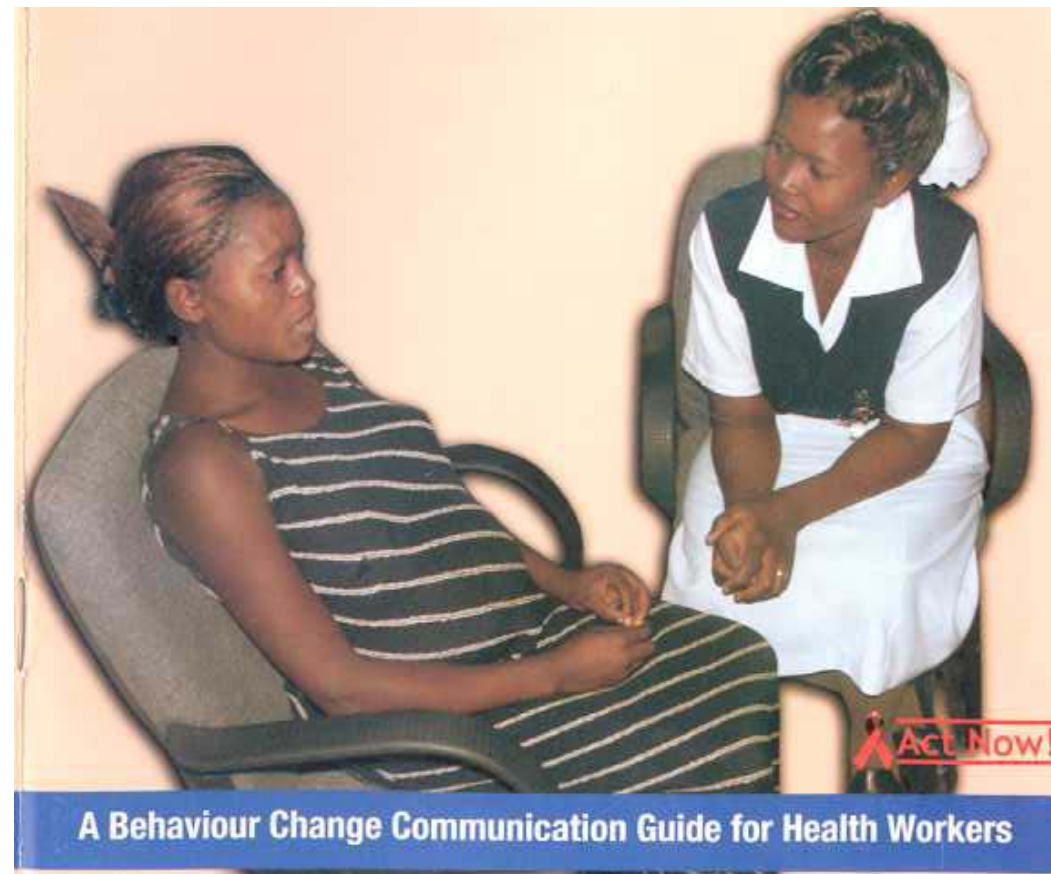


Prevention of Mother-to-child transmission (PMTCT) of HIV



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A Behaviour Change Communication Guide for Health Workers

CONTENTS

Facts about HIV and AIDS	1
HIV and AIDS	1
HIV and AIDS in Zambia	1
Modes of HIV transmission	1
Four phases of HIV and AIDS infection	2
Factors promoting the spread of HIV	2
Mother-to-child-transmission (MTCT) of HIV	3
Mother-to-child-transmission of HIV	3
Prevention of mother-to-child transmission (PMTCT) of HIV	5
The role of a health worker in PMTCT	7
Key messages for pregnant mothers	7
Communicating PMTCT and infant feeding messages	9
Why communicate PMTCT and infant feeding messages?	9
Behaviour change process	9
Opportunities for communicating with community members	11
Communicating PMTCT and infant feeding messages	11
TIPS	
Using interactive methods	14
How to communicate with mothers at the health facility	16
Communicating with clients during health talks	16
Communicating with clients during specialized group discussions	17
Motivating clients in one-on-one settings	19
How to feed a baby from birth to 2 years	21
Feeding a baby during the first 6 months	21
Feeding a baby from 6 months to 2 years	22
How to use educational materials	25
Working with communities	27
Partnering with communities	27
Working with community groups	29

ABOUT THIS BOOKLET

This booklet provides information which health workers can use to strengthen their role in prevention of mother to child transmission (PMTCT) of HIV, infant and young child feeding. It presents facts and tips on:

- HIV and AIDS
- Mother-to-child transmission of HIV
- PMTCT
- The role of health workers in PMTCT
- Communicating with mothers about PMTCT, infant and young child feeding
- Facilitating behaviour change communication activities
- Working with communities

HOW TO USE THE BOOKLET

Skim through the booklet to get a sense of what it contains. This should help you to identify the parts you may want to read in detail. Study the sections you need. Find time later to study the booklet in detail. This should help you return to the book for reference when you need to.

1 FACTS ABOUT HIV and AIDS

1.1 HIV and AIDS

HIV stands for human immuno-deficiency virus. This is the virus that causes AIDS. AIDS stands for acquired immune deficiency syndrome.

HIV attacks and weakens the immune system, leaving the body unable to defend itself. This leaves a person open to many infections. When a person begins to suffer from diseases because his or her body immunity has been weakened by HIV, the person is said to have developed AIDS.

1.2 HIV and AIDS in Zambia

The first case of HIV infection was reported in Zambia in 1984 (ZSBS). Since then, HIV prevalence in the country has continued to rise, and today Zambia is among the countries hardest hit by the HIV and AIDS epidemic. The Zambia Demographic and Health Survey (DHS), conducted in 2001-2002, estimated HIV prevalence at 15.6% among adults aged 15-49 years. HIV prevalence among men (12.9%), was slightly lower than among women (17.8%).

The rural areas had the lowest HIV prevalence rates (10.8%), while much higher rates were recorded among urban adults (23.1%) and young men and women aged 30-34 (25.1%). Provinces with high HIV prevalence included Lusaka (22.0%, Copperbelt (19.9%), Southern (17.6%) and Central (15.3%).

1.3 Modes of HIV transmission

- Having unprotected sex without a condom with a person infected with HIV is the most common way of contracting HIV.
- From an HIV-positive mother to her baby. It is estimated that 30%-40% of babies born to HIV-positive mothers contract HIV during pregnancy, labour and delivery, and breastfeeding.
- Use of contaminated skin piercing instruments, such as syringes, injection needles and ear piercing needles contaminated with HIV.

1.4 Four phases of HIV infection

Seroconversion refers to the process of converting from HIV-negative to HIV-positive status after HIV infection has taken place. The conversion period is referred to as the **window period**. During the window period, the presence of HIV cannot be detected with commonly used testing methods. It takes 3 weeks to 3 months after infection for these methods to detect evidence of HIV in the bloodstream. The infected person may infect people he or she has sexual intercourse with during the window period, although the presence of HIV is not detected in the blood.

Latent phase is the period in which a person is infected with HIV but feels no signs of illness. An HIV-positive person may live with HIV for 15 or more years without feeling any signs of illness. During this phase, the person may infect people he or she has sexual intercourse with.

Symptomatic HIV refers to the stage during which an HIV-positive person gets frequent illnesses which are not AIDS defining.

Full blown AIDS refers to the stage during which an HIV-positive person begins to get AIDS defining illnesses.

1.5 Factors promoting the spread of HIV

Since 1984, when the first case of HIV was identified in Zambia, HIV and AIDS have continued to spread in spite of the efforts being made to contain the epidemic. Factors promoting the spread of the epidemic include:

- Early initiation into sexual activities
- Engaging in unprotected sex with infected persons
- Low and improper use of condoms
- Sexually transmitted infections (STIs), which cause abrasions and ulcers in sexual organs and the pubic area
- Gender disparities, which deny women decision making and negotiation power in sexual matters
- Poverty and economic hardships, which promote practices such as commercial sex
- Cultural practices, which promote risk factors, such as having many sexual partners and sexual cleansing of widows
- Urbanisation and migration, which bring together many people who are not related by blood.

- Limited practice of male circumcision
- Denial and the tendency to feel that “HIV will infect the other person, not me”
- The wide gap that exists between knowing facts about HIV and AIDS and acting positively on the facts

Encourage communities to discuss these factors and find ways of stopping the spread of HIV and AIDS.

2 MOTHER-TO-CHILD TRANSMISSION (MTCT) OF HIV

30%-40% (UNAIDS) of babies born to HIV-infected mothers get infected during pregnancy, labour and delivery, and breastfeeding. It is estimated that 24,000 infants in Zambia get infected with HIV every year.

2.1 Mother-to-child transmission of HIV

Mother-to-child transmission rates
If 100 HIV-positive mothers get pregnant, deliver and breastfeed their babies, the likelihood is that:
<ul style="list-style-type: none">• About 63 of the babies will not be infected with HIV at all• About 7 babies may be infected during pregnancy• About 15 babies may be infected during labour and delivery• About 15 babies may be infected through breastfeeding, if the babies breastfeed for 2 years

Factors which contribute to mother-to-child transmission of HIV include the following:

a. Viral load

A high HIV viral load in the mothers' blood increases the chances of a baby being infected with HIV. Chances of a baby getting infected increase when the mother:

- Has an advanced infection or full-blown AIDS
- Gets a new infection during pregnancy or breastfeeding

b. Maternal factors

Chances of mother-to-child transmission of HIV increase when a mother has:

- Low immunity (low CD4 count)
- A poor nutritional status
- Breast conditions (e.g., cracked nipples or mastitis)
- An untreated Sexually Transmitted Infection (STI)
- No antiretroviral (ARV) treatment during and after delivery

c. Obstetrical factors

Chances of mother-to-child transmission of HIV increase with the following:

- Multiple vaginal examinations
- Premature rupture of the membranes
- Prolonged labour, which could lead to interventions that may increase chances of HIV infection
- Intrapartum hemorrhage
- Instrument delivery
- Episiotomy
- Milking the cord during delivery

d. Foetal factors

Chances of a baby being infected with HIV increase when:

- The baby is born prematurely
- The mother has a multiple pregnancy

e. Other factors

Other factors which contribute to babies getting infected through MTCT include the following:

- Mixed feeding
- Unnecessary suction of the baby during delivery
- Duration of breastfeeding
- Breastfeeding from an infected mother while the baby has lesions or

thrush in the mouth

- A mother having multiple sexual partners
- Inconsistent use of condoms
- Gender inequality, which makes it difficult for women to negotiate safer sex
- Adverse cultural practices (e.g., sexual cleansing of widows).

2.2 Prevention of mother-to-child transmission (PMTCT) of HIV

WHO's four-pronged approach forms the basis of PMTCT of HIV. The four prongs are:

- Prevention of HIV infection, particularly in women and young people
- Prevention of unintended pregnancies
- Prevention of MTCT
- Provision of care and support to affected families and individuals



FOUR PRONGED APPROACH TO		
<p>PREVENTION OF HIV IN WOMEN</p> <ul style="list-style-type: none"> • Addressing community norms and values through community engagement • Screening and treatment of sexually transmitted infections (STIs) • Life skills training • Provision of voluntary HIV counselling and testing (VCT) 	<p>PREVENTION OF UNINTENDED PREGNANCY</p> <ul style="list-style-type: none"> • Provision of VCT • Provision of family planning information • Access to contraceptive services • Life skills training 	
<p>PREVENTION OF MTCT</p> <ul style="list-style-type: none"> • Comprehensive maternal and child health (MCH) services (antenatal, delivery, post-natal) • Integration of VCT in MCH services • Provision of comprehensive MCH services, including malaria in pregnancy (MIP) intermitted prevention therapy (IPT) and insecticide-treated nets (ITNs) • Provision of antiretroviral treatment (ARVs) for PMTCT • Safe delivery practices, including provision and correct use of safe delivery kits • Counselling for optimal and safe infant feeding options as well as maternal nutrition • Provision of condoms 		
<p>CARE AND SUPPORT</p> <ul style="list-style-type: none"> • Screening and treatment of opportunistic infections among mothers and their families • Maternal tuberculosis (TB) prophylaxis • Pneumocystis carini pneumonia (PCP) cotrimoxazole prophylaxis in children • Palliative care and support for symptomatic mothers and their families • Nutrition, on-going counselling and psychosocial support for both the mothers and their families • Support for the creation of peer-support groups for infected mothers and their families • Supportive environment, economic support, community integrated management of childhood illness (IMCI) and infant feeding support groups in the community 		

3 THE ROLE OF A HEALTH WORKER IN PMTCT

- Provide diagnostic and clinical care to those who need it
- Inform, educate, motivate and counsel people to:
 - Practice safer sex
 - Go for VCT
- Motivate communities to develop capacity to inform, educate, motivate, and support each other to adopt safer sexual practices and care for the sick
- Provide specialized care to the sick

4 KEY MESSAGES FOR PREGNANT MOTHERS

Health workers should make sure that all mothers receive the messages in the table below during pregnancy. Choose the appropriate message to give depending on the mother's needs and stage of pregnancy.

ESSENTIAL MESSAGES FOR ALL PREGNANT MOTHERS	
Key messages	Support messages
<p>1. Start attending the antenatal (ANC) clinic as soon as you know that you are pregnant. Attend the clinic every month. Attend at least four times in each pregnancy. 1 time in the first 3 months, 1 time in the next 3 months and 2 times in the last 3 months.</p>	<p>At ANC clinics health workers:</p> <ul style="list-style-type: none"> -Examine and treat you for any diseases and complications you may have. -Advise you on how to care for yourself and avoid complications. -Give you medicines to protect you and your baby from common diseases and help the baby to grow and develop well.
<p>2. Go for voluntary counselling and HIV testing (VCT) to know your HIV status. Encourage your partner to go for VCT also. Support one another before and after VCT.</p>	<p>Knowing your HIV status:</p> <ul style="list-style-type: none"> -Opens doors to the services you may need. -Gives you an opportunity to adopt behaviours that can protect you, your baby and your sex partner from getting HIV. -Helps you to adopt behaviours that can lead to a longer life. -Increases your determination to remain free of HIV, if you are HIV negative.

Key messages	Support messages
<p>3. During pregnancy and breastfeeding (a) Use condoms to prevent infection, (b) Take malaria preventing medicine according to the instructions of a health worker and, (c) Sleep under an insecticide-treated mosquito net to protect yourself from malaria.</p>	<p>Malaria weakens your body's immunity, whether you are HIV-positive or not. The insecticide treated mosquito net kills mosquitoes which come in contact with the net.</p>
<p>4. Make early plans to deliver your baby at a health facility under the care of a trained health worker. If you deliver at home, always deliver under the care of a trained birth attendant or a trained relative who can support you during labour and delivery.</p>	<ul style="list-style-type: none"> - A trained health worker can recognise complications and take the action needed to save your life and the life of your baby. - The trained person supporting you will clean up the baby quickly so that the baby does not stay in blood and increase chances of infection. -Make an early booking to deliver at a health facility of your choice. -Keep at hand transport money to be sure that you can get to the health facility in good time. -During delivery, avoid early pushing. Early pushing can break the waters prematurely, break the skin of the baby and cause cuts in the birth canal. Broken skin increases the chances of infecting the baby.
<p>5. In the first 6 months breastfeed your baby. During this period, do not give the baby any other foods, not even water.</p>	<p>Breastmilk is the perfect diet for the baby for the first 6 months and has all the nutrients and water the baby needs. It has substances which protect the baby from common illnesses. Other foods given during this time may introduce germs into the baby's body or damage the inside of the baby's intestines and introduce infections which can make the baby sick.</p>
<p>6. If you test HIV-positive: -Discuss with your health worker or counsellor what you need to do to protect your baby from HIV infection and its effects. -Take antiretroviral medicine (if available) to protect your baby from HIV infection.</p>	<ul style="list-style-type: none"> -Discuss with your health worker or counsellor how to feed your baby in a way that will protect the baby from HIV infection. -Take antiretroviral medicines to reduce the chances of transmitting HIV to the baby during labour and delivery. -Mixing breastfeeding and other foods increases the chances of HIV transmission.

COMMUNICATING PMTCT AND INFANT FEEDING MESSAGES

Why communicate PMTCT and infant feeding messages?

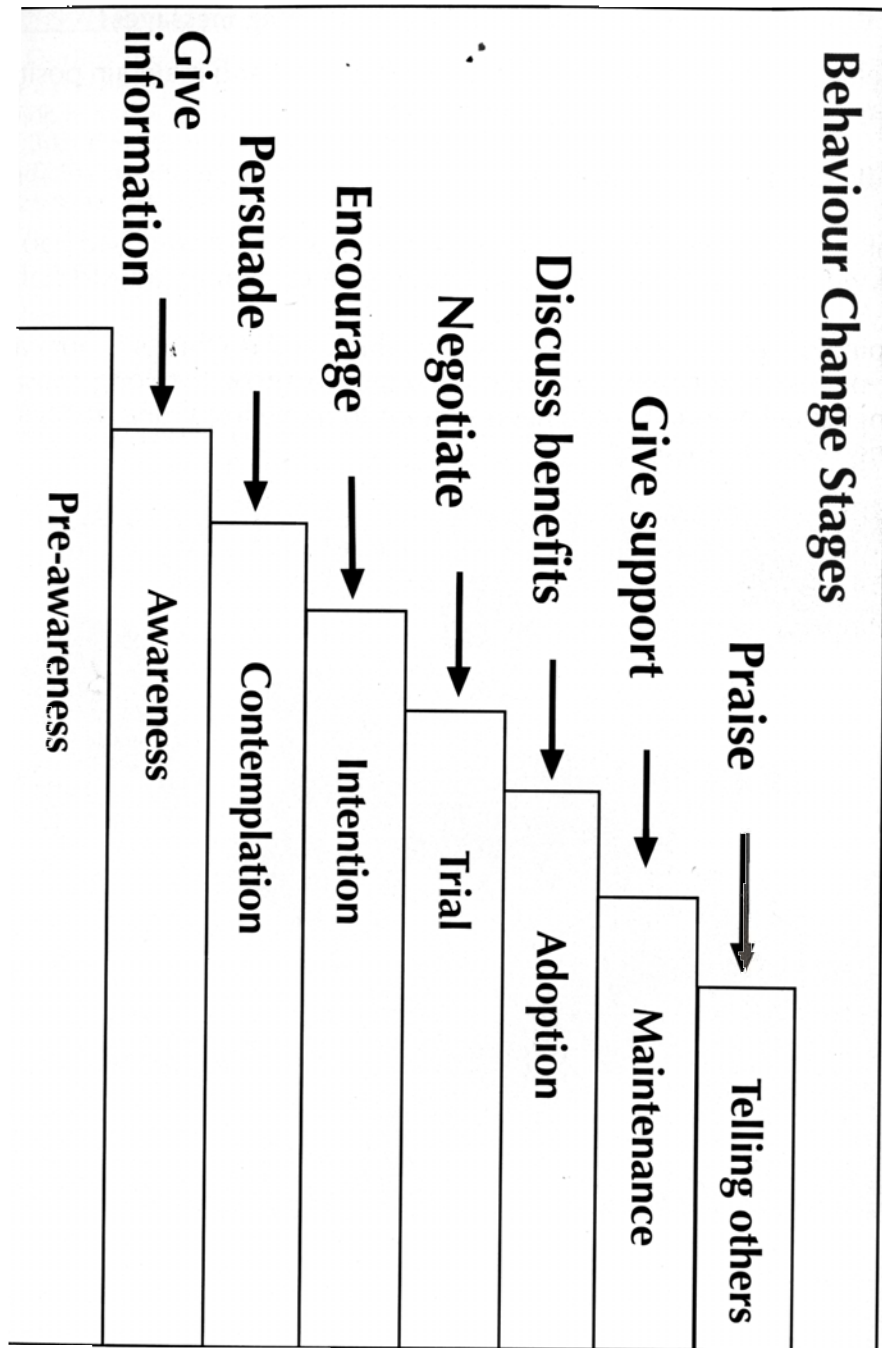
The aim of health communication is to bring about and maintain positive behaviours which can lead to better health.

: Behaviour change process

Think for a moment. When did you last change any of your bad habits? And when did you last help somebody else to change an old habit?

Helping people to change the way they think and do things is not easy. The stages of behaviour change on page 10 show the long road to changing behaviour. People need support to move from one behaviour change stage to the next.





5.3 Opportunities for communicating with community members

Opportunities for health workers and health promoters to disseminate PMTCT and infant and young child feeding messages to mothers and other community members include the following:

- At health facilities, such as ANC, family planning, post-natal and under 5 clinics:
 - During health talks
 - In specialised group discussions
 - One-on-one during examination and counselling
- During community meetings (e.g., women's meetings, youth meetings, kitchen parties, or men's group meetings)
- During meetings of support groups
- During home visits
- During religious meetings
- During counselling of people planning to marry



5.4 Communicating PMTCT and infant feeding messages

5.4.1 Know the PMTCT, HIV and AIDS situation

Learn as much as you can about PMTCT, HIV and AIDS in Zambia to be able to communicate PMTCT messages effectively. You need to know that:

- Some cultural beliefs and practices in Zambia promote high-risk sexual practices. Study the beliefs and practices which contribute to the spread of HIV. Also study what different communities are doing to modify the practices and make them less risky.
- Many people do not have a clear understanding of facts about HIV and AIDS, the mode of transmission and what they can do to prevent HIV infection.
- People are receiving conflicting PMTCT, HIV and AIDS messages from different sources.
- People have many unanswered questions they would like to ask about HIV and AIDS, but do not always know where to go for answers. Some are afraid to ask or do not always get the correct answers when they ask.
- Health workers do not always have the knowledge or the time to respond to clients' questions and concerns.
- Health workers and health promoters often use only verbal, one-way methods to communicate with community members. They do not help people to visualise messages clearly to help them take positive decisions and action.

5.4.2 Support the whole campaign and not just your area of work

Behaviour change communication strategies use different media and communication settings to achieve their objectives. The messages may be disseminated through:

- Mass media (e.g., radio and television)
- Groups (e.g., workshops and meetings of mother-to-mother support groups, mother-father support groups, men's groups, youth groups, religious groups)
- One-on-one encounters, such as during examination at a clinic, or during counselling.

Message dissemination may take place in the community, at a health facility, in a school classroom or church building. Regardless of the place, all the activities are related and should be mutually supportive. To support the campaign as a whole, team members should:

Learn about the efforts of other team members in the different media and places

- Refer to campaign activities that are taking place in different media and places. This helps to link the various components of the campaign. It also ensures that each aspect of the campaign supports and strengthens the other.



- Refer the audience to places where they can get more information and assistance.

5.4.3 Use ALIDRAA to communicate PMTCT messages

Adults have been living and managing their lives in their own way for a long time. In the process, they have made observations and decisions, and formed beliefs and habits by which they live. To help them change, you need to negotiate with them instead of merely giving information. ALIDRAA is a useful tool that can be used to negotiate behaviour change with target audiences. ALIDRAA stands for **A**sk, **L**isten, **I**dentify issues to focus on, **D**iscuss the issues, **R**ecommend possible action, **A**gree on action to take and make an **A**ppointment for the next meeting.

ALIDRAA: A TOOL FOR NEGOTIATING BEHAVIOUR CHANGE

1. **Ask** clients about their current practices. Ask follow-up questions to understand a client's thinking.
2. **Listen** carefully and respectfully to what a client says.
3. **Identify** issues and problems that need to be discussed.
4. **Discuss** with the client issues and options for action. In the discussion, help the client to relate the content of discussion to his or her own situation by asking questions such as:
 - What do you think about this?
 - Does any of this apply to you? How?
 - How would it benefit you?
5. **Recommend** possible actions that the client can take.
6. **Agree** on a feasible action the client is willing to try. Refer the client to where he or she can get further help or support if needed.
7. **Appointment:** Agree on the next meeting to assess progress and discuss the experience and problems the client may have encountered.

1.5. Using interactive methods

Interactive communication methods are methods which help to illustrate, demonstrate, or visualise issues and promote discussion. They include the following:

- Brainstorming
- Question/answer
- Group discussion
- Demonstrations
- Picture codes and other visuals
- Sharing testimonies from satisfied users
- Story telling
- Case studies
- Role plays
- Drama/role plays
- Watching and discussing video clips
- Playing games

- Merry-go-round contribution games
- Use of models
- Use of real items
- Sharing in support groups
- Visualisation in participatory programme (IPP) card collection
- Debates of various kinds
- Fish bone exercises
- Field visits

Select an appropriate method to use depending on the situation.



TIPS

6. HOW TO COMMUNICATE WITH MOTHERS AT THE HEALTH FACILITY

At health facilities, health workers communicate with mothers about PMTCT during:

- Health talks
- Specialised group discussions
- One-on-one communication and counselling

6.1 Communicating with clients during health talks



Health talks:

- Increase general awareness about a topic or issue
- Increase information available to clients
- Provide an opportunity for giving basic facts
- Give information a sense of importance and legitimacy
- Ensure that messages reach many people at the same time
- Reinforce and correct messages that people may have heard elsewhere
- Provide an opportunity to get people's reactions on the messages

How to facilitate health talks

To improve communication during health talks:

- Arrange the chairs or benches in a circle or semi-circle, if space allows. This helps participants to see the facilitator and to see each other.
- Introduce yourself to the audience.
- Inform participants about the topic of the day.
- Use ALIDRAA to facilitate discussion.
- Use participatory methods as far as possible.
- Reinforce what participants are already doing well.
- Invite participants to ask questions and share their knowledge and experiences freely.
- Ask questions from time to time to check how well participants understand.
- If participants ask questions, deflect questions to participants to answer. Answer only the questions that you need to answer personally.
- Towards the end, ask an evaluation question such as, "What is the most important thing you have learnt today?" Invite a number of participants to respond to the evaluation question.
- Summarise the important points learnt.
- Ask participants to indicate the behaviours they think they can try when they get home.
- Encourage participants to try the behaviours and share their experiences during the next meeting.

6.2 Communicating with clients during specialised group discussions



Specialised group discussions

- Build on the discussions started during health talks.
- Go deeper into the topic.
- Focus on participants' questions and concerns.
- Address rumours and misinformation.
- Make messages more acceptable (legitimate).
- Encourage participants to take a decision and select the action they will take (e.g., going for VCT or discussing with the partner).
- Build a pool of individuals who have information and can support one another, friends, and neighbours in the process of attitude and behaviour change.

How to facilitate a specialised group discussion

Use ALIDRAA to facilitate specialised group discussions.

- Thank participants for finding time to come to the discussion.
- Introduce the importance and benefits of the discussion.
- Ask participants about the concerns and questions they may have about the topic under discussion and write down their concerns.
- Select the issues to be discussed during the session.
- Discuss the issues one after the other.
- Allow participants time to ask questions and raise issues.
- Deflect the questions to other participants to stimulate discussion. (Answer only those questions you need to answer personally).
- Recommend concrete action(s)/behaviours that participants should consider taking (e.g., discussing HIV and AIDS at home).
- Ask participants whether the recommended behaviours can work for them. Encourage participants to share experiences and fears relating to the recommended behaviours.
- Encourage individual participants to indicate the behaviours they would be willing to try out (e.g., going for VCT or discussing with the spouse).
- Tell participant where the services they wish to take (e.g, infant feeding counselling) can be found.
- If the service is within the health facility and can be given on the same day (e.g., VCT) encourage the participant to go for the service straight after the discussion.
- Agree on an appointment when you can meet with individual clients to assess progress and discuss experiences and problems that may arise.
- Be available for further discussions on the appointed date.

Clients who have not made up their minds to take the HIV test.

- Let clients know that you are willing to answer any questions they may have.
- Inform clients about the services they can benefit from in their communities (e.g., health facilities, counsellors, community health promoters or support groups).
- Be available if a client wishes to see you.

6.3 Motivating clients in one-on-one settings



A one-on-one communication setting helps to:

- Establish a personal rapport with the client.
- Focus on the individual's specific concerns.
- Respond to questions and needs of a personal nature.
- Identify and fill information gaps.
- Encourage the client to decide the action he or she will take.

How to communicate in a one-on-one setting

- Welcome the client and establish a good rapport with him or her.
- If at a health facility, look at the clients' card to know the services the client has received and those he or she has not received.
- If not at the clinic, ask questions to find out the services the client has received and those he or she has not received. (If pregnant, for example, ask whether the mother is attending ANC clinics and the services

she has received.

- Find out why he or she has not received the services she should have received (e.g., VCT).
- Ask follow-up questions to understand the client's problems, thoughts, feelings, and difficulties about the services he or she may not have received.
- Praise the client for the good, health-promoting actions he or she has taken.
- Thank him or her for taking the tests and medication, and explain the value of such tests and medicines.
- If he or she has not gone for VCT, ask why.
- Explain the value of VCT.
- Discuss with him or her the difficulties he or she may have with VCT and discuss possible solutions.
- Ask if the client sees any of the suggested solutions working for him or her.
- Encourage him or her to try out the selected option.
- Agree on the date when you can get together with the client again to share experiences after trying out the solution.
- If the client is not in a position to select an option, let him or her know that you would be willing to continue the discussion if he or she wishes.
- Let him or her know about other people who live nearby and would be willing to discuss with him or her and support him or her (e.g., counsellors and community health promoters).
- Make yourself available for further discussions on the appointed date.

Note

If you go for VCT yourself, you will be in a better position to help clients with VCT.

7 HOW TO FEED A BABY FROM BIRTH TO 2 YEARS

7.1 Feeding a baby during the first 6 months



For the first 6 months, breastfeed the baby. During this period, do not give the baby any other food, not even water.

Put the baby on the breast as soon after birth as possible. Make sure that the baby begins to breastfeed within the first hour after birth.

Babies are born with a suckling instinct. The baby's suckling reflex is strongest about 30 minutes after birth.

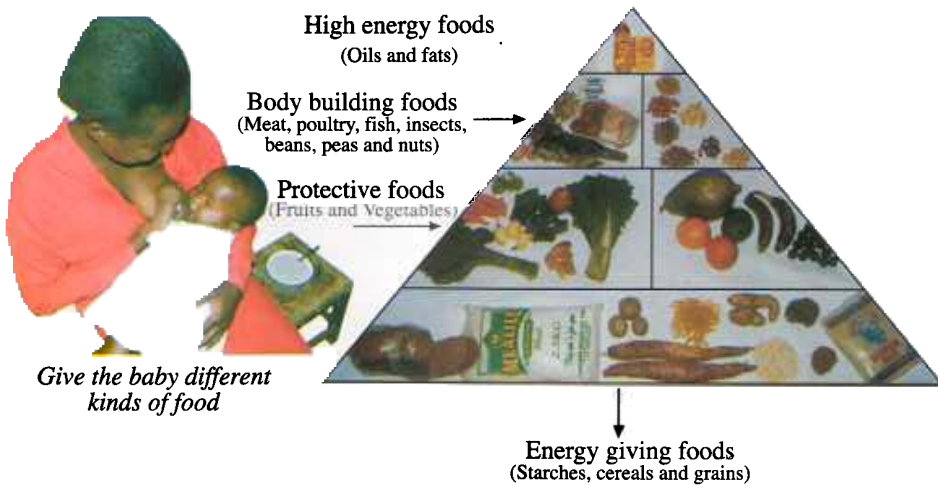
Ensure that the baby feeds on the first yellowish milk (colostrum). Colostrum has many nutrients and substances which protect the baby from diseases.

Breastfeed the baby on demand 10-12 times a day. If the baby sleeps for long hours, wake up the baby to breastfeed.

7.2 Feeding a baby from 6 months to 2 years

A baby needs the nutrients in breastmilk to grow and develop well. At 6 months, give the baby other foods in addition to breastmilk. At this age, the baby needs other foods to fill the gap between the nutrients a baby needs and the nutrients provided by breastmilk. Breastmilk provides:

- **Complete** nutrition for the first 6 months of life.
- **Half or more** of the nutritional needs of the baby between 6 and 12 months.
- **Up to one third** of the baby's nutritional needs between 12 and 24 months.



Breastfeed the baby first, then give other foods.

Continue to breastfeed the baby as often as the baby wants, day and night. Breastfeed the baby for as long as the baby wants. Introduce new foods one at a time. This will help you to know the foods the baby likes and the foods the baby may react to.

Give the baby different kinds of foods, as below:

Energy giving foods (starches, cereals and grains): These include maize flour, millet, sorghum, cassava, bread, sweet potatoes, rice, pasta, munkoyo and pumpkins. Give the baby the foods found at home. This group of foods should make up the bigger part of the food that the baby eats. These foods give energy and some proteins to the body.

High energy foods (oils and fats): Oils and fats provide more energy to

the body. They include cooking oil, pumpkin seeds, butter and margarine. Add oils and fats to the baby's food to give the body more energy. Do not add too much oil because it can make the body too fat.

Protective foods (fruits and vegetables): These give the baby vitamins and minerals, which protect the body from diseases and help the body to work well. Give the baby fruits and vegetables of different types and colours. Dark green, orange and red vegetables and fruits are the best for the body.

Body building foods (Meat, poultry, fish, beans, peas and nuts): This group of foods include eggs and milk. The foods give proteins for growth, development and repair of body parts. The foods also provide vitamins and minerals which help to make the immunity of the body strong.

Give the baby as much food as the baby will eat.

Increase the amount of food, as the baby grows older. Increase the frequency of feeding as the baby grows older. Serve the baby on a separate plate to be sure that the baby eats enough.

Feed the baby actively. Either feed the baby or sit with the baby and encourage the baby to eat.

Do not force the baby to eat. Instead, develop love and friendship between you and your baby.

If the baby is easily distracted, feed the baby in a quiet place. Gradually prepare the baby to accept the family diet.

Water: Give the baby water during every meal and whenever the baby wants water. Give water which has been boiled and left to cool. A person aged 6 months and older needs to drink water for the body to work well.

7.2.1 Feeding a baby between 6 and 12 months

At 6 months, give the baby other foods as you continue to breastfeed.

Start with soft foods which are pounded, mashed, or sieved. Between 6 and 8 months, give the baby food 2-3 times a day. Between 9 and 24 months, give the baby food 3-4 times a day. In between, give 2 snacks such as fruits, fruit juice, beans, mashed cassava or mashed sweet potatoes enriched with groundnuts, milk, munkoyo or pumpkins.

Increase the hardness of food as well as the frequency of feeding as the baby grows older.

After feeding the baby, give the baby previously boiled and cooled water or water treated with chlorine.

7.2.2 Feeding a baby between 12 and 24 months

- Breastfeed the baby as much as the baby will breastfeed.
- Give thick porridge enriched with sugar, oil, pounded groundnuts, caterpillars, or kapenta.
- Give food usually eaten in the family (such as nshima) with relish of green leafy vegetables, beans, fish, pounded kapenta, caterpillars cooked in oil, meat or thick porridge enriched with pounded relish.
- After breastfeeding, give the baby mashed food 4-5 times a day
- Between meals, give snacks such as fruits, fruit juice, beans, pounded groundnuts, cassava, sweet potatoes, milk, munkoyo or pumpkins.
- When giving water to the baby, make sure it has been boiled and cooled.

7.2.3 How to negotiate with parents on Infant feeding practices

Use **FADUA** to identify and discuss feeding needs with parents. FADUA is an acronym coined to help health promoters identify and discuss baby feeding needs with parents. Feeding discussions should cover, **F**requency **A**mount, **D**ensity, **U**talization of the food in the body, and **A**ctive participation by caretakers in feeding the baby.

FREQUENCY OF FEEDING

- How old is your baby?
- What do you feed the baby?
- How often do you breastfeed the baby?
- How often do you give the baby additional food?

AMOUNT

- How much does the baby eat during each feed?

DENSITY

- What kinds of foods do you include in the baby's diet?
- Is the baby receiving food from all the food groups?
- How thick or thin is the food you give to the baby?

UTILIZATION

- How will the baby's body use the different foods?
(See page 22 and 23)
- Prepare the baby's food with clean hands and use clean utensils. Clean hands and utensils protect the baby from germs and parasites. Parasites eat up food meant

for the body and can make the baby sick.

ACTIVE PARTICIPATION IN FEEDING:

How do you serve the baby - on the baby's own plate or from the same plate with other family members?

Does the baby eat on his or her own or is he or she fed or assisted by a caretaker?

8 HOW TO USE EDUCATIONAL MATERIALS



Educational materials

- Increase comprehension, retention, and the chances of taking positive action. Research shows that people retain 20% of what they hear, 40% of what they hear and see and 80% of what they discover for themselves.
- Make learning more interesting and effective.
- Give the messages importance and credibility.
- Remind the communicator or trainer of the important points to cover.
- Simplify the task of training (when used as handouts and reference materials).
- Remind the audience about messages after the session.
- Help to spread the messages even among those who did not attend the learning session.
- Make people happy that they have something to carry home.

Use ORPDA to improve use of educational materials

ORPDA is an acronym coined to help health promoters to use educational materials and life experiences more effectively in group learning. ORPDA stands for: **O**bserve, **R**eflect, **P**ersonalise, **D**ecide, and **A**ct on the decision taken.

OBSERVE: Show the picture or teaching aid to the audience to observe what is on it. Then discuss questions such as:

- What do you see in this picture?
- What is happening here?

REFLECT: Encourage the audience to reflect on what is happening in the picture or teaching aid by asking questions such as:

- Does this happen in real life?
- What do you think/feel about what is happening?
- Do you approve or disapprove of what is happening?
- What do you approve of in this illustration? What do you disapprove of? Why?
- What are the advantages and disadvantages of engaging in the activities shown in this illustration?

PERSONALISE: Encourage the audience to relate what they have observed and reflected upon to their own lives by asking questions such as:

- What do women in your community do in the same situation?
- Why?
- What would you do in this situation?
- What problems would you anticipate?
- What would you do to overcome the problems?

DECIDE: Encourage individuals to select the recommended behaviours they can try. Ask questions such as:

- What would work for you out of what we have discussed?
- Would you be willing to try it?
- What factors would make it possible for you to try the action?
- Do you anticipate any barriers?
- How would you overcome the barriers?

ACT: Encourage individuals to try their selected option. Agree on time and place for the next meeting to discuss experiences after trying the

new behaviour.

NB: If you are not using educational materials, skip observation and discuss participants' experiences instead.

9 WORKING WITH COMMUNITIES

The following tips improve cooperation between health workers and community members:

- Learn about the community.
- Identify formal leaders, opinion leaders, and other influential individuals to work with.
- Identify the various groups in the community to work with.
- Stimulate formation of suitable groups, where they do not exist.
- Brief community leaders about the programme and enlist their support.
- Brief leaders of groups identified and discuss and agree on the roles and responsibilities of the various groups.
- Work with leaders to develop procedures and processes of working together.
- Encourage selected groups to integrate PMTCT and infant and young child feeding content in their activities.
- Work with the various groups to identify and train trainers and supervisors to facilitate PMTCT and infant feeding activities in the various groups.
- Maintain frequent contact with the community.
- Strengthen cross referral between health facilities and the community.

9.1 Partnering with communities

Community members are the consumers of health services. To get maximum benefits from the services, health workers and community members should work together as partners.

Partners

Partners should:

- Acknowledge the existence of each other.
- Establish positive relationships.
- Have the will to interact and work together.
- Play by mutually accepted rules and standards.
- Discuss and agree on roles and responsibilities.
- Implement agreed activities.

Below are some organisations and individuals which can play a role in PMTCT promotion in Zambia.

ORGANIZATIONS AND INDIVIDUALS WHICH CAN PLAY A ROLE IN PMTCT PROMOTION IN ZAMBIA		
Organizations	Individuals	Possible contact places
Administration Elected representatives Neighbourhood committees Mother-to-mother support groups Mother/father support groups Orphans and vulnerable children's committees Home-based care groups Area-based organisations and prayer places Youth organisations Faith-based organisations Non-governmental organisations (NGOs) Community-based organisations (CBOs) Political parties Cooperatives Schools Solo and other clubs	Administrators Community leaders Mothers Fathers/men Men's group leaders Men in support groups/clubs/relaxation/games places Youth leaders/young people Women's group leaders/alangizi Traditional healers Traditional birth attendants Growth monitors and promoters Teachers Pastors Traditional leaders Home-based care volunteers	Health facilities, especially ANC/MCH/FP facilities Youth-friendly corners Churches and other religious places Schools (special meetings for adults) Women's group meeting places (including kitchen parties) Men's group meeting places, such as: bars/taverns, clubs and other entertainment places, such as Nsolo clubs Men's fellowships and sections in churches Homes Political parties Village/section/ward meetings Health centre meetings Market places Specially convened discussion groups Funeral gatherings Workplaces Cross-border areas

- Cooperate to resolve conflicts when they occur.

9.2 Working with community groups

Key strategies for working with community groups

- Motivate leaders and groups to integrate PMTCT, infant and young child feeding content in their day-to-day activities.
- Provide orientation and skills training to key people to enable them to train others and provide PMTCT, infant and young child feeding leadership in their groups.
- Encourage neighbouring groups to hold joint activities from time to time.
- Meet community groups frequently to share experiences and discuss new interventions.

9.2.1 Working with leaders



Community leaders are important gatekeepers and have the power to allow or reject a programme in their areas. Before implementing activities in the community, identify key community leaders to work with, brief them on the programme, and seek their support. Community leaders may be reached through courtesy calls, special meetings, workshops, or regular briefings. Keep community leaders well informed and motivated. If leaders are well informed, they can:

- Advocate for the programme.
- Put the programme on the national and local agenda.
- Give the programme increased importance and visibility.
- Mobilise human and material support for the programme.
- Serve as ambassadors and role models for programme goals.

9.2.2 Working with youth groups

Young people can be energetic and a great asset to a programme.

Identify and work with existing youth groups.

Respect young people as individuals and as groups.

Develop a partnership between the programme and young people.

Adult-youth partnership should involve the following

Roles and responsibilities	Attitudes
<ul style="list-style-type: none"> Establish clear goals, expectations and responsibilities for young people and adults. Be committed to youth-adult partnership. Support young people through training, capacity development and mentorship. Find time to supervise young people and share experiences. Ensure that meeting times are flexible Monitor relationships between young people and adults regularly. 	<ul style="list-style-type: none"> Address attitudes and misconceptions adults and young people may have about each other. Use training to reduce stereotypes and facilitate collaboration. Support positive attitude changes and build skills to enable young people and adults to work together. Change communication approaches to suit the different situations.
Recruitment and retention of youth	Participation
<ul style="list-style-type: none"> Establish criteria for selecting young people to serve on the various task forces. Support young people to balance school work, employment and family commitments. Accept that the turnover of young people will be high and develop a continuous system of recruiting young people, training and capacity development to be sure that young people will be available all the time. 	<ul style="list-style-type: none"> Determine how young people will be involved. Involve young people in all stages of inception of ideas, decision making, planning and implementation. This motivates them and increases their involvement. Ensure that young people have ownership and influence in decision making.

- Be honest about your objectives and expectations. Share your vision openly and agree on what young people will contribute. Let young people know that their contribution and involvement are important.
- Be open and non-judgemental.
- Encourage young people to volunteer for the various roles and to use the expertise they have to carry out activities.
- Incorporate young people in committees managing project activities. Keep young people well informed and draw on their views, energy, and resourcefulness.
- Focus more on field work. Meetings tend to bore young people.
- Support peer education activities. Train peer educators in participatory facilitation methods.

9.2.3 Involving men



Men hold power in their homes and in the community. Yet most health programmes do not involve them in promoting health behaviours. Men participate little in health, PMTCT, infant and young child feeding promotion because:

- They do not have facts about reproductive health, PMTCT, infant and young child feeding issues.
- They believe that services in these areas are meant for women and children.
- They do not understand the importance of reproductive health, PMTCT, infant and young child feeding.
- The services are usually located within health facilities, which are usually associated with women.

- Health facilities are not men friendly.
- Health workers and health promoters make little effort to involve men.
- Most stand-alone reproductive health and VCT services (where men feel more comfortable) usually do not include other PMTCT services.

To increase male involvement in reproductive health, PMTCT, and infant feeding:

- Encourage men to learn about reproductive health, PMTCT, infant and young child feeding. This can be done through seminars, workshops or in places where men gather, such as in homes, clubs, bars, taverns, nsolo clubs, or work places.
- Reach men where they are. Do not wait for them to come to you at the health facility.
- Promote discussion of reproductive health, PMTCT, infant and young child feeding, and make the benefits widely known in the community.
- Promote the importance and benefits of VCT to ALL people, and allay the fear that when you go for VCT you will test positive, worry, and die early (see the client VCT brochure for details).
- Discuss the role men can play in reproductive health, PMTCT, infant and young child feeding.
- Publicise the outcome of discussions and encourage men to play the role they identify for themselves. Assign men roles they have identified for themselves in all PMTCT infant and young child feeding activities.
- Develop skills of the various stakeholders in the community (including men) to play their respective roles effectively.
- Make health facilities (especially MCH/ANC services) more men friendly.
- Empower both men and women to discuss reproductive health, PMTCT, infant and young child feeding issues with their spouses.

9.2.4 Working with community health workers

Most communities have community health agents (CHAs) who educate and motivate people, and play a vital role in strengthening the linkage between the community and the health facility. In Zambia, community health agents include:

- Traditional birth attendants
- Community health promoters
- Growth monitoring promoters
- Home based care volunteers
- Mother support groups
- Nutrition promoters

- Community PMTCT motivators.



Identify community health agents and train them to integrate PMTCT messages in their day-to-day activities. Key areas of training and capacity development should include PMTCT, infant and young child feeding, behaviour change communication methods, monitoring progress, and using monitoring results to improve programmes at the community level. In addition, provide opportunities for CHAs to meet from time to time to share experiences and discuss common problems. The meetings can take place at various levels, among:

- motivators meeting on their own
- motivators meeting with their supervisors
- motivators meeting with community representatives
- motivators meeting with health agents