A STUDY EVALUATING THE SOCIAL AND CULTURAL CONTEXT OF A COUNSELLING BOOKLET CONTAINING INFANT FEEDING AND CARING MESSAGES – A COMPONENT OF A COMMUNITY-BASED HEALTH PACKAGE - IN UMLAZI, KWAZULU-NATAL.

BY

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ABSTRACT

Introduction

Exclusive breastfeeding (mother's milk only, with the exclusion of all other food or drink) reduces breast milk transmission of HIV compared with mixed feeding. This study was part of formative work for a community-based un-blinded randomised controlled trial (RCT) in an urban township with high antenatal HIV prevalence in KwaZulu-Natal (KZN), South Africa. The RCT sought to determine whether an integrated package of home-based care delivered by community health workers (CHWs) increases uptake of prevention of mother-to-child-transmission (PMTCT) interventions and improves neonatal outcomes. One example of where counselling is used is in Behaviour Change Communication (BCC) approaches. A counselling booklet, used by CHWs during home visits, was part of the integrated package. The primary objective of this study was to document the socio-cultural context in which infant feeding and caring decisions were made. The secondary objective was to field test the draft counselling booklet for the RCT.

Methods

This qualitative study used focus groups (n=8 groups) and individual interviews (n=6). All participants, of unknown HIV status, were purposively sampled from the study site. The focus group participants included, in separate groups, eight MRC researchers; 14 pregnant women (two separate groups of seven each); six non-pregnant women; eight older women; five men and 15 CHWs (separated into two groups).

Results

Data showed that socio-cultural factors, like the lack of social support systems; uncertainty regarding the role of men in infant feeding and caring issues; local beliefs and practices that encouraged risky infant caring practices; the lack of supply of formula and CHWs' lack of breastfeeding knowledge and experience; and HIV-related stigma may directly or indirectly, drive mothers to practice non-exclusive infant feeding. BCC principles acknowledge that people are affected greatly by social pressures exerted not only by their peers, but also by their larger communities (Bentley et al., 1999). For

example, with regard to the support systems, both pregnant as well as younger women felt that feeding and caring decisions regarding their infants were mostly made by older women – their husbands were seldom involved in such decisions. In relation to HIV-related stigma, many pregnant women felt that some clinics were not very supportive regarding HIV disclosure. In terms of health system factors, CHWs said that they were sometimes ill-equipped to deal with issues of disclosure due to a lack of training and confusion around the key feeding and caring messages. With regard to infant caring practices, the data revealed risky practices (using soap enemas and inappropriate hand washing practices), even amongst CHWs.

Participants said they would share the booklet with others in the community as it taught them important lessons regarding infant feeding and caring practices. For some, the pictures in the booklet enhanced their understanding of 'old' messages. Participants identified several weaknesses in the booklet and suggested that it be less repetitive; that voluntary counselling and testing (VCT) be given priority in earlier rather than later visits; that unfamiliar terms is explained; more pictures included; and the general tone of messages improved. Literacy rates were low among older women and some men in the study.

Conclusion and Recommendations

Socio-cultural factors drive mothers to practice non-exclusive feeding and care for their infants in ways that may unwittingly increase the risk of HIV transmission. There is a need for CHWs to include family members in discussions about feeding so that they can change their thinking around infant-feeding and caring issues. The data suggests that VCT is not given priority in the counselling booklet and support is lacking in some clinics, therefore policy makers should ensure that support for VCT becomes a priority in the future. Furthermore, some CHWs were confused about the messages they are disseminating, therefore, the training that facility managers give to CHWs should be adapted to suit socio-cultural contexts so that CHWs are better equipped to communicate messages pertaining to infant feeding and caring appropriately to mothers. With the data revealing general acceptability of risky infant caring practices, even amongst CHWs, the

health system needs to look at how it will effectively change health-related practices among health professionals. With literacy rates being low among older women and some men in the study, it was therefore recommended that gaining skills in materials design and improving CHWs' understanding of the BCC process, booklets such as this one needs to be designed together with the primary user in mind.

DECLARATION

I declare that this research report is my own, unaided work. It is submitted to the School of Public Health and Family Medicine, Faculty of Medicine, in partial fulfilment of the requirements for the degree of Masters in Public Health (General Track) by Coursework and Research Report at the University of Cape Town. It has not been submitted before for any other degree or examination in any other university.

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ABBREVIATIONS/ACRONYMS

AFASS - Acceptable, feasible, affordable, sustainable and safe.

ARV - Antiretroviral

BCC – Behaviour Change Communication

BF - Breastfeeding

CHWs – Community Health Workers

EAIFP – Exclusive appropriate infant feeding practices

EBF – Exclusive Breastfeeding

EFF – Exclusive formula feeding

FGD – Focus group discussions

HIV - Human Immunodeficiency virus

HW – Health Worker

IFF –Infant formula feeding

IMCI - Integrated Management of Childhood Illness

MF – Mix feeding

MRM - Mothers reminder material

MTCT - Mother-to-child transmission of HIV

ORT - Oral Rehydration Therapy

PMTCT - Prevention of mother-to-child transmission of HIV

VCT - Voluntary counselling and testing

UNICEF - United Nations Children Fund

USAID - United States Agency for International Development

WHO - World Health Organization

DEFINITIONS

- **Behaviour Change Communication** is the process of using information, education and communication approaches and tools to develop the skills and capabilities of people to promote and manage their own health and development. It also fosters positive change in people's behaviour, as well as in their knowledge and attitudes (UNICEF, 2004).

All definitions below appear in the 'Policy and Guidelines for the implementation of the PMTCT Programme. National Department of Health, 11 February 2008'.

- **Breastfeeding:** The child received breast milk directly or expressed from the breast.
- **Bottle-feeding:** The child receives liquid or semi-solid food from a bottle with a nipple/teat.
- **Complementary feeding**: The child receives both breast milk and solid or semi-solid food.
- **Counselling for maternal and newborn health:** is an interactive process between the skilled health worker and a woman and her family. Information is exchanged and support is provided so that the woman and her family can make decisions, design a plan and take action to improve their health.
- **Exclusive breastfeeding or exclusive breast milk feeding**: An infant receives only breast milk and no other liquids or solids, not even water, but may receive drops or syrups consisting of vitamins, mineral supplements or medicines that

are deemed necessary and essential for the child. When expressed milk is given, the preferred term is breast milk feeding.

- **Exclusive formula feeding**: Feeding infants who are receiving no breast milk with a diet that provides adequate nutrients until the age at which they can be fed solids. During the first 6 months of life, formula feeding occurs with a suitable commercial formula. Then complementary foods should be introduced.
- **HIV-negative:** Refers to people who have taken an HIV test with a negative result and who know their result.
- **HIV-positive**: Refers to people who have taken an HIV test which results have been confirmed positive and only those who know their result.
- **HIV status unknown:** Refers to people who have not taken an HIV test or who do not know the result of their test.
- **Infant:** A person from birth to 12 months of age.
- **Mixed feeding**: Breastfeeding as well as giving other milks (including commercial formula or home-prepared milk), foods or liquids.
- **Mother-to-child transmission:** Transmission of HIV from an HIV-positive woman during pregnancy, delivery or breastfeeding to her child. The immediate source of infection is the mother, but this does not imply blame on the mother.

AFASS Conditions

The first alternative to prolonged breastfeeding consists of the complete avoidance of breastfeeding, which is usually replaced by commercial infant formula (WHO, 2007).

UN definitions of AFASS conditions

- **Acceptable:** The mother perceives no barrier to choosing and executing the option for cultural or social reasons, or for fear of stigma and discrimination.

- **Feasible:** The mother has adequate time, knowledge and resources to prepare and feed the infant; and support to cope with family and social pressures.

- **Affordable:** The mother, with available community and/or health system support, can pay for the purchase/production, preparation and use of the feeding option, including all ingredients, fuel and clean water and equipment, without compromising the health and nutrition spending of the family.

- **Sustainable:** Availability of a continuous and uninterrupted supply and dependable system of distribution for all ingredients and commodities needed to safely implement the feeding option, for as long as the infant needs it.

- **Safe:** Replacement foods are correctly and hygienically prepared and stored in nutritionally adequate quantities, and fed with clean hands using clean utensils, preferably with cups.

CHAPTER ONE: INTRODUCTION

1.1. Background to the problem

Global studies show that the type of infant feeding in the first six months of life has a great impact on child health and survival. Compared with other feeding practices (predominant breastfeeding, mixed feeding and avoiding breastfeeding), exclusive breastfeeding has the greatest benefits for child health, growth and development (Saloojee, 2008). Exclusive breastfeeding has also been shown to reduce the risk of breast milk HIV transmission compared with mixed feeding (Coovadia et al., 2007; Illif et al., 2005). Inadequate and inappropriate infant feeding can cause malnutrition and increase the risk of postnatal HIV transmission. Data show that 58% of the world's children do not receive exclusive breastfeeding during the crucial first four months of life (Black et al., 2008), and that few South African children receive exclusive breastfeeding (Bland, 2007). With high HIV prevalence in South Africa, and a high burden of disease due to common childhood illnesses in sub-Saharan Africa (Black et al., 2008), it is important to understand how mothers are feeding their infants and what influences them towards particular infant feeding options. This will help promote infant health and help reduce infant morbidity and mortality.

1.2. Current WHO recommendations for feeding

Infants who are born to HIV-negative women or women of unknown HIV status should be exclusively breastfed for the first six months of life (WHO, 2009). At six months, nutritionally adequate and safe complementary foods should be introduced with continued breastfeeding for up to two years of age or beyond. HIV-positive mothers should only avoid

breastfeeding if their infants are not HIV-positive and they meet specific conditions: (which in 2006 was referred to as AFASS – affordable, feasible, acceptable, sustainable and safe) (WHO, 2009). According to the 2009 WHO rapid guidance, countries should choose at national or sub-national level whether they are a breastfeeding country or not. The implication of the guidelines is that many resource-limited setting would choose breastfeeding with nevirapine prophylaxis as the default option, and exclusive breastfeeding with nevirapine prophylaxis, if possible. According to WHO 2009 continued breastfeeding with additional complementary foods (WHO, 2009) and nevirapine prophylaxis is recommended for breastfeeding HIV-positive women.

1.3. The importance of taking cognisance of HIV-positive women – even if HIV status of respondents is unknown?

Breastfeeding is a critical child survival strategy in South Africa and sub-Saharan Africa. In some parts of South Africa, such as KZN, the antenatal HIV prevalence is as much as 44% (Ijumba & Barron, 2005). The risk of HIV transmission is about 5-20% with breastfeeding and no antiretroviral (ARV) prophylaxis. A study, undertaken in a rural area in KwaZulu- Natal province, found that postnatal maternal or infant ARV prophylaxis reduced the risk of HIV transmission to as low as 4.04% after five months of exclusive breastfeeding (Doherty, Chopra, Colvin, 2006). Thus even if one did not know respondent's HIV status in this area, almost half of all respondents would be HIV positive. It is against this backdrop that we need to take HIV status into consideration when describing and examining feeding practices. If women with HIV are expected to successfully and exclusively breastfeed, improvements in infant feeding practices in the

general population are necessary to make this practice the norm (Doherty et al., 2006).

1.4. The socio-cultural barriers to *infant feeding* & what have other studies shown

The application of the WHO recommendations by women in real life settings poses quite a challenge (WHO, 2004). Exclusive appropriate infant feeding practices is undermined by a wide range of socio-cultural beliefs and practices and poor health care systems. The traditional family support systems that help mothers cope with their everyday lives may not be present in many circumstances (Sibeko et al., 2005) and often deviates significantly from the clinical setting.

Clinics and health centres advise mothers to breastfeed exclusively for at least the first six months of their babies' lives. However, when mothers arrive home, several other factors come into play such as the role of men, families (men's and women's) and surrounding environments in mothers' decision-making (Sutherland, 2009). In the African context, mothers are usually not the sole decision-makers when it comes to their children. For example, a recent study showed how little input from fathers and community members with regard to infant feeding and care can contribute to low levels of breastfeeding (Sutherland, 2009).

Grandmothers play an important role in the mothers' and infants' lives and are said to have a strong influence over what mothers feed their babies. In Burkina Faso, for example, grandmothers are reported not to approve of exclusive breastfeeding (Irin News, 2009). Some women believe that breast milk alone is inadequate to "fatten the

baby" as a means of protecting the infant's health, therefore they mix feed (Pak-Gorstein, Haq & Graham, 2009). Early introduction of water is common in many communities and achieving EBF beyond the first month can be difficult for the mother if only limited support is available.

1.5. Health system barriers to *infant feeding*

Health system can mean different things to different people. In a reductionist view health system refers to the organisation of the heath system and procurements systems etc. In my perception health workers are the human resource drivers of the health system, and this is what the following paragraphs are addressing.

In Coovadia and colleagues' study, 82% of mothers breastfed exclusively for at least six weeks, and 67% for at least three months (Coovadia et al., 2007). They received skilled support from well-trained, lay infant-feeding counsellors and as many as 10 randomised trials in varied settings found this approach effective (Bhandari, Bahl, Mazumdar et al., 2003). However, another study found that inadequate knowledge of MTCT was widespread amongst mothers, even after receiving counselling (Chopra, Doherty, Jackson, Ashworth, 2005). In Chopra et al's study inadequate training of health workers and the lack of culturally-sensitive tools made it difficult for health workers to carry out appropriate and effective infant feeding counselling. Furthermore, an evaluation of the WHO/UNICEF infant feeding training in South Africa found low levels of knowledge amongst both participants and trainers (Chopra at el., 2005). Most participants (88%) over-estimated the risks of breastfeeding for HIV positive women and very few (10%)

knew of the health risks of formula feeding. In addition, health worker confidence in counselling after the training was disappointing – 44% were unwilling to counsel women with breastfeeding problems. Nankunda et al (2006) suggested that health workers should be adequately informed, managed, supported and supervised so that they are able to give mothers appropriate help – currently they are not.

There was one study in a semi-urban community near Cape Town which investigated the effect of a PMTCT program in South Africa on infant feeding and caring practices. The program provided HIV-infected mothers with the option to either exclusively breastfeed or formula feed for six months. The HIV-infected women reported that they had not experienced any negative social effects as a result of not breastfeeding (Chopra, Piwoz, Sengwana, 2002). However, this may not always be the case in other South African communities, especially in rural settings, where breastfeeding is the norm.

1.6. Common socio-cultural barriers to *infant caring*

Although women in sub-Saharan Africa are among those at greatest risk for HIV infection, their access to HIV counselling and testing services is often limited by disease-related stigma, social and gender norms that dictate behaviour and low socio-economic status (Varga, Sherman & Jones, 2006). An increasingly common phenomenon for pregnant African women is adjusting to an HIV-positive test result superimposed upon the cares and concerns of motherhood (Varga et al., 2006). The decision to disclose one's status is a difficult one, and must include to whom, when, where and how to reveal one's status to others (Sowell, Seals, Phillips, & Julious, 2003). This appears to have a tremendous impact on how women ultimately feed and care for their infants.

In countries where breastfeeding is the norm, formula feeding has been noted to alert a woman's family or community that she 'is' HIV-positive, and results in negative repercussions (de Paoli, Manongi & Klepp, 2002; Rollins et al., 2002) such as stigma, loss of economic support, disruption of family relationships etc (WHO, 2004). Therefore, women who *are* HIV-positive continue to breastfeed, to avoid stigmatization by their families and communities as shown by recent African studies (Doherty, Chopra, Nkoki, & Jackson, 2006; Piwoz et al., 2006). In light of the negative repercussions HIV-positive women experience, they should take greater consideration of the health services available and the counselling and support they are likely to receive (WHO, 2009).

1.7. Have counselling booklets been used anywhere?

One example of where counselling is used is in Behaviour Change Communication (BCC) approaches. BCC principles basically acknowledge that people are affected greatly by social pressures exerted not only by their peers, but also by their larger communities (Bentley et al., 1999). Behaviour at household level has been one of the main targets for research programmes aimed at improving neonatal mortality (Bhutta et al., 2008; Darmstadt et al., 2006). Over the last three decades BCC approaches have led to huge gains in the health status of newborns in the developing world (Seidel, 2005).

1.8. Some experiences with BCC approaches

By using BCC approaches, many significant gains were made in the 1980s and 1990s in home use of oral rehydration therapy; completion of childhood immunisations; breastfeeding and other nutrition-related practices; and various home hygiene and sani-

tation measures (Seidel, 2005). For example, in rural India, a programme was implemented to encourage evidence-based essential newborn care including skin-to-skin care (skin contact in order to improve the bonding between mother and infant); birth preparedness; immediate and exclusive breastfeeding; and hygienic skin and cord care. Community-based workers used interpersonal communication to deliver these messages to pregnant women, their families and influential community members. This intervention was well accepted and was perceived to prevent newborn hypothermia, improve the mother's capability to protect her baby from evil spirits and made the baby more relaxed (Darmstadt et al., 2006).

Another good example of the BCC approach was a United States national campaign encouraging first-time mothers to breastfeed exclusively for six months. The campaign's tagline was "Babies were born to be breastfed." The goal of the campaign was to increase the proportion of mothers who breastfeed their babies exclusively in the early postpartum period to 75% and those within six months postpartum to 50% by the year 2010 (Njoroge, 2007). The Campaign addressed the issue of breastfeeding as an individual decision that a mother has to make, but it failed to recognize that there were many prevailing social and cultural norms contributing to a woman's choice (Njoroge, 2007).

Hence, it was evident from the campaign that counselling and encouraging women to make an informed choice on infant feeding was not simply a matter of informing or educating mothers about the theoretical risks and different feeding options. Health workers need to assess every mother's situation to ascertain what is most feasible and

safe for her. Time is required to discuss the factors that hinder exclusive breastfeeding and increase risky caring practices so that these can be addressed. In addition, counsellors must be able to translate risky concepts in a way that is understood by women who may not grasp such dilemmas (Coutsoudis, 2005).

1.9. Infant and Young Child feeding - policy implications

Infant and young child feeding is a critical component of care in childhood. It is a major determinant of short- and long-term health outcomes in individuals, and hence of social and economic development of communities and nations (WHO, 2003). Even though knowledge about the factors that affect infant and young child feeding and interventions to address them has been increasing steadily over the past decades, more specifically the development of policies on infant feeding by HIV-infected mothers in resource-poor settings have so far been restricted by the scarcity of proper estimates of the risk of HIV acquisition through different feeding practices (Saloojee, 2008). Concern has been expressed though, that although these guidelines exist, they need to be strengthened through investments in high quality, widely available HIV counselling, support for choice of feeding, and exclusive breastfeeding for those HIV-infected mothers who opt to breastfeed now and in the future.

Some guidelines like The Innocenti Declaration (UNICEF, 1990) and the Baby-friendly Hospital Initiative (WHO, 1989) launched in the early 90s have been landmark events that set a new pace of global action. Considerable progress has been made since then in raising awareness and changing caregiver practices to exclusively breastfeed their young

infants. However, in spite of strong and accumulating evidence demonstrating the feasibility and effectiveness of large-scale programmes to improve infant and young child feeding and malnutrition, few countries are implementing such programmes (WHO, 2003). For example, there has been little progress in terms of large scale infant feeding programmes and general infant feeding policies in South Africa. This may be partly due to the fact that the South African Infant and Young Child Feeding policy has been adopted but still needs updating. The regulations for the SA Code of Marketing of Breastmilk substitutes are awaiting approval.

Therefore, the WHO/UNICEF Global Strategy for Infant and Young Child Feeding (2003) called for a revitalisation of commitment to appropriate infant and young child feeding. Such a strategy provides a basis for public health initiatives to protect, promote and support exclusive breastfeeding for six months and continued breastfeeding up to two years of age or beyond, while providing women access to support – within the family and community.

1.10. Study Rationale

Inadequate support for infant and young child feeding in health services has been a major contributing factor to poor breastfeeding and complementary feeding rates worldwide. (WHO, 2003) Health workers often do not have updated knowledge and skills to effectively support infant and young child feeding, and hospital and community practices and routines impede the initiation and continuation of appropriate feeding practices. Furthermore, despite increasing knowledge about preventing postnatal HIV transmission and maximizing child survival in the context of HIV little progress has been made in

terms of improving infant feeding counseling at health facility and community levels, and in improving feeding practices. Furthermore poor risk estimates of HIV acquisition through different feeding practices still exist in many countries (WHO, 2003). In light of the above, it is therefore apparent that infant feeding and caring practices are difficult to implement. Thus, qualitative research could provide vital information about what could motivate changes in infant feeding practices at household and community level (Parlato, Darmstadt & Tinker, 2004). In order to understand infant feeding and caring issues better, which is a critical part of improving newborn survival, the researcher conducted a qualitative study at community level with a focus on participants' general views on knowledge around breastfeeding issues, family decision making and support with regard to infant feeding, HIV-related stigma, the role health systems play in infant feeding, the cultural practices surrounding infant feeding and caring, as well as CHWs and researchers views on the above issues.

1.11. Putting this study into context

The goal of the larger 'Good Start III' study (which is currently underway) was to develop an integrated and scaleable community-based package delivered by community health workers targeting pregnant and postnatal women and their newborns to provide essential maternal/newborn care as well as increasing uptake of interventions for PMTCT of HIV, using a cluster, un-blinded RCT design. A counselling booklet which is part of the community-based package is a tool that is being used as part of a structured programme of home visits by CHWs.

The booklet outlines the specific content that should be covered at each visit and linkages to the health system for antenatal care, PMTCT, childbirth care, family planning, immunization and management of complications or illness. There are also two extra visits for women with low birth-weight babies. The visits are discussed in more detail in the methodology section. The hypothesis for the larger study is that infants in the intervention clusters will have significantly higher levels of HIV-free survival and exclusive appropriate feeding at 12 weeks, relative to clusters receiving improved health facility care and a child grant intervention (control clusters).

1.12. Study Aim and Objectives

This study aimed to assess the understanding and personal viewpoints of key informants of the messages contained in a counselling booklet which is part of a community-based health package that is being used for the 'Good Start III' study in the poor urban setting of Umlazi, KwaZulu-Natal (KZN).

The primary objective of this study was to document the socio-cultural context in which infant feeding and caring decisions are made. There were also sub-objectives, aiming to:

- Better understand participants' general views on exclusive appropriate infant feeding practices;
- Describe family support decision making in relation to mothers' efforts to implement exclusive appropriate infant feeding practices;
- Explore what the local beliefs and practices are which might have had a bearing on infant caring practices;

- Investigate what community health workers knowledge and skills are with regard to infant *caring* practices;
- Investigate what community health workers knowledge and skills are with regard to infant *feeding* methods;
- Determine what the effect of the lack of formula is on infant feeding practices;
- Investigate the relationship between one's HIV status and appropriate infant feeding decision making and practices.

The secondary objective was an evaluation of the booklet which was used by CHWs while visiting women at home.

CHAPTER TWO: METHODOLOGY

2.1. Research Design

A qualitative study was conducted using focus group discussions (FGD) and individual interviews. A qualitative method was selected to provide in-depth information about social practices and contexts like infant feeding and caring practices. Qualitative research helps with the development of concepts, which may help to understand social phenomena in their natural settings, giving emphasis to the meanings, experiences, and views of all the participants (Pope & Mays, 1995). The use of both individual interviews and focus groups allows for rich, comprehensive data which is feasible (Mays & Pope, 1995). FGDs can offer a more comfortable situation to those who may not want to be interviewed alone; may prompt those who feel they have nothing to say to talk; and allow participants to explore issues in a group setting (Kitzinger, 1995).

2.2. Population and Sampling of the larger study (The 'Good-Start III Study')

2.2.1. Context of the larger study

The site for the cluster un-blinded RCT is Umlazi, a peri-urban settlement close to Durban in KwaZulu-Natal that has a mixture of formal and informal housing. The infant mortality rate was around 60/1000 live births. While there was no reliable figure of the neonatal mortality rate (NMR), most estimates placed the NMR at about 25/1000 live births. There was a population of approximately one million and an HIV prevalence of 44% amongst antenatal clients (Ijumba & Barron, 2005). Over 98% of all births in Umlazi occur in one major hospital, namely Prince Mshiyeni Hospital. Umlazi was the site of two previous studies conducted in 2001-2 and 2003-4 – Good Start I and II. The

former aimed to evaluate the national PMTCT programme in three purposively selected sites and the latter aimed to determine the effect of peer counselling on exclusive breastfeeding rates.

Map 1: Umlazi in relation to Durban

2.2.2. Cluster selection and cluster size

The trial consists of approximately 30 randomized clusters (15 in each arm) of the population with each containing a sufficient number of women delivering babies to obtain a sample size to determine differences between the intervention and control sites.

2.2.3. Sample and sample size

The study sample consists of all pregnant women who give informed consent for study participation and their newborns during the recruitment period. All neonates who are weighing under 2, 5 kg are released from hospital within a day and received two extra visits from the CHWs who belong to the study.

2.2.4. Recruitment of participant mothers

In intervention areas, CHWs are identifying pregnant women and encouraging them to seek antenatal care. CHWs have also been informing pregnant women about the Goodstart III study which is being conducted on infant feeding and child health. In control clusters a CHW is recruiting all pregnant women. CHWs in control clusters are providing key information and support to the mother on how to obtain social welfare grants, particularly the Child Support Grant.

On a weekly basis the data collectors are given the cards of women identified by the CHWs. They then go to the mothers' homes to inform them about the study in detail and obtain written, informed consent from mothers who wish to participate in data collection. They ask mothers if they underwent counselling and HIV testing at the antenatal clinic and whether the mother was willing to disclose her test result. The activities of the CHWs and data collectors are kept completely separate. Visits are between 40 and 45 minutes each. These visits are scheduled as follows: Two antenatal visits; Visit in the first 24-48 hours after birth; Visit at day 3 or 4; Visit at 10-14 days; Visit at 3-4 weeks; A routine clinic visit at 6-7 weeks; And final visit at 7-8 weeks

2.3. Population and sampling of this study

2.3.1. Nature and recruitment of the sample in this study

Research assistants working on the larger study, who were based at Prince Mshiyeni Hospital recruited all the participants for this study. All pregnant women, younger women, older women and men were among this peri-urban hospital-based convenience sample. The CHWs and MRC researchers were chosen using the criteria in section 2.3.2.

Six categories of participants were chosen to participate in eight FGD and six individual interviews.

The researcher asked an MRC researcher (known to her) in KZN to recruit fellow MRC researchers in the study, as part of a convenience sample. None of the MRC researchers who took part in the study were known to the researcher. There were no refusals but if they did not wish to participate they were asked if they knew other people that would be interested in participating in the study. In addition to CHWs, fieldworkers were also selected as part of a convenience sample, by a project manager who was involved in the larger study. The project manager was asked to select the CHWs and fieldworkers because she resides in KZN and was more familiar with the study area, whereas the researcher resides in the Western Cape. Furthermore, the project manager was involved in the larger study and has already established a working relationship with the CHWs and fieldworkers. No individual interviews were held with CHWs due to time constraints and MRC researchers and CHWs were not compensated for their time. They all participated on a voluntary basis.

The focus group participants included, in separate groups, eight MRC researchers; 14 pregnant women (2 groups); six non-pregnant women; eight older women; five men and 15 CHWs (separated into 2 groups). Individual interviews were also conducted with one participant representing each of the above categories except for CHWs due to time constraints (*See Table One*).

2.3.2. Rationale behind the selection of participants

For efficiency, BCC programmes are tailored around specific target populations. For this study, it meant communicating with chosen categories of informants, based on factors such as infant feeding and caring. The researcher thought the first step, was to identify the different groups of participants and to consider those that may be most at risk or the primary target population. The primary target populations in this study consisted of pregnant women who were the main group of individuals whose behaviour the project wanted to influence and support. The target population was further divided into subgroups, also known as the secondary target populations (UNAIDS, 2005).

The secondary target population are the people whose support or neglect determines whether or not the primary target population responded to the messages being communicated. In this study the secondary target population included men (boyfriends, husbands etc), older women (grandmothers, mother-in-laws etc), younger women (those who have children, non-pregnant women, sister-in-laws, aunts etc), MRC researchers (various units in the MRC, KZN) and CHWs who were doing the home visits and who had first-hand experience with mothers in the community. MRC researchers were only included in the study as expert/key informants who could add valuable information to the study objectives.

2.3.3. Logistics and/characteristics for FGD and individual interview participants

The individual interviews were held with participants who did not take part in the FGD. With the exception of two MRC researchers who were Asian, all other informants across

the different categories came from the same cultural/linguistic background which was of African origin and they were Zulu speakers, except for a few who could speak English as well. The researcher's first language is English and therefore was present only as an observer at all the interviews because of the language barrier. The researcher conducted the individual interview with an MRC researcher and the FGDs with the MRC researchers and CHWs herself though, because they could speak English. Each focus group discussion was moderated by two of the four fieldworkers, except for the FGD with the MRC researchers. One led the discussion while another took notes and handled the tape recorder. Discussions were tape-recorded and after the participants had left, an informal debriefing session was held with the fieldworkers to evaluate the process of the interview, and observations made to ensure that all themes were explored and to increase the reliability of the original data.

None of the participants were exposed to the counselling booklet prior to data collection of this study, except for the CHWs who were involved in the larger study. Prior to going to the field, the researcher spent two days in KZN familiarizing the four fieldworkers with the counselling booklet, and with the aims of the study. Community leaders and structures in Umlazi were familiar with the research protocol of the main study.

Data was collected during a one-week period in March 2008. All FGD and individual interviews were conducted at a central location convenient to all participants, i.e. the Prince Mshiyeni Hospital study office. All participants were reimbursed for their transport costs (R10) and time spent in the interviews (R40). A second focus group with pregnant women was needed because of poor attendance from the first group.

The characteristics of the sample were as follows:

Table One:

Category	No. of focus groups (number of people per focus group)	Individual Interview	Age
Professionals	1 (6)	Done	25-30
Pregnant	FG 1 (7) FG 2 (7)	Done Done	18-30
Non-Pregnant	1 (6)	Done	18-30
Older women	1 (8)	Done	45-older
Men	1 (5)	Done	30-35
CHWs	FG 1 (7) FG 2 (8)	Not done Not Done	25-35

2.4. Data Collection

2.4.1. Research Team

The research team consisted of: The researcher (myself) – responsible for managing and co-ordinating the fieldworkers to conduct the interviews, conducting FGD and individual interviews with MRC researchers and CHWs, responsible for analysis and write-up of thesis; four fieldworkers who conducted interviews in Zulu; research assistants based at Prince Mshiyeni Hospital to recruit participants. They were used as data collectors for the larger study.

The researcher's study mainly focused on evaluating the opinions about the infant feeding and caring messages and not the development of the counselling booklet – it was developed prior to this study. For the purpose of the larger study, the researcher used the information from the debriefing sessions after the interviews to write a report on participants'

views/comments. The report was used to improve messages in the booklet prior to the larger study. Revisions were made to the booklet and appear in Appendix F.

2.4.2. The counselling Booklet

The counselling booklet was one tool included in the larger community-based package. A description of the booklet:

- ***Format/Layout*:** a structured tool that outlines the visits that should occur (i.e. two antenatal, five postnatal, and two extra visits for low birth weight babies) and the specific content needed to be covered at each visit (refer to 2.2.4.), and the linkages to the health system for antenatal care, PMTCT, childbirth care, family planning, immunization and management of complications or illness (IMCI).

  Antenatal messages included the importance of VCT, key messages on appropriate infant feeding, birth plans, emergency plans (such as transportation), homecoming arrangements and input regarding infant communication and the mother-infant relationship.

  Postnatal messages included assessment of newborn (breathing, thermal care, colour, bleeding, neonatal eye care, checklist of danger signs); early recognition of illness; exclusive breastfeeding or appropriate infant feeding support; hygienic cord care; ensuring that babies of HIV positive women have received Nevirapine; 1st clinic visit reminder, especially for immunisation; mother-infant attachment and

testing for postnatal depression; whether the HIV exposed child been tested for HIV and is receiving cotrimoxazole at six weeks; and family planning.

- ***Language:*** The booklet was translated from English to Zulu because participants spoke in their mother tongue (Zulu). However, the booklet remained in English for MRC researchers (FGDs and individual interviews) and CHWs (only FGDs) as it was easier to conduct interviews in English.

- ***Pictures:*** The pictures emphasised some of the messages being conveyed. They included a spouse attending clinic with his partner; a baby suckling a breast; hand washing; a family sitting together; a mother with her baby close to her chest etc (*See Appendix E*).

- ***Purpose of the booklet:*** The messages in the booklet were used to engage participants in discussion during interviews. In the larger study the intention was that the booklet be given to pregnant women in the community. CHWs visited pregnant mothers at various times during and after their pregnancy to talk and educate mothers on the various messages at each visit (*see 2.2.4 for the visits*).

2.4.3. Data collection and handling

A topic guide (See Appendix: H) was developed before the discussion which was intended for fieldworkers to use during the FGDs and individual interviews. It contained a set of open and close-ended questions that could be used flexibly with the different categories of participants. The interviewer used probing questions to solicit further

information when necessary. During the discussion, reflective listening prompts were used for clarification and to encourage participants to talk. The interviews were between 45 minutes to an hour long.

2.5. Analysis

Audio-recorded interviews were transcribed verbatim and translated from Zulu to English. The ideal was to have the interviews back-translated and checked, however, this could not be done due to time and resource constraints. The qualitative data was analysed using thematic content analysis. The researcher read and coded each transcript by identifying repeating words or phrases that was organized and grouped into categories. During analysis of the data, the researcher found that certain issues from the FGDs and individual interviews required further exploration or understanding. Therefore, the researcher conducted two additional FGD with CHWs in order to confirm and substantiate some of the initial data and emphasis coming out of the FGD. This was to the researcher's advantage, because by this point the CHWs working on the larger study had time to establish rapport with the mothers they were visiting and knew the family and socio-cultural dynamics in the households.

In terms of data saturation, the researcher felt that there was no need to continue interviewing people since the individual interviews were not adding to the findings or repeating what was already found in the FGDs and the CHWS confirmed some of the initial data and emphasis that came out of the FGDs.

2.6. Ethics

Permission to conduct this study was obtained from the Research Ethics Committee of University of Cape Town. The following issues were considered before doing the study.

2.6.1. Autonomy

The facilitator explained the purpose and themes of discussion, and tape-recorder, requesting permission to record participants. Upon agreement participants were asked to sign informed consent forms. Participants were free to withdraw from the study at any point. All participants were reimbursed for their transport costs (R10) and time spent in the interviews (R40) in order to prevent poor attendance by participants due to their involvement in other research programmes running concurrently in this particular study site.

2.6.2. Confidentiality

Audio recordings were kept anonymous and no identifying information about the participants existed. Audio recordings are being kept safe and after publication of the research, it will be destroyed. Notes and transcriptions were only accessible to the researcher and translator. To ensure privacy, interviews were conducted in outside view and hearing of other participants. However, there were times when this was not possible.

2.6.3. Benefits

Participants were told that the study would not benefit them directly. Benefit would be in the form of the development of targeted evidence-based health information provided to

the wider community. Another potential advantage to mothers includes improved antenatal care, counselling and appropriate referral for themselves and their children.

2.6.4. Risks or risk reduction

The only potential risk to mothers would be the psychological, social and economic impacts of knowing their HIV status and that of their infants. CHWs helped to mitigate such risks, but where they could not assist, they referred mothers to the nearest clinic for assistance.

2.7. Data Quality

2.7.1. Strengths

In qualitative research the researcher is the interpretive instrument (Dahlgren, Emmelin & Winkvist, 2004). It was therefore critical that measures were in place to ensure the quality of collected data. Trustworthiness of the findings of this study was judged by criteria for qualitative research, such as credibility, transferability, and dependability. (Dahlgren et al., 2004). These are described in more detail below:

The **credibility** criterion meant establishing that the results of the qualitative research were believable from the perspective of the participant (Trochim, 2006). Credibility of the findings was enhanced by the researcher being present during all interviews and debriefing the research team. Emerging questions were added to follow-up interviews to improve the validity of findings.

Triangulation was another method of increasing the validity and credibility of the data and involved the use of a number of methods of gathering data (Trochim, 2006). In this study both individual and FGD methods were used (i.e. method triangulation). Furthermore, both individual interviews and FGD were used with different categories of informants (i.e. data triangulation). The use of more than one method provided a rich picture of the study. For example, the data from different categories of informants revealed a range of views on infant feeding and caring practices, including those of the researcher herself. Interviewing different categories of informants allowed the researcher to compare what different people were saying about the same issue and, to see what routines and behaviours that the different categories of informants carried out were the same as or different to each other. In addition, CHWs could compare what mothers said during their home visits with what they actually did in practice. Furthermore, the fact that the researcher is a mother adds to her ability to carry out this research. The researcher's personal ideas, opinions and feelings were kept in a personal diary for cross referencing at a later stage.

Transferability refers to the degree to which the results of qualitative research can be generalized or transferred to other contexts or settings (Trochim, 2006). In this study, transferability was facilitated by providing a clear description of the participants in the methodology chapter.

Dependability was assessed through discussions with colleagues as a form of co-analysis and consulting with the literature. This increased the dependability of the qualitative findings as it helped to offset the subjective bias of one researcher. The researcher's

supervisors and two other colleagues were involved in the process. It allowed for challenging interpretations and for new ones to be presented.

Other strengths included: The number of participants for each focus group was small enough for sharing and large enough to provide diversity of perceptions and attitudes. The groups were relatively homogeneous in terms of gender and age which provided a non-threatening atmosphere. The researcher assumed that when the participants perceive each other as fundamentally similar, they would obviously spend less time explaining themselves to each other and more time discussing the issues at hand. In contrast, mixed groups spent much time on getting to know each other and building trust before they felt safe enough to share personal information. An incentive was given to make participants feel that their input was valued and appreciated.

2.7.2. Limitations

The limitations of the study could have impacted negatively on the results of the study: Firstly, the skill of the fieldworkers or just their presence could have been intimidating for participants, which may have resulted in conflicting responses between participants (within the same category) in the FGD and the individual interviews.

Secondly, owing to translation between languages, some nuances and cultural expressions in the interviews might have been lost which may have affected the internal validity of the results.

Thirdly, participants were purposively sampled and there might have been sampling bias, that is some members of the population were less likely to be included than others,

resulting in a biased sample being utilised – this could have undermine the trustworthiness of the study. The cause of the sampling bias could be the result of research assistants having recruited a certain cadre of participants that they were familiar with. For example, mothers who were known or suspected HIV positive were probably not selected, or perhaps did not want to take part in the study due to the issue of disclosure being a component of the study. Also, because of their HIV status, participants might not have fully disclosed their thoughts, ideas, and views during the interview which once again calls into question the validity of the results. The method used for selection of the "convenience" sample of the MRC researchers and CHWS could have also led to a biased sample.

CHAPTER THREE: RESULTS AND DISCUSSION

The purpose of this study was to use the counselling booklet as a medium to explore the personal experiences of community members, CHWs and researchers. The results were linked to the specific sub-objectives of the study with the sub-objectives being grouped under the relevant sub - headings below. The results highlighted some of the messages contained in the counselling booklet in bold and italics and the responses participants' gave with regard to that specific message. Limitations were discussed where possible, and suggestions were made for ways to improve infant feeding and caring practices. Many of the messages were repeated throughout the booklet therefore only some messages were chosen to highlight some of the more pertinent issues for the purpose of this study. The results were divided into six sections and they are explained in more detail below.

3.1. General discussion around infant feeding issues

- **Sub-objective:** To better understand participants' general views on exclusive appropriate infant feeding practices.

"You must only use one method of feeding, either exclusive breastfeeding or formula feeding" (Antenatal visit Two).

Most of the participants were literate (except for some older women and some of the men) and could read and understand information on infant feeding and caring. In theory, those participants who were literate were able to read and understand the

risk of HIV transmission through breastfeeding and could choose appropriate infant feeding methods with reduced risk of MTCT. Some of the older women, who did understand information on infant feeding, expressed the issue of exclusivity by saying:

- *'I think we can breastfeed her [the baby] for 6 months and then start her on solid food, because if you give the baby solid food while she is still too small, the baby might get HIV if the mother is HIV positive*' (Older woman –FGD).

- *'The best way is for them not to breastfeed and only give the baby formula'* (Older woman – FGD).

However, despite their literacy, there were still many participants who were not aware of HIV transmission through infant feeding methods. Younger women and pregnant mothers felt that many mothers faced an internal struggle between prevention of HIV infection and the desire to breastfeed. The CHWs in the study confirmed that quite a few mothers in the community were confused as to whether they should exclusively breastfeed or formula feed if they became HIV positive. A possible reason for this is that at many very poor rural PMTCT sites in South Africa, inadequate knowledge of MTCT is widespread amongst mothers, even after counselling (Health Systems Trust, 2002). A similar experience was encountered by CHWs in Doherty et al's (2006) study which described how HIV has created confusion about infant feeding because of mixed messages. Participants in her study said that there were posters promoting breastfeeding and others promoting formula feeding within the same clinic those women attended.

"Use only one method of feeding – exclusive breastfeeding is best for your baby" (Post - natal Visit One).

In terms of the message above, all the participants in the study felt that breast was best for the infant. The majority of women in the study, who were knowledgeable about the potential risks linked to HIV transmission through breastfeeding, said that they would decide to breastfeed their babies if they had to find out that they were HIV positive. However, they did not specify how long they would breastfeed for. There appeared to be conflicting thoughts with regard to the duration of breastfeeding, with most participants' overwhelming preference for breastfeeding ranging from the first six months up to two years. From the interviews, it also appeared that a few younger women have received mixed messages from the clinic in terms of duration for breastfeeding.

> *'Some of the nurses at the clinic say we must breastfeed for four months, others say we must feed for six months. So who must you believe?'* (Pregnant woman – individual interview).

All the men in the study appeared confused by the message above and had no knowledge as to how long a baby should be breastfed or when a baby should begin with solids. Despite this, men were against the early introduction of other foods and fluids:

> *'I encouraged her [to breastfeed only] because it is the right thing to do and I was also raised in that way by my mother'* (Man - FGD).

"Breast milk makes babies healthier, stronger and they do much better at school than babies who are not breastfed" (Antenatal visit Two).

Most of the participants in the study in favour of breastfeeding felt that breastfed babies would be healthier and free of diseases.

> *'Breast milk is best for the baby because it has all the nutrients that formula does not have and that formula can cause the baby to have worms and a running stomach'* (Pregnant women - FGD).

Most of the older women in the study were in agreement that:

> *'Breastfed babies are much stronger, cleverer and when you breastfeed your baby it is exciting because she looks at you like she is learning something from you'* (Older women - FGD).

The quote above confirms that breastfeeding was considered important to women in this study. This finding was consistent with a study conducted by Doherty et al (2006) which strongly demonstrates the power of breastfeeding as a cultural practice and moral commitment from women in their role as mothers. Other motives for breastfeeding mentioned by older women only, included that breastfeeding was easier because one did not have to worry about hygiene of milk bottles which they perceived would otherwise expose the baby to a host of infections. For the researcher, this appeared to be more of a justification by older women for younger women not to bottle feed.

Some of the men in the study said they would prefer that their wives breastfeed due to the financial constraints they were experiencing. In a study conducted in Zimbabwe, HIV-

infected mothers declared having opted for breast-feeding due to financial constraints. Similar findings were reported in Kenya (Orne-Gliemann, 2006).

> *'I will need an explanation from my wife as to what is the reason for her not wanting to breast feed the baby, because formula milk is expensive and besides that, breast milk is healthy for the baby, she will need to explain this to me so that my mother will also understand that my baby will not be breastfed because of whatever reasons…'* (Man - FGD).

3.2. Social Support Systems

- **Sub–objective:** Describe family support decision making in relation to mothers' efforts to implement exclusive appropriate infant feeding practices.

During the focus group discussions with the breastfeeding mother (pregnant and younger women), it was evident that mother-in-laws (older women) and husbands, boyfriends, partners (men) were identified as key persons who can promote and support exclusive breastfeeding within the family. According to WHO (1996), mothers require enabling environments to breastfeed optimally and this can only be done with support at household and community level.

3.2.1. Older Women

Many older women in this study perceived breast milk to be insufficient (in quality and quantity) and believed that other liquids beside breast milk could be given to the infant from one-month of age onwards. Water, in addition to breast milk, was given to quench the baby's thirst or simply because it was seen as a traditional practice. Similarly, in a focus group study in Nigeria, grandmothers, mothers, and health workers all expressed the

belief that exclusive breastfeeding was never sufficient and that infants needed water to stay healthy (Davies-Adetugbo, 1997).

> *'Water with sugar and a pinch of salt helps a lot. It acts as glucose and you can make it at home if you don't have money to buy milk… and if you are breastfeeding it's fine to give this to the baby…'* (Older woman – FGD).

Also, while being understood by some of the older women in the present study, as being necessary, 'milk as a liquid' was not considered sufficient to 'make the child grow' or to satisfy hunger. This finding was consistent with studies conducted previously in Tanzania and other African countries (Coutsoudis, 2005; Shirima, Greiner, Kylberg & Gebre-Medhin, 2001). The researcher also assumed that there was probably some mixing or confusion of public health messages as the quote above appeared to refer to Oral Rehydration Therapy (ORT).

The quote below reflects grandmothers' transmission of their own infant feeding practices.

> *'I have raised many children in my lifetime, I have the right to have a say in what my grandchildren are fed how they should be cared for'* (Older woman, FGD).

It has been reported in Abidjan, Cote d'Ivoire, that HIV-positive women who failed to stop breastfeeding early were pressurised by their mothers-in-law (Becquet et al., 2005b) to quit.

The actions of older women could be explained in a study by Grassley & Eschiti (2008), which looked at contextual factors influencing breastfeeding women in Hong Kong. A lack of breastfeeding knowledge limits female family members' ability to support mothers. On

the other hand, a study by Kerr, Dakishoni, Shumba (2008) concluded that older women can change their beliefs about infant feeding practices if or when information is presented to them in culturally appropriate ways that acknowledge their perspectives.

Some of the CHWs said that during their first few visits with mothers, other family members would normally be present, especially their in-laws. They were curious to know why the CHW was visiting and what they had to say. Some men in the household were at first very reluctant to have a stranger come to their house, but after a while also welcomed the idea of the CHWs helping their wives during and after pregnancy.

3.2.2. Other women (pregnant and non-pregnant/younger women)

"Know how to respond when people advise you to give your baby water, porridge or baby food" (Postnatal visit Two).

With regard to the above message, most pregnant and non-pregnant women in the study felt that they often did not have a say in what their children were fed. Pregnant and younger women said that it was generally the culture in their community where the extended families are caregivers, and as daughters-in-law they were not allowed to question their elders' intentions. Some of the younger women admitted to there being tension between older women and themselves when it came to issues of feeding and caring. This problem was not restricted to less educated women, judging by the quote below:

Interviewer: *'How does it feel to you that sometimes your mother makes decisions about your child?'*

Respondent*: 'Yes, some of us educated woman we also face a problem where we come home after work and sometimes we do not want our babies to be given just anything unless it is something recommended. Yet, when we grew up it wasn't like that at all, our parents used to give us just about anything to eat or drink and we do not want that for our children today. I am an educated mother and I experience some of these difficulties myself. Even when I say no to my mother-in-law or my mother, they will start telling me that they gave me anything to eat when I was young and nothing happened to me. You know when I think about this I feel like crying'* (Female MRC Researcher – individual interview).

According to a study by Leshabari et al (2007), although a woman makes a decision on how to feed her infant, she may not be able to do so in practice because her mother or mother-in-law decides otherwise. Formative research from Senegal (Aubel, Toure, & Diagne, 2004) and South Africa (Montgomery, Hosegood, Busza et al., 2006) indicated that grandmothers' advice during pregnancy and postpartum was always adhered to.

Younger women in this study said that all they wanted was for older women to understand and trust the process of breastfeeding so that older women could offer them loving encouragement when they experienced difficulties rather than pressuring them to supplement their breastfeeding with formula and other foods. In response to this statement, the researcher assumed that older women wanted to be helpful when they stated during the FGDs that young mothers often did not come forward to ask for their assistance.

3.2.3. Men

In response to the picture above which appears under Antenatal visit One, there appeared to be uncertainty around the role of men in the study. Some men in the FGD claimed that they played a relatively active role in baby feeding support and decisions which was particularly noteworthy in this study, as traditionally men are not seen to be involved in such matters. According to the CHWs in this study however, only a few men had taken the opportunity to come to the antenatal clinic for testing and counselling. Most of the pregnant and younger women in the study hardly mentioned their husbands as decision-makers on infant feeding practices. Clinic antenatal services do not accommodate men and in Umlazi, the tradition was that men do not look after babies.

- *'Our Zulu culture doesn't allow us to be present during the delivery of the baby nor can we carry the baby before [it] is six months old'* (Man –FGD).
- *'I told my sons who are now 20 years old, that they should never touch a newborn baby until it is six moths old and they should not go near their wives after she has given birth for at least eight months* (Man – FGD).

In the second response above, it appeared to the researcher as if some men were imposing their own beliefs and practices onto the future generation, which is probably how they were brought up. In response to this, the MRC researchers in the study recommended that in order to 'stop this vicious cycle' men be included in future PMTCT programmes since evidence shows that men are important actors in infant feeding decisions.

3.3. Local beliefs and practices

- **Sub –objective:** To explore what the local beliefs and practices are which might have had a bearing on infant caring practices.

Participants did not express any harmful cultural beliefs or practices related to infant feeding in this study. But, there were some risky lay practices related to infant caring.

3.3.1. Lay practices

"Traditional or over-the-counter medicines should not be given to babies who are exclusively breastfed" (Antenatal Visit Two).

With regard to the message above, this study found that most of the other women (pregnant and non-pregnant/young), men and CHWs valued the use of traditional herbal preparations (muthi), herbal enemas or over-the-counter medicines to treat or protect infants from disease:

'…we use Zulu muthi which is mixed with all kinds of animals…' (Man – FGD).

In addition, CHWs were aware of the lay practices women were using, some of which could have potentially dangerous consequences, but they felt they could not engage women on them. After this issue was explored further in the interviews with CHWs, it became apparent that CHWs despite acknowledging that it is not safe, entertained such practices themselves. They said that they carried out the same or similar practices on their own babies simply because *'it works wonders.'* For example, some CHWs said:

> *'Some women use a mixture of kiwi polish and Colgate or garlic and Vaseline together which helps the baby in passing stools and lowering the body temperature when the baby is sick'* (CHWs – FGD).

- **Sub –objective:** Investigate what community health workers knowledge and skills are with regard to infant caring practices.

"Small babies hate dirt. The invisible dirt on people's hands can make them sick – make sure the mother and family members wash their hands with soap before touching the baby and limit the number of people who touch the baby" (Antenatal Visit Three).

It also appeared as if messages in the booklet pertaining to hygiene were taken for granted amongst many of the participants. Some of the MRC researchers in the FGD did not see the point of having a message as important as hand-washing in the booklet.

This was unexpected since hand-washing is regarded as very important when it comes to the health of babies. The researcher thought that perhaps the MRC researchers felt that this was a message that was too obvious to be included in the booklet since it is assumed that everyone knows about hand washing. Also, one of the older women in the FGD felt that it was not necessary to include health care messages related to the infant such as cord cutting and eye care. Some of these women were seen referring for these tasks as the responsibility of the clinic staff:

> *'Nurses gave these messages to mothers at the clinic and so these messages do not need to be repeated in the booklet'* (Older women –FGD).

There were some pregnant and younger women who said that hygiene and cleanliness was important but stated further that the issue of cleanliness was difficult to maintain in the present Umlazi socio-cultural context because babies were usually born into extended families with many neighbours, and friends who all want to carry the baby, so it would be inappropriate to tell other people to wash their hands before they could carry your baby.

> '*They might think that you are being rude'* (Pregnant woman - FGD).

In addition, all the participants agreed that part of caring for your baby also means playing with your baby.

> *'It is important to play with your baby as a way of stimulating them and so that they can achieve their developmental milestones'* (MRC professionals - FGD).

3.4. Health System factors

- **Sub-objective:** To determine what the effect of a lack of formula is on infant feeding practices.

3.4.1. Supply of formula

Pregnant and younger women in this study, who were told by the clinic to bottle feed for whatever reason, said that they often struggled to stick to their choice. This was because of the shortage of formula; they either struggled to buy the necessary amounts or, those who were given six months' free formula as part of the PMTCT program, often ran out of formula, complaining that it was not sufficient and resorted to dilution or mixed (breast) feeding.

> *'If you go to the clinic before the due date to collect formula they chase you away'* (Pregnant women - FGD).

According to UNICEF (2004), despite the provision of free formula milk, over one-third of mothers had run out of formula milk within the first three months. This was due to both insufficient supplies and short intervals at which supplies were given. This in turn had indirect cost implications for women in terms of travel to the clinics. This has been described in other African settings as well, where formula milk was provided as part of the PMTCT program and suggested that a policy to provide free formula needs to be accompanied by the necessary health system infrastructure to ensure milk supplies. (UNICEF, 2004).

A study by Seidel et al (2000) found that some mothers who had chosen formula feeding could not easily do so as close relatives insisted on breastfeeding. Therefore, all HIV-positive pregnant women should be counselled on infant feeding methods and be supported by health personnel in their choice to ensure adherence to the chosen method.

3.4.2. Training of health workers

- **Sub-objective:** Investigate what community health workers knowledge and skills are with regard to infant feeding methods.

The study found that some participants did not associate HIV transmission with infant feeding methods as referred to in section 3.1. One of the reasons could have been due to mothers receiving inadequate counselling on the transmission of HIV through different infant feeding methods by the CHW, as well as the lack of reinforcement during antenatal clinic attendance by the nurse. The pregnant and younger women with little knowledge on MTCT of HIV pose a risk of transmitting HIV to their unborn babies and through breastfeeding due to this poorly perceived susceptibility and the inability to make an informed decision on appropriate infant feeding methods. The above consequences could be the cause of majority of CHWs not being trained sufficiently in PMTCT and accordingly not being confident enough to advise pregnant women attending antenatal clinics on PMTCT. This appeared to be the case, as some CHWs in the study felt that they were sometimes ill-equipped to deal with issues of disclosure and after receiving training on the messages in the booklet, still felt that they were not sure about some of the key infant messages that they should be disseminating to mothers in the community.

- *'When we were trained we were not given these counselling booklets because the booklets were still being printed. We had a field guide which we went through during training. When we went into the communities to do the research, we did not understand the purpose of the scales [SEE SCALE BELOW] which appear after each visit in the booklet because we were not trained on how to rate the scales. So when we were asked a question on the scales we did not know how to answer it and we were reluctant to answer the question in case we said the wrong thing'* (CHWs – FGD).

- *'If a woman disclosed her status to me, I had to refer her to the clinic but she refused to go. She said she didn't want anyone else to know [her status] I didn't know what else to do'* (CHW- FGD).

IMPORTANCE *(Circle one below)*

1 *2* *3* *4* ***5*** *6* *7* *8* *9* ***10***

Not at all important **somewhat important** **extremely important**

……

……

CONFIDENCE *(Circle one below)*

1 *2* *3* *4* ***5*** *6* *7* *8* *9* ***10***

Not at all important **somewhat important** **extremely important**

……

……

P.S. *The scales appeared after every visit. For the importance scale, mothers had to rate how important they thought the messages were at a particular visit. For the confidence scale, mothers had to rate how confident they felt to abide to the messages.*

This finding is supported by a study by Chopra et al (2002) which found that health workers in a pilot project in South Africa were generally confused about the key infant messages they should be disseminating. Because it is clear that many baby feeding decisions are made together with CHWs, it is recommended that CHWs counselling skills be increased as it is of paramount importance in promoting and supporting optimal baby feeding practices. According to Seidel et al (2000), health care workers' words were often taken as the final word. It is therefore essential that CHWs are thoroughly trained and have high-quality, up-to-date information to impart to mothers in the communities

3.5. HIV - related stigma

- **Sub-objective:** Investigate the relationship between one's HIV status and appropriate infant feeding decision making and practices

"Feel good about knowing your HIV status. Knowing your status enables you to look after your health and that of your baby" (Antenatal Visit Two).

Older women and men associated formula feeding with HIV. Thus, it was perceived by pregnant and younger women that the choice of formula milk reveals ones HIV status, which may act as a barrier to women who are HIV-positive who want to maintain confidentiality. This shows that stigma and discrimination is a strong barrier towards an individual's ability to take appropriate action.

Some of the pregnant and younger women mentioned that some clinics were not a very supportive context for relationship-building and did not easily facilitate openness with regard to taboos and socially sensitive issues.

> *'…when you hang around or is seen walking past the VCT area, people automatically assumed you are HIV positive. If I was waiting at the VCT area and my neighbour saw me at the clinic, I'm afraid that that neighbour will tell everyone I am HIV positive'* (Pregnant woman – FGD).

Most of the younger women realised the importance of disclosing their status if they were HIV positive, however, some said that if they were HIV positive they would fear the negative consequences of disclosure, i.e. less help from family when looking after their children.

> *'You said I can disclose, but it is not easy as you think it is. You know when you are told that you are HIV positive, you feel that there is no one on earth that you can talk to, so you need time to counsel your self, you then try to find someone whom you can trust and talk to, since I am not treated the same in the family again'* (Pregnant woman - FGD).

The pregnant woman who said this was very emotional and was on the verge of crying. During the debriefing session with the fieldworkers, the researcher discovered that she was HIV positive but had difficulty disclosing to her family.

In addition, pregnant and younger women felt that older women were not very educated when it came to issues around HIV/AIDS and disclosing their status to older women would cause a lot of tension in the family.

'Disclosing your status is very difficult and I recommend that clinics educate the community on issues around disclosure and stigma' (Younger women – individual interview).

Furthermore, CHWs said that if mothers were HIV-positive, some felt more comfortable disclosing their status to the CHWs than to their own families. It is clear that the direct impact of socio-cultural constraints within the community, such as stigmatisation or discrimination, on infant feeding practices needs to be further explored.

3.6. The Booklet

- **Sub-objective:** To evaluate the booklet used by CHWs while visiting women at home.

3.6.1. Summary of the main findings and concepts

Overall, participants said that the booklet taught them some important lessons with regard to infant feeding and caring practices. They said that they gained new information even though there were some messages which they were already familiar with. One older woman in the FG said that even though the booklet does not really apply to her, she still thought that the booklet was really useful and that she will share it with friends and family who have babies and pregnant women in her community. Others said:

- *'Even though I feel that the booklet is directed toward mothers, I will read it if it concerns my baby because I have now learnt that I need to be just as much a part of the baby's life as the mother is'* (man - FGD).

- *'It mustn't be for your own knowledge only'* (Older woman – FGD).

Some of the older women in the FGD did not understand certain words, such as kangaroo care, umbilicus since they were illiterate. For better comprehension and understanding, MRC researchers suggested that the vocabulary be simplified. Most of the pregnant and younger women suggested that VCT be highlighted and emphasised from Antenatal visit One and not in later visits as was the case in the booklet.

3.6.2. Density

The general feeling among participants was that the messages under each of the visits were too dense and there was too much repetition of the same messages. This meant less space for more important and relevant messages. The MRC researchers suggested that footnotes be inserted at the bottom of the page to explain a concept further, hence creating more space for more important messages and their explanations. According to CHWs, because the messages were so dense, they noticed that when they visited mothers at their homes, mothers just skimmed through the booklet, looking at the pictures rather than reading each and every message. They also found that children of the women they visited were using the booklets as toys.

3.6.3. Tone

All participants thought that the messages in the booklet were generally appropriate, but only the MRC researchers felt that methods used to enforce messages were not doing so. For example:

> '*You must only use one method of feeding — either exclusive breastfeeding or formula feeding. Exclusive breastfeeding is best for babies up to 4-6 months.'* (Antenatal visit Two).

They felt that there was a strong tone coming across in the messages like the one above and said that the booklet needs to refrain from using commands.

3.6.4. Concrete action

Only some of the MRC researchers and CHWs were concerned that there was no link between the messages in the booklet and some form of action. For example:

> *'Have you made emergency plans to get to the hospital if you go into labour during the night?'* (Antenatal visit One).

The concern with the above message was that if women, especially pregnant women said 'no,' then what form of action does the CHW have to take to make sure that this is addressed? One of the MRC researchers suggested that the CHW refer the mother to a nearby doctor or clinic.

3.6.5. Purpose

Some pregnant and younger women did not understand what the purpose of the counselling booklet really was. The MRC researchers in the FGD put forward that the booklet ultimately boils down to two main issues, i.e. health of the baby and the mother. However, their impression was that the messages pertaining to the baby and those pertaining to the mother were mixed together and became very confusing for the reader.

3.6.6. Appropriateness of images related to the local context

Some participants did not agree with the some of the pictures contained in the booklet. A response to the picture of the vegetables (See picture under section 3.2.3) was:

'Not everyone can afford to buy vegetables to keep healthy. I suggest that other vegetables be represented such as African vegetables, like African potatoes, and home gardening is seen to be a much cheaper option for poorer people living in the rural communities' (MRC researcher - individual interview).

4. Conclusion and recommendations (either for implementers or policy makers).

Data showed that socio-cultural factors, like the lack of social support systems at the household and community levels; uncertainty regarding the role of men in infant feeding and caring issues; local beliefs and practices with regard to infant caring; the lack of supply of formula and CHWs' lack of breastfeeding knowledge and experience; and HIV-related stigma may directly or indirectly, drive mothers to practice non-exclusive infant feeding and care for their infants in ways that may increase the risk of HIV transmission. The implications are that stigma and shame can stifle community discussion around exclusive appropriate infant feeding practices and other issues.

The study pointed strongly to the fact that the home circumstances of women who chose to feed their infants, irrespective of whether it was exclusive breastfeeding or exclusive formula feeding, appeared to influence their infant feeding choices. Pregnant women and younger women felt that feeding and caring decisions regarding their infants were mostly made by older women - their husbands were hardly involved in such decisions. The recommendation is for CHWs to include family members in discussions to change their beliefs on infant-feeding and caring issues.

Some of the pregnant and younger women in the study pointed out that some clinics were not a very supportive and did not easily facilitate openness with regard to issues like HIV status. Knowing one's HIV status is crucial to making choices about feeding, therefore it is recommended that policy makers ensure that support for VCT becomes a priority. In addition, CHWs said that they were sometimes ill-equipped to deal with issues of disclosure and were also sometimes confused about the key infant messages they should be disseminating. Therefore facility managers need to make sure that CHWs receive up-to-date evidence-based knowledge on proper infant feeding practices to provide adequate counselling and support to mothers (Luo, 2000).

With regard to infant caring practices, the data also revealed general acceptability of infant caring practices that could be risky (such as using soap enemas and inappropriate hand washing practices), even amongst CHWs. For the researcher, this section was very interesting and raised some key issues. Since some of the MRC researchers and many of the CHWs mainly came from the same area as Umlazi, it is assumed that they would therefore have similar beliefs and practices. However, their increase in knowledge did not change these beliefs and practices. Thus, policy makers face the huge challenge of effectively changing health-related practices amongst health professionals.

Participants felt that they would share the booklet with others in the community as it taught them important lessons regarding infant feeding and caring practices. For some, the pictures in the booklet enhanced their understanding of 'old' messages. With literacy rates being low among older women and some men in the study and conveying of

messages being a challenging task for some of the CHWs, the recommendation is that booklets such as this one should be designed with the primary user in mind.

Finally, this small exploratory study relied on interviews among a peri-urban clinic-based convenience sample. Certainly, a follow-up study on the counselling booklet should be undertaken with more participants, involve family and community members and use a triangulated approach that would allow for multiple perspectives and validation of reported experiences. It is hoped that the findings of this study, nevertheless broadens our understanding of how socio-cultural factors fits into the lives of mothers and their families and ultimately the impact it has on infant feeding and caring practices.

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Appendices

Appendix A: Ethics acceptance letter

Appendix B: Letter requesting expedited review

Appendix C: Informed consent for Focus Group discussions (English)

Appendix D: Informed consent for Individual Interviews (English)

Appendix E: Informed consent for Focus Group discussions and Individual Interviews (Zulu)

Appendix F: The counselling booklet (English)

Appendix G: The counselling booklet (Zulu)

Appendix H: Topic guide

Appendix I: The revised booklet

Formatted: English (U.K.)

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The Medical Research Council

1 March 2008

To Whom It May Concern:

MPH candidate: Ms Naeema Hoosain

This letter is to confirm that due to travel commitments I am unable to sign the Application for Medical Research form and the D1 Form for Study Approval for Ms. Hoosain's planned research.

I am fully supportive of the research and will sign the necessary forms at my earliest convenience.

Yours truly,

Signed by candidate
Signature Removed

Dr Mark Tomlinson
Senior Specialist Scientist
Health Systems Research Council
Medical Research Council

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The Medical Research Council

1 March 2008

To Whom It May Concern:

MPH candidate: Ms Naeema Hoosain

This letter is to request that the ethics permission for Ms. Hoosain's planned research is expedited. The formative work that she is planning is integral to a large cluster randomised controlled trial that is scheduled to begin in the next four months in Umlazi, Durban.

I would be willing to forward any further information that might expedite the ethics permission for Ms. Hoosain's research.

Yours truly,

Signed by candidate

Signature Removed

Dr Mark Tomlinson
Senior Specialist Scientist
Health Systems Research Council
Medical Research Council

Appendix C: Informed consent for Focus Group discussions

A study exploring the applicability and cultural appropriateness of a counselling booklet that is part of a community-based package in Umlazi, KwaZulu-Natal.

Information and informed consent form for focus group discussions

Good morning,

My name is …….. (facilitator's name). I am working at the Medical Research Council in Cape Town and I will be facilitating the group discussion/conducting the interview.

We have invited you to participate in a group discussion about your knowledge, experiences and opinions on the cultural appropriateness of the visual material contained in the counselling booklet. We are interested in hearing your opinions as they will be of importance to us in improving our intervention.

I would like to know if you are willing to take part in a counselling session and then a focus group discussion a few days later. The discussion will last for approximately one hour and participation is voluntary. If you are willing to participate you have the right to not discuss topics that you do not feel comfortable with. You are also able to withdraw from the discussion at any time without giving any reasons. If you decide you do not want to participate in this study it is perfectly okay. Your decision will not affect in anyway the care and support given to women and their babies in the clinic and at the hospital. We do not expect any correct answers; we are only interested in your opinions, feelings and beliefs. You can disagree with each other and you can change your mind. There are no incentives or payment for you to participate in this study.

This discussion will be taped and then written down on paper. The tapes and texts will be kept safe so only the research team have access to them, and will be destroyed when the research has been completed. Your names will not appear on paper. We ask the participants today to keep the information exposed confidential, but the study team cannot guarantee this. The information from these discussions will be used for research purposes only.

There are no immediate benefits to you from participating in this study. However, this study will be helpful to us in developing a project to assist women in making better feeding choices.

If you would like to receive feedback on our study, we will record your phone number on a separate sheet of paper and can send you the results of the study when it is completed sometime after March 2009.

If you feel that you have been harmed in any way by participating in this study, please call me, Mark Tomlinson at the Medical Research Council at 021 938 0401.

CONSENT FOR PARTICIPATION IN COUNSELLING SESSION

I hereby agree to participate in a research study which will go through a counselling session with me. I understand that I am participating freely and without being forced in any way to do so. I also understand that I can stop participating at any point should I not want to continue and that this decision will not in any way affect me negatively.

I understand that this is a research project whose purpose is not necessarily to benefit me personally in the immediate or short term.

I understand that my participation will remain confidential.

……..

Signature of participant **Date**:……..

CONSENT FOR FOCUS GROUP DISCUSSIONS

I hereby agree to participate in research which looks at my knowledge, experiences and opinions regarding the cultural appropriateness of a counselling booklet in Umlazi. I understand that I am participating freely and without being forced in any way to do so. I also understand that I can stop participating at any point should I not want to continue and that this decision will not in any way affect me negatively.

I understand that this is a research project whose purpose is not necessarily to benefit me personally in the immediate or short term.

I understand that my participation will remain confidential.

……..

Signature of participant **Date**:……..

CONSENT FOR AUDIOTAPING

I hereby agree for the counselling session and the focus group discussions to be recorded using a tape recorder. I understand that these recordings will be locked away with kept at a central secure location, and all audiotapes will be kept under lock and key for two years after the publication of the research, after which time they will be destroyed. No one other than people on the research team will be able to have access to the tapes.

I hereby agree to the tape-recording of my participation in the study.

……..

Signature of participant **Date**:……

Appendix D: Informed consent for Individual Interviews

A study exploring the applicability and cultural appropriateness of a counselling booklet that is part of a community-based package in Umlazi, Kwazulu Natal.

Information and informed consent form for individual interviews

Good morning,

My name is …….. (facilitator's name). I am working at the Medical Research Council in Cape Town and I will be facilitating the group discussion/conducting the interview.

We have invited you to participate in an individual interview about your knowledge, experiences and opinions on the cultural appropriateness of the visual material contained in the counselling booklet. We are interested in hearing your opinions as they will be of importance to us in improving our intervention.

I would like to know if you are willing to take part in a one-on-one interview. The discussion will last for approximately one hour and participation is voluntary. If you are willing to participate you have the right to not discuss topics that you do not feel comfortable with. You are also able to withdraw from the discussion at any time without giving any reasons. If you decide you do not want to participate in this study it is perfectly okay. Your decision will not affect in

anyway the care and support given to women and their baby in the clinic and at the hospital. We do not expect any correct answers; we are only interested in your opinions, feelings and beliefs. You can disagree with each other and you can change your mind. There are no incentives or payment for you to participate in this study.

This discussion will be taped and then written down on paper. The tapes and texts will be kept safe so only the research team have access to them, and will be destroyed when the research has been completed. Your names will not appear on paper. Whatever information is exposed in the interview will be kept confidential, but the study team cannot guarantee this. The information from these interviews will be used for research purposes only.

There are no immediate benefits to you from participating in this study. However, this study will be extremely helpful to us in developing a project to assist women in making better feeding choices.

If you would like to receive feedback on our study, we will record your phone number on a separate sheet of paper and can send you the results of the study when it is completed sometime after March 2009.

If you feel that you have been harmed in any way by participating in this study, please call me, Mark Tomlinson at the Medical Research Council at 021 938 0401

CONSENT FOR PARTICIPATION IN INDIVIDUAL INTERVIEW

I hereby agree to participate in a research study which will go through a counselling session with me. I understand that I am participating freely and without being forced in any way to do so. I also understand that I can stop participating at any point should I not want to continue and that this decision will not in any way affect me negatively.

I understand that this is a research project whose purpose is not necessarily to benefit me personally in the immediate or short term.

I understand that my participation will remain confidential.

……..

Signature of participant **Date**:……..

CONSENT FOR INDIVIDUAL INTERVIEW

I hereby agree to participate in research which looks at my knowledge, experiences and opinions regarding the cultural appropriateness of a counselling booklet in Umlazi. I understand that I am participating freely and without being forced in any way to do so. I also understand that I can stop participating at any point should I not want to continue and that this decision will not in any way affect me negatively.

I understand that this is a research project whose purpose is not necessarily to benefit me personally in the immediate or short term.

I understand that my participation will remain confidential.

……..

Signature of participant **Date**:……..

CONSENT FOR AUDIOTAPING

I hereby agree for the counselling session and the individual interview to be recorded using a tape recorder. I understand that these recordings will be locked away with kept at a central secure location, and all audiotapes will be kept under lock and key for two years after the publication of the research, after which time they will be destroyed. No one other than people on the research team will be able to have access to the tapes.

I hereby agree to the tape-recording of my participation in the study.

……..

Signature of participant **Date**:……

Appendix E: Informed consent for Focus Group discussions and Individual Interviews (Zulu)

bifaado csifuiui ukwitzi tigiuiiiisiko eocwadi yezeluleko kiimplmkalhi waseMlazi,

Igiiina lami nglngu Naeema Hoosain. Ngisebenzela inkampani ye Medical Reserarch Council eKapa. Ngizobn umhleli wenu ngalengxoxo yocwaningo,

Siyanimema ukubii nibambe iqbaza kulengxoxo mbuzo ngolwazi nangembono yakho, mayelana nokuviimelana kanys nokuhambisana namasiko kuielfbhuku lokululeka 'dkiiyiiigxcn\ c e./osetshenziswa emphakatliini. Kungaba tmokozo Likuthola imibono yenuoku'yintb cbaiiiiekile kuthina ukukhultsa [entervention yethu].

Ngingathanda ukuba ngazi ukuthi tingaba. nesifiso sokuba ingxenye yalengxoxo mbuzo yeliiu. Lengxoxo yetKit ingasithathit cisbe isikhathi esingange liora futhi ukuba ingxenye yayo uyazik[iethela. Uma unesifiso sokuba ingxenye unalo ilungclo lokungaxoxi ngezihloko ezingsikuphathi kahle. Uvumelekile ukuphiima kulengxoxo noma ingasiplii isikhathi rtgaphandle kokusinikeza isizalhu. Uma unquma ukuthi awuthandi ukuba

ingxenye ynlesisiCundo lokho kuyilungelo lakho. Isinqumo sakho ngeke silimaze indlela yokunakekela kanye nokusekela okucikezwa omama kanye nabantwana babo abasemlholiimpilo kanye nasezibhedleta. Asilindele izimpendulo ezihingile zodwa, kodwn silhatlinndit irniboiio yenu, imizwa, kanye nezinkolelo zenu. Ungangavumelani oalpwo tiilhi ungflWUshintsha nomqondo waklio. Akuyikubakliona ukuklioklielwa ngotoibfl iilgxcnyc yalcsisiiiindo.

l.einibono i/oqoshwa bese ibhalwa emaphepheni. Azogcinwa endaweni epliephile niaiapho atokwaziwa khona iqembu labacwaningi, Uma ucwaningo seluphelile .n/ol;ihlw[!. Amagamn ababandakanyekayo ngeke afakvve emaphepheni. Niyacelwa ukuba izinto ezrcubimguiiwe kulengxoxo zibe imfihlo yenu ezosetshenziselwa ucwaningo, Akukhu mvnzo olheni okwamanje kulolucwaningo kodwa luzoba usizo olukhulu ckukhuliseni Mniseiv/.L ozosiza omama ngokuqonda izindlela zokuphatha kwabantwana

Uma kukliona ofuna ukukwazi ngalolucwaningo sizothatha izinombolo zakho zocingo besc siyakuthumelela imiphumela uma seliphothuliwe ucwaningo. Singase siphothule ngezikfaatbi zika Ndasa (March) 2009.

Uma kukhona ohlukumczekayo ngokuba yingxenye yaloiucwaningo ngiceta uthinte mina uNaeeniii IHoosain c.Mcdical Research Council kulenombolo 021-938-0401

sivumeJwano sokuhlolwa kolwazi. Mina ngiyavuma ukuzibandakanya nalolucwaningo oluhlota ulwazi, kulandela isivumelwano kanye namasiko kwezokuluieka abantwana

abancane abanesandulela ngculaze esigcemeni saseMlazj, Ngiyazi ukuthi mina ngizikhethele ukuba ingxenye , Sngiphoqwanga muntu.

Ngiyazi futhi ukuthi ngingayeka uma ngingasathandi futhi lesisinqumo angeke singikhinyabeze.

Ngiyaqonda ukuthi ukuzibandakanya kwami kuyohlale kuyimfihlo.

Sayina Lapha Usuku

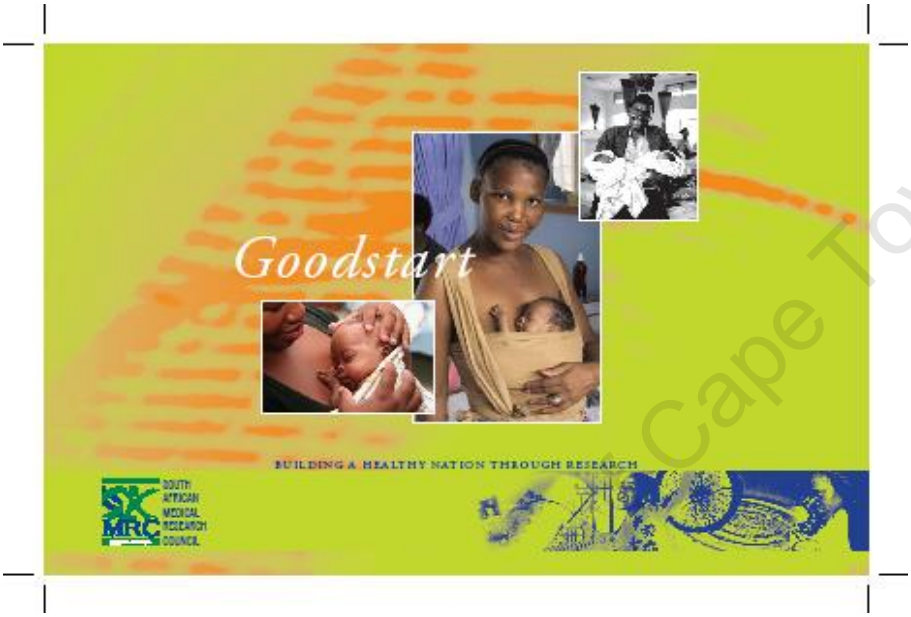
IsivUmehvano Sokuqopha

Ngiyazi ukuthi iziqophamazwi ziyovalelwa zibekwe endaweni ephephile iminyaka emibili uma ucwaningo seliphoth'uiiwe. Ngemuva kwesikhathi ziyosatshalaliswa. Akekho umuntu oyovumeleka ngaphandle kwabacwaningi ukuba azithintele,

Ngiyavuma ukuthi kuqoshwe ukuzibandakanya kwami kulolucwaningo

Sayina Lapha Usuku

Appendix F: The counselling booklet



Appendix G: The counselling booklet (Zulu)

UMAMA ONEMPILO WE NGANE ENEMPILO: Ibhukwana lezaluleko

Isethulo.

Lelibhukwana lilungiselelwe/ lenzelwe omama abakhulelelwe, abasanda kubeletha nemindeni yabo. Inhloso yalo ukwenza lula imiyalezo enqala/ esemqoka enizoxoxisana ngayo no CHW (umnakekeli) ngesikhathi evakashela umama ekhaya

Sifisa ukuvuselela intshisekelo nonakelelo komama abakhulelwe nabasanda kubeletha ekutheni bafune futhi bazinakekele bona nezi ngane zabo ezisanda kubelethwa ngezikhathi zonke. Ikhasi ngalinye kulelibhukwana limele umyalezo osemqoka okumele kuxoxwe ngawo uma uvakashelwe.

Eminingi imiyalezo iphindiwe ekuvakashelweni ngakunye iyona ndlela esifisa ukuqinisekisa ngayo ukuthi imiyalezo izwakalile ephathelene nendlela esibheka ngayo ukuziphatha kukamama nengane yakhe esanda kubelethwa

Ukondla umtwana ngokungaxubi nokuyikonakona iyona ngqikithi yalelebhukwana lokwalulekwa. Ngakho ke ekugcineni kokuvakashelwa ngakunye uCHW (umnakekeli) uzobuza umama okhulelwe noma esanda kubeletha ukuthi akale noma alinganise ukubaluleka kokuthi azimbandakanye ekutheni angaxubi.

UKUVASHELWA KOKUQALA EKHAYA UNGAKABELETHI

Sicela uvumele uCHW (umnakekeli) akusize ekuxhumaneni kkwakho nomndeni wakho (i.e ubaba wengane, umama wakho, nomamezala wakho etc.) abangaba nomthelela ezinnqumweni zakho ozozenza ekubhekeni impilo yakho neyomtwana wakho.

Noma ngabe abukho ubunzima ekukhulelweni kwakho, kubalulekile ukuvakashela umtholampilo wakho.

Wena nengane yakho nidinga unakekelo oluphambil, kubalulekile ukuthi nivakashele umtholampilo ngenkathi usakhulelwe okungenani kane(4) noma ngabe uzizwa uwumqemane.

Okunye ukugula okufana ne HIV (isandulela ngculazi), Syphilis (izifo zocansi) Anemia (igazi elingenele emzimbeni) ne BP, ezivame ukutholwa omama abakhulelwe ziyingozi kumama nengane futhi zingalapheka emitholampilo noma esibhedlela.

Uma ubona wopha, uphathwa ikhanda, izinyawo ezivuvukile, ukushoda kwegazi emehlweni, ukuphalaza okunganqamuki noma umkhuhlane kumele uye emtholampilo ngokushesha.

Ukudla ukudla okunempilo nokuxubile kubalulekile futhi kuhle empilweni yakho nomtwana wakho ongakazalwa.

Kuyokusiza ukubeka imali eceleni njengamalungiselelo okobeletha. Uvumelekile ukuthi uxoxisane nomnakekeli (CHW) ngezindlela ongazisebenzisa ukuze wena nobaba wengane nigcine imali oyoyisebenzisa uma sewuyobeletha.

Kubalulekile ukuthi wenze izinhlelo eziphuthumayo zokuya esibhedlela noma emtholampilo uma uficwa ukubeletha ebusuku. Kubalulekile ukuthola ukuthi okokuhamba emphakathi kubiza malini.

Uma uphuza noma ubhema ngesikhathi ukhulelwe lokhu kwedlulela emtwaneni ongakazalwa. Angakhubazeka futhi umtwana.

Kubalulekile kakhulu ukuthi uphuze amaphilisi owanikezwa emtholampilo ngenkathi ukhulelwe, asiza kakhulu impilo kamama nomtwana.

Umlando wempilo yomtwana wakho kusukela ezalwa kuya eminyakeni emihlanu; kubala isisindo nemigomo kuyobhalwa ekhadini elibizwa ngokuthi IKHADI LOMGOMO. Kumele uqikelele ukuthi uyalithola ikhadi lomgomo esibhedlela noma emtholampilo obelethele kuwo ngaphambi kokuba uye ekhaya.

UKUVAKASHELWA KWESIBILI EKHAYA UNGAKABELETHI

Sicela uvumele uCHW (umnakekeli) akusize ekuxhumaneni kkwakho nomndeni wakho (i.e ubaba wengane, umama wakho, nomamezala wakho etc.) abangaba nomthelela ezinnqumweni zakho ozozenza ekubhekeni impilo yakho neyomtwana wakho.

Kubalulekile ukukhetha indlela eyodwa yokondla umtwana wakho; kungaba ukunika ingane ibele lodwa noma ubisi lwethini/ ibhodlela lodwa kube yiyona ndlela ongondla ngayo umtwana wakho kuze kushaye isikhathi esinqunyiwe.

Zonke izingane ziyalamba emveni kohambo kodwa abanye basuke bekhathele kakhulu ukuba bengakhala, zonke izingane kumele zondliwe emveni kokubelethwa, ukunceliswa ngokushesha emveni kokubelethwa kuyenza ingane iqine futhi ibe nempilo kuyasiza futhi umama ekopheni.

Indlela encomekayo yokukhulisa umkhiqizo wobisi emabeleni, ukubeka ingane ngokushesha ebeleni ukuze incela. Uma ingane incela kakhulu ilapho uzokhula kakhulu umkhiqizo wobisi.

Ubisi lwebele lwenza izingane zibe nempilo, ziqine futhi zenze kangcono nasesikoleni kunezinye izingane ezingalitholanga ibele.

Ziningi izizathu ezingenza ingane ikhale, akuhlale kuyikuthi ingoba zilambile
Abesifazane abakhulelwe abahamba umtholampilo bayanikwa izaluleko ngesandulela ngculazi babuye bahlolwe isandulela ngculazi ukuze bazi ngesimo sabo, kungakusiza ekutheni ubhekelele impilo yakho neyomtwana wakho.

Umlando wempilo yomtwana wakho kusukela ezalwa kuya eminyakeni emihlanu; kubala isisindo nemigomo kuyobhalwa ekhadini elibizwa ngokuthi IKHADI LOMGOMO. Kumele uqikelele ukuthi uyalithola ikhadi lomgomo esibhedlela noma emtholampilo obelethele kuwo ngaphambi kokuba uye ekhaya.

Ukunika ingane ibele lodwa kusho ukondla ingane ngebele lodwa izinyanga ezine kuya kweziyisithupha (4-6) zokuqala ezelwe umtwana hhayi okunye.

Uma uzonika ibele lodwa kumtwana wakho khumbula ukuthi asikugqugquzeli ukuthi aphuze imithi yesizulu noma oyithengele yona esitolo, anganikwa kuphela imithi kadokotela umnakekeli (CHW) uyokusiza ukuchaza kabanzi kumalunga omndeni ngalokhu.

Yazi ukuthi kumele uphendule uthini kubantu abakuqguqguzela ukuba unike ingane yakho amanzi, iphalishi noma ukudla kwezingane ekubeni wena ukhethe ukunika ibele lodwa.

Uma uthelelekile ngesandulela ngculazi qikelela ukuthi wena nomtwanna wakho niyawasebenzisa amaphilisi/ imithi eniyinikwa emtholampilo.

UKUVAKASHELWA KOKUQALA EKHAYA USUBELETHILE

Sicela uvumele uCHW (umnakekeli) akusize ekuxhumaneni kkwakho nomndeni wakho (i.e ubaba wengane, umama wakho, nomamezala wakho etc.) abangaba nomthelela ezinnqumweni zakho ozozenza ekubhekeni impilo yakho neyomtwana wakho.

Ezinye izifo ziyingozi eziye ziphathe omama abasanda kubeletha kuyancomeka ukuthi uphuthume esibhedlela uma wopha kakhulu, uphelelwa ngamandla noma kuphuma okunukayo esithweni sakho sangasese. Izifo ezihambisana lalezi kubalulekile ukuthi siziyele esibhedlela.

Ezinye izifo ziyingozi eziye ziphathe izingane. Vakashela ngokushesha isibhedlela uma ingane yakho isanda kuzalwa inganceli kahle, noma ingaqinile kahle, noma inokukhala okungajwayelekile, iphalaza okungapheli, ubunzima bokuphefumula, umzimba oshisayo, inkaba yengane inamagciwane nokuba phuzi komzimba noma amehlo. Izifo ezihambisana nalezi kubalulekile ukuthi siziyele esibhedlela.

Ingane ezalwe kungakabi isikhathi noma ezalwe inesisindo esincane idinga ukondliwa njalo njalo ngoba kwesinye isikhathi bayakhathala bese bengakhali ukuze ubone ukuthi uselambile .
Badinga ukunceliswa njalo noma emva kwamahora amabili emini, okungenani kabili ebusuku noma bengakhalanga nama ngabe uyamvusa.

Kubalulekile ukuhlanza izandla zakho ngensipho namanzi ngaphambi kokugeza inkaba yengane. Hlanza inkaba yengane ngensipho namanzi bese uyayilinda yome. Ungayivali inkaba ngamambhandishi noma indwangu. Vumela lokhu okufaswa ngakho inkaba kuziwele khona wenzele ukuvikela ukuthi kungophi.

Ukuhlanza amehlo nsuku zonke kubalulekile ekuvikeleni amehlo omtanakho. Uma ugeza ubuso bomtwanakho qala ngengaphandle lamehlo ngokuthi usule ngokunakekela kusuka ngaphakathi kuya ngaphandle iso ngalinye ngethwula elihlanzekile futhi elimanzisiwe ngamanzi angafakangwa lutho.

Omama ababeka izingane esifubeni engagqokile omama bazo benza umzimba emzimbeni indlela lena encomekayo ukugcina ingane ezalwe isikhathi singakashayi noma ezalwe inesisindo esiphansi ifudumele. Ungacela uCHW (umnakekeli) ukuthi akusize kulokhu.

Kuyancomeka ukuthi sisebenzise indlela eyodwa yokondla umtwana; ukunika ibele lodwa ikona okusemqoka empilweni yomtwana wakho.

Kubalulekile ukuvakashela umtholampilo ngosuku lwesithupha umtwana ezelwe khona umhlengikazi ezohlola impilo yakho neyomtwana wakho.

Ukufaka ingane ebeleni ngendlela kuyasiza ukuvikela izingono ezikayekayo nezivuvukayo futhi kukhulisa umkhiqizo wobisi. Zijwayeze ukubeka ingane ebeleni ngendlela okuyiyona, noma ucele uCHW (umnakekeli) akusize kulokhu.

Uma uthelelekile ngesandulela ngculazi zama ngayoyonke indlela ukuphuza amphilisi noma imithi oyinikwa emtholampilo noma esibhedlela.

Ukunika ingane ubisi lwebele kusho ukunika ibele lodwa hhayi okunye izinyanga ezine kuya kweziyisithupha (4-6) zempilo.

Ukunika ingane ubisi lwethini/ibhodlela kusho ukunikeza ubisi lwetini izinyanga eziyisithupha hhayi okunye.

Yazi ukuthi kumele uphendule uthini kubantu abakuqguqguzela ukuba unike ingane yakho amanzi, iphalishi noma ukudla kwezingane ekubeni wena ukhethe ukunika ibele lodwa.

UKUVAKASHELWA KWESIBILI EKHAYA USUBELETHILE

Sicela uvumele uCHW (umnakekeli) akusize ekuxhumaneni kkwakho nomndeni wakho (i.e ubaba wengane, umama wakho, nomamezala wakho etc.) abangaba nomthelela ezinnqumweni zakho ozozenza ekubhekeni impilo yakho neyomtwana wakho.

Izingane ezincane akumele zihlale endaweni engahlanzekile. Ukungcola okungabonakali okuba sezandleni zabantu kungenza ingane igule, qinisekisa ukuthi wena mama namalunga omndeni niwasha izandla zenu ngamanzi nensipho ngaphambi kokuthinta umtwana. Uma kungenzeka sengathi bengebe baningi abantu abathinta umtwana.

Ezinye izifo ziyingozi eziye ziphathe izingane. Vakashela ngokushesha isibhedlela uma ingane yakho isanda kuzalwa inganceli kahle, noma ingaqinile kahle, noma inokukhala okungajwayelekile, iphalaza okungapheli, ubunzima bokuphefumula, umzimba oshisayo,

inkaba yengane inamagciwane nokuba phuzi komzimba noma amehlo. Izifo ezihambisana nalezi kubalulekile ukuthi siziyele esibhedlela.

Ezinye izifo ziyingozi eziye ziphathe omama abasanda kubeletha kuyancomeka ukuthi uphuthume esibhedlela uma wopha kakhulu, uphelelwa ngamandla noma kuphuma okunukayo esithweni sakho sangasese. Izifo ezihambisana lalezi kubalulekile ukuthi siziyele esibhedlela.

Yazi ukuthi kumele uphendule uthini kubantu abakuqguqguzela ukuba unike ingane yakho amanzi, iphalishi noma ukudla kwezingane ekubeni wena ukhethe ukunika ibele lodwa.

Kubalulekile ukuvakashela umtholampilo ngosuku lwesithupha umtwana ezelwe khona umhlengikazi ezohlola impilo yakho neyomtwana wakho.

Uma unesandulela ngculazi KUBALULEKILE ukuthi ingane yakho iphuze umuthi obizwa nge Cotrimozole oyowunikwa umhlengikazi noma udokotela kuze kubuye imiphumela yesandulela yengane.

Uma uzizwa ubuthaka noma ungaphilile yazisa umnakekeli (CHW) futhi umvumele ukuthi akulekelele.

Khumbula ukulandela indlela encomekayo yokuhlanza inkaba yengane namehlo ukuze umvikele emagciwaneni nasezifweni umtwana wakho.

Ukubeka ingane esifubeni sikamama ingagqokile (inyama enyameni) uma ingane izalwe kungakabi isikhathi noma izalwe inesisindo esiphansi uze weneliseke ngesisindo sakhe.

Ukunika ingane ibele kusho ukumnika ibele lodwa hhayi okunye izinyanga ezine kuya ezinyangeni eziyisithupha.

Ukunika ingane ubisi lwethini/ ibhodlela kusho ukumnika ibhodlela lodwa izinyanga eziyisithupha

UKUVAKASHELWA KWESITHATHU EKHAYA USUBELETHILE

Sicela uvumele uCHW (umnakekeli) akusize ekuxhumaneni kkwakho nomndeni wakho (i.e ubaba wengane, umama wakho, nomamezala wakho etc.) abangaba nomthelela ezinnqumweni zakho ozozenza ekubhekeni impilo yakho neyomtwana wakho.

Phuthuma esibhedlele ngokushesha uma wopha, izinyawo ezivuvukile, ukushoda kwegazi emehlweni, uphalaza kunganqamuki noma umkhuhlane.

Ezinye izifo ziyingozi eziye ziphathe izingane. Vakashela ngokushesha isibhedlela uma ingane yakho isanda kuzalwa inganceli kahle, noma ingaqinile kahle, noma inokukhala okungajwayelekile, iphalaza okungapheli, ubunzima bokuphefumula, umzimba oshisayo, inkaba yengane inamagciwane nokuba phuzi komzimba noma amehlo. Izifo ezihambisana nalezi kubalulekile ukuthi siziyele esibhedlela.

Ukhumbule ukukhuluma nokudlalisa umntwana wakho.Abantwana abathola ukukhulunyiswa nokudlaliswa ngasosonke isikhathi, yibo abayebahlakaniphe kakhulu bathole nokushesha ukufunda ulimi lwabo masinyane.

Uma uzizwa udangele, kuthi khala, usha ukucasuka, kungalaleki ebusuku futhi unobunzima ekubhekeni umtwana wakho isikhathi esiningi, xoxisana nomnakekeli (CHW) futhi umvumele ukuthi akulekelele.

Imibono yakho ngokubaluleka kokukhetha indlela eyodwa yokondla utwana nokuyiyona yona kuwena iyona eyokubeka esinqumweni sokuthi uzomondla kanjani.

Kubalulekille ukuthi uzazi futhi uzixazulule izinto ezingaba zithiyo endleleni oyikhethile yokondla umtwana.

Kubalulekile ukuhlela ukuthi uvakashele umtholampilo khona nizonakekela impilo kamama nomtwana.

Umnakekeli (CHW) uzokulekelela wena nomndeni wakho kulokho osewukukhethile ukuthi uzokondla ngakho ingane yakho, kungaba ibele noma ithini/ ibhodlela.

Ukunika ingane ibele kusho ukumnika ibele lodwa hhayi okunye izinyanga ezine kuya ezinyangeni eziyisithupha.

Ukunika ingane ubisi lwethini/ ibhodlela kusho ukumnika ibhodlela lodwa izinyanga eziyisithupha

UKUKUVAKASHELWA KWESINE EKHAYA USUBELETHILE

Xoxisana ne-CHW ukuze ibeno-kukulekelela ezingxoxweni nomndeni wakho, njengo maqondana wakho, umama kanye nomamezala okuyibo abantu abangase babe nemibono yabo ethile engase ibenemithelela ethile ezinqumeni zakho ezenzayo mayelana nendlela othanda ngayo ukunakekela umntwana wakho.

Kungaba kuhle uma wena nomntwana wakho kanye nomaqondana wakho uma kungenzeka nonke niye emtholampilo evikini lesithupha emva kokubeletha.Umntwana uyokalwa, agonywe bese nawe uthole ukumpompolwa.

Uqaphelisise ukuthi umntwana uyahlolelwa igciwane lesandulelangculazi ekuvakasheni kwamaviki ayisithupha.Lohku kuyosiza ukuthi umntwana athole ukunakekeleka okusemqoka.

Ukhumbule ukuphatha ikhadi lomgomo ngazozonke izikhathi uma uvakashela emtholampilo ukuze umntwana agonywe, ekalwa bese akwazi ukuthola nemithi yakhe.

Ukhumbule futhi ukuthi ukukhala komntwana iyona ndlela akwazi ukusho ngayo uma kunento engasamphethe kahle njengokufuna ukushintswa inabukeni elimanzi, ukuphathwa, ukulala, ukucikeka.Akusho ukuthi abantwa akhala njalo besuke bekhaliswa ukulamba.

Ukhumbule ukukhuluma nokudlalisa nomntwana wakho. Abantwana abathola ukukhulunyiswa nokudlaliswa ngasosonke isikhathi, yibo abahlakanipha kakhulu bathole nokushesha ukufunda ulimi lwabo masinyane

Ezinye zezifo ezibanjwa ngabantwana zinobungozi, ubohambisa umntwana wakho esibhedlela masinyane uma umbona enobunzima bokuncela, ukukhala okungajwayelekile, ephalaza kakhulu, ephefumula kanzima, umzimba wakhe ushisa, nenkaba yakhe imbomvu, ukudlikiza komzimba,amehlo kanye nenkaba eyelo (Jaundice.)

Ezinye zezifo futhi eziyezigulise abantu abasanda kukhululeka zinobungozi. Kundingekile ukuba usheshe uphuthume esibhedlela uma
wopha kakhulu, uzizwa unenzululwane ekuqulekisayo, nephunga elingejwayelekile esithweni sakho sangasese.

Ningakwazi ukuthi wena nomaqondana wakho nihlele emtholampilo eseduzane kwenu ngesithuba nexoxisana ngamalungiselelo okuvakashela kuwo evikini lesithupha ukuze nithole usizo kulomnyango wokuhlela imindeni.

UKUVAKASHA KWESIHLANU EKHAYA USUBELETHILE

Xoxisana ne-CHW ukuze ibeno-kukulekelela ezingxoxweni nomndeni wakho, njengo maqondana wakho, umama kanye nomamezala okuyibo abantu abangase babe nemibono yabo ethile engase ibenemithelela ethile ezinqumeni zakho ezenzayo mayelana nendlela othanda ngayo ukunakekela umntwana wakho.

Zijwayeze ukuba nokuqonda nolwazi olugcwele mayelana nekhadi lomntwana wakho lokugoma.Shiyelana ulwazi no CHW ngalelikhadi emuveni kokuba kade evakashele emtholampilo emasontweni ayisithupha.

Ukhumbule ukukhuluma nokudlalisa umntwana wakho.Abantwana abathola ukukhulunyiswa nokudlaliswa ngasosonke isikhathi, yibo abayebahlakaniphe kakhulu bathole nokushesha ukufunda ulimi lwabo masinyane.

Ukuhlela undeni kwenza umama asheshe asimame ibuye yonke impilo yakhe asimame ngokwanele, kuye kwenze nokwehlisa ukushona komama bebulawa izifo eziphathelene nokukhulelwa kanye nokubeletha.

Imibono yakho mayelana nokwazi ukuba semqoka kangakanani ukuncelisa ibele lodwa kwenza kubelula kuwe ukwenza izinqumo mayelana nendlela uzokwazi ukuyikhetha yofida umntwana wakho.

Kusemqoka ukuba nolwazi lokuthi uzobhekana kanjani nezigqinamba ezingase zibe sendleleni yakho zikuphazamise endleleni yakho osuyikhethile yokufida umntwana wakho.

Kuyoba semqoka ukukwazi ukubona izithizathiza ezingase zivimbe indlela oyiqokile yokufida umntwana wakho, bese uba nendlela ephusile yokubhekana nazo.

Kusemqoka ukupulana ukuvakashela kwakho emtholampilo ukuyozihlola wean nomntwana wakho.

I CHW iyosizana njalo nawe kanye nomdeni wakho ukuze nilekelelane nonke ngokuncelisa ibele lodwa noma ifomula yodwa kwenikukhethele umntwana wenu.

Umntwana uyawuphuza umuthi awunikwe ngudokotela noma ngunesi lokhu akusho ukuthi uyafidwa ngalokho.

Ukuncelisa ibele lodwa kuze kuphele izinyanga ezine-kuya kweziyisithupha kuphela kusho unganiki umntwana amanzi noma yini enye ngaphandle kwemithi ekhishwe ngudokotela kuphela.

Ukupha umntwana ifomula kusho ukumupha ifomula kuphela kuze kuphele izinyanga eziyisithupha.

Qaphela ukuyekisa ibele emntwaneni uma abantwana beshiyana ngeminyaka emithathu,lokhu konciphisa ukushona kwabantwana abangaphansi kweminyaka eihlanu bezelwe.

Ngaphambi kokuba uyekise umntwana wakho ibele xoxisana ne CHW kanye nomdeni wakho kakhulukazi labo kuwo abazoba nomthelela kumaplani akho okuyekisa umntwana wakho ibele bese nixoxisana ngezindlela abzokusiza ngazo kukho konke okuphathelene nalesisimo.

Uqikekele ukulandela into ebesewuyihlosile ukuyenza mayelana nokuyekisa umntwana ibele, uma uhlangabezana nezinkinga uthintane ne CHW ngokushessha khona niyoxoxisana ngazo

Uma unegciwanelesandulelagculazi uyokwamukeliswa ubisi lwethini izinyanga eziyisithupha ekliniki yangakini ukuze ukwazi ukufida umntwana wakho.

Uma unegciwanelesandulelagculazi unakekele ukuthi umntwana wakho uyahlolelwa igciwane emasontweni ayisithupha. Umntwana wakho uyonikezwa umuthi obizwa ngokuthi i cotrimoxazole aze athole imiphumemela yakhe ye test ye HIV abese exoxisana nodokotela noma nenesi ngohlelo okufanele kuqhuthwe ngalo mayelana
nempilo yakhe umntwana.

UKUNEZELA KOKUVAKASHA KOKUQALA EKHAYA KWABANTWANA ABASHAYE ISIKALI ESINCANE

Ukwenza ithuba elivulelekile le CHW ukuba ixoxisane nabomndeni wakho abanjengo phathina wakho,ngumamezala, kanye nabanye abangase babe nezeluleko kanye nezinqumo ezithize empilweni yakho nomtwana kuyoba nosizo olukhulu kuwena nomtwana wakho.

Ezinye zezifo futhi eziyezigulise abantu abasanda kukhululeka zinobungozi. Kundingekile ukuba usheshe uphuthume esibhedlela uma
wopha kakhulu,uzizwa unenzululwane ekuqulekisayo, nephunga elingejwayelekile esithweni sakho sangasese.

Ezinye zezifo ezibanjwa ngabantwana zinobungozi, ubohambisa umntwana wakho esibhedlela masinyane uma umbona enobunzima bokuncela, ukukhala okungajwayelekile, ephalaza kakhulu, ephefumula kanzima, umzimba wakhe ushisa, nenkaba yakhe imbomvu, ukudlikiza komzimba,amehlo kanye nenkaba eyelo (Jaundice.)

Abantwana abazalwe beshaya isikali esincane badinga ukufidwa kaningana kunalaba abanye futhi babanokukhathala uma bethi bayakhala ukuze bakwazise
ukuthi balambile. Baphe ubisi uma bekhombisa ukulidinga njalo ngemuva
kwamahora amabili emini nakabili ebusuku,noma ngabe akakhali,futhi uze ubavuse uma belele.

Uma usebenzisa indlela yokumbeletha ngesifuba, (Kangaroo Care) uqaphele ukuthi umbeke kuwe ngendlela efanele enithokomalisayo nobabili.
Ukupha umntwana ifomula kusho ukumupha ifomula kuphela kuze kuphele izinyanga eziyisithupha.

Ukuncelisa ibele lodwa kuze kuphele izinyanga ezine-kuya kweziyisithupha kuphela kusho ungamuphi umntwana amanzi noma yini enye ngaphandle kwemithi ekhishwe ngudokotela kuphela

Sebenzisa indlela eyodwa yokufida umntwana wakho. Ibele lodwa yilo elisemqoka

Ukubamba kahle ingono yebele komntwana yikhona okuye kuvimbele ikudabuka kwengono, futhi kuye kwehlise kakhulu ubisi emabeleni. Zifundise ukufaka kahle umntwana wakho ebeleni bese ucela nosizo lwe CHW.

Ukhumbule ukuvakashela ekliniki ngelanga lesithupha usubelethe ukuze unesi ahlole impilo yakho kanye neyomntwana wakho.

UKUNEZELA KOKUVAKASHA KWESIBILI EKHAYA KWABANTWANA ABASHAYA ISIKALI ESINCANE

Ezinye zezifo futhi eziyezigulise omama abasanda kukhululeka zinobungozi kakhulu,kubalulekile ukuthi uphuthume esibhedlela uma wopha kakhulu uzizwa unenzululwane ekuqulekisayo, nephunga elingejwayelekile esithweni sakho sangasese. Izifo ezitshengisa lezimpawu kumele uphuthume esibhedlela lapho zizoya kothola ukwelashwa khona.

Ezinye zezifo ezibanjwa ngabantwana zinobungozi, ubohambisa umntwana wakho esibhedlela masinyane uma umbona enobunzima bokuncela, ukukhala okungajwayelekile, ephalaza kakhulu, ephefumula kanzima, umzimba wakhe ushisa, nenkaba yakhe imbomvu, ukudlikiza komzimba,amehlo kanye nenkaba eyelo (Jaundice.)

Abantwana abazalwe beshaya isikali esincane badinga uthando nokufidwa kaningana kunalaba abanye futhi babanokukhathala uma bethi bayakhala ukuze bakwazise ukuthi balambile. Bancelise njalo emuva kwamahora amabili,okungenani,nakabili ebusuku. Lokhu kufanelekile ukuthi uzame ukukwenza noma ngabe umntwana wakho engakhali.,noma uze umvuse noma kuthiwa ulele.

Uma usebenzisa indlela yokumbeletha ngesifuba, (Kangaroo Care) uqaphele ukuthi umbeke kuwe ngendlela efanele enithokomalisayo nobabili.

Ukuncelisa ibele lodwa kuze kuphele izinyanga ezine-kuya kweziyisithupha kuphela kusho unganiki umntwana amanzi noma yini enye ngaphandle kwemithi ekhishwe ngu dokotela kuphela.

Ukupha umntwana ubisi lwethini kusho ukumupha lona kuphela kuze kuphele izinyanga eziyisithupha.

Ukuncelisa ibele lodwa kuze kuphele izinyanga ezine-kuya kweziyisithupha kuphela kusho ungamuphi umntwana amanzi noma yini enye ngaphandle kwemithi ekhishwe ngudokotela kuphela

Sebenzisa indlela eyodwa yokufida umntwana wakho. Ibele lodwa yilo elisemqoka.

Ukubamba kahle ingono yebele yikho komntwana kuvimbela ikudabuka kwengono kwehlise kakhulu ubisi emabeleni. Zifundise ukufaka kahle umntwana wakho ebeleni ucele nosizo lwe CHW.

Appendix H: Topic Guide

The topic guide explored the following areas:

- What are your general views regarding the value of breastfeeding and formula feeding
- What support exists for you to make exclusive breastfeeding or formula feeding a viable option?
- What advice and support is given to you about breastfeeding by family members, partners, and clinic professionals?
- What enables you to adhere to exclusive infant feeding?
- What have been the biggest challenges for you to maintain exclusive infant feeding?
- What are your beliefs regarding the value of infant caring practices?
- What cultural/traditional/lay practices do you practice/exist in your community regarding infant caring?
- What do think are the problems around disclosure and how does it affect infant feeding practices? What are your experiences in this regard?
- What issues regarding infant caring practices do you think should be noteworthy?.
- What role do men play in your lives when it comes to infant caring support and decisions?
- What is your general opinion about the booklet?
- Other issues they think are relevant to infant feeding and caring?

Appendix I: The revised booklet

ANTENATAL VISIT 1

How are you doing with your pregnancy - are you well

Your baby needs special care and attention- it is important to go to ANC at least 4 times- even if you feel healthy.

Some sicknesses that pregnant women get are dangerous for the mother and baby and can best be treated at a health facility'.

As soon as you have bleeding, headache, swollen legs, pale eye lids, excessive vomiting or fever you must go straight to the clinic

Eating more food and healthy foods is important for your health and is also good for the health of your unborn baby

Prepare for your hospital delivery by putting money aside.

Have you made emergency plans to get to the hospital if you go into labour during the night.

If you smoke or drink alcohol during your pregnancy this passes directly into your unborn baby

It is very important that you take all the supplements that the clinic will give you during your ANC visits as these are very important for your health and for that of your baby

ANTENATAL VISIT 2

You must only use one method of feeding – either exclusive breastfeeding or formula feeding. Exclusive breastfeeding is best for babies up to 4-6 months.

All babies are hungry after their journey but some are too tired to let you know through crying – all babies should be fed as soon as the cord is cut-early feeding makes the baby strong and healthy and can help prevent the mother bleeding'
The best way to start the milk, or to increase the quantity of milk, is to put the baby to the breast as early as possible to suck. The more they suck the more milk there will be

Breast milk makes babies healthier, stronger and they do much better at school than babies who are not breastfed. There are a lot of different reasons why babies cry – it does not always mean that they are hungry. Feel good about knowing your HIV status. Knowing your status enables you to look after your health and that of your baby

Make sure that you get your baby's Road to Health Card from the hospital where you give birth. If you are HIV+ make sure that you take your medicine and make sure that your baby takes their medicine that the clinic gives you.

Traditional or over the counter medicines should not be given to babies who are exclusively breastfed

POSTNATAL VISIT 1

Some sicknesses that recently delivered women contract are dangerous for the mother. Go to a facility immediately if you have excessive bleeding, loss of consciousness or foul discharge. Diseases with these symptoms need to be treated immediately by the hospital

Some sicknesses that newborns contract are dangerous. Go to a facility immediately if the newborn has difficulty sucking, a weak or abnormal cry, is weak/soft, has excessive

vomiting, difficulty breathing, hot body, red umbilicus, convulsions or jaundice. Diseases with these symptoms need to be treated immediately at the hospital

Small babies need feeding frequently but are sometimes too tired to cry to tell you they are hungry. Show your love by feeding small babies every two hours and at least twice at night- even if they don't cry or you have to wake them up

Hygienic cord care, eye care

Thermal care, skin to skin care and Kangaroo care if needed for preterm babies
Use only one method of feeding – exclusive breastfeeding is best for your baby
Make sure that you go to the clinic at six days for your clinic visit – this is to check on your and your baby's health
Good attachment to the breast – avoid cracked nipples
If you are HIV+, make sure that you and your baby take the medicines that the clinic / hospital gives you

POSTNATAL VISIT 2

Small babies hate dirt. The invisible dirt on people's hands can make them sick- make sure the mother and family members wash their hands with soap before touching the baby and limit the number of people who touch the baby

Some sicknesses that newborns catch are dangerous. Go to a facility immediately if the newborn has difficulty sucking, a weak or abnormal cry, is weak/soft, has excessive vomiting, difficulty breathing, hot body, red umbilicus, convulsions or jaundice.

Some sicknesses that recently delivered women catch are dangerous for the mother. Go to a facility immediately if the delivered woman has excessive bleeding, loss of consciousness or foul discharge. Know how to respond when people advise you to give your baby water, porridge or baby food

Make sure that you go to the clinic at six days for your clinic visit – this is to check on your and your baby's health. Make sure that if you are HIV+ that your baby takes cotrimoxazole until they are tested for HIV at six weeks
Ask whether the mother has found she feels fragile and weepy
Hygienic cord care, eye care

Thermal care, skin to skin care and Kangaroo care if needed for preterm babies

POSTNATAL VISIT 3

As soon as you have bleeding, headache, swollen • legs, pale eye lids, excessive vomiting or fever insist that they/you go straight to a health facility.

Some sicknesses that newborns catch are dangerous. Go to a facility immediately if the newborn has difficulty sucking, a weak or abnormal cry, is weak/soft, has excessive vomiting, difficulty breathing, hot body, red umbilicus, convulsions or jaundice.

Remember to talk to and play with your baby – this will make your baby more intelligent and will help them develop their language

Who are the key decision makers at home

Importance and confidence of the choices you are making

Signs of postnatal depression
Plan follow-up visits to the clinic to check on your and your baby's health
Continued support for feeding choice
Discouragement of solids introduction

POSTNATAL VISIT 4

Some sicknesses that newborns catch are dangerous. Go to a facility immediately if the newborn has difficulty sucking, a weak or abnormal cry, is weak/soft, has excessive vomiting, difficulty breathing, hot body, red umbilicus, convulsions or jaundice.

Some sicknesses that recently delivered women catch are dangerous for the mother.
Go to a facility immediately if the delivered woman has excessive bleeding, loss of consciousness or foul discharge. Remember that babies cry for lots of reasons – natural history of crying

Remember to talk to and play with your baby – this will make your baby more intelligent and will help them develop their language

Make sure that you attend the clinic at six weeks for the mother to have access to family planning, and the baby to be weighted and immunised

Make sure that your baby is tested for HIV at six weeks – this will ensure that you will be able to give your baby the best care that is possible

Continued support for feeding choice

POSTNATAL VISIT 5

Infant weight from clinic card (from 6 week visit)

Remember to talk to and play with your baby – this will make your baby more intelligent and will help them develop their language
Family planning helps the mother to regain her health and strength before the next pregnancy, and reduces the deaths of women related to pregnancies and birth.

Importance and confidence of choices you are making

Family planning and counselling message
Stop breastfeeding at about 4-6 months, if children are spaced more than 3 years apart. This will reduce the risk of death of children under 5years of age.

Further input on feeding including advice regarding weaning
Continued support for feeding choice
Formula sustainability for HIV positive women using formula milk
Has the child been tested for HIV at six weeks and receiving cotrimoxazole if tested positive

EXTRA VISIT 1 FOR LOW BIRTH WEIGHT INFANT

Some sicknesses that catch recently delivered women are dangerous for the mother. Go to a facility immediately if the delivered woman has excessive bleeding, loss of consciousness or foul discharge. Diseases with these symptoms need to be treated immediately with hospital medicine

Some sicknesses that catch newborns are dangerous. Go to a facility immediately if the newborn has difficulty sucking, a weak or abnormal cry, is weak/soft, has excessive vomiting, difficulty breathing, hot body, red umbilicus, convulsions or jaundice• diseases with these symptoms need to be treated immediately with hospital medicine'

Small babies need feeding frequently but are sometimes too tired to cry to tell you they are hungry. Show your love by feeding small babies every two hours and at least twice at night- even if they don't cry or you have to wake them up

Importance and confidence of your choices
If using Kangaroo care make sure baby is positioned correctly
Use only one method of feeding – exclusive breastfeeding is best for your baby
Make sure that you go to the clinic at six days for your clinic visit – this is to check on your and your baby's health

Good attachment to the breast – avoid cracked nipples

EXTRA VISIT 2 FOR LOW BIRTH WEIGHT INFANT

Some sicknesses that catch recently delivered women are dangerous for the mother. Go to a facility immediately if the delivered woman has excessive bleeding, loss of consciousness or foul discharge. Diseases with these symptoms need to be treated immediately with hospital medicine

Some sicknesses that catch newborns are dangerous. Go to a facility immediately if the newborn has difficulty sucking, a weak or abnormal cry, is weak/soft, has excessive vomiting, difficulty breathing, hot body, red umbilicus, convulsions or jaundice diseases with these symptoms need to be treated immediately with hospital medicine

Small babies need feeding frequently but are sometimes too tired to cry to tell you they are hungry. Show your love by feeding small babies every two hours and at least twice at night- even if they don't cry or you have to wake them up

If using Kangaroo care make sure baby is positioned correctly

Use only one method of feeding – exclusive breastfeeding is best for your baby

Good attachment to the breast – avoid cracked nipples

Message on the back of the booklet

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