

PRIORITIES IN CHILD HEALTH

Easily digestible information for
health workers on managing
the young child



BOOKLET 1

INTRODUCTION

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health workers on managing
the young child

The EQUITY Project, South Africa Nursing Council Building
3rd Floor, 602 Pretorius Street, Arcadia, Pretoria
PO Box 40394, Arcadia, 0007, South Africa
Telephone: +27 (0) 344 6117
Facsimile: +27 (0) 12 344 6115
Email: publications@equityproject.co.za
Website: www.equityproject.co.za



BOOKLET 1

INTRODUCTION

FOREWORD

This series of booklets is a course of self-based learning on the comprehensive management of the sick infant and young child. It is intended for use by first level health workers who, in South Africa, are generally nurses. The principles used are based on the World Health Organisation strategy "Integrated Management of Childhood Illness (IMCI)". For those who have not yet benefitted from full IMCI training, the booklets provide specific information on important elements of child health care that each nurse should know and use. As her knowledge and experience expands, she will increasingly approach each child in the comprehensive manner promoted in this series. The booklets are not intended as a substitute for existing training programmes, but rather as an adjunct to such learning.

Short case studies are employed to illustrate problems to be discussed in each section.

Introduction to comprehensive management

- Booklet 1* *Underlying principles*
 The Road to Health Chart
 Nutrition
 Maternal well-being
- Booklet 2* *Immunisation*

Management of the sick child under 5 years

- Booklet 3* *Acute respiratory infection*
Booklet 4 *Diarrhoeal disease*
Booklet 5 *Promoting healthy growth*

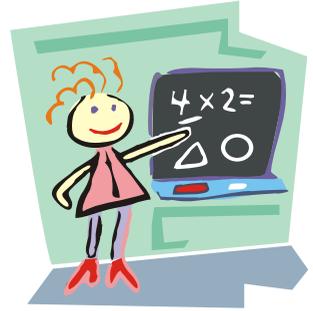
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At the end of the course the learner should

- be better able to assess and manage children with the important and common illnesses
- understand and apply the most important preventive and promotive strategies in line with national policy
- communicate better with carers and be more accessible to the child and his/her family

Before you start, why not test your knowledge by answering the following questions!



QUESTIONS ON BOOKLET 1

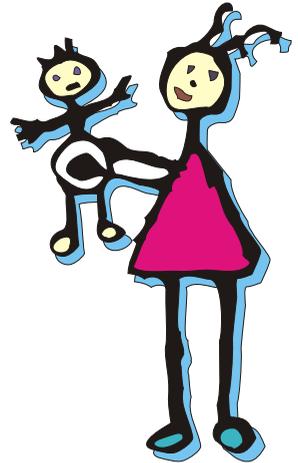
Are the following statements true or false? If false, correct them!

1. The integrated approach to childhood illness is intended for use only by nurses.
2. The integrated approach to childhood illness emphasises provision of curative services.
3. The integrated approach to childhood illness is intended for children up to 12 years of age.
4. Measles may be more severe in malnourished children.
5. Complementary foods should always be started at 4 months of age.
6. Children born to mothers who are poorly nourished have a greater risk of mortality.
7. The Road to Health Chart can be used to record a child's illnesses.
8. The centile lines are based on a large sample of South African children.
9. The "danger line" is 60% of the third centile weight.
10. Weight can be recorded up to the age of 5 years.
11. Early feeding of solids to a baby may result in diarrhoea.
12. Early feeding of solids to a baby may diminish the amount of breast milk.
13. Early feeding of solids to a baby may result in early pregnancy of the mother.
14. Early feeding of solids may cause baby to gain too much weight.
15. Breast milk contains less lactose than cow's milk.
16. A baby whose growth is along the 3rd centile line is malnourished.
17. Breast milk contains immune cells and antibodies.
18. Having to return to work is no reason to stop breast feeding.
19. Spinach is a good source of Vitamin A.
20. Cow's milk has adequate amounts of iron for the baby.

Answers on page 30

MEET VUSI

Vusi, aged 10 months has just arrived in the city with his mother from a small town 100 kilometres away. She is worried about some sores which have come out on his face, so she takes him to a health facility. The nurse is very busy and they must wait for 2 hours before being seen. The consultation lasts only a minute. The nurse tells her “this is just impetigo”, and gives an ointment she is to apply 3 times a day. Two weeks later Vusi is brought back to the health facility. He has been very feverish for 4 days, and has now come out in a rash all over his body. Vusi looks very ill; he has lost weight, is coughing and breathing quickly.



In this, and the next booklets, we are going to discuss ways in which Vusi's visit to the health facility could have been made more effective, and how his serious illness could have been prevented.

Road to Health Chart 

IMPORTANT: Always take this card with you when you visit any health clinic, doctor or hospital, and present it the staff as usual only.

Client's name: Vusi Mhlangu Sex: M Male

Date of birth: 3.3.92 Place of birth: Kruger

SW: 2200 Birth length: 34cm Birth head circumference: 34cm

Problems during pregnancy/childhood:

AFSA: 1 (100%) 4 Genitourinary: 39 Diabetes: 369

18 (100%) 10

Screening for: X/1056

V.A.C.C.	Date given	Signature	BOOSTERS	
			Date given	Signature
1	<u>12/15/92</u>	<u>[Signature]</u>		
2	<u>12/15/92</u>	<u>[Signature]</u>		
3	<u>12/15/92</u>	<u>[Signature]</u>		
4	<u>12/15/92</u>	<u>[Signature]</u>		
5	<u>12/15/92</u>	<u>[Signature]</u>		
6				
7				
8				
9				
10				

Note: The 'Measles' row in the table is circled in red.

What do you think could be the cause of Vusi's serious illness?

Probably measles with pneumonia as a complication.

Could it have been prevented?

Yes. **Vusi** caught measles while waiting in the overcrowded health facility. Waiting areas in health centres are places where measles can be transmitted. All children should be checked to see if they have been immunised. The opportunity to immunise **Vusi** against measles was missed.

How can a busy doctor or nurse be sure that he or she does not make mistakes like this?



The nurse should have examined his Road to Health Chart, which would have showed that he had not yet been given measles immunisation. Had he received it then, measles would have been prevented.

WHAT IS INTEGRATED MANAGEMENT?

'**INTEGRATED MANAGEMENT**' makes a difference because in every encounter with a sick child:

- Not only the health problem, but the child as a whole are assessed - for nutrition, development, immunisation and other possible risk factors*
- The child is treated*
- The mother or carer is counselled*
- Clear advice about follow-up is given*

WHAT ARE THE ULTIMATE AIMS OF THIS STRATEGY?

If the health worker follows this strategy with each child she/he will:

- Prevent more illness from occurring*
- Reduce the risks of death in the young children*
- Reduce the frequency and severity of illness*
- Reduce disability*
- Contribute to their child's improved growth and development*

THE SOUTH AFRICAN UNDER 5'S POPULATION

According to the 1996 census, South Africa's child population of 0-5 year olds is about 6 million, representing 16% of the total population. About 1.5 million babies are born each year.

The health of these children shows huge disparities. There are great differences between races and regions, and between urban and rural areas. Deaths in the first year of life per thousand live births (Infant Mortality Rate) are a crude but fairly easy measure of health in a child population. Estimates of IMR's vary between 11 and 81 per thousand live births. The South African Health and Demographic Survey (SADHS) of 1998 estimated IMR about 40 deaths per 1000 live births. It is the rural black children from poor homes and those who have recently moved from rural to urban shack areas who are most likely to die.

- Infant deaths due to inadequate care of the mother during her pregnancy and delivery or soon after make up fully 33% of all the deaths in this age group. These are called 'perinatal deaths' (The perinatal mortality rate is the number of still births older than 28 weeks gestation plus the deaths of babies up to seven days of age per 1000 total births in that year.)
- Low birth-weight (weight less than 2.5 kilograms at birth - also the result of poor maternal health) increases the later risks to the child's development.
- After birth, young children often die early or suffer needlessly from ordinary diseases which are easily preventable.



THE MAJOR KILLING DISEASES

DO YOU KNOW WHAT THESE EASILY PREVENTABLE DISEASES ARE?

Seven in every 10 of the child deaths in developing countries around the world are due to **5 DISEASES**:

THE FIVE MAIN CHILDHOOD KILLING DISEASES INCLUDE

- Diarrhoea
- Acute Lower Respiratory Infections (ALRI)
- Measles
- Malnutrition
- Malaria

Diarrhoea is the major killer of babies in poor rural areas, especially where water supplies are unsafe or unreliable.

Acute Lower Respiratory Infection, often called pneumonia, are infections of the chest that cause cough and fast breathing. These affect all socio-economic groups.

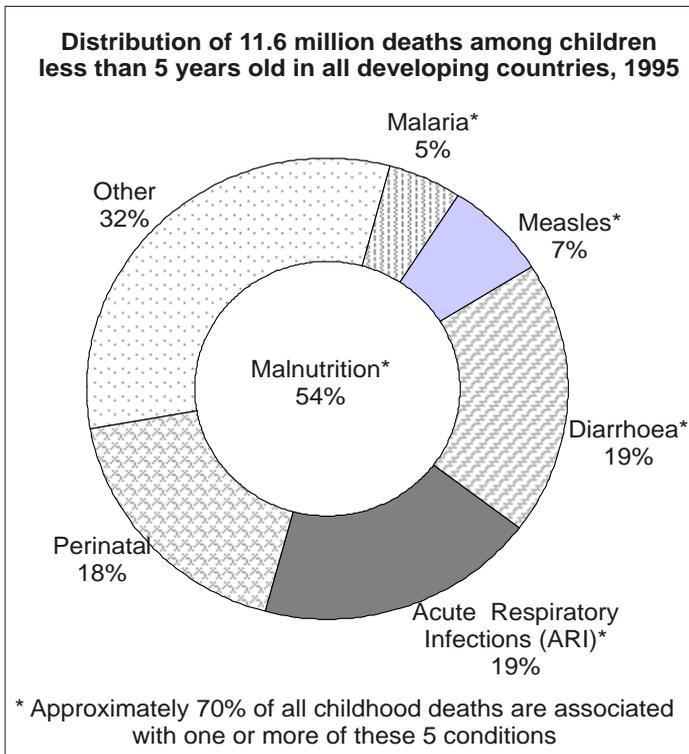
Measles, thanks to successful immunisation campaigns, is now much less common in South Africa than it was a few years ago, but is far from eliminated. Some, like **Vusi**, can still suffer or even die from measles. Every child must be immunised against measles.

A malnourished child suffers more frequent and severe infections, so that **malnutrition** generally kills by adding to the severity of the other diseases.

Malaria is a major problem in many parts of South Africa, such as Kwazulu-Natal, Mpumalanga and the Northern Province. It is widespread in adjoining Mozambique and Zimbabwe. Because people travel so freely across borders today, everyone should be aware of the potential threat of malaria.

Every day, millions of parents seek health care for their children, taking them to hospitals, health centres, pharmacists, general practitioners and traditional healers. At least three out of four of these children are suffering from one of these five conditions.

This chart shows the distribution of 11.6 million child deaths in all developing countries in the year 1995 (WHO June 1997)



IN THIS FIGURE 32% OF DEATHS ARE CAUSED BY "OTHER" ILLNESSES. WHAT DO YOU THINK THE MAIN CAUSES OF DEATH IN THE "OTHER" GROUP ARE?

- **Accidents, poisoning and violence** in and outside the home are major causes.
- **HIV infection** is playing an ever increasing role in mortality of children.

Nearly all children in the cities of South Africa have ready access to simple and affordable care which will cure or prevent the five illnesses. However millions of poor rural-dwelling children do not have access to this same life-saving care. CORRECT CASE MANAGEMENT CAN GREATLY LESSEN THE NUMBER OF DEATHS AND CHRONIC ILL-HEALTH FROM THESE CONDITIONS.

CASE MANAGEMENT STRATEGIES

DO YOU KNOW WHAT THESE STRATEGIES ARE?

- For diarrhoea* - *Oral rehydration therapy*
- For respiratory infection* - *Antibiotics for pneumonia*
- For measles* - *Vitamin A supplementation (better still is prevention by immunisation!)*
- For malnutrition* - *Feeding and micronutrient supplementation*
- For malaria* - *Available and appropriate antimalarial drugs*

Over the last two decades the World Health Organisation and other international agencies have helped to implement simple relatively inexpensive treatment strategies.

These strategies have resulted in significant reductions in deaths and hospital admissions in many countries.

WHAT ARE THE DRAWBACKS OF THESE STRATEGIES?

Important as they are, these strategies against single disorders have several drawbacks:

- *They do not place emphasis on prevention and the promotion of good health*
- *Children often present with more than one clinical problem. For example:*
 - *Pneumonia AND diarrhoea are frequently present together in children with measles or malnutrition*
 - *Rapid breathing, may be a sign not only of pneumonia, but also of malaria or severe diarrhoea*
- *They do not consider the well-being of the mother or carer*

In the integrated approach, these broader aspects aimed at maintaining the well-being of the child are considered at every encounter with a sick child.

WHAT ARE THE PREVENTIVE AND PROMOTIVE FACTORS WHICH MUST BE CONSIDERED?

- Monitoring the child's growth and early home action to promote growth (See **Booklet 5**)
- Ensuring proper nutrition
- Endeavouring to ensure maternal well-being and counselling
- Ensuring that immunisation is up to date (See **Booklet 2**)



These principles apply equally to all those dealing with sick children, whether lay health workers, doctors and nurses in health facilities or family practitioners in private practice.

HOW WOULD THE INTEGRATED APPROACH HAVE HELPED VUSI?

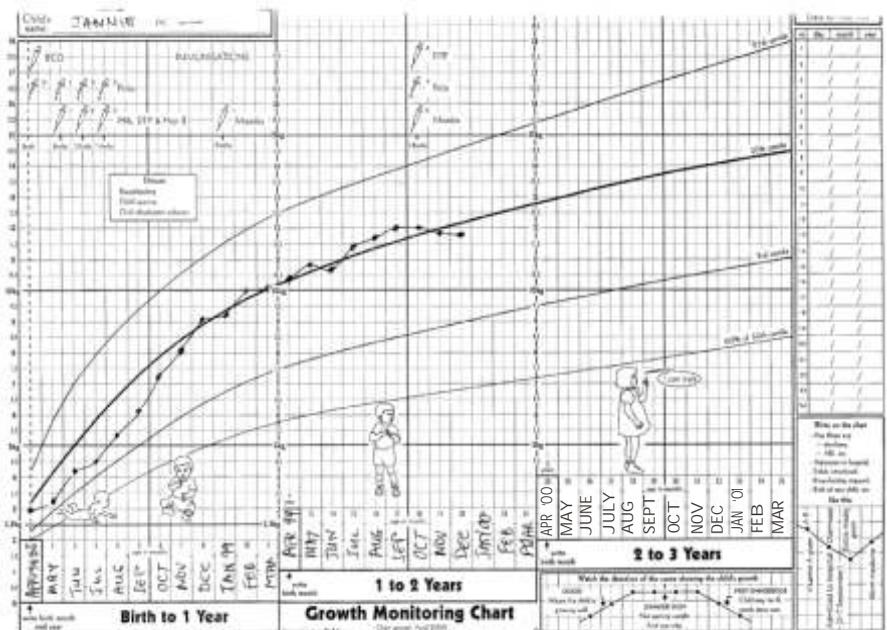
In **Vusi's** case,

- The whole child would have been assessed, not just the health problem: **Vusi's** poor nutrition and lack of immunisation would have been recognised and corrected
- His mother would have been counselled about feeding
- Guidance about follow-up would have been given

GROWTH MONITORING AND THE ROAD TO HEALTH CHART

WHAT IS THE "ROAD TO HEALTH CHART"?

It is a record of the young child's history held by the parents and kept at home. The chart is printed on both sides. On one side is the growth chart on which weights can be recorded as dots to be connected in a line showing how the child grows for the first three years.



On the other side there is a chart for recording weights in the 4th and 5th years, and there are also spaces to write in details about the birth, immunisations, and other possibly important information.

Road to Health Chart Department of Health

IMPORTANT! Always take this chart with you when you visit any health clinic, hospital or hospital, and present the chart on school entry.

Chart's Name: **Sandra Geisha**

Date of Birth: **26/03/1995** Sex: **Female**

Birth weight: **3.5kgs** Birth length: **45 cms** Birth head circumference:

Problems during pregnancy/deliverability: **No problems**

APGAR: 1 min. 5 min. 10 min.

Mother's Sex: **Female** Antenatal: Delivered:

IMMUNISATIONS	PRIMARY	BOOSTERS	
Date given	Signature	Date given	Signature
B.C.G. 26/03	X Mahalela	29/12	W Molese
6/05	A Nombida		
2/06	W Molese		
1/07	M Msauli		
6/05	A Nombida		
2/06	W Molese		
1/07	M Msauli		
6/05	A Nombida		
2/06	W Molese		
1/07	M Msauli		
29/12	C Maqaqa		
5/04	A Nombida		

Other:

W.A.

Remember to stress child spacing

Chart 1: Chart 2: (GR 9/03)

Address: Address:

Mother's name:

Father's name:

Does mother still breastfeed?

Where does the child live?

How many children has the mother had?

Number born: Number alive now:

SPECIAL NOTES (write if answer becomes YES)

Was the baby less than 2.5 kg at birth?

Is the baby or baby in the baby's health?

Does the mother need more family support?

Are any brothers or sisters underweight?

Are there any other reasons for taking extra care for the example - Admitted, single parent etc.

Water screening (A5 - 2 yrs) Hearing screen (7 to 9 months)

Result: Date: Result: Date:

CARD GIVEN AND MOTHER TAUGHT BY:

CLINICAL HISTORY:

PASTOR DATES:

ROUTINE SCREENINGS

Head/Mentum/Thy: Date: State:

TB screen:

TB retest:

Space is also provided to record illnesses and treatment given for these. In this way a continuous record is available even if the mother moves from one health centre to another.

THE CHART IS OFTEN REFERRED TO AS THE "CLINIC CARD". WHY SHOULD WE DISCOURAGE THIS NAME?

Because it implies that the card is for the use of the health facility and not for the mother or care-giver.

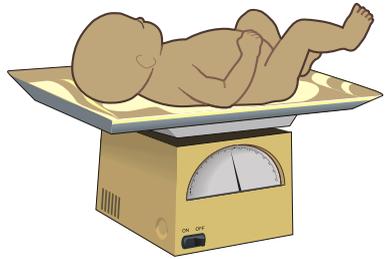
A better name is the Child Health Chart or "Road to Health Chart" or RTH Chart.

THE GROWING CHILD

The healthy infant and young child grow and develop at a rapid rate. Regular weighing is a simple way to keep an eye on how the child is growing, and a very valuable health measure. If a child is not gaining weight at a healthy rate, it may not be obvious to the eye, but it becomes obvious to you and the child's parents when the weight is plotted on the chart.

HOW DO YOU WEIGH A CHILD?

- *Use an appropriate scale for weighing (spring scale, beam balance or an electronic scale). Bathroom scales are not accurate.*
- *Remove the child's clothes (including nappy) and shoes before weighing, but leave light clothing on, especially in cool weather.*
- *Enlist the co-operation of the mother by getting her to undress the child and put him/her on the scale.*
- *Make sure that the child does not touch any person or surrounding objects while being weighed.*
- *Weigh the child to the nearest 0.1 kg and note the weight.*



WHAT HAVE WE LEFT OUT?

- *Always zero the scale before weighing.*
- *Check scale against a known weight!*

HOW DO YOU RECORD THE WEIGHT?

1. *Write in the month of birth in the first block along the bottom of the weight chart. The first space per year is heavily outlined. This is the space to write the child's birth month. Then write in all the other months for the first five years. There is one space per month for the full five years.*
2. *Find the month of this visit.*
3. *Move up the column from the name of the month to the level of the nearest 0.5 kilogram line - then estimate the weight position to the nearest 0.1 kilogram.*
4. *Place a dot in the centre of the column on the vertical dotted line.*
5. *Connect the dot to the last weight dot.*
6. *See if the line has gone up (weight gain) since last dot.*
7. *Tell the mother what you see!*

If the weight changes in a way that you do not expect:

- *Zero the scale and check it.*
- *Weigh the child again.*
- *Make sure the weight has been plotted accurately.*



IS IT NOT IMPORTANT TO MEASURE THE CHILD'S LENGTH ALSO?



Healthy, normal children should grow at a steady rate, and regular monitoring of linear growth (the length or height) is a useful measure. But children never lose length, even if sick,



while weight loss is an important sign of health problems. Length reflects the long term growth up to that point. It is also more difficult to measure length than weight accurately in the child under two years, so increases can only be shown over a longer period. The child is measured lying down until the age of two years (length), and standing after this age (height).

Length measure is not as important as weighing.

WHAT OTHER SIGNS SHOW THE PARENTS THAT THEIR CHILD IS HEALTHY?

- *The child has shiny skin, strong shiny hair, and bright eyes.*
- *He or she has a good appetite.*
- *Is active and playful.*



THE ROAD TO HEALTH CHART has many uses:

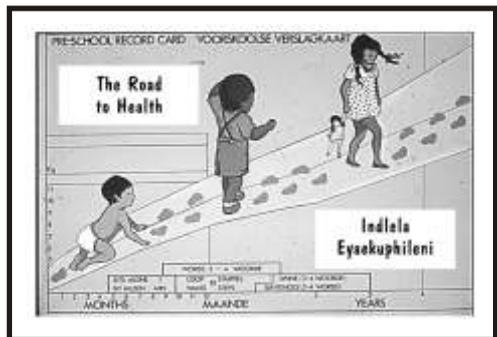
For the child

It shows whether or not steady weight gain is taking place. A **healthy** child grows each month.

It does not rely on 'one-off' measurements to detect malnutrition but rather on the growth pattern over time.

It helps promote adequate and healthy growth.

Graphs are not easily understood by people with limited education. The concept is therefore presented of a “Road to Health” along which the child should make steady progress. The particular point on the chart is not so important, but rather whether the weight is following a path on, or parallel with the growth lines, always going up - that is, growing each month.



For the mother

The “Road to Health Chart” is a very visible record of her child's well-being. With it **she can SEE her child's growth**. It also provides the mother, the father and the parents and family with the knowledge and understanding about the child's progress - recognition of the vital role they play in child survival.

For the health worker

It provides a home-based record of *perinatal events, immunisation, development and illnesses*, and is an aid in **identifying early problems affecting health and physical development**. Faltering growth is a sign that something is not right.

Space is provided to record illnesses and treatment given for these. In this way a continuous record is available even if the mother moves from one health centre to another.

WHAT DO THE LINES MEAN ON THE GROWTH CHART

The growth chart uses internationally accepted standards, based on a large sample of North American children. Boys are generally larger and heavier than girls, but to keep it simple there is a single growth chart for both sexes.

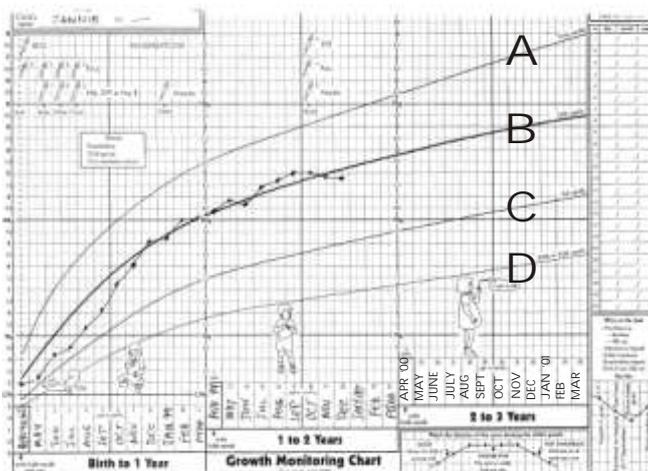
Healthy children come in different shapes and sizes, but they vary within a certain range of normal weights (and lengths). Different lines are therefore used to show this range. They are termed 'percentiles' or 'centiles'.

WHAT DO WE MEAN BY THESE TERMS?

'Average' or 'median' growth is shown by the 50th centile (B). This means that if we took the weights of 100 normal children at any age, 50 would fall on or above the line and 50 would fall on or below it. The weights of most children would be close to this line. Another name for this line is 'the reference curve' or 'standard'.

The 97th percentile is the upper limit of normal growth (A) - above which only three out of every hundred normal children would lie. These children are either obese or will be very tall!

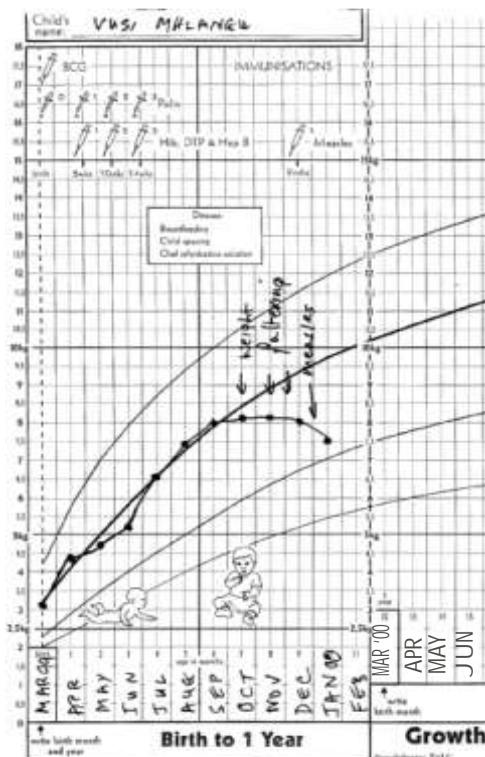
The 3rd percentile is the lower limit of normal growth (C). Only three out of every hundred healthy children would lie below this line. Most children falling below this line are small, or undernourished or both of these.



In addition, many charts have a 'danger line', representing 60% of the standard for that age (D). (That is, 60% of the 50th centile). Children below this line are severely malnourished, and need urgent medical attention. Monthly monitoring of growth will assure intervention before a child ever reaches this dangerous condition.

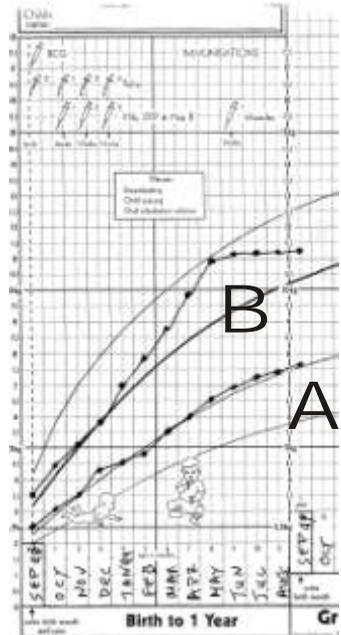
THIS IS VUSI'S GROWTH CHART. HOW DO YOU INTERPRET IT?

Vusi's chart shows that his growth was faltering at the time of his first visit to the health facility. A month later, after the measles, his weight showed a real decline. A levelling off or a downward movement of the growth line is a serious matter, and the reason for this must be found. In **Vusi's** case it shows the severe impact of measles.



The direction of the growth line is more important than the position of the dots. For example, in line A of this diagram, the little girl is growing well even though the growth is along the 3rd centile. She is small because her parents are small, or because she had a low birth weight.

In line B, this little boy has been growing above the 50th centile but his faltering is cause for concern. You should take action early when there is growth faltering, even if still “above the good line”.



WHAT MIGHT BE POSSIBLE CAUSES FOR THIS FALTERING IN GROWTH?

- Inadequate food supply:
 - Lack of, or poor breast feeding
 - Insufficient or low energy weaning foods
- Acute or chronic infection
 - Especially gastro-enteritis
 - TB
 - HIV infection
- Heavy intestinal parasite infestation
- Chronic disorders of heart
- Lack of maternal care
- Neglect or abuse

In **Vusi's** case he lacked food when the mother moved to the city, and then lost a lot of weight with the measles.

*Growth faltering will be discussed further in **Booklet 5**.*

FEEDING INFANTS AND YOUNG CHILDREN

BREAST FEEDING



Breast milk is the perfect food for babies, and bestows many advantages compared with bottle feeding.

All health workers should know about these advantages.

They should encourage potential mothers to breast feed.

They should give practical and logistical support to those who do.

CAN YOU NAME THE ADVANTAGES OF BREAST FEEDING OVER ARTIFICIAL FEEDING?

WHY BREAST MILK IS A PERFECT FOOD

It contains all the nutrients that a baby needs for the first 4-6 months and is easily digested. It contains:

- Most suitable protein, fat and fatty acids
- More lactose than most other milks
- Enough vitamins
- Enough iron
- Enough water, even in a hot dry climate
- Most beneficial content of sodium, calcium and phosphate
- Contains enzymes such as lipase and amylase, which aid digestion.

BABIES WHO ARE BREAST FED HAVE FEWER INFECTIONS

More advantages of breast feeding

Breast milk contains:

- *Living white cells which kill bacteria*
- *Antibodies (immunoglobulins) to many common infections*
- *Bifidus factor, which helps protective bacteria grow in the baby's intestine*
- *Lactoferrin, which binds iron, protecting against some bacteria that need iron*

FURTHER ADVANTAGES OF BREAST FEEDING

- *Bonding. Breast feeding helps mother and baby develop a close, loving bond*
- *When put to the breast immediately after delivery, suckling helps milk flow better, **and** stimulates the uterus to contract*
- *The contraceptive effect: frequent feeding both day and night delays ovulation.*
- *Convenience*
 - *Breast milk needs no preparation*
 - *It never goes sour*
 - *It does not have to be shared among the family, like artificial milk*
 - *It is cheap - you don't have to buy it*



WHY MOTHERS NEED HELP

With so many advantages one would think the majority of mothers would breast feed their babies for at least 6 months, but this is often not the case. Three factors tempt mothers into taking what they think is 'the easy way out', and changing to bottle feeding.

These factors are

- *Lack of support from other women close to them*
There are many false ideas that formula feeds are better. When friends or relatives think that breast feeding is difficult, a nuisance, old-fashioned or embarrassing, mothers are more likely to fail.

- *Lack of support from health services*
Some health workers are too ready to recommend the bottle when the mother is encountering breast feeding problems.
- *The pressures of modern urban life*
Having to return to work, and lack of creche or breast feeding facilities at work, are major problems to the breast feeding mother.

10 STEPS TO SUCCESSFUL BREAST FEEDING

These are the steps recommended to all hospitals and health centres by the "Baby Friendly Hospital Initiative":

1. Have a written breast feeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breast feeding.
4. Help mothers initiate breast feeding within half-an-hour of birth.
5. Show mothers how to breast feed and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breast milk, unless medically instructed.
7. Practise rooming in - allow mothers and infants to remain together 24 hours a day.
8. Encourage breast feeding on demand.
9. Give no artificial teats or dummies to breast feeding infants.
10. Foster the establishment of breast feeding support groups and refer mothers to them on discharge from the hospital or health facility.

FOR FURTHER INFORMATION, READ 'HELPING MOTHERS TO BREASTFEED' BY F SAVAGE KING (AMREF), 1992

COMPLEMENTARY FEEDING

Introducing foods other than milk to the child's diet is essential for healthy growth and development from 6 months onwards. These foods “complement” or add to breast milk. But this must not be started too early, or too late.

WHAT ARE THE DANGERS OF INTRODUCING FOODS TOO EARLY?

EARLY INTRODUCTION OF SOLIDS MAY

- *Result in child getting harmful germs into the mouth, causing bowel infection (diarrhoea).*
- *Diminish the amount of breast milk because there is less suckling, therefore less demand.*
- *Result in early pregnancy, because with less lactation, menstruation may resume.*
- *Induce allergy because the baby's bowel is too immature and proteins can be absorbed unaltered.*



WHAT ARE THE DANGERS OF WAITING TOO LONG?

THE DANGERS OF DELAY IN INTRODUCING FOODS

- *Weight faltering or growth failure*
- *Iron and other micronutrient deficiencies*
- *Difficulties in trying new foods*

WHAT SHOULD YOUR ADVICE TO MOTHERS BE?

ADVICE TO MOTHERS ON COMPLEMENTARY FOODS

- Start other foods at about 6 months. Some babies grow faster than their mothers' milk allows by the age of 4-5 months. A flat growth line will show that breast milk alone is no longer enough for the baby
- Give very soft food (such as porridge) at first, a spoonful or 2, increasing a bit each day
- Feed often - about 5 times a day
- Gradually increase the amount, and kinds of food
- Add energy rich food (eg a little oil or margarine) to the porridge or vegetables
- Add some protein-rich foods (beans, groundnuts, milk, eggs)
- Add some green vegetables or fruit
- Give the child her own plate of food
- Continue feeding the sick child

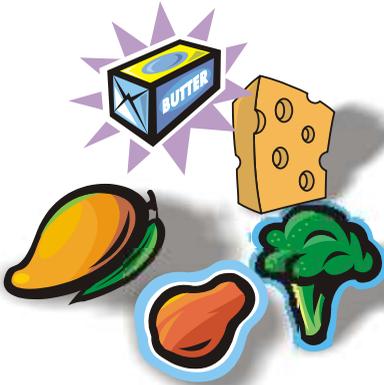
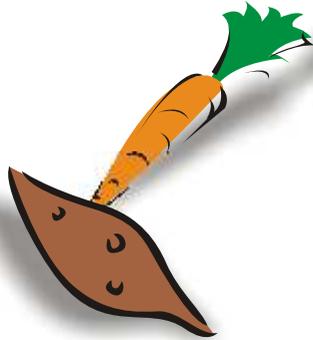


VITAMIN A IS OF PARTICULAR IMPORTANCE TO THE GROWING CHILD

What foods are rich in Vitamin A?

Excellent sources:

- *Breast milk*
- *Liver*
- *Sweet potato*
- *Carrot*



Good sources:

- *Kidney*
- *Butter/margarine*
- *Yellow cheese*
- *Spinach*
- *Broccoli*
- *Butternut*
- *Mango*
- *Paw paw*

Note: Dietary fat is needed for absorbing Vitamin A, especially from vegetable sources

FOOD SUPPLEMENTATION

In disadvantaged communities pregnant and lactating women and young children are the groups most likely to suffer the effects of undernutrition. Fully 30% of undernourished mothers will give birth to babies of low birth weight, and this is an important cause of infant mortality, long term ill health and poor achievement. Food supplements given to impoverished individual mothers and children or to groups, such as refugees, has been shown to be effective in preventing low birth weight, and in improving the health of children, when combined with other general health care measures.

MATERNAL HEALTH, WELL-BEING AND KNOWLEDGE

THE MOTHER OR CARER

At every visit the mother or carer's understanding of the child's condition must be considered, as well as her own health and well-being.

She should be counselled about the child's illness, and feeding during and after the illness.

Guidelines for specific follow-up instructions and dates are given.

Lastly, she should be counselled on her own health, such as nutrition, immunisation sexually transmitted diseases, and protection from early pregnancy.



CAN YOU NAME THE FOUR STEPS THAT SHOULD BE TAKEN IN COUNSELLING THE MOTHER OR CARE-GIVER?

- Step 1 **Ask the right questions about the child's condition.** *What complementary foods does **Vusi** eat? How much? How often?*
- Step 2 **Praise and encourage the mother's good practices.** *It is good that she continues breast feeding. That is excellent for Vusi.*
- Step 3 **Advise her what else to do.** *This medicine is for his fast breathing. Give one teaspoonful three times a day for 5 days.*
- Step 4 **Check her understanding.** *Please tell me how you are going to give the medicine.*

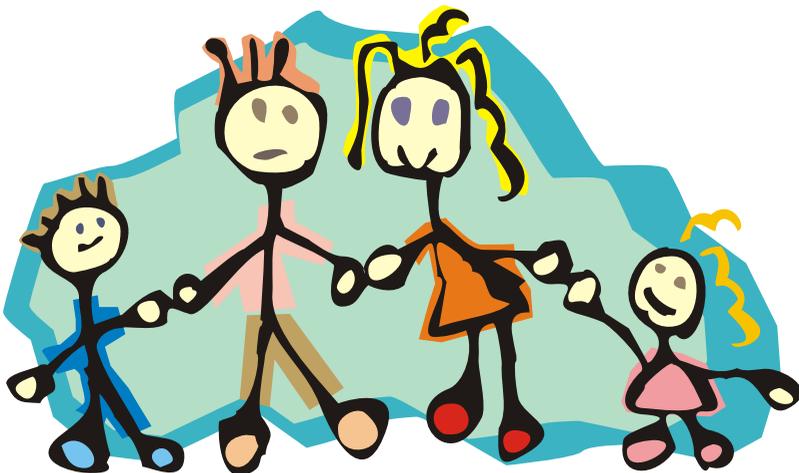
FAMILY SPACING

The spacing, timing and number of births are very important factors in both the mother's health and the child's survival. Infant mortality in babies born after a birth interval of less than 2 years is 80% higher than when the birth interval is 2-4 years.

Women should be counselled as to how to time and space their pregnancies and plan to have their babies when they are best prepared.

Family spacing has many aspects:

- Promoting a caring and responsible attitude to sexual matters
- Ensuring acceptance of family spacing for the sake of health of both child and mother
- Ensuring that every child is a wanted child
- Understanding the family's socio-economic potential
- Creating awareness among young people of the disastrous effects of unchecked population growth
- Remembering that infertility is also worthy of attention



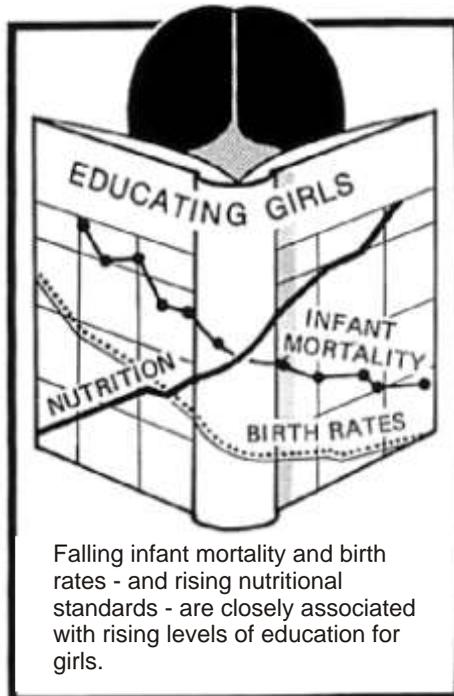
FEMALE EDUCATION

Although girls are not generally discriminated against in their early education in South Africa, the enormous potential for improving maternal and child health through education must always be borne in mind.



Female literacy is an obvious indicator of general living standards, but it has also been demonstrated to be a powerful independent force in child survival.

Mothers *can* understand and *can* learn. *They* are the first level health workers. Make them your partners by explaining and being sure they understand.



FURTHER READING

Kibel MA and Wagstaff LA. Child Health for All: A Manual for Southern Africa. 2nd Edition. Oxford University Press. Cape Town. 1996.

King F Savage and Burgess A. Nutrition for Developing Countries. ELBS with Oxford University Press. 1992.

King F Savage. Helping Mothers to Breastfeed. AMREF. 1992.

Before the child goes home from the health facility, make sure that :

- he or she is fully immunised
- the mother has received nutritional advise
- the mother can repeat the instructions in her own language



ANSWERS

- | | | |
|-----|---|---|
| 1 | - | F |
| 2 | - | F |
| 3 | - | F |
| 4 | - | T |
| 5 | - | F |
| 6 | - | T |
| 7 | - | T |
| 8 | - | F |
| 9 | - | F |
| 10. | - | F |
| 11. | - | T |
| 12. | - | T |
| 13. | - | T |
| 14. | - | T |
| 15. | - | F |
| 16. | - | F |
| 17. | - | T |
| 18. | - | T |
| 19. | - | T |
| 20. | - | F |

This booklet was developed in consultation with :

MAIN CONTRIBUTORS:

Child Health Unit:

*Maurice Kibel
Michael Hendricks
Greg Hussey
George Swingler
Heather Zar*

MSH/EQUITY:

Jon Rohde

CONSULTANTS:

Child Health Unit

*Marian Jacobs
Jawaya Small
James Irlam*

MSH/EQUITY

*John Bennett
Eta Banda*

EASTERN CAPE HEALTH DEPARTMENT

*Gerry Boon
Zoe Kati
Joyce Matebese
Gloria Nchukana*

WESTERN CAPE HEALTH DEPARTMENT

*Fawzia Desai
Leana Olivier*

NORTHERN CAPE

*Pieter Jooste
Carvie Madikane
Florrie Richards*

NATIONAL DEPARTMENT OF HEALTH (MCWH)

Walter Loening

EDITORS:

*Maurice Kibel (main author)
Michael Hendricks
Jon Rohde*

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