communication are taken together since they are in many ways connected. It is impossible to think of socialisation without a form of communication, even with a poor use of spoken language or when no language is possible. Man is a social being and socialisation is therefore an accepted and essential part of our daily lives. To be socialised means to be an active member of the community, to conform to its demands, and to share its benefits. For a traditional birth attendant socialisation occurs naturally and unobtrusively. She belongs to the same cultural group, to the same church and shares the same environment. This belonging to a specific social group is of great consequence for her recognition as a TBA.

The families in which the TBAs grow up are of assistance in socialising them especially the role played either by their mothers or mothers in law. Through socialisation the TBAs are taught through observation the skill of assisting with infant delivery. These women mature under the guidance of knowledgeable parents which in return help in them learning to take responsibility.

The adequate communication is a prerequisite for successful socialisation. It allows for an easier acceptance of traditional birth attendants in their communities. Since the cognitive element implies the act of knowing which is closely related to perceiving, the TBA must be able to perceive or observe and then understand before she can know. This is always the way they are instructed to assist pregnant women during delivery. The understanding part is of course the most important even for those TBAs who have never been to school. As stated earlier that cognition implies knowing, this starts with the TBA herself, knowing initially her body and its inherent parts and their functioning before she can assist another woman.

2. Motivation

Motivation means supplying a motive or a strong reason for a person to perform a task, and having completed it, one feels satisfied with the end-result. Such motivation exhorts him to tackle more tasks for even better achievement. For the traditional birth attendant motivation would be the inner satisfaction from a task well performed (delivering babies) and successfully completed. The more difficult the task, the greater joy there will be in the completion thereof and the more pleasurable the feeling of achievement will be. This is always the case with TBAs when they are experiencing problems with the placenta or any other difficulty when assisting with delivery. These are the successes that make them who they are and that make them earn the respect of their villagers.

Assisting women to get healthy babies by the TBAs serves as a stimulant to help even in difficult situations. This therefore, shows that there is a connection between stimulation and motivation. The TBA is at the same time motivated to assist the woman at labour successfully. There are therefore three elements in the stimulation process, namely, the action by the mother or mother in law encouraging their daughters or daughter in laws to observe while they assist with delivery, response from the daughters by observing, looking with understanding while asking questions and participation by the daughters (later, TBAs), when they later deliver babies themselves.

3. Group participation

One can safely say that the ability to participate in the activities of a group leads to effective socialisation. In the villages, group participation begins in the home, as this is the child's first experience of being one of a group especially if one is a member of a large family. Many TBAs view group participation from a positive angle as they deem it necessary to be a member of a group of TBAs, and yet not be a participant. Many are called in to go and watch the birthing process while not participants yet.

During the training group participation should also be fostered through games which are drawn up to encourage winning by all. The activities should be presented in such a way that everybody really enjoys group work. Enjoyment is akin to motivation and brings improvement in anything that is attempted.

Other forms of group participation involve activities such as giving feedback on behalf of the group, taking turns in role-plays. The use of group work therefore creates an opportunity for all to participate.

4. Learning by doing

Learning by doing is a generally accepted educational principle which should be applied everywhere as far as the potential of the candidate will allow. Learning by doing implies that the stress is on "self." Before this can be expected of the TBA much preparation on the part of the instructor will be necessary. The tasks will naturally be performed under supervision. Here the trainer's attitude and knowledge of the learner and her potential are of the utmost importance. In the first place the trainer should know what to expect of the child, thereafter she should be judicious and patient. The learner may be slow yet still intent on performing the task.

5. Question and answer

The trainer starts teaching by asking questions on the topic she is to present and wait in expectation for different answers as people see things differently. When the learner gives an incorrect answer, it is advisable for the trainer not to say she is wrong but rather: “

TRAINING TIME TABLE

Date/ time	8.30-9.00	9.00-12.00		12.00- 13.00	13.00-16.00		
Day 1	Opening and orientation	Pre- test	HIV and AIDS	Break for lunch	HIV and AIDS VCT	Prevention of HIV from mother to child	
Day 2	Revise and verify	Antenatal care			Obstetric care		
Day 3	Revise and verify	Obstetric care continued	Demonstrati ons		Post-partum care for the mother and the baby		
Day 4	Revise and verify	Breast feeding techniques			Counselling on safe infant feeding (the baby from HIV positive mother)		Site visit to PHC and Hospital
Day 5	Revise and verify	Status and role of traditional birth attendants	Traditional medicine and rituals in delivery and infant care		Monitoring, follow up, and records necessary for TBA	Post -test	Closing

MODULE 1: HIV AND AIDS

Materials: Flipchart and permanent markers, condoms for demonstration

Methodology:

Brainstorming, question and answer, small group discussions, role-plays, lecture input, plenary

1. **Introduction:** Each day is started with singing and dancing with enthusiasm to start the day. Prayer by one participant follows the singing. Then each person introduces herself and puts a nametag on so that everybody knows one's name and the trainer as well.

2. **Icebreaker:** The trainer should start a game which will involve everybody. It can be a game where the group is in a boat and the boat starts capsizing and in order for the group to survive the participants have to form either group of three, four, fives, etc. This is one of the games that make the participants to loosen up as it encourages moving around, counting and bringing them closer to one another.

3. **House rules:** Paste the flipchart with the participants' house rules on the wall as a constant reminder. These are the common rules that emanate from the participants. Emphasize that the set of rules agreed upon are to be respected by every participant and they encompass the following:

- Agreeing on a starting time and end time
- Cell phones switched off
- Respecting one another
- Unity as a family
- One person to talk at a time
- Empowering one another
- Punctuality
- Tea breaks and lunch time

4. **Group expectations:** The trainer finds out from the group what their expectations are in attending the training and lists them all on the flip chart. Discuss each expectation and inform the participants which of their expectations will be or will be not addressed in the training and the reasons for that.

Tell the participants about your own expectations from them so that they know what their responsibilities are. Once the participants' expectations are noted, the trainer has to state the aims and objectives of the training programme and hand out the programme while stating what will be done each day. The trainer further informs the participants about what they are going to achieve at the end of the last day of the training i.e. certificates and TBA training kits as this will motivate them more.

Learning objectives: at the end of this module the TBA should be able to:

1. Define HIV and AIDS
2. Advise pregnant women on modes of HIV transmission
3. Counsel pregnant women on sexual and other behaviour that put people at risk of HIV
4. Identify and explain HIV and AIDS signs and symptoms
5. Promote HIV testing, referral for VCT and disclosure of HIV status
6. Provide information on prevention of HIV
7. Conduct a condom demonstration

Objective 1: Define HIV and AIDS

What is “human immune deficiency virus” (=HIV)?

HIV is a virus (a kind of germ, in Xhosa “intsholongwane”) that attacks cells (called CD4 cells or T4 cells) that are responsible for the body’s defense system. HIV reduces the body’s ability to fight disease. The reduction of the body’s resistance to infections is known as immune deficiency.

H – human - only infects human beings

I – immunodeficiency - because it attacks the body’s immune system

V – virus (a kind of germ)

What is AIDS?

AIDS (e.g. in Xhosa, ugawulayo) is an illness resulting from a collapse in the immune system due to HIV infection in the body.

A - Acquired

I - Immuno

D - Deficiency

S - Syndrome

A person with AIDS can get sick very easily – from many different illnesses such as diarrhoea, pneumonia, tuberculosis, or a serious type of skin cancer. Most persons with AIDS die from diseases (opportunistic infections) their bodies are no longer strong enough to fight.

Objective 2: Advice pregnant women on modes of HIV transmission

How is HIV transmitted?

- The main mode of transmission of HIV is through unprotected sexual intercourse (vaginal, oral and anal);
- The HIV virus can be transmitted through non-sexual contact, e.g. from mother to child during pregnancy, during child birth and after birth through breast feeding;
- Transfusion or other contact with contaminated blood or blood products;
- By sharing needles or syringes for injecting drugs with a person who is HIV positive;
- Possibilities of spread through needle stick injuries, needles used by drug addicts or traditional instruments procedures such as scarification (e.g. razor blade) or circumcision;

Scarification



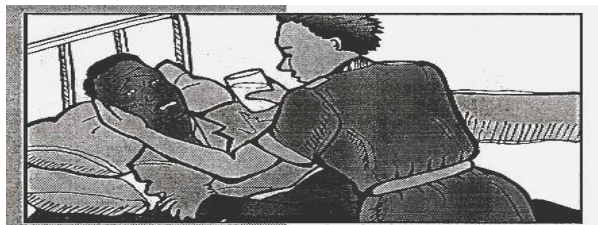
How is HIV NOT transmitted?

The following fluids do not transmit HIV: saliva, tears, sweat, faeces (stool), urine.

You cannot get HIV through social contact (shaking hands, hugging and kissing).

You cannot get HIV from a mosquito: HIV cannot survive in the digestive tract of a mosquito.

→By sitting next to the person with HIV/AIDS



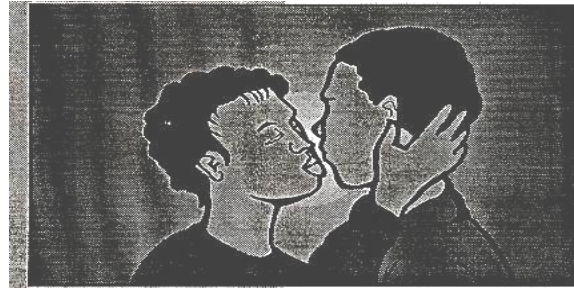
→Sharing plates and knives



→ By sharing food or meal



→ By kissing except when there is blood or open sores



→ By sharing a toilet



Objective 3: Counsel pregnant woman on risky sexual behaviour

- Frequent change of partners
- Unprotected sex
- Several sexual partners at the same time
- A partner who has other sexual partners
- Unprotected sex with casual partners or commercial sex workers
- Having sexual intercourse in the presence of signs and symptoms of a STI
- Not informing infected sexual partners that they need treatment
- Harmful practices, e.g. dry sex, widow inheritance

Dry sex: Some men and women use some herbal medication to help promote dry sex. There is a belief that dry sex prolongs the sexual activity. With dry sex the woman takes time to reach orgasm, by so doing prolonging the sexual activity. In some women, dry sex is used after delivery to help the woman's vagina to become smaller.

Objective 4: Identify and explain HIV and AIDS signs and symptoms

A person who becomes infected with HIV will usually go through various stages that occur over a long period of time, i.e. 5-8 years depending on the life style circumstances. The HIV infected person usually experiences a period of good health in which the virus remains clinically silent. The person is able to spread the virus during this stage.

Stages of HIV and AIDS

Early HIV infection (stage I)

In the first 4-8 weeks after HIV infection there may be a short, i.e. 1-2 weeks illness which cause the following:

- High temperature (fever)
- Tiredness
- Rash
- Sore throat
- Muscle and joint pains
- Some swelling of the lymph glands

Clinically latent or "silent" infections

- The HIV infected person usually experiences a period of good health in which the virus remains clinically silent (asymptomatic)
- The phase may last between 3 and 7 years (even up to 10 years) depending on lifestyle circumstances.
- The person is able to spread the virus during this stage.

Minor HIV-related symptoms (stage II)

Between 3 and 7 years after infection, some people may develop minor symptoms and signs secondary to the HIV infection. These may include the following:

- Chronic swelling of the lymph nodes felt in the neck axilla and below the jaw
- Herpes zoster (shingles, e.g. in Zulu *ibhande*)
- Occasional fever
- Skin rashes
- Fungal mouth infection/white patches in mouth
- Repeated mouth ulceration
- Repeated infection of the ears, nose and throat
- Weight loss
- Diarrhea

HIV related diseases –the symptoms phase (stage III)

After about 5-8 years following HIV, the immune system continues to deteriorate and becomes immune deficient. At this stage, the body is left with little or no resistance to infection. During the AIDS stage, infections are usually more severe and prolonged, as the client does not always respond readily to treatment. Signs of more severe HIV related disease begin to appear. The most common signs and symptoms of this stage of HIV related disease are as follows:

- Oral or vaginal thrush
- Hairy tongue
- Recurrent cold sores or genital herpes infection
- Herpes zoster
- Bacterial skin infection resembling acne

- Persistent fever and night sweat
- Skin rash
- Generalized lymphadenopathy (swollen lymph nodes, e.g. in Xhosa *idlala*)
- Persistent diarrhea
- Weight loss
- Reactivation of tuberculosis

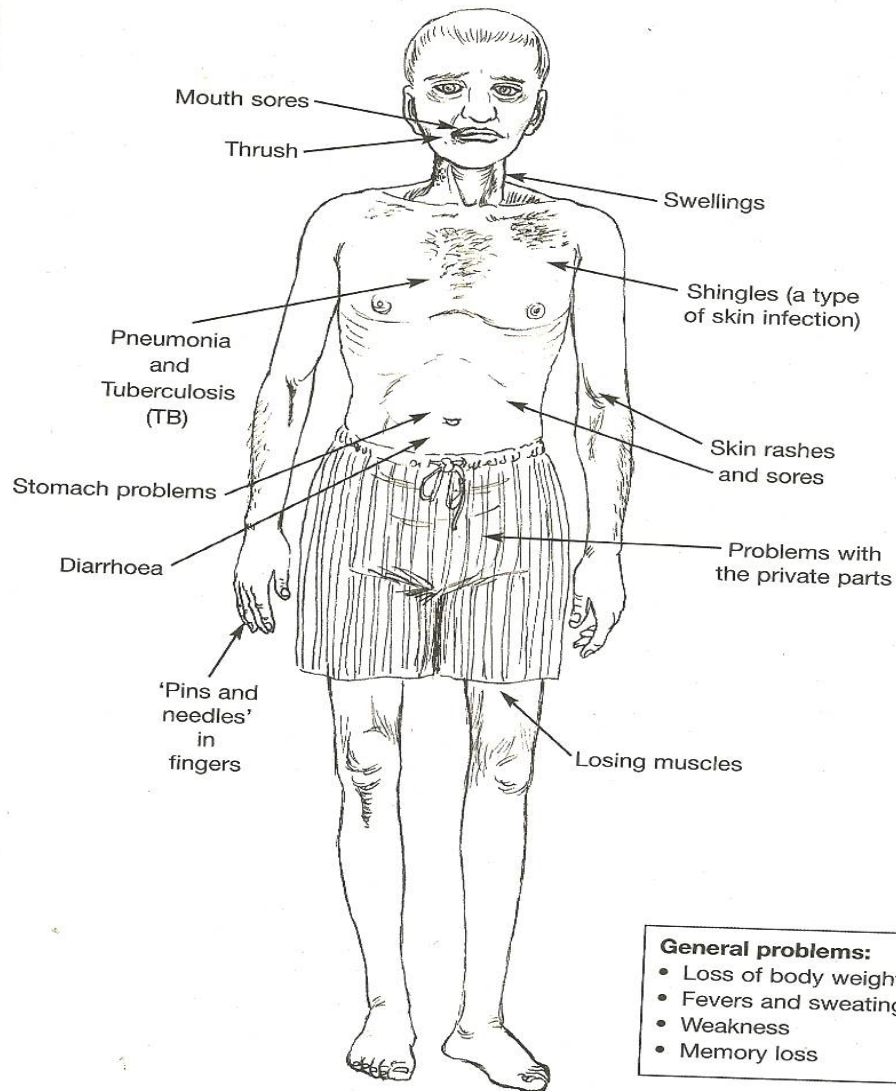
Severe HIV related disease- AIDS the severe symptoms (stage IV)

The symptomatic phase usually progresses over the next 18 months into the fully developed AIDS stage of the disease. Signs and symptoms of AIDS may differ from one client to another depending on which system is affected, e.g.:

- Variety of skin rashes and skin condition
- Persistent cough, chest pain and fever
- Oral and/or genital thrush
- Ongoing diarrhea infection of the brain presenting with headache, fits and other neurological conditions
- Cancer such as Kaposi's sarcoma
- Severe tiredness, fatigue and weakness
- Memory and concentration loss

The sicknesses a person with AIDS may get

A person with AIDS will not have all these sicknesses at the same time. The picture shows the different sicknesses a person with AIDS may get over a period of time.



HIV/AIDS is a variable disease:

There are few rules

- Some clients progress rapidly whilst others more slowly
- Serious and severe opportunistic infections can appear at a variety of different clinical and immune levels
- Some clients may suddenly deteriorate and progress very rapidly to severe illness and death
- Some may have a slow and gentle decline
- Some may remain very well for many years and then suddenly deteriorate
- Some may never get ill
- Some may get repeated opportunistic infections with many different conditions

- Some may suffer from a few of the common opportunistic illnesses
- Some clients can get reasonably after being very sick
- Others may get very sick after being reasonably well

Differences between HIV/AIDS symptoms and a traditional healer's calling/illness (e.g. *Ukuthwasa*). *Ukuthwasa* may include the following symptoms: sharp pains, weight loss, tiredness, headache, hysterical symptoms, eye problems, abdominal pains, loss of appetite, stomach enlargement/full of air, fainting, ancestors talking, and swollen feet.

Objective 5: Promote HIV testing and referral for Voluntary Counselling and Testing (VCT)

Voluntary counselling and testing advice must be given to all pregnant women. The benefits to a woman of knowing her HIV status include the ability to make informed choices about infant feeding options, earlier access to care for both mother and child, the opportunity to terminate pregnancy where desired, and the ability to make informed decisions about sexual practices and fertility. VCT can also be promoting openness and acceptance of HIV as important community and social issue.

How the HIV test is done:

If you agree to be tested, the health professional should counsel you before the test about the way your life may change after you receive the test results. If the test indicates that you have HIV, you should be given a second test to confirm the results. The health professional will provide counselling to help you decide which treatment options are best for you and your baby. If the test indicates that you do not have HIV, you may receive counselling on HIV prevention.

- About 5ml of blood sample is taken from the vein and is sent to the laboratory. In this type of testing the results can be available from 48 hours to two weeks.
- A rapid test can be done whereby a finger prick with a sharp instrument is made. A drop of blood is collected from the prick and this is analysed locally with the results available in less than one hour.

HIV positive means: HIV antibodies have been detected in a person's blood. Person can infect others with HIV virus. Person can develop AIDS at a later stage.

HIV negative means: HIV antibodies have not been detected in a person's blood. This means that a person may not have HIV. Person may be having HIV but still in the window period. There is a need to do a repeat test to confirm one's sero-status.

Objective 6: Provide information on HIV prevention

Everyone is at risk of getting HIV. Preventing infection is essential. You can protect yourself and others from getting HIV in the following ways:

STI/HIV/AIDS infection can be prevented through **A B C** and others

- **A**bstinence from sex: this is the safest way to prevent infection
- **B**eing faithful: have one mutual partner where both partners are HIV negative
- Correct and consistent **C**ondom use at all times you have sex
- Making condoms available/accessible
- Educating on dangers of traditional practices such as tribal marking, ear piercing and skin incision
- Educating about alternatives to penetrative sex, e.g. thigh sex

- Educating about drug and alcohol abuse and sexual risk behaviour
- Providing information and education about STIs and dangers of untreated STIs
- Promoting safe sexual behaviour

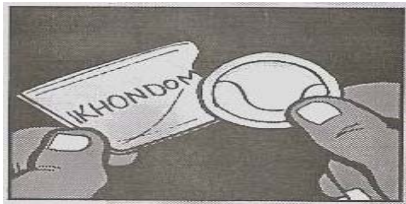
Precautions to reduce HIV exposure for TBAs

- Hand washing before and after delivery
- Putting on gloves for each and every procedure
- No re-use of needles, porcupine quills syringes and razor blades
- Cleaning of surfaces after procedures
- Sterilization and safe disposal of needles and sharp instruments
- Careful handling of laundry to avoid contamination

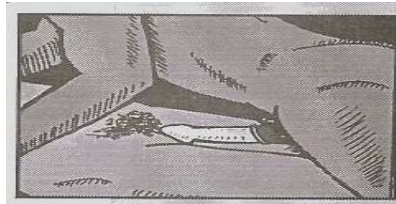
Objective 7: To conduct a condom demonstration

TBA should be able to explain and demonstrate how to use condom correctly.

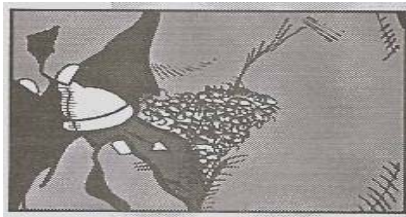
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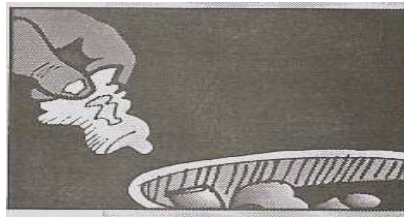
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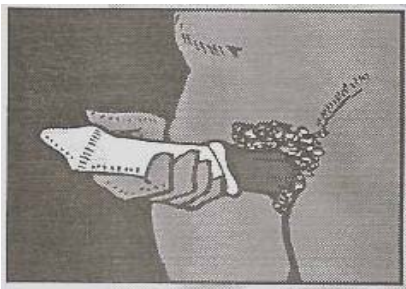
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MODULE 2: PREVENTION OF HIV FROM MOTHER-TO-CHILD (PMTCT) AND ANTI-RETROVIRAL TREATMENT (ART)

Materials: Flipchart, permanent markers

Methodology: Lecture input, question and answer, small group discussion, plenary

Learning objectives; at the end of this module the TBA should be able to:

1. Define MTCT & PMTCT
2. Motivate and support pregnant women to use PMTCT services
3. To provide or remind to take Nevirapine to those pregnant women and the baby
4. Understand and promote Anti-Retroviral Treatment (ART)

Objective 1: Define MTCT & PMTCT

Mother-to-Child Transmission (MTCT) is:

The virus that causes AIDS can be transmitted from an infected mother to her newborn child. HIV Can be passed from mother to child during pregnancy (5-10% of the time), during labour and delivery (10-20% of the time) and during breastfeeding (5-20% of the time). The baby is more likely to be infected if the delivery takes a long time. During delivery, the newborn is exposed to the mother's blood. Drinking breast milk from an infected woman can also infect babies.

Prevention of Mother-to-Child Transmission (PMTCT) is: an intervention that may lead to avoiding or minimizing the risk of HIV transmission from mother to the child.

Prevention of infection of the New Born

1. Use antiviral medications: The risk of transmitting HIV is extremely low if antiviral medications are used. Even if the mother does not take antiviral medications until she is in labour, two methods cut transmission by almost half. One dose of Nevirapine during labour, and one dose for the newborn, 2 to 3 days after birth.

2. Keep delivery time short: The risk of transmission increases with longer delivery times. Mothers with a high viral load might reduce their risk if they deliver their baby by caesarean (C-) section.

3. Do not breast-feed the baby: Some babies will get HIV infection from infected breast milk. This risk can be eliminated if HIV-infected women do not breast-feed babies. Baby formulas should be used.

Risk factors for mother-to-child HIV transmission (MTCT): The following factors have been shown to increase the risk of MTCT

1. **Maternal factors:** The mother's health status may be one of the most important factors influencing the risk of mother-to-child HIV transmission. Being responsive to your own health will, in due course, benefit your unborn baby as well.
2. **Behavioural factors:** cigarette smoking, drug use, and unprotected sexual intercourse during pregnancy
3. **Obstetrical factors:** placental infection, mode of delivery e.g. elective caesarean section shown to be reduces risk.
4. **Infant factors:** pattern and duration of breast feeding
5. **Viral factors:** high level of HIV virus

Objective 2: Motivate and support pregnant women to use PMTCT services

The TBA must support and advice all pregnant women to join the PMTCT programme. For women who will voluntarily have their blood tested and accept test results the following is done:

1. Pre-test counselling (group counselling when you attend ANTE-NATAL clinic).
2. Post-test counselling: individual counselling whether results are negative or positive.
3. At 28 weeks Nevirapine pill is given to the HIV positive mother to take as soon as she experiences labour pains.
4. After delivery the baby is given Nevirapine syrup within 2-3 days of the birth.
5. During post-test counselling if the mother chooses breast-feeding – (it should be exclusive breast feeding) she will put the baby on the breast (in detail: see Module 6: Counselling on safe infant feeding)
6. If the mother chooses formula feeds on discharge she is given Pellargon.
7. Pellargon is offered freely for 6 or 12 months.
8. The baby will be given vitamins and followed up for 2 years to see the progress.

Women who are HIV positive and pregnant

Women who are HIV positive and pregnant can pass the HIV virus to their babies. This can be very hard to cope with, especially if the woman only finds out that she is HIV positive when she is already pregnant. Women who know that they are HIV positive should think carefully before they decide to have the baby. This is because:

- About one out of every three babies born to HIV-positive mothers will also have the HIV virus if the mother and baby do not take ARV medicine to stop this from happening.
- Babies who have the HIV virus get sick often. They usually die when they are small.
- If you are HIV positive and pregnant, you may get sick with AIDS more quickly.

If a woman is HIV positive and pregnant, she has the same right to an abortion as other women do. If she chooses to have an abortion, it is better to have it early in pregnancy. An abortion can be done until a woman is 20 weeks pregnant. Refer the patient to a health worker for more advice.

Management of HIV positive pregnant women

Pregnant women who are HIV positive pose special and unique management challenges. The TBA has to expand support to pregnant women by advising them to receive counselling services, receive routinely ante-natal and post-delivery care programmes. There is also a need to develop a supportive environment for HIV positive women, disclosure, as well as non-discrimination from family and community.

Having a baby is a very personal decision, as is the way a woman chooses to proceed with her pregnancy. While this may vary from woman to woman, a comprehensive strategy to prevent mother-to-child HIV transmission is made up of four basics:

1. Good prenatal care (see module 3.)
2. A comprehensive anti-HIV strategy (see objectives 3 & 4)
3. A plan for delivery of the baby

Delivering your baby is a personal and emotional experience, and how you deliver your baby is a choice. You may choose to undergo elective C-section based on the latest reports that they may lower risk of vertical transmission. You may also choose to deliver your baby naturally. Either choice is a good choice, as long as it's your own. All HIV positive pregnant women must delivery the baby in health service facility.

4. A decision about breast-feeding

HIV is present in breast milk. Women living with HIV with safe alternatives to breast milk are urged to avoid breast-feeding to decrease the risk of vertical transmission.

Objective 3: How to administer Nevirapine to pregnant women and the baby

Nevirapin administration

To prevent HIV transmission, the HIV infected pregnant woman should swallow one 200 mg dose of Nevirapine tablet orally as soon as labour begins (labour is when pains are strong and regular, coming every five minutes or less for at least one hour or when water breaks). Self-administration of Nevirapine by women at the onset of labour is more efficacious than waiting until arriving in the health care facility. If the pregnant woman discovers that the tablet is lost and is unable to go to the clinic, the TBA should quickly report to clinic or hospital to get another tablet. The baby should ideally be given the Nevirapine at 48-72 hours after birth (though there is still some reported benefit when given within 7 days). If the baby unit dose was given by the clinic or hospital, then it should be administered as described within 48-72 hours. If the unit dose was not given the TBA should assist in getting the baby to the hospital or clinic ideally within 48-72 hours and if not possible at that time, it must be within 7 days. If the pregnant woman or baby vomits within 30 minutes of taking Nevirapine, the TBA must quickly arrange to get another dose from the clinic or hospital. Side effects are not common with one dose of Nevirapine. However, it is possible that the following can occur: nausea, fatigue, diarrhoea, vomiting and rash. Note and report any side effects to the health professional.

Support in taking other medicines

It has been recommended that trimethoprim/sulfamethoxazole (TMP/SMX) (trade names: Cotrimoxazole, Bactrim, or Septra) preventive treatment be given from 6 weeks through 15 months of age for all HIV exposed infants. This is to prevent pneumonia which is common in HIV positive infants. The TBA will also need to assist and support the mother in making sure cotrimoxazole is given to the baby daily. If the baby becomes positive and starts antiretroviral therapy (ART) or the mother is started on ART, the TBA will also need to assist and support.

Objective 4: Anti-Retroviral treatment (ART)

New medicines called “anti-retrovirals” (ARVs) can help people with HIV/AIDS stay healthy and live longer. They do not kill HIV or cure AIDS, but they make the sickness easier to live with. These drugs interfere with the viral life cycle to stop, or at least slow down, the progression of HIV disease. Anti-retroviral treatment is currently offered in district hospitals to people living with HIV. People living with HIV/AIDS should know that ARVs do slow down the replication of the virus and can help people to live longer and can prevent the transmission from mother to child. These ARVs must be taken life long to avoid developing resistance. They also have side effects that should be considered prior to taking the drugs. Most people do not need ART when they find out that they are HIV positive. They can still live for a long time before they start treatment. The patient should see the health worker about when to start ART. If the CD4 count (“the body’s soldiers”) of the patient is less than 200 or has illnesses associated with AIDS, the patient (adult or child) will be put on ART; pregnant women can start ART only after the first trimester (=three months) of pregnancy.

Anti-retroviral treatment (ART)



Call AIDS Helpline for more information:
0800 012 322

MODULE 3: ANTENATAL CARE

Materials: Flipchart, permanent markers, pregnancy progress chart

Methodology: Trainer demonstration, participants' demonstration, pregnancy progress chart

PROCEDURE

1. Games

Everybody is in the boat and we need to balance for the boat not to sink. Once the trainer gives a command for all to go in sevens, sixes, etc., all should follow the command. Once people cannot make the number, they should go into the centre, sing and dance. Some had to write their names using their heads in the air.

Exercise 3/1

Now divide yourselves into four groups and answer the 4 following questions. Select a scribe (the person who is taking the notes) for the group and a presenter. Both the scribe and the presenter will come to the front and assist each other during presentation. The group can assist if there is something left behind.

1 What causes pregnant women to have convulsions?

2 What causes swollen legs and feet during pregnancy?

Learning objectives: at the end of this module the TBA should be able to:

1. Encourage pregnant women to go for antenatal care
2. Familiarize pregnant women to antenatal services in PHC or hospital
3. Advice on pregnancy care
4. Advice on minor disorders and disorders that need immediate action
5. Encourage pregnant women to deliver in health care facilities

Objective 1: Encourage pregnant women to go for antenatal care

The TBA should understand antenatal health care from a public health care professional so that they can disseminate the information to pregnant women and prepare them for antenatal health care. Also, the TBA should facilitate early and regular clinic visits.

The TBA should explain to pregnant women why they need to seek antenatal care from a health care professional.

1. To support and encourage a family's healthy psychological adjustment to childbearing.
2. To monitor the progress of pregnancy in order to ensure maternal health and normal foetal development.
3. To recognize deviation from the normal and provide management or treatment as required.
4. To ensure that the woman reaches the end of her pregnancy physically and emotionally, and is prepared for her delivery.
5. To help and support the mother in her choice of infant feeding;
6. To offer family advice on parenthood either in a planned programme or on an individual basis.

7. To build up a trusting relationship between the family and their caregivers which will encourage them to participate in and make informed choices about the care they receive.

Objectives for booking visit

- To assess levels of health by taking a detailed history and to employ screening tests as appropriate.
- To ascertain base-line recordings of weight, height, blood pressure and haemoglobin level in order to assess normality. These values are used for comparison as the pregnancy progresses.
- To identify risk factors by taking accurate details of past and present obstetric and medical history.
- To provide an opportunity for the woman and her family to express any concerns they might have regarding this pregnancy or previous obstetric experiences.
- To give advice on general health matters and those pertaining to pregnancy in order to maintain the health of the mother and the healthy development of the foetus.
- To begin building a trusting relationship in which realistic plans of care are discussed.

Objective 2. Familiarize pregnant women to antenatal service from a health professional

The TBA must know and understand the process and services of antenatal care in a clinic or hospital so that they can be able to explain and give an overview to pregnant women. This would reduce stress among pregnant women and motivates them to have continuing visits to antenatal care.

Services and procedure of antenatal care:

For ANC, all pregnant women must visit and receive services from a public health professional or PHC nurse at least 4 times;

Age of gestation 1-6 months (1st and 2nd trimester) should go for ANC at least one time

Age of gestation 7-9 months (3rd trimester) should go for ANC at least once a month

First visit to antenatal care (major examinations and history):

1. History taking includes:
 - Family and social circumstances.
 - Medical history: knowing medical conditions that can have effect on the present pregnancy.
 - Surgical history: both major and minor operation, especially caesarean section.
 - Family history: looks at hereditary conditions, e.g. twin pregnancy, genetic disorders.
 - Previous obstetric history: any complications that a patient has experienced, e.g. previous caesarean section, assisted deliveries, retained placenta, parity, miscarriages.
 - Present obstetrics: planned or having any problems.
 - Allergy, use of medications, alcohol, tobacco and other substances.
2. Physical examination:
 - General examination includes weight, height, heart rate, oedema, teeth and gums, breasts, thyroid, heart and lung examination.
3. Screening tests: essential screening investigations
 - Blood pressure: to detect high blood pressure.
 - Urine analysis: to detect diabetes mellitus and kidney function.
 - Blood tests: to detect anaemia, this might also include counselling and motivation for screening and testing for HIV status and give appropriate advice and planning for further prevention of the baby; including syphilis, blood group and haemoglobin level.
4. High risk of pregnancy must be identified at first visit

High risk in pregnancy means any conditions which found or occurs during pregnancy and will be harmful to health and life of the pregnant woman and the baby. The TBA must identify high risk of pregnancy in their client and advice pregnant women to seek care from health professional as soon as possible.

5. Final assessment for risk status, estimate of gestation age, expected date of delivery, plan for management of any problems, then antenatal record book is given to mother.

For subsequent antenatal visit:

1. Physical examination: abdominal examination to see the baby's position, size of abdomen, heart beat of the baby, level of fundus and general well-being
2. Urine analysis: to monitor sugar and kidney function
3. Body weight: to monitor weight gain and growth of the baby
4. Blood pressure: monitors risky pregnancy
5. Give necessary treatment and vitamin supplements, e.g. iron tablet
6. Give tetanus vaccine 2 doses
7. In some cases there is need to do ultrasound and scan for specific investigations by the physician (normally in abnormal case)
8. Give information about delivery plan and new born care plan

TBA should be able to identify pregnant woman who need intensive care during pregnancy as listed below

Factors that indicate the need for intensified antenatal care

High risk (must receive antenatal care at hospital and delivery at hospital only)

- First pregnancy aged less than 18 or over 35 years
- Previous fertility treatment
- Previous myomectomy, cervical or vaginal surgery, classical cesarean section
- Previous still birth or neonatal death, preterm delivery.
- Three or more previous miscarriages
- Diabetes mellitus, hypertension, renal disease, asthma, epilepsy, heart disease, active tuberculosis, auto immune disease, history of venous thrombosis
- Psychiatric illness, including previous post-partum depression or psychosis
- Thyroid disease or thyroidectomy
- Serious disease or deformity of spine, pelvic or hip and any other serious medical conditions
- Uncertain expected date of delivery
- Smoking more than 10 cigarettes a day
- Maternal weight over 85 kg or less than 45 kg
- Maternal height less than 150 cms

Purpose of continuing antenatal care

TBA should support all pregnant women to continue to visit to ante natal clinic;

1. To continue observe for maternal health and freedom from infection
2. To assess foetal well-being
3. To ascertain that the foetus has adopted a lie and presentation that will allow vaginal delivery
4. To offer an opportunity to express or worries or labour.

Objective 3: Advice on pregnancy care

In contact of the TBA with pregnant women, the TBA has ample opportunities to discuss a healthy lifestyle for the pregnancy in terms of diet, exercise and personal habits. Sometimes the mother will

ask for the TBA's guidance. It is often helpful to link advice to a specific problem the woman is experiencing, such as minor disorders of pregnancy, because at such times the woman will be more receptive to health information.

1) Nutrition

Diet is important in three counts: the health of the woman herself, her developing foetus and alleviating minor disorders of pregnancy. The TBA may explain that the regular intake of food ensures a regular supply for the unborn baby and should counsel the mother to avoid rushing a meal or missing them. Of particular importance is the intake of meat, fish, cheese are prime sources, but cheaper sources may be advised on such as peas, beans or lentils, milk and eggs. Milk and cheese supply calcium; red meat and dark green vegetables and some red fruits are containing iron. Iron and calcium are vital for pregnancy.

Mothers should encouraged to eat quantities of fresh fruit and vegetables; at least half of kilogram per day. These will also contribute to the fibre content of the diets which helps to prevent constipation. Other high fibre includes whole meal bread, cereals. Mothers should be encouraged to avoid high sugar intake.

Some mothers may need special advice. Those with low income or who have no other support may need help with budgeting and with making sensible choices. The TBA should encourage mothers to consult health professionals. New vegetarians may need advice from a dietitian to ensure the range of foods they eat is adequate to supply all their nutritional requirements. Pregnant women should reduce salty food, black tea and coffee. Pregnant women should not eat uncooked or undercooked meat.

2) Alcohol

Moderate or high levels of alcohol have been founded to give rise to foetal problems. No safe level of alcohol consumption has been established during pregnancy; therefore it is wise to stop drinking alcohol prior to conception.

3) Smoking

Understanding that smoking reduces the baby's oxygen and food supply may motivate the pregnant woman to quit smoking. A smoky environment will not be good for the baby in the future and must be avoided.

Tips for TBA to give advice to pregnant women to give up smoking:

- Leave a longer stub
- Use filter tips
- Keep hands busy
- Only smoke when sitting down
- Do not inhale
- Cut out the first cigarette in the day and the last one at night
- Try chewing gum or sucking peppermints.

4) Consult a health worker every time when they want to use any medications.

5) Personal hygiene, e.g. shower with clean water, wear clean cloths especially underwear.

6) Dressing, e.g. use loose and comfortable clothes, do not wear high heeled shoes.

7) Exercising and working: do not have limitations for movement, light exercise, and household work except for excessive exercise and heavy work, e.g. fetching the water especially in the first three months and 1 last month of pregnancy. If the mother is used to regular work or exercise such as walking, there is no reason to stop, as long as she feels comfortable.

8) Rest both physically and mentally, e.g. have some nap during the daytime, use a pillow support for the legs/feet during sleep for blood circulation.

9) Breast and nipple care: after 3 months breasts will enlarge and become heavy, pregnant women should use the comfortable bra to support breasts and clean nipples with soap and warm water everyday. In case of a short nipple, one should carefully pull out the nipple every day during shower.

10) Releasing urine: at the last stage of pregnancy pregnant women will frequently urinate because of the extended size of the uterus and the head of the infant presses on the bladder.

Stool: pregnant women always have problems of flatulence and constipation because of decreased bowel movement and pressure of the uterus on the intestines, less physical movement, and insufficient drinking of water. So the pregnant women should:

- Increase consumption of food with high fibre, fruits and vegetables
- Drink more clean water, at least 8-10 glasses per day
- Try to have a regular time to pass stool out
- Have regular light exercise, e.g. walking
- If necessary, use a purgative (laxative) prescribed by the health worker

11) Sexual intercourse

Sometime couples fear that sexual intercourse in pregnancy may harm the baby. It is absolutely safe and normal unless special conditions pertain. If the woman is nauseated in early pregnancy she may feel disinclined to have intercourse but the couple can be encouraged to find other ways of loving. Towards the end of pregnancy when the abdomen is large, couples sometimes have to adopt different positions. There are certain situations when caution is advised. If a mother has a history of miscarriages she should avoid intercourse in the early months, especially at times when her period would usually have started. If any bleeding is seen at any stage the couple should abstain and seek advice.

12) Dental care: pregnant women should go for dental check up at the beginning stage of pregnancy; if any problems are identified they should receive treatment to prevent the spread of infection and complications.

The mother can be reassured that her pregnancy is likely to proceed smoothly and without complication. It adds to her security if she knows clearly when she should seek the help of a professional.

Managing Morning Sickness is essential for HIV positive pregnant women

Nausea or *morning sickness* during pregnancy is normal, and usually poses a problem only during the first trimester. However, women living with HIV may experience particular difficulty with nausea. The ability to control it and keep medications "down" is important for two reasons. First, it helps maintain adequate drug levels in your body throughout the day. Second, it helps maintain the nutritional benefits from food. Be assured, however, that when nausea and vomiting occur in the first trimester, it is normal. If nausea persists into the second trimester (weeks 13-26), or if you cannot hold food down at all or lose weight, you should go to the doctor at once. This could be a sign of a more significant problem.

A Few Tips on Morning Sickness

- Eat small, frequent meals every two or three hours, even through the night.
- Keep dry crackers or graham crackers beside your bed and eat a couple before getting up in the morning. It also sometimes helps to eat crackers about an hour before your first drug dose of the day.
- Eat lots of carbohydrates, like dry-toast, bananas, baked potatoes, rice and whole-grain breakfast cereals.
- Flat soda and sweet juices in the morning can help nausea.
- Ginger tea with honey and candied ginger may help.

Opportunistic Infection Prevention and Treatment for HIV positive pregnant women

Prevention for tuberculosis (TB) is recommended during pregnancy for HIV-infected women who have either a positive TB skin test or a history of exposure to active TB, after active TB has been excluded. Preventive measures for certain infections are best avoided during pregnancy because of the potential drug toxicity to the developing baby. Finally, vaccines for Pneumococcal, hepatitis B

and the flu appear safe for pregnant women and should be offered when appropriate. Live virus vaccines such as measles, mumps and rubella should be avoided during pregnancy.

Objective 4. Minor disorders and disorder that need immediate action in pregnant women

TBA should be able to advise when pregnant women have some disorder during pregnancy, and support the mother with basic self care and the TBA must make sure that all pregnant women know the signs and symptoms that need immediate action from health professionals.

Minor Disorders of Pregnancy:

1. Nausea and vomiting. This presents between 4-16 weeks of gestation. If vomiting becomes severe, the mother may lose weight and becomes dehydrated. The TBA should advise the mother to seek help from health professionals

2. Heartburn. Heartburn is most troublesome during about 30-40 weeks of pregnancy. Small meals take up to less room in the reduced stomach space and are digested more easily. Sleeping with more pillows than usual and lying on the right side can sometime help. For persistent heartburn the doctor may prescribe antacids.

3. Excessive salivation. This occurs from 8 weeks gestation and is thought to be caused by the hormones of pregnancy. It may accompany heart burn.

4. Pica. This is the term used when a mother craves for certain foods or unnatural substances such as coal. The TBA needs to be aware that this condition can occur and to seek medical advice since substance craving is potentially harmful to the unborn baby.

5. Constipation. It is helpful to increase the intake of water, fresh fruit, vegetables and whole meal foods in diet. A glass of warm water in the morning before breakfast may activate the gut and help regular bowel movements. Exercise if helpful, especially walking.

6. Cramp. The cause of leg cramp in pregnancy is unknown. The mother may be advised to exercise the foot and to raise the foot off the bed about 25 cms. It may be helpful to make gentle leg movements whilst in a warm bath prior to settling in the night. This enhances circulation and removes waste products from muscle.

7. Leucorrhoea. This is the term used for the increase of white, non-irritant vaginal discharge in pregnancy. It is helpful to offer advice concerning personal hygiene. She should wear cotton underwear and avoid tights. Washing with plain water twice a day should be adequate.

8. Fainting. In early pregnancy fainting may be occurring. Avoiding long periods of standing is helpful and being quick to sit or lie down if she feels slightly faint.

9. Varicosities. Varicose veins may occur in the legs, anus (haemorrhoids) and vulva. The situation is compounded by pelvic congestion. The TBA must be aware of mothers at risks, for example, those with a family history of varicose veins and those doing work, which demands long periods of standing or sitting. Exercising the calf muscles by rising onto the toes or making circling movements with the ankles will help the venous return. In the early days of pregnancy, resting with the legs vertical against the wall for a short time will drain the veins. Support tights increase comfort and should be put on before rising or after resting with the legs elevated. Vulva varicosities are rare and very painful. A panty-girdle or sanitary pad may give support. The TBA should listen and offer advice pregnant women to seek care from health professional to prevent haemorrhage from a ruptured vein during delivery.

10. Skin: The mother needs to observe her skin changes closely and will often comment upon the linea nigra and the areola of the breast. The mother may be reassured that this will diminish as soon as the baby is born. Sometimes she has generalized itching which often starts over the abdomen. This is thought to have some connections with the liver's response to the hormones in pregnancy. It clears as soon as the baby is born and comfort can be gained from local applications.

11. Insomnia. This must never be dismissed lightly. There are physical reasons for sleep disturbance such as nocturnal frequency and difficulty in getting comfortable in bed due to the growing foetus. This may be overcome by going to bed earlier in the hope that the baby will have an

active time earlier and allow the mother to sleep when she wants to. Remember the increased anxieties which pregnancy may bring, the TBA may ask the mother what dreams or thoughts she has as she falls asleep. Talking through some of the very common fears of pregnancy may help a mother to come to terms with her own anxieties.

It is common to dream of delivering monsters or animals and also to dream that the baby is born dead. Sensitive listening and expressing that the mind is presenting fears through dreams can be helpful. Knowing that it is very common is reassuring. Later in pregnancy it is wise to recommend that the mother has a lie-in in the morning or has a rest in the afternoon when sleep often comes easily. This may help to prevent the tiredness and some of the depression that can occur in the last trimester of pregnancy. Sharing her feelings can result in a sense of normality and lightness for the mother and can greatly enhance her perception of care and experience of pregnancy.

If a TBA is concerned that the mother's moods are not simply those of normal pregnancy, medical aid should be sought. The minor disorders can provide the TBA with opportunities to advise the mother and help her to achieve the most comfortable and safe pregnancy possible. She will be alert to any need for referral.

Disorders that require immediate action

Most minor disorders can escalate into a more serious complication of pregnancy. Mothers should be encouraged to seek advice if at any time they feel unwell or the signs exceed what they have been led to expect. In addition there are certain incidents, which should always be reported to the midwife or doctor. The following signs or symptoms the pregnant woman should observe:

- Vaginal bleeding, vaginal discharge
- Reduced foetal movements than usual
- Severe headaches
- Severe vomiting
- Abnormal vision/visual abnormalities
- Sudden swelling
- Rupture of the membranes (drainage liquor from vagina)
- Premature onset of contraction and abdominal pain
- Pre-eclampsia or imminent eclampsia
- Maternal anxiety for whatever reason.
- Severe illness e.g. shortness of breath or abdominal pain

Domestic Violence During Pregnancy

Abused women suffer greatly, as do their babies. Expectant mothers are at increased risk for poor weight gain, infection, bleeding, anaemia and substance abuse during pregnancy compared to women who are not abused. Many abused women do not access prenatal care, and those who do more likely seek it in the third trimester, after complications may have already arisen. Babies born to abused women are more likely to be low birth weight and premature. They are also more likely to be abused as children. Specialists estimate that the rate of abuse among pregnant HIV-positive women may be even higher, particularly among young women.

No woman deserves to be hurt. While not every woman can leave her abuser immediately, every woman can take safety measures. Talking with somebody you trust -- a friend or a health care provider -- can be an important first step. Preparing an "emergency kit" in case you have to leave suddenly is important. This should include medications, money, important papers and an extra set of clothes. Most importantly, remember that help is available.

Objective 4: Encourage mothers to deliver in health care facility

Most complications occur in women with no ANC risk factors during labour and delivery. For this reason all women should be encouraged to deliver in health facilities and pregnant women should be assisted to get to the health facilities (practical transport arrangement to the point of delivery). Those that come from far, arrangements for “waiting mothers” accommodation near the point of delivery in the absence of suitable or reliable transport should be made. It should only be in cases of emergency (e.g. no time to refer as the woman is about to deliver) where TBAs find themselves having to deliver a woman at home.

Reasons why every attempt should be made to get women to deliver in a health facility:

- The baby will be bigger than the previous birth
- Liquor will be meconium stained
- Second stage will be delayed
- Baby is pre-term
- Breech presentation
- Twin pregnancy
- Mother will have post partum haemorrhage
- Mother is HIV positive and is on the PMTCT programme.

Other signs of special risk at delivery include:

- If she is under 15, over 40, or over 35 at her first pregnancy
- If she has had more than 5 or 6 babies
- If she is especially short or has narrow hips
- If the woman is suffering from a chronic or acute illness such as diabetes
- If the woman is very anaemic, or if her blood does not clot normally (when she cuts herself)

The most important reason that all pregnant women have to deliver their baby in the health facility is that the onset of complications cannot be predicted and complications can occur in any woman including women without any ANC risk factors.

Objective 5. Recognize the onset of labour

The TBA should advise the mother how to recognize the onset of labour. This will help the pregnant woman and their family to know the onset of labour and they can get prepared and make arrangements for transport to be available to go for delivery in the health facility. Especially, in the remote area, the family and the community should have contact with the primary health care services and/or other community members who live nearby and have a car which could be used when needed.

The onset of Labour

The onset of labour is most important for the TBA to advise mother since it is on the basis of this finding that decisions are made which will affect the management of labour. TBAs must ensure that they have enough information to assist the mother to recognize the onset of true labour.

Pre-labour is the period during the last few weeks of pregnancy where a number of changes occur:

- Lighthening,
- Walking becomes more difficult, but breathing easier, vaginal secretion also becomes more profuse at this time,

- Frequent of micturition,
- Many women experience contractions before the onset of true labour, which may be painful and may even be regular for some time, causing women to think that labour has started. The two features of labour which are absent are retraction and dilation of the cervix.
- During the pre-labour period many women feel cumbersome, ungainly and tired. Mood swings are common.

Transport arrangements to go to the hospital for delivery should be made when regular rhythmic uterine contractions are experienced, occurring at 10 minute intervals and perceived as uncomfortable or painful. Contractions will usually be accompanied or preceded by a bloodstained, mucoid show. Occasionally the membranes will rupture, which should always be reported to the midwife.

Recognition of the first stage of labour

- Show: It is quite common to lose a jelly-like discharge in late pregnancy but when a pink jelly-like loss is noted, labour is likely to be imminent or under way.
- Contractions are more noticeable in the late pregnancy and some women experience them as painful. They are irregular or their regularity is not maintained and they often last more than one minute. True labour contractions exhibit a pattern of rhythm and regularity, usually increasing of length, strength and frequency as time goes on. When the woman first feels contractions she may only be aware of backache but if she places a hand on her abdomen she may perceive simultaneous hardening of the uterus. Contractions will be short initially, lasting 30-40 seconds, and may be as much as half an hour apart. At this stage the TBA must have arranged transport for delivery in the health facility.

Differential diagnosis of true and spurious labour

True labour	Spurious labour
Uterine contraction Always present Rarely exceed 60 seconds Recur with rhythmic regularity Are accompanied by abdominal tightening, discomfort or pain Are often accompanied by backache	Uterine contraction Not always present Must last 2-3 minutes Are erratic May or may not be painful Not accompanied by backache

MODULE 4: OBSTETRIC CARE (EMERGENCY DELIVERY)

Materials: Flipchart, koki pens

Methodology: Group discussions, demonstration, delivery kit, pictures showing the whole process, role-plays

PROCEDURE

1. Delivery kit demonstration

The trainer opens the delivery kit taking out instruments one by one while naming them to the group and demonstrating its use.

2. Assisting with birth – a demonstration in the use of instruments

The facilitator narrates as she takes one of the participants and demonstrates:

- Arrange instruments in appropriate place and order
- Ensure that your garbage bag is next to you so that you can throw everything
- Check if the mother is in real labour
- Wipe the baby's eyes with salty water at birth
- Demonstrate to cut and tie the umbilical cord
- When the baby comes, ensure that you wash the baby so as to see if there is something wrong especially with its private parts
- Demonstrate how to protect the child so that it does not catch cold
- Use clean clothes when assisting with delivery

3. Role plays

The participants are in pairs doing the process as the trainer demonstrated to them. They exchange roles.

4. Group discussion

Exercise 4/1

4.1.1 Working in 3 groups of eight, discuss the 3 stages of labour each group taking one stage. Write down the process of delivery and put up your flipcharts against the wall so that we can see if there are any gaps in your presentation. Now I need three speakers from each group, different people.

4.1.2 Two people from each group must come and demonstrate the process of washing the newborn baby.

Learning objectives: at the end of this module the TBA should be able to:

1. Use only clean instruments for delivery and delivery kit
2. Protect themselves and others from contracting HIV infection when assisting delivery
3. Conduct safe delivery without increasing the risk of mother to child transmission of HIV.
4. Provide primary care during and after delivery within 24 hours of referral to the hospital
5. Infection control for TBA, mother and relatives

The TBA should best avoid emergency delivery by preparing the mother during pregnancy. However, the TBA should prepare a delivery kit to be ready for any emergency case. In case of emergency the skills of the TBA need are list below.

Objective 1: Use only clean instruments for delivery and delivery kit

Delivery is a process, which starts with labour pains followed by delivery of the baby and the placenta. This is a period in which most of mother to child transmission of HIV takes place. Many of the services given to mothers to assist delivery may increase the risk of transmission of the virus to the child. Therefore it is important that TBAs are capacitated so that they can perform safe delivery and reduce mother to child transmission of HIV and possible transmission from the TBA to the mother and child.

- Maintain cleanness of
 - TBAs hands
 - Private part of a pregnant woman
 - Delivery instruments
 - Delivery place and surrounding of delivery area,
 - Clean linen for both mother and the baby
 - Boil lengths of string to tie umbilical cord and keep them in clean place

Delivery kit TBAs should have:

Clean mates, soap, gloves, clean clothes for the mother and the baby, apron, Jik, torch, new razorblades, poster, Antenatal card, bucket, a washing basin, clean thread for tying the umbilical cord. This delivery kit should be kept ready by the TBA in case of an emergency home delivery.

TBAs should advise pregnant women to prepare the list below both for themselves and for the baby (*kept in a basket or paper box*) for use after the delivery in the health facility:

<i>For mother:</i> Clean towel, big and small; Clean dress <ul style="list-style-type: none">- Plastic sheet- Sanitary pad, Cotton- Newspaper or papers- Soap and soap container- 3 clean big bottles to keep boiled water- Tray, basket, kettle, enamelled basin or big pot- Buckets- Big bowl or enamelled basin- Bed pan or spittoon- Clean matt, bed sheet, pillows case- A vacuum flask for keeping water hot	<i>For infant:</i> <ul style="list-style-type: none">- Baby soap- Baby mattress- Clean towels- Sheets for baby- Clothes- Baby bath basin box
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Objective 2: Protect themselves and others from contracting HIV infection when assisting delivery

Delivery involves blood and body fluids. Traditional birth attendants should take note of the following:

- Consider all women including yourself potentially HIV positive and have the necessary protective equipment ready in case of emergency delivery, i.e.: plastic aprons, visor masks, gloves, disposable draw sheets, disposable napkins, cord clamp, new razor blades, plastic bags for receiving soiled linen and placenta – mechanical suction, mucus extractors using 20ml syringe, detergent for washing hands, webcol swabs for cleaning baby's cord. Soap and water for cleaning vulva, clean water and cotton wool for cleaning baby's eyes, surgical spirits to clean the cord.
- All the above equipment is supposed to be used only once for each patient. To economise, a razor blade can be broken into half.

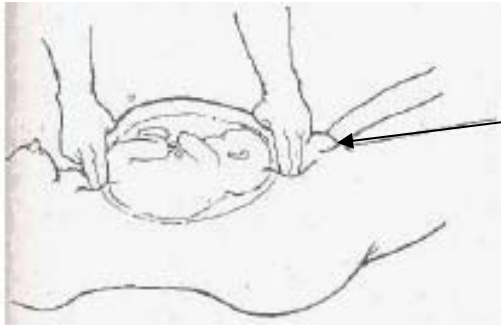
- After use disposable draw sheets, disposable napkins and other materials should be burnt or put into a red refuse bag and take to the clinic. Plastic aprons may be reused after cleaning with disinfectant.

Objective 3: Conduct safe delivery without increasing the risk of mother to child transmission of HIV

Although the TBA encourages the pregnant woman to deliver in the health facility, in an emergency situation she will have to follow the following procedures:

Checking if the Baby Is in a Good Position

1. To make sure the baby is head down, in the normal position for birth, feel for his head, like this:



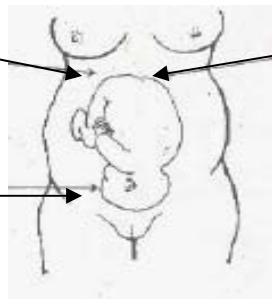
1. Have the mother breathe out all the way.

With the thumb and 2 fingers, push in here, just above the **pelvic** bone.

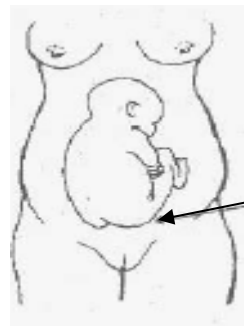
With the other hand, feel the top of the womb.

The baby's butt is larger and wider

His head is hard and round




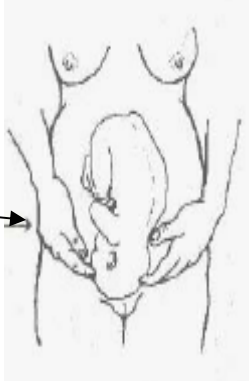
Butt up feels larger high up.



Butt down feels larger low down



2. Push gently from side to side, first with one hand, then the other.

<p>If the baby's butt is pushed gently sideways, the baby's whole body will move too.</p> <p>But if the head is pushed gently sideways, it will bent at the neck and the back will not move</p>		<p>If the baby still is high in the womb, you can move the head a little. But if it has already engaged (dropped lower) getting ready for birth, you can not move it.</p> <p>A woman's first baby sometimes engages 2 weeks before labour begins.</p> <p>Later babies may not engage until labour starts.</p>	
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→If the baby's head is *down*, his/her birth is likely to go well.

→If the head is *up*, the TBA must refer the mother to give birth in hospital only.

→If the baby is *sideways*, the mother must have her baby in a hospital. She and the baby are in danger.

SIGNS THAT SHOW LABOUR IS NEAR

- Usually, a few days before labor begins, **the baby moves lower** in the womb. This lets the mother breathe more easily, but she may need to urinate more often because of pressure on the bladder. (In the first birth these signs can appear up to 2 weeks before delivery.)
- A pregnant woman with signs indicating that labour is near should be assisted to move close to a health facility and efforts should be made to accommodate the pregnant woman, e.g. waiting mother's home. Alternatively transport should be ensured.
- A short time before the labour begins, **some thick mucus** (jelly) may come out. Or some mucus may come out for 2 or 3 days before labour begins. Sometimes it is tinted with blood. This is normal.
- The **contractions** (sudden tightening of the womb) or labour pains may start up to several days before childbirth; at first a long time usually passes between contractions – several minutes or even hours. When the contractions become stronger, regular, and more frequent, labour is beginning.
- Some women have a few **practice contractions** weeks before labour. This is normal. On rare occasions, a woman may have false labour. This happens when the contractions are coming strong and close together, but then stop for hours or days before childbirth actually begins.
- Women with signs indicating that labour is near should be assisted to move close to the health facility and efforts should be made to accommodate the pregnant woman, e.g. waiting mothers, and alternative transport should be ensured.

Labour pains are caused by contractions or tightening of the womb.
Between contractions the womb is relaxed like this:



During contractions, the womb tightens and lifts up like this:



The contractions cause the cervix or ‘door of the womb’ to open – a little more each time

- The **bag of waters** that holds the baby in the womb usually breaks with a flood of liquid sometime after labour has begun. If the water breaks before the contractions start, the mother should be referred to the hospital immediately and not wait for onset of labour at home. Especially an HIV positive mother should arrive at the health facility within 12 hours.

THE STAGES OF LABOUR: Labour has 3 parts or stages:

- The first stage lasts from the beginning of the strong contractions until the baby drops into the birth canal.
- The second stage lasts from the dropping of the baby into the birth canal until it is born.
- The third stage lasts from the birth of the baby until the placenta (afterbirth) comes out.

THE FIRST STAGE OF LABOUR usually lasts 10 to 20 hours or more when it is the mother’s first birth, and from 7 to 10 hours in later births. This varies a lot. During the first stage of labour, the mother should not try to hurry the birth. It is natural for this stage to go slowly. The mother may not feel the progress and may begin to worry. TBAs should give information about labour process and emotional support to lessen anxiety and tell her that most women have the same concern. If a TBA found a pregnant woman in this stage, she still should refer her to the hospital.

In case the woman is HIV positive (disclosed the HIV status) the TBA should remind her to swallow the Nevirapin tablet. If the mother’s HIV status is unknown, the TBA can remind her by asking the question such as “Are there any tables that you were given by the nurses in the clinic, which you were asked to take when you are in true labour?”

The mother should not push or bear down until the child is beginning to move down into the birth canal, and she feels she has to push. The mother should keep her bowels and bladder empty.

If the bladder and the bowels are full, they get in the way when the baby is being born.



During labor, the mother should urinate often. If she has not moved her bowels for several hours, an enema may make labor easier. During labor, the mother should drink water or other liquids often. Too little liquid in the body can slow down or stop labor. If labor is long, she should eat lightly, as well. If she is vomiting, she should sip a little Rehydration Drink, herbal tea, or fruit juices between each contraction.

DURING THE FIRST STAGE OF LABOR, the TBA should:

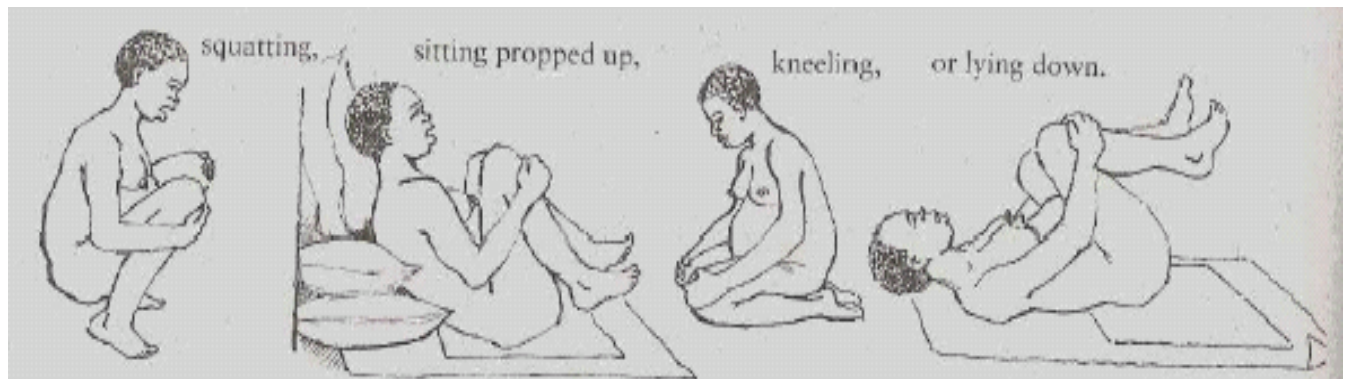
- Wash the mother's belly, genitals, buttocks, and legs well with soap and warm water. The bed should be in a clean place with enough light to see clearly.
- Spread clean sheets, towels, or newspapers on the bed and change them whenever they get wet or dirty.
- Have a new, unopened razor blade ready for cutting the cord, or boil a pair of scissors for 15 minutes. Keep the scissors in the boiled water in a covered pan until they are needed.

The TBA should **not** massage or push on the belly. She should **not** ask the mother to push or bear down at this time.

If the mother is frightened or in great pain, have her take deep, **slow**, regular breathes during each contraction, and breathe normally between them. This will help control the pain and calm her. Reassure the mother that the strong pains are normal and that they help to push her baby out.

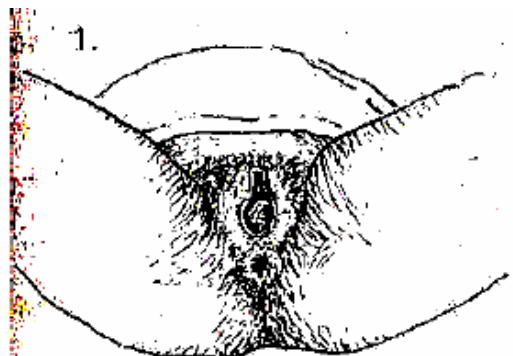
THE SECOND STAGE OF LABOR, in which the child is born. Sometimes this begins when the bag of waters breaks. It is usually easier than the first stage and takes less time.

When mother is ready to bear down: TBA must always communicate clearly with mother to gain co-operation and be supportive and encouraging. Put the mother in a suitable position (see picture below). During contractions, tell the mother to make a deep breath, put her chin on her chest and bear down for as long as possible to deliver the baby. If the child comes slowly after the bag of water breaks, the mother can double her knees like this, while pushing the baby down.

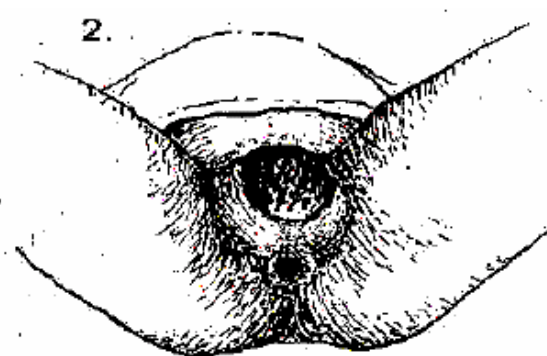


When the birth opening of the mother stretches, and the baby's head begins to show, the midwife or helper should have everything ready for the birth of the baby. At this time the mother should try **not** to push, so that the head comes out more slowly. This helps prevent tearing of the opening. When the head comes out, the midwife may support it, but must *never pull on it*. *Always wear gloves to attend the birth* – to protect the health of the mother, baby and midwife. Today this is more important than ever.

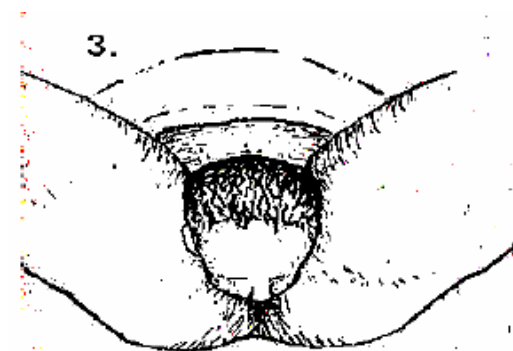
Normally the baby is born head first like this:



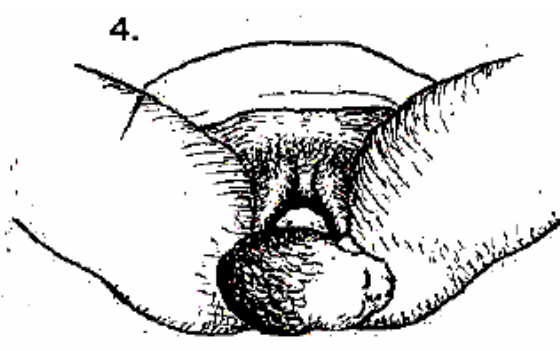
Now push hard.



Now try not to push hard. Take many short, fast breaths. This helps prevent tearing the opening.

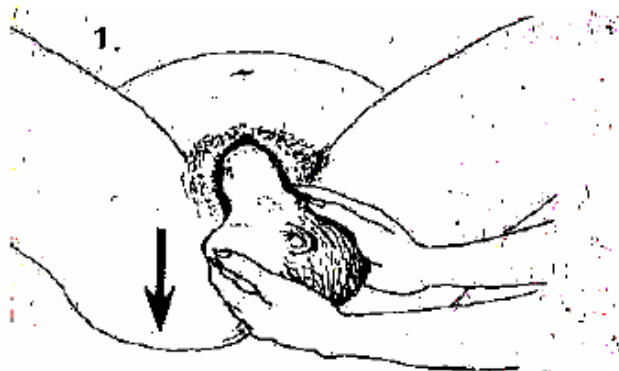


The head usually comes out face own.

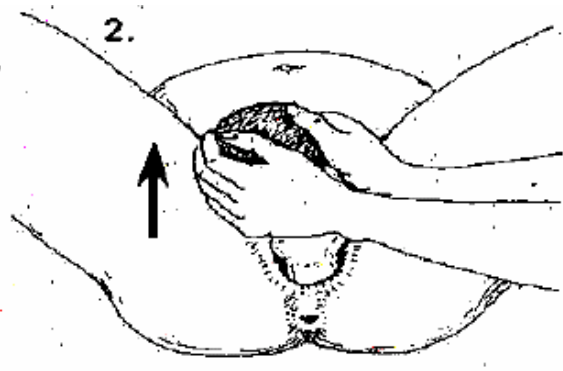


Then the baby's body turns to one side so the shoulders can come out.

If the shoulders get stuck after the head comes out:



The TBA can take the baby's head in hands and lower it very carefully, so the shoulder can come out.



Then she can raise the head a little so that the other shoulder comes out.

All the force must come from the mother. The TBA should *never pull on the head or twist or bend the baby's neck*, because this can harm the baby.

THE THIRD STAGE OF LABOR begins when the baby has been born and lasts until the placenta (afterbirth) comes out. Usually, the placenta comes out by itself 5 minutes to an hour after the baby. In the meantime, **care for the baby**. If there is a lot of bleeding or if the placenta does not come out within 1 hour, seek medical help.

CARE OF THE BABY AT BIRTH

Immediately after the baby comes out:



- Wipe the baby's eyes clean **before** the eyes open, that is, before any possible infection has had a chance to get into them.
- Put the baby's head down so that the mucus comes out of his mouth and throat. Keep it this way until he begins to breathe. Gently suction the baby's mouth and nostrils to the mucus out of this nose and mouth with a suction bulb or a clean cloth wrapped around the finger.
- Keep the baby **below** the level of the mother until the cord is tied. (This way, the baby gets more blood and will be stronger.)
- If the baby does not begin to breathe right away, rub his back with a towel or a cloth.
- **Prevention of hypothermia:** Dry the wet infant with clean towel. Discard all moist coverings and wrap baby in a clean dry towel which cover the head and the body. Place the baby in

the mother's arm to be fondled and suckled. Avoid any exposure to cold. The room environment must be free from drought and have air ventilation.

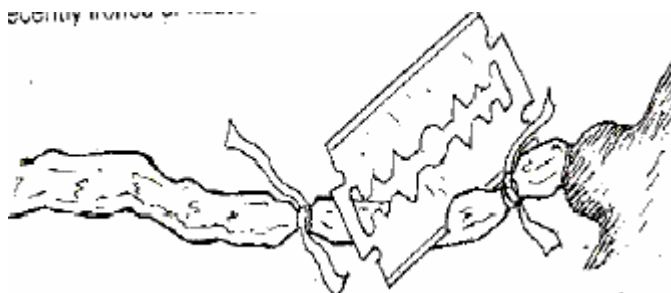
How to Cut the Cord

Clamping the umbilical cord: An infant's blood volume is related to time of cord clamping after birth in full term babies, it is recommended to clamp the cord within 30 to 60 seconds

When the child is born, the cord pulses and is fat and blue. **WAIT.**



After a while, the cord becomes thin and white. It stops pulsing. Now tie it in 2 places with very clean, dry strips of cloth, string, or ribbon. These should have been recently ironed or heated in an oven. Cut between the ties, like this:

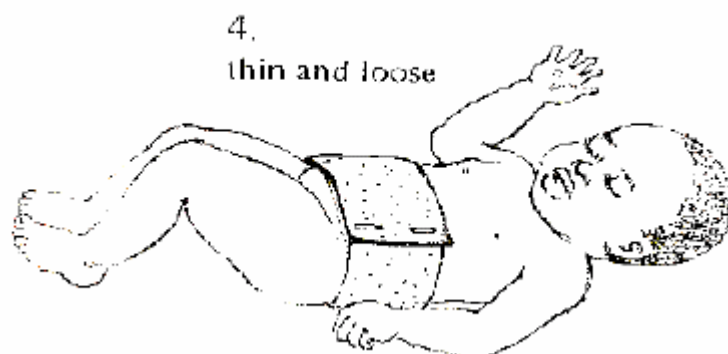
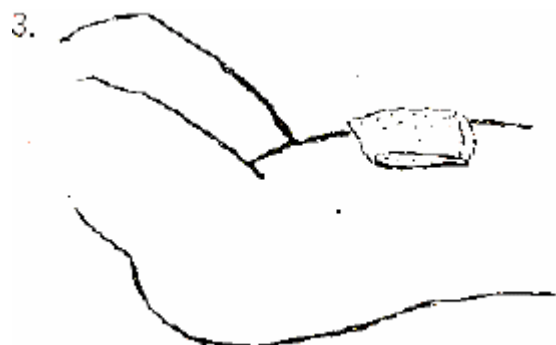
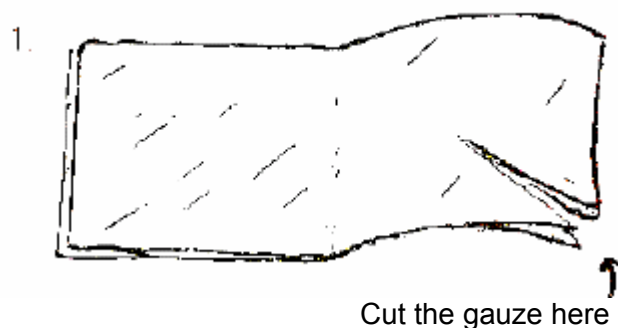


IMPORTANT: Cut the cord with a clean, unused razor blade. Before unwrapping it, wash your hands very well. If you do not have a new razor blade, use freshly boiled scissors. **Always cut the cord close to the body of the newborn baby.** Leave only about 2 centimeters attached to the baby. These precautions help prevent tetanus.

Care of the Cut Cord

The most important way to protect the freshly cut cord from infection is to **keep it dry**. To help it dry out, **the air must get to it**. If the home is very clean and there are no flies, leave the cut cord uncovered and open to the air.

If there are dust and flies, cover the cord lightly. It is best to use sterile gauze. Cut it with boiled scissors. Put it on like this:



If you do not have sterile gauze, you can cover the navel with a very clean and freshly ironed cloth. It is better not to use a bellyband, but if you want to use one, use a thin, light cloth, like cheesecloth, and be sure it is loose enough to let air in under it, to keep the navel dry. Do not make it tight.

Be sure the baby's nappy (diaper) does not cover the navel, so that the cord does not get wet with urine.

Cleaning the Newborn Baby

With a warm, soft, damp cloth, gently clean away any blood or fluid. It is better **not** to bathe the baby until after the cord drops off (usually 5 to 8 days). Then bath him daily in warm water, using a mild soap.

TBA must discuss feeding options with mother in the context of HIV. If mother chooses exclusive breast feeding or is HIV negative, place the baby at its mother's breast as soon as the baby is born.

The delivery of the placenta (afterbirth): Normally, the placenta comes out 5 minutes to an hour after the baby is born, but sometimes it is delayed for many hours.

Checking the placenta afterbirth:

When the afterbirth comes out, pick it up and examine it to see if it is complete. If it is torn and there seem to be pieces missing, get medical help. A piece of placenta left inside the womb can cause continued bleeding or infection. Use gloves (or plastic bags) on your hands to handle the placenta. Wash your hands well afterwards.

When the placenta is delayed in coming:

If the mother is not losing much blood, do nothing. **Never pull on the cord.** This could cause dangerous haemorrhage (heavy bleeding). Sometimes the placenta will come out if the woman squats and pushes for a while. If the mother is losing blood and the placenta does not come out seek medical help fast.



Disposal of placenta

In African setting disposal of placenta can be determined by the family of the pregnant woman on what they want to do with it. The Traditional Birth Attendant will be directed by them, while she maintains highest precautionary measures to prevent transmission of HIV.

NEVIRAPINE for the baby

If the mother is HIV positive (disclosed) the TBA should remind her to give Nevirapine to the baby as soon as possible after delivery or support the mother to take the new born baby to receive Nevirapine at the clinic as soon as possible, not more than 72 hours after delivery. If the mother's HIV status is unknown, the TBA should remind the mother to give Nevirapine to the baby by asking the question e.g. "Is there any syrup that you were given by the nurses in the clinic, which you were asked to give to the child after delivery?"

The Nevirapine pack for the mother (tablet) and for the baby (syrup) is normally given to the mother together with indications, which should be similar to the figure below:

HolyCross Hospital PMTCT Programme					
Name of Mother _____	Date Dispensed _____				
Igama likaMama _____	Umhla elikhutshwe ngawo _____				
					
<p>Nevirapine 200mg Tablet for Mother Ipilisi yeNevirapini kaMama Swallow Tablet when Labor Starts Ginya ipilisi xa uqalisa ukuva inimba</p>	<p>Nevirapine Syrup for Baby Isirapu yeNevirapini yosana *Push liquid/Syrup into baby's mouth within 72hrs from birth. *Nyanzela isirapu emlonyeni wosana kwisithuba seyure eziyi 72 (kwisithuba seentsuku ezintathu).</p>				
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 2px;">Lot/Batch Icandelo</td> </tr> <tr> <td style="padding: 2px;">Expiry Date Umhla wophelelo</td> </tr> </table>	Lot/Batch Icandelo	Expiry Date Umhla wophelelo	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 2px;">Lot/Batch Icandelo</td> </tr> <tr> <td style="padding: 2px;">Expiry Date Umhla wophelelo</td> </tr> </table>	Lot/Batch Icandelo	Expiry Date Umhla wophelelo
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<i>*Nurse to demonstrate to mother before dispensing</i>					

Objective 4: Provision of primary care during and after delivery within 24 hours of referral to the hospital

Accompanying mother to hospital

Within 24 hours after delivery the TBA must accompany the mother to go with the baby to the hospital to receive postpartum care, Nevirapine, and for full check-up of the baby and immunization.

During delivery the TBA should observe abnormal signs and provide primary care as follows:

Abnormal signs of mother during delivery	Scope of practice to assist the mother
1. Infant breech presentation (Prolapsed foot)	<ul style="list-style-type: none"> - Refer as soon as possible - Do not press to force out the infant - Use clean cloth to cover the foot of the infant
2. Infant in reverse position (Prolapsed foot or arm)	<ul style="list-style-type: none"> - Refer as soon as possible - Do not press to force out the infant - Use clean cloth to cover the foot of the infant
3. Prolapsed cord	<ul style="list-style-type: none"> - Refer as soon as possible - During referral do not press to force out the infant - Do not use hands to push the cord inside - Let the mother lie down on flat floor without pillow
4. No progress of labour even after frequent contraction <ul style="list-style-type: none"> - First pregnancy has labour 	<ul style="list-style-type: none"> - Refer as soon as possible - During referral do not press to force out the infant

<p>pain more than 2 hours</p> <ul style="list-style-type: none"> - 2nd or more pregnancy has labour pain more than 1 hour 	
5. Fresh bleeding from vagina	<ul style="list-style-type: none"> - Refer as soon as possible - Let the mother lie down on flat floor and put cloths under to support blood - Rub the uterus to increase contraction and reduce bleeding
6. Leak or rupture of amniotic fluid	<ul style="list-style-type: none"> - Refer as soon as possible
7. Contraction of abdomen and have two lobes above mon pubic	<ul style="list-style-type: none"> - Refer as soon as possible - Do not press abdomen
8. Swollen, convulsion and severe headache	<ul style="list-style-type: none"> - Refer as soon as possible - If any convulsion, during referral: support and prevent biting of the tongue by put clean cloths on small stick to bite, prevent obstruction of airway by using a rubber pump to remove secretion

To refer post delivery mother to health services, TBAs have to help and give primary care as listed below:

Abnormal sign of mother after delivery within 24 hours	Guidelines for practice
1. A lot of bleeding from vagina	<ul style="list-style-type: none"> - Refer as soon as possible - During referral roll or fondle the uterus to keep it contract all the times and use clean cloths to support under the buttock
2. Pale, cold skin, sweat, fast breath, vertigo, partially blind	<ul style="list-style-type: none"> - Refer as soon as possible - During referral let the women lie down on flat floor and keep warm with blanket
3. High fever	<ul style="list-style-type: none"> - Refer as soon as possible - During referral wipe the skin with warm water, let woman drink a lot of water or juice and keep her body warm with a blanket.
4. Retention of urine	<ul style="list-style-type: none"> - Drink a lot of water - Stimulate to urinate by pouring warm water on the pubis or genital - if still not urinate, refer to health care centre

In addition, the TBA and mother should observe the following signs and symptoms in the baby and report them to the health professional:

1. Cord bleeding
2. Jaundice (yellow skin, eyes)
3. Pale
4. Abnormal breathing
5. Fever
6. Not sucking milk

7. Vomiting after drinking milk
8. Not passing the grey stool
9. Not passing urine
10. Green/blue skin
11. Convulsion
12. Crying all the time (unidentified cause)

Objective 5: Infection control for TBA, mother and relatives

To know how to protect relatives and others from acquiring HIV from a delivered mother and TBA:
For TBA:

- Care during disposal of placenta and blood (use gloves and put in plastic bag)
- Rinse reusable instrument (e.g. plastic apron, bucket, washing basin) Jik 1/6 for ten minutes then wash them with soap followed by boiling for 30 minutes before reusing
- Mother clothes which are contaminated with blood should be soaked in Jik before they are given to a relative for washing

For the mother and relatives:

- Maintain cleanness after delivery
- Cleanness of clothes of the mother and her body
- Cleanness of the child
- Sanitary disposal by burying or burning

MODULE 5: POST-PARTUM CARE

Materials : Flipchart, koki pens

Methodology: Revision, Lecture input, discussion

Revision: Recapping the previous 2 day's lessons,
Ask the participants to demonstrate the delivery kit

Learning objectives; at the end of this module the TBA should be able to:

1. Do a post-partum visit
2. Encourage mother to have post partum check up at clinic
3. Advise mother for necessary postpartum practice

Objective 1: Post-partum visit

After mother and the baby come back from the hospital, the TBA should visit because the mother needs to have appropriate information on how to prevent post-partum infection. If the post delivery mother observes appropriate self-care, she will recover to the normal status faster and safely.

Time period for post-partum visit

- Within first 7 days: TABs should visit mother and infant at least two times
- Between 7 to 14 days at least one visit
- 4-6 weeks for check up 1 visit

Post-Partum Daily Examination

Even if a woman delivers at a health facility and if she delivered (by TBA) at home, the TBA can still provide post partum care, support, and counsel her on:

General well- being

The mother should be greeted and asked how she is feeling. The TBA should take particular note if the mother complains of feeling unduly tired. Any woman who is developing an infection or who is anaemic will not feel well.

Tiredness and fatigue

Many women feel tired following delivery but they do not feel unwell. Undue fatigue may result from sleep disturbance because of the baby's needs and may be relieved by arranging a quiet period and place where the woman can gain extra sleep. Many women will recover rapidly after only a few hours of extra and undisturbed rest. A mother who complains of tiredness in spite of adequate opportunity to sleep may be showing early signs of depression and should be given an opportunity to discuss her feelings and provided with extra help with the baby until she feels more able to cope.

The uterus

Although the rate of reduction in size varies in different women, involution should follow a progressive pattern. It is usually more rapid in women who breast feed and in primigravidae. The uterus should be well contracted and not painful. Sub-involution is identified if the uterus remains the same size for several days. A bulky uterus may indicate the presence of blood clots or of retained products of conception. Tenderness of the uterus suggests infection. The TBA must report such findings to the doctor.

The lochia

Lochia is the term used to describe the discharges from the uterus during the puerperium. Lochia have an alkaline reaction in which organisms can flourish more rapidly than in the normally acid secretions of the vagina. The odour of the lochia is heavy but not offensive, and the amount varies in different women. The character and amount of the lochia are noted and the TBA should expect to see a gradual change in the colour and amount of the lochia as the puerperium progresses.

The lochia undergo sequential changes as involution progresses:

Red lochia (lochia rubra). This is the name given to the lochia during the first 3-4 days of the puerperium. As the name implies they are usually red in colour and consist of blood from the placental site and debris arising from the deciduas and chorion.

Serous lochia (lochia serosa).

These are pink in colour and discharged during the next 5-9 days. The lochia now have less blood and more serum and contains leucocytes from the placental site.

White lochia (lochia alba)

The discharges are paler, creamy-brown in colour, and contain leucocytes, cervical mucus and debris from healing tissues. Some evidence of blood may continue to be seen for a further 2 or 3 weeks.

The quantity, colour and odour of the lochia are significant. An increase in the amount lost and in the blood content may be seen when the mother becomes more active. Scanty lochia may suggest infection. The presence of small blood clots may be normal during the first 24 hours especially in multiparae, but if this continues or is accompanied by pain, it suggests that products of conception may not have been fully expelled. Offensive lochia may not have indicated poor vulval hygiene and contamination by faecal debris; if, however, this situation persists in spite of improvement in vulval hygiene, then it is indicative of infection of the genital tract, possibly of the uterus itself.

Micturition

The woman should be encouraged to pass urine as soon as possible after delivery and preferably within 12 hours. Most women are fit enough to visit the lavatory where they can enjoy privacy and a more normal position than seated on a bedpan in bed. If a woman has difficulty in emptying her bladder, the reason must be sought. If the problem is not resolved early, retention of urine may be tried include the sound of running water or sitting in the bath. The TBA should insist that the mother visits a health professional if this problem occur.

The perineum, vulva and anus

The TBA should ensure that the vulva pads are being changed frequently and that perineum is free from stale lochia which could be a source of infection. Any severe pain and swollen must be reported to a health professional.

Objective 2. Encourage mother to have post-partum check up at clinic

The TBA should remind the mother to visit a clinic for post-partum check up after 6 weeks. The importance of a post-partum visit at a clinic is:

1. Prevention of complication and infections for both mother and infant
2. To provide scope and guidelines for self-care of mother
3. Advice on how to look after the infant, e.g. infant feeding (formula, mixed and breastmilk), hygiene, vaccination/immunizations
4. Advice and motivate for family planning
5. Disadvantages of mixed feeding

6. Use of grip water only when choosing exclusive breastfeeding
7. Prevention of complication and infections for both mother and infant
8. Advice on how to look after the infant, e.g. breast feeding, hygiene, vaccination
9. To monitor the baby's growth – weight and height has to be monitored on every visit.

Objective 3: Advise postpartum practice to mother

The necessary information for post-partum practices that TBA should advise mother include;

Food and nutrition for breast-feeding stage: mother can eat every type of food, no taboo food, but must avoid spicy or too hot food, alcohol and caffeine.

Sexual intercourse: should skip sexual intercourse post delivery 6 weeks

Family planning and health post-partum check up: about 6 weeks after delivery she must go for check up at health facility and family planning

Prevention of infection

Puerperal infection is still a cause of maternal death. It must be prevented by strict cleanliness. The uterus provides an ideal environment for multiplication of organisms. Any degree of trauma will increase the tendency for development of infection. Possible foci of puerperal infection are:

- Breast infection
- Infection of the genital tract
- Infection of the urinary tract
- Upper respiratory tract infection

Genital tract infection is more likely to occur in women who have suffered tears or abrasions to the vulva, vagina and perineum. Bruising reduces the tissues' resistance to infection and there is danger that ascending infection may involve the uterus and the placental site. It can be prevented by careful attention to the mother's hygiene, encouragement of drainage of lochia by early ambulation.

The mother's hygiene should be maintained by a bath or shower at least once a day, frequent use of the bidet and care of vulva after toilet use. Vulva pads should be changed frequently and the mother should be warned not to let the pad rub between the anus and vulva when removing it as this may transmit organisms from the anus, contaminating the perineum and vulva. Vulva cleanliness promotes the healing of trauma and prevents urinary tract infection. Clean the genital organs after pass stool or urine.

Urinary tract infection affects a number of women during pregnancy and may recur in the puerperium. It may be caused by lack of vulval hygiene and is more likely to occur if there is retention of urine due to poor fluids intake or lack of exercise. Constipation must be avoided.

Upper respiratory tract infection may occur to any person at any time. The TBA and family members who are suffering from colds should not visit the mother and the baby.

Ambulation and exercise

Ambulation increases muscle tone and venous return from the legs and lower abdomen. It also increases the drainage of the lochia and voiding of urine. Ambulation should be encouraged as soon as possible after delivery and most women are able to walk to the bathroom with help approximately 6 hours after delivery. Increasing amount of exercise should be taken each day and it is important that mothers are encouraged to walk about and not just sit by the bedside as this will help them to feel better emotionally and physically. Postnatal exercises help to increase muscle

tone and are usually commenced during the first 3 days after delivery. In case of normal delivery, the mother can get up and walk within 12 hours but not drinking or eating during exercise, do exercise in the open air or good ventilated environment, regular exercise (e.g. everyday) and choose the appropriate exercise activities.

Rest and sleep

Ensuring adequate rest and sleep is a vital part of postnatal care. The healing of trauma is aided by physical rest; emotional well-being can be eroded when a mother has insufficient sleep or time for personal refreshment. However, achieving adequate rest for mothers is not easy. Caring for a small baby brings busy days and broken nights. These difficulties can be overcome by:

1. It should be a cardinal rule at home that a sleeping mother is not woken for any reason. A mother often falls into deep sleep in the early hours after feeding her baby and should be allowed to sleep on.
2. This mother's bed room should be kept as quiet as possible. Many women benefit from the opportunity of a few hours uninterrupted sleep during the daytime.
3. The need for adequate rest should be emphasized and the family encouraged taking over the care of the baby for a period of time each day to allow the mother to continue her pattern of resting at least once during the day.

MODULE 6: NEWBORN CARE AND COUNSELLING ON SAFE INFANT FEEDING FOR A NEWBORN FROM AN HIV POSITIVE MOTHER

Materials: Flipchart, koki pens

Methodology: Lecture input, small group discussions, demonstration in pairs

Learning objectives:

1. Provide guidance of new born care
2. Explain benefits of the mother's breast milk and techniques of breast feeding
3. Explain different safe infant feeding options for an infant borne to an HIV infected mother.
4. Methods of infant feeding of newborn whose mother is HIV infected
5. Preparation of milk of infant formula milk

Objective 1: Newborn care

1. AFTER BIRTH- Immediate Care

Wherever possible, do not separate the baby and the mother, and ensure adequate warmth.

1.1 Cord: Check the clamp and swab the cord with surgical alcohol. Keep it exposed to promote drying.

1.2 Bathing: Clotted blood and meconium may be removed after birth, do not bath the baby if found the baby's skin too cold.

1.3 Dressing: After bath cloth the baby in a cotton vest and a short gown which ties at the back.

1.4 Temperature: Maintain the environment temperature in the room that baby sleep in a comfortable level.

1.5 Respiration: Count and record the breathing rate half-hourly for the first two hours. The following signs are abnormal:

- A sustained rate over 40 per minute
- Rib or sternal recession
- Grunting

These indicate respiratory distress which needs urgent investigation and treatment.

1.6 Neurological function: Assess movement and behaviour half hourly for two hours. The following factors are abnormal:

- excessive drowsiness
- Irregular breathing
- A tense fontanel
- Seizures

1.7 Birth injuries: The following signs are indicative of birth trauma:

- Infant cries excessively when moves or picked up.
- Facial asymmetry on crying
- Bulging fontanel

1.8 Congenital abnormalities: Obvious abnormalities should be detected at the first examination.

1.9 Feeding: A normal a baby and its mother remain together and demand-feeding is encouraged. Ensure that an infant who has been separated from the mother receives a feed within two hours of birth.

2. AFTER BIRTH- CONTINUING CARE

A baby must be examined fully on the first day. TBAs must advice the mother or family member to take the baby to visit a health professional within the first day for check up.

However, the TBA and mother are supposed to have knowledge and need to continue checking of the baby's condition as follows:

- 2.1 Skin:** inspect the baby's body for rashes, pustules, scratches, perineal redness, peeling, jaundice.
- 2.2 Temperature:** check baby's skin temperature (too warm or too cold).
- 2.3 Cord:** swab the umbilicus three times a day with spirits (if redness or oedema, bleeding or discharges, offensive smell report to health professional).
- 2.4 Eyes:** remove crusted material from the nasal margins with the moist swap (if a discharge from the eyes report to health professional).
- 2.5 Nose:** cautiously remove crusted secretions from the nostrils with moist cotton wool buds (report a basal discharge to health professional). Note: A "blocked" nose is common and is often associated with sneezing. This does not imply "flu" or a 'cold". It is a normal event.
- 2.6 Mouth:** inspect the mucosa of the lips and cheeks for thrush.
- 2.7 Stool:** record the number of stools passed daily, check colour and consistency of each stool (report to health professional a delay of passing meconium more than 24 hours, diarrhoea, blood in stool).
- 2.8 Urine:** check the urine daily (report delay of passing urine of more than 36 hours, constant dribbling).
- 2.9 Feeding:** breast feeding poses difficulty for many mothers and the TBA should spent time explaining various problems. Common difficulties are a delay in milk production, sore nipples, engorged breasts, uncertainty of the amount of milk taken at each feed and excessively drowsy baby and refusal to suck the breast.
The following problems need immediate attention:
- inadequate sucking reflex
 - persistent vomiting
- 2.10 Mother-baby relationship** (infant-parent relationship): The first hour after birth is a time of particular sensitivity for mother. Close contact with her baby during this time facilitates the attachment process. Keep mother and the baby together, ensure quietness, especially at night. **The father:** the father is surprised at his profound emotional response to the birth of their baby. He feels a sense of deep satisfaction and self-esteem and is elated and keen to touch and hold his baby and his wife.
- 2.11 Follow-up:** a baby should be examined and receive vaccinations at the primary health care clinic after six weeks.
- 2.12 Prevention of infection**
A source of infection should not handle babies e.g. friend, relatives or children who are sick or have a cold should not visit. Daily bathing, washing baby face and napkin area should be carried out once or twice a day. Cleanliness of umbilical cord is essential. The mother should be handling the baby with washed hands, cleansing with clean water and keep the cord dry. It is advisable to ensure that the cord is not enclosed within the baby's napkin where contamination by urine or faeces may occur. The baby's buttock must be washed and dried carefully at every napkin change. Sore buttocks may occur in case the stools are loose or the skin traumatised by overenthusiastic rubbing. Hair is washed and dried carefully at the first bath but need not to be washed daily. The baby's eyes do not need to be cleansed unless a discharge is present.
- 2.13 Prevention of hypothermia** can be done by avoiding exposure of the baby. The infant should be dressed in a cotton gown and covered by two blankets. An additional blanket underneath the bottom sheet will provide extra warmth for babies who are having difficulty in maintaining their temperature. Additional clothing may be required during winter. Overheating should also be avoided. Bath water should be warm and wet clothing should be changed as soon as possible. Swaddling should be loose enough to permit movement of arms and legs.
- 2.14 Prevention of injury and accident**

Sensible precautions should be observed by the mother. The baby should not be left unattended unless in his cot. The temperature for the bath should be tested prior to immersing the baby and the temperature of the bottle feed tested before is offered to the baby. If the baby's nails are long or ragged he may scratch his or her face. Babies do not require a pillow until the age of two years. Mothers should be advised that placing the pillow behind the baby's head is unsafe and an unnecessary decoration in pram or cot. Waterproof mattress covers should enclose the mattress completely to prevent suffocation.

2.15 Tetanus in newborn baby

Tetanus is one of the communicable diseases, which can be found in the infant at 8-10 days. Cause of tetanus in infant e.g. use dirty/unclean instrument to cut cord, not cleaned the cord properly, used unclean powder or powder with some chemical for cord, unclean delivery place and areas, unclean hands of the delivery assistant.

Signs: fever, cord abscess, at first stage has convulsions and locked jaw (can not open the mouth), not able to suck the milk, convulsion when exposed to touch, noise or bright light. At a late stage the infant has bend back and is restless.

Objective 2: Benefits of mother's breast milk and Breast Feeding Techniques

Breast milk is the specific food of infant. Its qualities have been perfected through evolutionary and the natural way for a baby to obtain nourishment is to ensure at the breast. Babies who receive only human milk have a number of unique advantages;

- It has natural antibodies, which protect the baby from diseases like diarrhoea and respiratory disorders and also protection against allergy
- It is available easily
- It has more nutrients than in the formula milk
- It has the correct temperature
- Has no costs
- No need of preparation
- It is clean
- Brings about a close relationship between the child and the mother
- Breast milk has enough water for the child, which is adequate even when it is hot.

Techniques of breast-feeding

1. **Time of the first feed:** The baby may be put to the breast immediately after delivery. This enables milk production and also aids contraction of the uterus. The normal baby is allowed to suckle on demand.
2. **One or both breasts:** Optimum drainage of milk is achieved by using both breasts at each feed. The infant initially suckles the breast last used at the previous feed. This ensures that at least one breast is emptied at each feeding session.
3. **Duration of feeding:** A baby should suckle long enough. It can range from five minutes per breast on the first day to approximately 15 minutes by the third or fourth day of breast-feeding. The longer interval is favoured if the breasts are engorged.
4. **Demand-feeding:** Put the baby to breast whenever signs of hunger appear, such as sucking of fingers, rooting or crying. The new born may demand to be fed every two hours in the early days after birth. This is not unusual especially as small volumes of colostrums are obtained on each occasion. Large infants may desire feeds more frequently. A convenient routine is usually established within four to five days.

5. **Taking the baby off the breast:** Any attempt to pull the infant off the breast will result in injury to the nipple. Gently squeeze the nostrils, which prompt the baby to open the mouth, or slip a finger alongside the nipple into the baby's mouth to break the suction.
6. **Position during feeding:** A mother should feed in the position she finds most comfortable and relaxing for herself and the baby. She may wish to feed while lying or sitting in bed, or she may prefer to sit in a chair.
7. **Care of nipples:** the nipple may be washed with soap and water once a day and with water only before feeding. Care should be taken to dry the nipples after feeding and to keep them soft by massaging in a small quantity of lanolin. Breasts should have a well-fitting bra which must not compress the nipples. Cracked and painful nipples can be prevented by a good antenatal care and by promoting the correct techniques of sucking.

Feeding problems

1. **Sore nipples:** others often experience a tickling sensation in the nipple when the baby starts to suck. This is normal. A truly sore nipple is red and may be cracked. In most cases soreness can be avoided by adequate attention to nipples between feeds and suction on the nipple should always be released at the end of the feed. Encourage healing by keeping the nipple dry and by massaging it with lanolin. Short exposure to sunlight will also aid healing. A cracked nipple should be rested for 24 hours. Milk can be expressed manually and given to the infant by cup or spoon.
2. **Breast engorgement:** This may be occurring on the third or fourth day.
Signs: the breast is full, heavy and painful; it may be feeling lumpy, the overlying skin become oedematous and red and veins are prominent, the nipple becomes swollen.
Treatment: In a mild case advise mother to take a hot shower before putting the infant to the breast. Iced cabbage leaves may be placed around the breast for relief. Encourage frequent feeding to empty the breast and maintain adequate milk drainage. In a severe case sucking may be not possible owing to swelling of the nipple and breast. Place warm compresses on the red and oedema areas. Then attempt to express milk. TBAs must advise the mother with severe breast engorgement to consult and seek help from health care professionals.
3. **Inadequate lactation:** Adequate lactation may take several weeks to establish. This is not an indication to discontinue breast-feeding. An inadequate milk production can be associated with:
 - The older mother
 - Maternal malnutrition
 - Contraceptives tables
 - Anxiety
 - Poor sucking**Treatment:** 1) frequent feeding, e.g. two hourly, is encouraged to stimulate the release of milk. 2) adequate milk is established, 3) daily intake of fluid should be between 1-2 liters, 4) factors causing anxiety must be treated.
4. **Mastitis:** The condition is usually intra mammary and results in stagnation of milk.
Signs: A tender lumps is palpitation, the overly skin is red and the auxiliary lymph nodes are enlarged. **Treatment:** TBAs must advise the mother to seek care from a health professional as soon as possible.
5. **Overfeeding:** Most breast-fed babies can regulate their requirements accurately and it is doubtful whether overfeeding is exists. Rapid milk flow at the beginning of a feed can cause coughing or vomiting. The rate of flow can be controlled by pressing the areola between the second and third fingers and by leaning back during the feed.
6. **Underfeeding:** A poor gain in weight by the fourth day of birth is the most accurate indication of underfeeding. In fact it may be the only sign as the infant may appear content after feeds. Other features include persistent crying and sucking of the fingers and reduction

in the amount of stools and urine. The underfed infant will require extra fluid. The mother should consult a health care professional to solve problems related to breasts engorgement, etc.

7. **Introduction of Solids:** The contented breast-fed baby who is thriving does not need solid food before six months of age.

Objective 3: Safe infant feeding options for an infant borne to an HIV infected mother.

Breast milk does contain HIV, and there is a definite risk that HIV can be transmitted via breastfeeding. There are ways, however, to minimise the risk. You can choose to use formula milk exclusively instead of breastfeeding or you can breastfeed exclusively for four to six months.

Exclusive breastfeeding means not giving your baby formula or any other foods or liquids, not even water or Roiboos tea. This is because giving a baby food and water before six months of age can damage the baby's stomach and the lining of the intestines. This increases the chances of HIV transmission.

If the pregnant woman uses a government service point, the HIV positive mother may be provided with free formula feed for 6 to 12 months. If the HIV positive mother chooses to feed the baby with formula, it is important to use clean water that has been boiled and cooled, and to scrub and sterilize bottles and teats. Unclean water and unsterilized bottles can result in severe diarrhoea illnesses leading to dehydration, and oral thrush which could be fatal to the baby

Alternative infant feeding of a child whose mother is HIV infected includes:

- Exclusively breastfeeding for the first six months. and at 4 months the baby can start on solids.
- Replacement of infant feeding: use cow's milk, goat's milk, soya milk or infant formula.

Objective 4: Methods of infant feeding of newborn whose mother is HIV infected

Methods of good breastfeeding:

- Breastfeed the child immediately after birth and continue as long as the child shows that she/he wants to continue breastfeeding.
- The whole breast nipple should be inside the mouth of the child
- Breastfeed from each breast every time. If the child started breastfeeding from the right breast this time, the child should start from the left breast next time.
- Breastfeed on demand of the child.
- From time to time inspect the baby's mouth to see if there is no fungal infection, which requires immediately treatment.
- Keep you nipples clean after every meal, whip them with a clean cloth and apply body lotion to prevent them form cracking.
- From time to time inspect the breast and the nipple to see if there is no abscess and cracks, which require immediately treatment.

Factors that may increase the risk of mother to child transmission through breastfeeding:

1. Ulcers, cracks on the nipples of the breast.
2. Ulcers and fungal infection in the baby's mouth.
3. Mixed breastfeeding
4. Prolonged breastfeeding of more than six months.
5. A mother with AIDS.
6. Recent infection with HIV.

Safe sexual practice is important during pregnancy and breastfeeding.

Objective 4: Preparation of milk or infant formula

Overall principles for preparing infant formula

1. Prepare formula milk: Cow's milk, goat's milk or infant formula only
2. Prepare utensils: feeding cup, feeding spoon, buckets, clean water, soap, plastic feeding bottles and caps, teats, metal knife for leveling milk powder, and bottle brush, large cooking pot with lid.
3. Prepare and feed infant in hygienic way to avoid diarrhoeal diseases.
4. Utensils used for infant feeding should not be shared or used for other purposes.
5. Clean hands with water and soap before starting preparations.
6. Feeding instruments should be kept in very hygienic conditions.

A) Preparation of cow's or goat's milk

1. Clean your hands with clean water and soap
2. Take two cups of either cows or goat's milk and put in clean pot.
3. Take one cup of clean (boiled) water and mix with milk.
4. Boil the milk, after boiling cover the pot and let the milk cool down to a temperature at which the child will take comfortably.
5. Serve a portion of the milk and feed the child.
6. Make sure that the milk is covered in clean way.
7. Clean the vessels, which you used and keep them clean.

B) Preparation of Infant formula

1. Prepare it according to manufacturer's instructions.
2. Wash hands with clean water and soap.
3. Boil clean water enough to last the whole day for half an hour and then let it cool.
4. Measure some milk powder and mix it with water according to instructions.
5. Prepare milk every time a child needs to drink.
6. Wash containers and keep them clean every time after use.

Cleaning techniques:

Rinse all items immediately after use, invert the teats and squirt water through the holes to ensure potency. Scrub the bottles and teats once a day detergent and the rinse with water.

Sterilization: boiling

Immerse items in a pot of water and boil for 10 minutes. Remove them with tongs dipped in boiling water beforehand.

Milk Powder: A scoop is provided with each tin of milk. It is specific for that product and may not be used for other milks. Fill the scoop with powder and level powder to the rim with a knife edge. Do not compact the powder against inner edge of the tin or with a knife as this will over concentrate the feed.

Fluid: Boil water, let it cool. Now reconstitute milk by adding a scoopful of powder to each 25 ml of warm (boiled) water. This ratio may vary depending on the size of the scoop (read instructions on the tin).

MODULE 7 (TBA) MODULE 1 (Midwives): STATUS AND ROLE OF THE TRADITIONAL BIRTH ATTENDANT

Materials: Trainer's notes, flipchart, koki pens,

Methodology: Brainstorming, facilitator input, sharing experiences on the role of traditional birth attendant in antenatal care, delivery and postnatal care by TBAs and skilled birth attendants

Learning objectives:

1. Definitions and categories of traditional healing and birth attendants
2. Role of TBAs in the health care system

Objective 1: Definitions and categories of traditional healing and birth attendants

The following definitions are based on the South African Bill to establish the Interim Traditional Health Practitioners Council:

Terms/word	Definition(s)
Traditional Birth Attendant (TBA)	Means a person who engages in traditional health practice and is registered under this act. In communities that are very small, there may be no TBAs because no woman has the opportunity of gaining enough experience to become recognized in that way. In cultures where there are TBAs, their work is often restricted to one extended family or clan, so they would deliver up to about 20 babies a year. Only a few TBAs have a wider practice and make it their main means of living. They may deliver up to 120 per year. Even where there are TBAs, many women still deliver by themselves or just with the help of a close female relative or friend.
Traditional health practice	Means the performance of function, activity, process or service based on a traditional philosophy that includes the utilization of traditional medicine or traditional practice and which has as its object: The maintenance or restoration of physical or mental health or function; or The diagnosis, treatment or prevention of a physical or mental illness; or The rehabilitation of a person to enable that person to resume normal functioning within the family or community; The physical or mental preparation of an individual for puberty, pregnancy, childbirth and death.
Traditional Health Practitioner	Means a person registered under this Act in one or more of the categories of traditional health practitioners
Traditional Medicine	Means an object or substance used in traditional health practice for the purpose of: The diagnosis, treatment or prevention of a physical or mental illness; or For any curative or therapeutic purpose, including the maintenance or restoration of physical or mental health or well-being in human beings, but does not include a dependence-producing or dangerous substance or drug used.

Objective 2: Role of TBAs in the health care system

The TBA is an important person who has a role in providing maternal and child health services and family planning for people in the community for a long period in history until the present. The role was not assigned by government but naturally developed from believe, trust and respect from people in the community. The TBA willingly accepts the role and sacrifices her time to help people in the community without any financial rewards. TBAs always give help to people whenever they are asked to help; even if they grow older they still dedicate their help to people.

TBAs have shown to be effective in:

- performing initial screening of pregnant women for risk factors,
- referring high risk patients to appropriate sources of care,
- following a normal pregnancy through labour, delivery and the postpartum period, and
- providing family planning information and services.

Trained TBAs have a role in:

- Searching for pregnant women in the villages and report to midwife.
- Advice pregnant women to book for antenatal care at the clinic and offer moral and emotional support
- Advice pregnant women to get the tetanus vaccine from the clinic during pregnancy
- Identify and advice on high risk pregnancy and refer to midwife
- Help mother in normal delivery (if necessary, in emergency situations only), the TBA should advice pregnant women to deliver at the hospital
- Advice on postpartum care and practice, also the care of the infant
- Promote the use of a health record card for the mother and infant
- Motivate people for family planning
- Provision of HIV/AIDS education to their clients
- Mobilization of women for VCT at health facilities
- Administration of Nevirapine to HIV-positive mothers and referral of these mothers to health facilities post-natally to allow their infants to receive Nevirapine syrup
- Reporting back to health facilities on their activities on a monthly basis
- Mobilise communities on emergency preparedness, mainly transport arrangements for the pregnant woman
- Advocate for safe traditional practices and be able to highlight dangers posed to the mother's and baby's health by some of the practices.

MODULE 8/2: TRADITIONAL MEDICINE AND RITUALS IN DELIVERY AND INFANT CARE

Materials: Trainer's notes, flipchart, koki pens,

Methodology: Brainstorming, facilitator input, sharing experiences, discussion, values clarification, question and answer.

PROCEDURE

1. Asking questions

- Ask participants what they understand about traditional medicines
- What traditional medicines/herbs are used for during pregnancy?
- Do they see these traditional medicines as harmful or beneficial?
- Are there any rituals related to childbirth?
- How meaningful are these rituals?

Record responses and use their responses to facilitate discussion later between the TBAs and the Midwives.

FACILITATOR'S NOTES

Learning objectives:

1. Traditional medicine
2. Rituals

Objective 1: Traditional medicine

Women use traditional medicines or herbs like *imbelekisane* (a herbal mixture with oxytocic properties) to induce labour because they believe that this herb or medicine expedites the birthing process. The TBAs prepare *imbelekisane* before touching the pregnant women and then rub it in their hands when doing the inspection. They especially use it when shaking the woman's belly so as to make the baby move and this helps in changing the baby's position in case it was reverse.

Isihlambezo is an herbal decoction used by many Zulu women as a preventative health tonic during pregnancy. Pharmacological analysis suggests the possibility of both therapeutic and harmful consequences. *Umsintsana* (*Erythrina humeana* Spreng): The burnt bark is powdered and applied to the umbilical cord of newly born babies for fast healing of the umbilical cord. *Umsintsana* (*Erythrina lysistemon* Hutch): Strips of the bark are cut from all four sides of the trunk and are bound together into a bundle of herbs from which an infusion is made to ease labour pains during childbirth. The knowledge and use of some of these traditional medicines are associated with supernatural powers and hence some of the preparations and treatments are followed by rituals and the chanting of incantations. Plant extracts of traditional medicines such as *Agapanthus africanus* and other herbs used by black South African women during childbirth were tested on rats and found to potentate the response of the uterus to oxytocin. However, studies suggest that the use of

traditional medicine during pregnancy may contribute to high rates of foetal distress and ruptured uterus.

TBAs recommend that the pregnant woman should start taking *imbelekisane* at five to seven months not at birth as the woman may take overdose leading to problems with the baby during delivery.

The trainer must state to TBAs that shaking the mother's belly is not recommended and not supported because of its association with many complications e.g. premature separation of the placenta. The taking of herbs may not cause harm for the pregnant woman and the baby. However, the TBA should know that if the mother follows the advice of healthy practices during pregnancy, it will be sufficient for her and the baby's health.

Objective 2: Rituals

The TAB cannot control ritual practice, but must consider if it is of no harm or no risk for mother and the baby. Rituals that promote psychological and emotional support for the mother are encouraged. Example of some practices:

- If there is a bundle of wood in the house when the TBA arrives, the TBA asks the people to untie it. This will help in loosening up everything in the woman so that she gives birth easily.
- The cord that fell from the baby is kept safe by the mother by tying it on the cloth that is tied around her stomach and when she comes back to her in laws she must give it to the mother in law and say 'here is the child's mercy' and the cord is hung up in the roof inside the house, overlapping outside. This signifies that this is the baby's home and that the child when grown up must not give problems and that he/she must know his/her home so that he does not live in another house.
- Every child born on the soil according to our tradition, as soon as the baby cries we say **ha-la-la** (traditional praise) then I wash the baby and take the dust and follow the procedure I have already explained to you. In our custom we say the baby is given its customary needs and that it will not wander about like a vagabond.
- Then after delivery the cord that fell from the baby is kept safe by the mother by tying it on a piece of cloth and again remains tied around the mother's waist so that she can give it to her in laws if she went to deliver at her parents' house as this is a custom with the first baby, according to the women. On arrival at her husband's home, she must say **umntwana uwisile** ('here is the child's mercy') (meaning that the baby's cord has fallen) and the cord is hung up in the roof inside the house and this process is followed by **ukusoka** (giving of presents). This is a customary practice which means that this is the baby's home and that the child when grown up must not give problems and that she/he must know his home so that he does not wander about. Whenever a woman gives birth again, the same process should be followed and when the cord falls it must be hung up no matter how many children one has.
- A woman goes to her home and when it is clear sky early at sunrise, a man from the family will go and take some fur from a cow's tail in the kraal and roll it into a belt that will be tied around the baby's waist and neck. From the same cow, dung will be taken to the house, when evening comes, the baby is taken outside and a sharp object is used to make some cuts on the baby, 2 on both sides of the chest, 2 on both sides of the arms, 2 on both sides of the back behind the shoulders and 2 on both hind legs. Then a red stone is crushed and applied on the child. Then the mother and the baby are both covered with a blanket so that

people cannot see her face. It is only after the belt is finished and worn by the baby that the mother can show her face.

- **Efukweni:** Some women are instructed not to go to hospital to get Nevirapine before 14 days as they are to receive home-based postnatal care (Efukweni). It is believed that the woman must stay “efukwini” for 2 weeks after delivery, which means postnatal care at home until the umbilical cord falls off to avoid exposing the child to evil spirits. The TBA should try to solve these problems because they affect personal hygiene – no exercise, no bathing sometimes and this creates sub involution leading to puerperal sepsis, infection of the reproductive system after delivery. This belief leads to some women not taking their newborns to clinic for Nevirapine syrup within 72 hours. The TBA should explain to family members the importance of taking mother and the baby for post delivery check-up and can still come back and modify the “Efukweni” to a more healthy practice.
- Another belief is that the new born baby should be given “isicakati” as their first feed for a couple of days which is contrary to the expectations of the PMTCT programme, which indicates that the first feed should be NVP. In most cases, the mother-in-law forces “Makoti” meaning the bride, to observe this ritual. Some people believe that the new born baby should be taken to “ilawini”, which means to a “coloured” traditional healer to make sure they get a bottle for the relief of evil spirits to ensure that “umoya uphumile”, that is bad spirits are removed.

MODULE 9/3: MONITORING AND FOLLOW-UP

Materials: Flipchart, koki pens, TBA record and delivery note

Methodology: Brainstorming, discussions, demonstration

PROCEDURE

Questions and answers

Ask participants whether they record women they assist with delivery.
What do they write in their record books?

Purpose of recording

Record keeping is a way of ensuring that information collected is secured, therefore it is very important.

Ask participants to mention the various ways they keep records.
Trainer to show appreciation of those using traditional methods.

Learning objectives:

1. To explain the process of monitoring and follow-up
2. List important issues for documentation

1. Different ways of follow-up

- Joint meeting between TBAs and health services providers in the community (e.g. on prevention of poor outcomes including death in women or infants, and discussion as well as agreement on items for monitoring and record keeping).
- Use different methods to document data, e.g. small sticks, for documenting the number of children who were born.
- The TBA's role in monitoring and follow up include two time periods:
During pregnancy: The TBA must record the number of pregnant women in their area, follow pregnant women to ensure that they visit an antenatal clinic, VCT and PMTCT participation of the pregnant women, record abnormal signs or risk during pregnancy and report to health care professional. The TBA must monitor if the transportation or mother's home had been prepared for every pregnant woman. For HIV positive pregnant women, the TBA must monitor and record taking Nevirapine.
After delivery: The TBA should monitor all mothers and babies to receive post partum care in a health facility, thereafter the home visit should be made (details in module 5).

2. Important things for documentation

- Number of visits of pregnancy women, number of pregnant women who book ANC, and number HIV positive mother)
- Number of women who delivered: TBA should record cause why can not go to deliver at health facility and record instruments use and delivery problems)
- Number of Nevirapine tablets given to pregnant women and the baby.
- Number of pregnant women referred and record problems occurred
- Number of women undergo VCT before pregnant
- Number of delivery kits and Nevirapine received and used
- Number of maternal deaths

- Number of neonatal deaths.

Delivery note

Record Book: Delivery By TBAs

Name.....Surname.....

Address.....

Mother	Infant
Name.....Surname.....	Date of birth.....
Address.....	Time.....
No. of this pregnancy.....	Body weight.....
Health of Mother <input type="checkbox"/> Strong , good health <input type="checkbox"/> Bleeding after delivery <input type="checkbox"/> Retain placenta <input type="checkbox"/> High risk pregnancy <input type="checkbox"/> Maternal death <input type="checkbox"/> High fever	Sex Male <input type="checkbox"/> Female <input type="checkbox"/> Health of infant <input type="checkbox"/> strong, good health <input type="checkbox"/> weak <input type="checkbox"/> disability <input type="checkbox"/> infant death <input type="checkbox"/> feeding option, indicate:.....

Appendix: Educational Outcome/Assessment Criteria:

At the end of each module the TBA is expected to have core competences as list below:

Module 1: HIV and AIDS

- i. Explain HIV and AIDS,
- ii. List mode of transmission,
- iii. Describe stages of HIV and AIDS,
- iv. Explain prevention,
- v. State their role in VCT

Module 2: Prevention of HIV from mother to child

- 1) Describe MTCT and PMTCT
- 2) Explain PMTCT service procedure
- 3) State role of TBA in promotion of PMTCT
- 4) State role of TBA in providing Nevirapine and ART

Module 3: Antenatal care

- 1) Explain antenatal care in a health care facility
- 2) Describe why pregnant women need to book for ANC
- 3) Describe pregnancy care
- 4) List disorders during pregnancy and state disorders which need immediate action
- 5) State role of TBA and describe how to support pregnant women to deliver in a health facility

Module 4: Obstetric care

- 1) Explain how to clean every delivery instrument
- 2) Prioritize safe delivery process
- 3) State how TBAs protect themselves during delivery
- 4) Explain primary care for post delivery and referral
- 5) Indicate infection control for mother and family members

Module 5: Postpartum care

- 1) Indicate post partum visit and list the necessary check up
- 2) Support mother and the baby check up at health facility
- 3) Identify important issue on post partum practice

Module 6: Counselling on safe infant feeding

- 1) Explain new born care
- 2) List benefits of breastfeeding and its techniques
- 3) State feeding options
- 4) Describe method of feeding the baby from HIV positive mother
- 5) Indicate infant formula preparation

Module 7/1: Status and role of traditional birth attendants

- 1) Differentiate types of traditional health practices
- 2) State role of TBA in health care sector

Module 8/2: Traditional medicine and rituals in delivery and infant care

- 1) Describe role of TBA in promoting the use of safe traditional medicine
- 2) State role of TBA in safe and compromising rituals practice
- 3) Explain how TBA deals with different perspectives with midwife

Module 9/3: Monitoring and follow-up

- 1) Describe time and items for follow up and monitoring of pregnant women and post delivery
- 2) Give examples of necessary documentation