INFANT AND YOUNG CHILD FEEDING COUNSELLING: AN INTEGRATED COURSE

Trainer's guide

Second edition

unicef

World Health Organization

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Abbreviations used in this course

These abbreviations are mentioned throughout the course in this *Trainer's guide*, the Web Annexes and in accompanying material. They are listed here for ease of reference.

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
ARV	antiretroviral
ARV3	triple antiretroviral treatment (i.e. 3 doses per day)
AZT	azidothymidine
BFHI	Baby-friendly Hospital Initiative
BMI	body mass index
CBR	crude birth rate
CSB++	milk-fortified corn–soy blend
DTG	dolutegravir
EFV	efavirenz
FTC	emtricitabine
GMP	growth monitoring and promotion
HIV	human immunodeficiency virus
HMIS	health management information system
IgA	immunoglobulin A
IgG	immunoglobulin G
ILO	International Labour Organization
IMCI	Integrated Management of Childhood Illness
IQ	intelligence quotient
IUD	intrauterine device
IYCF	infant and young child feeding
LQAS	lot quality assurance sampling
MGRS	WHO Multicentre Growth Reference Study
MNP	multiple micronutrient powder
MTCT	mother-to-child transmission of HIV
NVP	nevirapine
ORS	oral rehydration solution
PIP	programme impact pathway
PMTCT	prevention of mother-to-child transmission of HIV
RDT	rapid diagnostic test
RUSF	ready-to-use supplementary food
RUTF	ready-to-use therapeutic food
SD	standard deviation
SMART	specific, measurable, achievable, relevant, time-bound
3TC	lamivudine
TB	tuberculosis
TDF	tenofovir
UHT	ultra-high temperature
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USA	United States of America
WASH	water, sanitation and hygiene
WHA	World Health Assembly
WHO	World Health Organization

Glossary

Absorbed iron: The iron that passes into the body after it has been released from food during digestion. Only a small proportion of the iron present in food is absorbed. The rest is excreted in the faeces.

Accuracy: Correctness. The accuracy of a measurement depends on whether the instrument is correctly calibrated and whether the observer measures correctly (i.e. takes, reads and records the measurement correctly).

Active encouragement: Assistance given to encourage a child to eat. This includes praising, talking to the child, helping the child put food on the spoon, feeding the child, making up games.

Afterpains: Contraction of the uterus during breastfeeding in the first few days after childbirth, owing to release of oxytocin.

AIDS: Acquired immune deficiency syndrome, which means that a person who is living with HIV has progressed to active disease.

Allergy: Symptoms when fed even a small amount of a particular food (so it is not dose related).

Alveoli: Small sacs of milk-secreting cells in the breast.

Amenorrhoea: Absence of menstruation.

Anaemia: Lack of red cells or lack of haemoglobin in the blood.

Antenatal preparation: Preparation of a mother for the delivery of her baby.

Antibodies: Proteins in the blood and in breast milk that fight infection.

Anti-infective factors: Factors that prevent or that fight infection. These include antibodies.

Appropriate touch: Touching somebody in a socially acceptable way.

Areola: Dark skin surrounding the nipple.

Artificial feeding: Feeding an infant on a breast-milk substitute.

Artificial feeds: Any kind of milk or other liquid given instead of breastfeeding.

Artificially fed: Receiving artificial feeds only, and no breast milk.

Asthma: Wheezing illness.

Attachment: The way a baby takes the breast into their mouth; a baby may be well attached or poorly attached to the breast.

Baby-friendly Hospital Initiative (BFHI): An approach to transforming maternity practices, as recommended in the joint World Health Organization (WHO)/United Nations Children's Fund (UNICEF) statement on *Protecting, promoting and supporting breastfeeding: the special role of maternity services* (1989).[1]

Baby-led feeding: *See* **Demand feeding**.

Bedding-in: A baby sleeping in bed with their mother, instead of in a separate cot.

Bilirubin: Yellow breakdown products of haemoglobin, which cause jaundice.

Blocked duct: A milk duct in the breast becomes blocked with thickened milk, so that the milk in that part of the breast does not flow out.

BMI: Body mass index; a ratio that indicates a person's weight in proportion to their length/height, calculated as kg/m^2.

BMI-for-age: A growth indicator that relates BMI to age.

Bonding: Development of a close loving relationship between a mother and her baby.

Bottle-feeding: Feeding an infant from a bottle, whatever is in the bottle, including expressed breast milk, water, formula milk, etc.

Breast pump: Device for expressing milk.

Breast refusal: A baby not wanting to suckle from their mother's breast.

Breastfeeding history: All the relevant information about what has happened to a mother and baby, and how their present breastfeeding situation developed.

Breastfeeding supplementer: A device for giving a baby a supplement while they are suckling at a breast that is not producing enough milk.

Breastfeeding support: A group of mothers who help each other to breastfeed.

Breast-milk substitute: Any food being marketed or otherwise represented as a partial or total replacement for breast milk, whether or not it is suitable for that purpose.

Calibration: Checking a measuring instrument for accuracy and adjusting if necessary and possible.

Calories (or kilocalories): A measure of the energy available in food.

[1] Protecting, promoting and supporting breastfeeding: the special role of maternity services. A joint WHO/UNICEF statement. Geneva: World Health Organization; 1989 (http://apps.who.int/iris/bitstream/10665/39679/1/9241561300.pdf).

***Candida*:** Yeast that can infect the nipple, and the baby's mouth and bottom. Also known as "thrush".

Care for development: Care intended to stimulate emotional, intellectual and motor development.

Casein: Protein in milk, which forms curds.

Cessation of breastfeeding: Completely stopping breastfeeding, including suckling.

Chapati: A flat bread made by mixing whole-wheat flour with water and then shaping pieces of the dough into flat circles and baking on a griddle (hot metal sheet). Traditionally eaten in India and Pakistan.

Cleft lip or palate: Abnormal division of the lip or palate.

Closed questions: Questions that can be answered with "yes" or "no".

Colic: Regular crying, sometimes with signs suggesting abdominal pain, at a certain time of day; the baby is difficult to comfort but otherwise well.

Cold compress: Cloths soaked in cold water to put on the breast.

Colostrum: The special breast milk that women produce in the first few days after delivery; it is yellowish or clear in colour.

Confidence: Believing in yourself and your ability to do things.

Contaminated: Containing harmful bacteria or other harmful substances.

Commercial infant formula: A breast-milk substitute formulated industrially, in accordance with applicable *Codex Alimentarius* standards,[1] to satisfy the nutritional requirements of infants during the first months of life up to the introduction of complementary foods.

Complementary feeding: The child receives both breast milk, or a breast-milk substitute, and solid (or semi-solid) food.

Complementary food: Any food, whether manufactured or locally prepared, used as a complement to breast milk or to a breast-milk substitute.

Counselling: A way of working with people so that you understand their feelings and help them to develop confidence and decide what to do.

Cup-feeding: Feeding from an open cup without a lid, whatever is in the cup.

Deficiency: Shortage of a nutrient that the body needs.

Dehydration: Lack of water in the body.

Demand feeding: Feeding a baby whenever they show that they are is ready, both day and night. This is also called "unrestricted" or "baby-led" feeding.

Distraction (during feeding): A baby's attention is easily taken from the breast by something else, such as a noise.

Ducts, milk ducts: Small tubes that take milk to the nipple.

Dummy: An artificial nipple made of plastic for a baby to suck. Also known as a pacifier/soother.

Early contact: A mother holding her baby during the first hour or two after delivery.

Eczema: Skin condition, often associated with allergy.

Effective suckling: Suckling in a way that removes the milk efficiently from the breast.

Empathize: Show that you understand how a person feels from her/his point of view.

Engorgement: The breast is swollen with breast milk, blood and tissue fluid. Engorged breasts are often painful and oedematous and the milk does not flow well.

Essential fatty acids: Fats that are essential for a baby's growing eyes and brain, and that are not present in cow's milk or most brands of formula milk.

Exclusive breastfeeding: An infant receives only breast milk and no other liquids or solids, not even water. Drops or syrups consisting of vitamins, mineral supplements or medicines, including oral rehydration solution, are permitted.

Expressed breast milk: Milk that has been removed from the breasts manually or by using a pump.

Express: To squeeze or press out.

Family foods: Foods that are part of the family meals.

Fat: A nutrient that provides energy.

Feeding history: All the relevant information about what has happened to a mother/caregiver and baby, and how their present feeding situation developed.

Fermented foods: Foods that are soured. For example, yoghurt is fermented milk. These substances can be beneficial and kill pathogens that may contaminate food.

Fissure: Break in the skin, sometimes called a "crack".

Flat nipple: A nipple that sticks out less than average.

Foremilk: The watery breast milk that is produced early in a feed.

Formula milks: Artificial milks for babies made out of a variety of products, including sugar, animal milks, soybean and vegetable oils. They are usually in powder form, to mix with water.

Fortified foods: Foods that have certain nutrients added to improve their nutritional quality.

[1] Codex Alimentarius. International food standards (http://www.fao.org/fao-who-codexalimentarius/about-codex/en/).

Full breasts: Breasts that are full of milk, and hot, heavy and hard, but from which the milk flows.

Fully breastfed: Exclusively breastfed.

Gastric suction: Sucking out a baby's stomach immediately after delivery.

Germinated seeds/flour: Seeds that have been soaked and allowed to sprout. The sprouted seeds can be dried and milled to make germinated flour. If a little of this flour is added to warm thick porridge, it makes the porridge soft and easy to eat.

Gestational age: The number of weeks a baby has completed in the uterus.

Ghee: Butter that has been heated so that the fat melts and the water evaporates. It looks clear. It can be made from cow's or buffalo's milk and is widely used in India. In the Middle East, it is called *samna*.

Gross motor development: Development of movement and body control related to use of the larger muscles (e.g. development of crawling and walking skills), as contrasted with fine motor development (e.g. use of the hands and fingers to grasp small objects). *See also* **Gross motor milestones**.

Gross motor milestones: Important achievements related to movement and body control, including sitting without support, standing with assistance, hands-and-knees crawling, walking with assistance, standing alone and walking alone.

Growth factors: Substances in breast milk that promote growth and development of the intestine, and that probably help the intestine to recover after an attack of diarrhoea.

Growth spurt: Sudden increased hunger for a few days.

Gruel: Another name for thin porridge. Examples are *atole* in Central America and *uji* in Africa.

Gulp: Loud swallowing sounds, owing to swallowing a lot of fluid.

"High-needs" babies: Babies who seem to need to be carried and comforted more than other babies.

Hindmilk: The fat-rich breast milk that is produced later in a feed.

HIV: Human immunodeficiency virus, which causes AIDS. *See also* **AIDS**.

HIV infected: Refers to a person infected with HIV, but who may not know that they are infected.

HIV negative: Refers to a person who has been tested for HIV with a negative result and who knows their result.

HIV positive: Refers to a person who has been tested for HIV, whose results have been confirmed and who knows and/or their parents know that they tested positive.

HIV status unknown: Refers to a person who has been tested for HIV or who does not know the result of their test.

HIV testing and counselling: Testing for HIV status, preceded and followed by counselling. Testing should be voluntary and confidential, with fully informed consent. The expression means the same as the terms: "counselling and voluntary testing", "voluntary counselling and testing", and "voluntary and confidential counselling and testing". Counselling is a process, not a one-off event: for the client living with HIV, it should include life planning, and, if the client is pregnant or has recently given birth, it should include infant feeding considerations.

Hormones: Chemical messengers in the body.

Hypoglycaemia: Low blood sugar.

Immune system: Those parts of the body and blood, including lymph glands and white blood cells, that fight infection.

Immunity: A defence system that the body has to fight diseases.

Ineffective suckling: Suckling in a way that removes milk from the breast inefficiently or not at all.

Infant: A child not more than 12 months of age.

Infant feeding counselling: Counselling on breastfeeding, on complementary feeding, and, for women who are living with HIV, on HIV and infant feeding.

Infantometer: A board designed to be placed on a horizontal surface to measure the length (lying down) of a child aged less than 2 years.

Infective mastitis: Mastitis resulting from bacterial infection.

Inhibit: To reduce or stop something.

Inspection: Examination by looking.

Intolerance (of food): Inability to tolerate a particular food.

Inverted nipple: A nipple that goes in instead of sticking out, or that goes in when the mother tries to stretch it out.

Jaggery: Brown sugar made from the sap of the palm flower. It is widely used in the Indian subcontinent.

Jaundice: Yellow colour of the eyes and skin.

Judging words: Words that suggest that something is right or wrong, good or bad.

Kwashiorkor: A form of severe undernutrition characterized by generalized oedema, thin, sparse hair and dark or cracking/peeling patches of skin.

Lactation: The process of producing breast milk.

Lactation amenorrhoea method: Using the period of amenorrhoea after childbirth as a method for family planning.

Lactogogue: A special food, drink or herb that people believe increases a mother's supply of breast milk.

Lactose: The special sugar present in all milks.

Length/height-for-age: A growth indicator that relates length or height to a child's age.

Lipase: Enzyme to digest fat.

Low birth weight: Weighing less than 2.5 kg at birth.

Marasmus: A form of severe undernutrition referred to alternatively as "non-oedematous malnutrition". A child with marasmus is severely wasted and has the appearance of "skin and bones".

Mastitis: Inflammation of the breast (*see also* **Infective mastitis** and **Non-infective mastitis**).

Matooke: Green banana.

Mature milk: The breast milk that is produced a few days after birth.

Meconium: The first dark stools produced by a baby soon after birth.

Median: The middle value in a rank-ordered series of values.

Median duration of breastfeeding: The age in months when 50% of children are no longer breastfed.

Micronutrients: Essential nutrients required by the body in small quantities (such as vitamins and some minerals).

Micronutrient supplements: Preparations of vitamins and minerals.

Milk ejection: Milk flowing from the breast due to the oxytocin reflex, which is stimulated in response to the sight, touch or sound of the baby.

Milk stasis: Milk staying in the breast and not flowing out.

Mistaken idea: An idea that is incorrect.

Milk expression: Removing milk from the breasts manually or by using a pump.

Mixed feeding: Feeding both breast milk and other foods or liquids.

Montgomery's glands: Small glands in the areola that secrete an oily liquid.

Multiple birth: Birth of more than one child at the same time, e.g. twins.

Natural (passive) immunity: The protection a baby inherits from their mother.

"Nipple confusion": A term sometimes used to describe the way babies who have fed from a bottle may find it difficult to suckle effectively from a breast.

Nipple sucking: When a baby takes only the nipple into their mouth, so that they cannot suckle effectively.

Non-infective mastitis: Mastitis due to milk leaking out of the alveoli and back into the breast tissues, with no bacterial infection.

Non-verbal communication: Showing your attitude through your posture and expression.

Nutrients: Substances the body needs that come from the diet. These are carbohydrates, proteins, fats, minerals and vitamins.

Nutritional needs: The amounts of nutrients needed by the body for normal function, growth and health.

Mother-support group: A community-based group of women providing support for optimal breastfeeding and complementary feeding.

Mother-to-child transmission: Transmission of HIV to a child from a woman infected with HIV during pregnancy, delivery or breastfeeding.

Obese: Severely overweight; weight-for-length/height or BMI-for-age above the 3 *z*-score line.

Obesity: The condition of being obese.

Oedema: Swelling due to fluid in the tissue.

Offal/organs: Liver, heart, kidneys, brain, intestines, blood.

Open questions: Questions that can only be answered by giving information, and not with just a "yes" or a "no".

Overweight: Weighing too much for one's length/height; weight-for-length/height or BMI-for-age above the 2 *z*-score line.

Oxytocin: The hormone that makes the milk flow from the breast.

Pacifier: Artificial nipple made of plastic for a baby to suck, a dummy.

Palpation: Examining by feeling with the hand.

Partially breastfed or **mixed fed:** Breastfed and given some artificial feeds, either milk or cereal, or other food.

Pasteurized: Food (usually milk) made safe by heating it to destroy disease-producing pathogens.

Pathogen: Any organism that causes disease.

Perinatal: Around the time of birth.

Perpendicular: Positioned at a right angle (90° angle).

Persistent diarrhoea: Diarrhoea that starts as an acute attack, but that continues for more than 14 days.

Pesticides: Substances (usually sprays) used by farmers to prevent pests from attacking crops.

Phytates: Substances present in cereals, especially in the outer layer (bran), and in peas, beans and nuts. Phytates combine with iron, zinc and calcium in food to form substances that the body cannot absorb. Eating foods containing vitamin C helps protect iron from the adverse effect of phytates.

Pneumonia: Infection of the lungs.

Poorly protractile: Used to describe a nipple that is difficult to stretch out to form a "teat".

Porridge: Made by cooking cereal flour with water until it is smooth and soft. Grated cassava or other root, or grated starchy fruit can also be used to make porridge.

Positioning: How a mother holds her baby at her breast; the term usually refers to the position of the baby's whole body.

Postnatal check: Routine visit to a health facility after a baby is born.

Precision: The smallest exact unit that an instrument can measure. For example, the UNISCALE measures with precision to the nearest 0.1 kg.

Predominantly breastfed: Breastfed as the main source of nourishment, but also given small amounts of non-nutritious drinks such as tea, water and water-based drinks.

Prelacteal feeds: Artificial feeds given before breastfeeding is established.

Premature, preterm: Born before 37 weeks' gestation.

Prolactin: The hormone that makes the breasts produce milk.

Protein: Nutrient necessary for growth and repair of the body tissues.

Protractile: Used to describe a nipple that is easy to stretch out.

Psychological: Mental and emotional.

Pulses: Foods that include peas, lentils, beans and groundnuts.

Puree: Food that has been made smooth by passing it through a sieve or mashing it with a fork, pestle or other utensil.

Quinoa: A cereal grown at high altitude in the Andes in South America.

Recumbent: Lying down.

Reflect back: Repeat back what a person says to you, in a slightly different way.

Reflex: An automatic response through the body's nervous system.

Rejection of baby: The mother not wanting to care for her baby.

Relactation: Re-establishment of breastfeeding after a mother has stopped, whether in the recent or distant past.

Replacement feeding: The process of feeding a child who is not receiving any breast milk with a diet that provides all the nutrients they need until they are fully fed on family foods. During the first 6 months, this should be with a suitable breast-milk substitute. After 6 months, it should be with a suitable breast-milk substitute, as well as complementary foods made from appropriately prepared and nutrient-enriched family foods.

Responsive feeding: Feeding infants directly and assisting older children when they feed themselves, being sensitive to their hunger and satiety cues.

Restricted breastfeeds: When the frequency or length of breastfeeds is limited in any way.

Retained placenta: A small piece of the placenta remaining in the uterus after delivery.

Rooming-in: A baby staying in the same room as their mother.

Rooting: A baby searching for the breast with their mouth.

Rooting reflex: A baby opening their mouth and turning to find the nipple.

Rubber teat: The part of a feeding bottle from which a baby sucks.

Scissor hold: Holding the breast between the index and middle fingers while the baby is feeding.

SD score: Standard deviation score. *See* ***z*-score**.

Secrete: Produce a fluid in the body.

Self-weaning: A baby more than 1 year old deciding by themself to stop breastfeeding.

Sensory impulses: Messages in nerves that are responsible for feeling.

Silver nitrate drops: Drops put into a baby's eyes to prevent infection with gonococcus or chlamydia.

Skin-to-skin contact: A mother holding her naked baby against her own skin.

Sore nipples: Pain in the nipple and areola when the baby feeds.

"Spillover": A term used to designate the feeding behaviour of new mothers who either know that they are HIV negative or are unaware of their HIV status – they do not breastfeed, or they breastfeed for a short time only, or they mix-feed, because of unfounded fears about HIV, misinformation or the ready availability of breast-milk substitutes.

Stadiometer: A board for measuring the standing height of children age 2 years or older.

Stagnation: Staying the same. A flat growth line indicates stagnation of growth.

Stunted: Short for one's age; length/height-for-age below the −2 *z*-score line; **severely stunted** is below the −3 *z*-score line.

Sucking: Using negative pressure to take something into the mouth.

Sucking reflex: A reflex that allows a baby to automatically suck something that touches their palate.

Suckling: The action by which a baby removes milk from the breast.

Supplements: Drinks or artificial feeds given in addition to breast milk.

Sustaining: Continuing to breastfeed up to 2 years or beyond; helping breastfeeding mothers to continue to breastfeed.

Swallowing reflex: A reflex whereby a baby automatically swallows when their mouth fills with fluid.

Symmetrical: The same (mirror images) on opposite sides separated by a straight line.

Sympathize: Show that you feel sorry for a person, from your point of view.

Tare: As used in these modules, to store a weight in the memory of a scale so that an additional weight can be registered independently. In **tared weighing**, the scale is reset to zero while an adult is still standing on it; when the adult is then given a child to hold, only the child's weight appears.

Taring scale: A scale that can be reset to zero while someone (who has just been weighed) is still standing on it. When they then hold a child on the scale, only the child's weight appears.

Tarwi: A bean grown in the Andes in South America.

"Teat": Stretched out breast tissue from which a baby suckles.

Thrush: Infection caused by the yeast *Candida*; in the baby's mouth, thrush forms white spots

Tortilla: A flat bread made by mixing maize flour and water and then making the dough into a thin round shape. It is cooked on a hot metal griddle. It is traditionally eaten in Central America. Wheat flour can also be used.

Toxin: A poisonous substance.

Undernourished: Any of the following:

- underweight or severely underweight (below the −2 or −3 *z*-score line in weight-for-age)
- wasted or severely wasted (below the −2 or −3 *z*-score line in weight-for-length/height or BMI-for-age)
- stunted or severely stunted (below the −2 or −3 *z*-score line in length/height-for-age). However, if overweight or trending toward overweight, the child is no longer considered as primarily undernourished.

Undernutrition: The condition of being undernourished.

Underweight: Weighing too little for one's age; weight-for-age below the −2 *z*-score line; **severely underweight** is below the −3 *z*-score line.

UNISCALE: An electronic scale made by UNICEF that allows tared weighing.

Unrestricted feeding: *See* **Demand feeding**.

Wasted: Weighing too little for one's length/height; weight-for-length/height or BMI-for-age below the −2 *z*-score line; **severely wasted** is below the −3 *z*-score line.

Warm compress: Cloths soaked in warm water to put on the breast.

Weight-for-age: A growth indicator that relates weight to age.

Weight-for-length/height: A growth indicator that relates weight to length (for children aged less than 2 years) or height (for children aged 2 years and older).

Whey: Liquid part of milk that remains after removal of casein curds.

Young child: A person from the age of more than 12 months up to the age of 3 years (36 months).

***z*-score:** A score that indicates how far a measurement is from the mean, also known as "standard deviation (SD) score". The reference lines on the growth charts (labelled 1, 2, 3, −1, −2, −3) are called ***z*-score lines**; they indicate how far points are above or below the mean (*z*-score 0).

Checklist of training skills

Practise using these skills when you conduct sessions, and comment on these points when you give feedback to other trainers. For more information, see pages 26 to 37 of this guide.

Preparation

- Follow the session plan accurately and completely – use your *Trainer's guide*.
- Prepare thoroughly – read the text and practise.
- Prepare your helpers or co-facilitators (e.g. for role-plays) before the session – practise if possible.
- Have the required supplies, equipment and teaching aids ready – check and arrange them before the session.
- If needed, place a table at the front of the room to set up visual aids and teaching materials.
- Arrange the room so that all participants can see clearly what is happening – if possible, arrange seats in a U-shape with no more than two rows of seats.
- Do not introduce too much extra material – give local or personal examples when appropriate.

Audiovisuals and teaching aids

- Make sure audiovisual equipment is available and working.
- Make sure audiovisuals and teaching aids can be seen by all participants.
- Write clearly on the board or flipchart – arrange words carefully so there is enough room.
- Let participants handle teaching aids that you use for demonstrations.
- Cover, turn off or remove teaching aids that are not in use any more.

Presentations

- Take centre stage – don't hide behind a podium or desk.
- Follow the *Trainer's guide* – but talk in your own way.
- Face the audience when speaking – not the board or screen.
- Make eye contact with people in all sections of the audience.
- Speak slowly, clearly and loudly enough for everyone to understand and hear.
- Vary the tone and level of your voice.
- Use natural gestures and facial expressions.
- Avoid blocking the participants' view – watch for craning necks.

Interaction

- Involve all participants. Ask questions to quiet ones. Control talkative ones.
- Move around the room – approach people to get their attention or response.
- Use participants' names.
- Allow time for participants to answer questions from the *Trainer's guide* – give hints when needed.
- Repeat responses from participants when it is likely that not everyone heard.
- Respond encouragingly and positively to all answers – correct errors gently.
- Reinforce participants by thanking them for comments and praising good ideas.
- Respond adequately to questions – offer to seek answers if not known.
- Handle incorrect or off-the-subject comments tactfully.

Demonstrations

- Follow the instructions in the *Trainer's guide*.
- State clearly the objective of the demonstration.
- Demonstrate the entire, correct procedure (no short-cuts).
- Describe the steps aloud while doing them.
- Project your voice so all can hear. Stand where everyone can see.
- Encourage questions from participants.
- Ask participants questions to check their understanding.

Written exercises

- Give clear instructions and a time limit before starting the exercises.
- While participants work, look available, interested and willing to help.
- Give individual help quietly, without disturbing others in the group.
- Sit down next to the participant whom you are helping.
- Check answers carefully – listen as participants give reasons for their answers.
- Encourage and reinforce participants' efforts – give positive feedback.
- Help participants to understand any errors – give clear explanations.
- Remember to use your counselling skills when giving feedback.

Clinical practice sessions and group work

- Before dividing into groups, explain clearly the purpose of the activity, what participants will do, and the time limit.
- If needed, demonstrate a skill before asking participants to do it on their own.
- Select suitable cases for the session's objectives.
- Observe participants carefully as they work with real mothers or counselling stories.
- Use the CLINICAL PRACTICE DISCUSSION CHECKLIST.
- Try to get participants to identify their own strengths and weaknesses. Ask questions such as –"What did you do well?", "What difficulties did you have?", and "What would you do differently in the future?".
- Provide feedback on things that participants did well and on things that they need to improve on – be gentle and tactful when correcting errors.
- Keep participants busy by promptly assigning another mother or case scenario.

Role-plays

- Set up role-plays carefully. Obtain the necessary props (e.g. dolls). Brief those who will play the roles and allow them time to prepare.
- Clearly introduce the role-play by explaining its purpose, the situation and the roles to be enacted.
- Keep the role-play brief and to the point.
- After the role-play, guide a discussion. Ask questions of both the players and observers.
- Summarize what happened and what was learnt.

Time management

- Keep to time – not too fast or too slow. Don't take too long with the early part of a session. Don't lose time between sessions (e.g. going to clinical practice session and group work). Before participants begin to move, explain clearly what they will do.

KEY MESSAGES FOR COMPLEMENTARY FEEDING

1. Breastfeeding for 2 years or longer helps a child to develop and grow strong and healthy
2. Starting other foods in addition to breast milk at 6 completed months helps a child to grow well
3. Foods that are thick enough to stay on the spoon give more energy to the child
4. Animal-source foods are especially good for children, to help them grow strong and lively
5. Peas, beans, lentils, nuts and seeds are good for children
6. Dark-green leaves and yellow-coloured fruits and vegetables help the child to have healthy eyes and fewer infections
7. A growing child needs 2–4 meals a day, plus 1–2 snacks if hungry: give a variety of foods
8. A growing child needs increasing amounts of food
9. A young child needs to learn to eat: encourage and give help… with lots of patience
10. Encourage the child to drink and eat during illness, and provide extra food after illness to help them recover quickly

Introduction to the course

Why this course is needed

Breastfeeding and appropriate, safe and timely complementary feeding are fundamental to the health and development of children, and important for the health of their mothers. The World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) have long recognized the need for promotion of exclusive breastfeeding in the first 6 months of life, and sustained breastfeeding together with adequate complementary foods up to 2 years of age or beyond, to reduce child morbidity and mortality.

WHO and UNICEF developed The *Global strategy for infant and young child feeding*[1] in 2003, to revitalize world attention to the impact that feeding practices have on the nutritional status, growth, development, health and survival of infants and young children. The sixty-third World Health Assembly Resolution WHA63.23 urges Member States to implement the *WHO child growth standards* by their full integration into child health programmes.[2]

In 2015, with the endpoint of the United Nations' Millennium Development Goals[3] and the transition to the Sustainable Development Goals,[4] a new set of 17 goals defined the global agenda to end poverty, protect the planet and ensure prosperity for all. The second goal (end hunger, achieve food security and improved nutrition and promote sustainable agriculture) and the third goal (ensure healthy lives and promote well-being for all at all ages) directly link to nutrition actions, though most of the other goals also reflect nutrition issues. *The global strategy for women's, children's and adolescents' health 2016–2030*[5] aims to achieve the highest attainable standard of health for all, by putting women, children and adolescents at the heart of the Sustainable Development Goals.

The *WHO child growth standards*,[6] published in 2006, were developed using a sample of children from six countries: Brazil, Ghana, India, Norway, Oman and the United States of America. The WHO Multicentre Growth Reference Study (2004)[7] was designed to provide data describing how children should grow, by including in the study's selection criteria certain recommended health behaviours (for example, breastfeeding, providing standard paediatric care and not smoking). A key characteristic of the new standards is that they explicitly identify breastfeeding as the biological norm and establish the breastfed child as the normative model for growth and development,[8] and are a most appropriate complement to the WHO/UNICEF *Global strategy for infant and young child feeding*.[1]

Many mothers have difficulty breastfeeding from the beginning, and health-care practices in many facilities hinder the process of appropriate infant and young child feeding. However, even mothers who initiate breastfeeding satisfactorily often start complementary feeds or stop breastfeeding within a few weeks of delivery, and children, even those who have grown well for the first 6 months of life, may not receive adequate complementary foods. This may result in malnutrition, which is an increasing problem in many countries. More than one third of children aged under 5 years are undernourished – whether stunted, wasted or deficient in vitamin A, iron or other micronutrients. On the other hand, inappropriate feeding is probably contributing to an increased incidence of overweight/obesity in childhood. Application of the *WHO child growth standards* and counselling on infant and young child feeding, as presented in this course, aim to address the practices that lead to undernutrition, as well as those that predispose to the accumulation of excessive weight.

Information on how to feed young children comes from family beliefs, community practices and information from health workers. Advertising and commercial promotion by food manufacturers is sometimes the source of information for many people, both families and health workers. It has often been difficult for health workers to discuss with families how best to feed their young children, owing to the confusing, and often conflicting, information available. Inadequate knowledge about how to breastfeed, the appropriate complementary foods to give, and good feeding practices is often a greater determinant of malnutrition than the availability of food.

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[1] Global strategy for infant and young child feeding. Geneva: World Health Organization; 2003 (http://apps.who.int/iris/bitstream/10665/42590/1/9241562218.pdf).

[2] Resolution WHA63.23. Infant and young child nutrition. In: Sixty-third World Health Assembly, Geneva, 17–21 May 2010. Resolutions and decisions, annexes. Geneva: World Health Organization; 2010: 47–50 (http://apps.who.int/gb/ebwha/pdf_files/WHA63-REC1/WHA63_REC1-en.pdf).

[3] The Millennium Development Goals Report 2015. New York: United Nations; 2015 (http://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20(July%201).pdf).

[4] Sustainable Development Knowledge Platform. Sustainable Development Goals (https://sustainabledevelopment.un.org/sdgs).

[5] The global strategy for women's, children's and adolescents' health 2016–2030. Survive, thrive, transform. Geneva: World Health Organization; 2015 (http://www.who.int/pmnch/media/events/2015/gs_2016_30.pdf).

[6] The WHO child growth standards. In: Child growth standards [website]. Geneva: World Health Organization; 2021 (https://www.who.int/toolkits/child-growth-standards/standards).

[7] de Onis M, Garza C, Victora CG, Bhan MK, Norum KR, editors. WHO Multicentre Growth Reference Study: rationale, planning and implementation. Food Nutr Bull. 2004;25 (Suppl. 1):S15–26. doi:10.1177/15648265040251S103.

[8] de Onis M, Garza C, Onyango AW, Martorell R, guest editors. WHO child growth standards. Acta Paediatr. 2006;Suppl. 450:1–101.

All health workers who care for women and children during the postnatal period and beyond have a key role to play in establishing and sustaining breastfeeding and appropriate complementary feeding. Many health workers cannot fulfil this role effectively because they have not been trained to do so. Little time is assigned to counselling and support skills for breastfeeding and infant feeding, in the pre-service curricula of either doctors, nurses, midwives or other professionals.

Hence, there is an urgent need to train all those involved in infant feeding counselling, in all countries, in the skills needed to support and protect breastfeeding and good complementary feeding practices. The materials in this training course are designed to make it possible for trainers, even those with limited experience on teaching the subject, to conduct up-to-date and effective training.

The counselling material available from WHO/UNICEF includes modules related to:

- counselling skills
- breastfeeding
- complementary feeding
- growth assessment
- HIV and infant feeding.

In addition, there is material on policies and programmes related to infant and young child feeding; supportive supervision/mentoring and monitoring; and tools/Job aids.

The course materials are not intended to be conducted in their entirety. The course facilitators will need to decide which sessions from which chapters to cover, depending on the priorities and context of the country and the participants. For instance, for some topics there are multiple similar sessions to choose from, depending on the situation. The material could thus be used, for example, to hold a 5-day course on infant and young child feeding counselling, a 5-day course on growth assessment and infant and young child feeding counselling, or courses on specific subjects, such as breastfeeding counselling.

"**Counselling**" is an extremely important component of this course material. The concept of "counselling" is new to many people and can be difficult to translate. Some languages use the same word as "**advising**". However, counselling means more than simply advising. Often, when you advise people, you tell them what you think they should do. When you counsel, you listen to the people and help every person decide for themselves what is best for them, from various options or suggestions, and you help them to have the confidence to carry out their decision. You listen to them and try to understand how they feel. This course aims to give health workers basic counselling skills, so that they can help mothers and caregivers more effectively.

The course material can be used to complement existing courses or as part of the pre-service education of health workers.

This course material does NOT prepare people to have responsibility for the nutritional care of young children with severe malnutrition or nutrition-related diseases such as diabetes or metabolic problems. In addition, it does not prepare people to conduct full voluntary confidential counselling and HIV testing – which includes pre-test and post-test counselling for HIV, and follow-up support for those living with HIV. Nor does it cover in depth the topics on treatment, care and management of people living with HIV, including the use of antiretroviral drugs or antiretroviral therapy. The material covers only aspects specifically related to infant feeding in the context of HIV. Participants are encouraged to refer mothers or young children for further services and care as necessary.

Course objectives

After completing this course, participants will be able to counsel and support mothers to carry out WHO/UNICEF-recommended feeding practices for their infants and young children, from birth up to 24 months of age.

Each session of the course has a set of learning objectives. The trainer should make sure that they are clear about what these are when preparing to give a session.

Target audience

This course is aimed at the following groups of people:

- lay counsellors
- community health workers
- counsellors for prevention of mother-to-child transmission of HIV (PMTCT; first-level counsellors at district level)
- primary health-care nurses and doctors – especially if supervising and/or a referral level for lay counsellors, community health workers or PMTCT counsellors
- clinicians at first referral level
- paediatricians, family practice physicians, nurses, clinical officers, health assistants and nutritionists who measure and assess the growth of children or supervise these activities.

Course participants are not expected to have any prior knowledge of infant feeding.

The trainers

The trainers should be people who have hands-on experience of caring for infants and mothers/caregivers; they should be qualified by becoming familiar with the course material as participants, and using it in their daily practice before training their peers.

It is essential that those trained as trainers are available to mentor participants and conduct the follow-up and evaluation following the training. A follow-up session is planned after the course because it is unlikely that the participants will have learnt all the practical skills covered after completing the the course. The trainers should, therefore, be people who live locally, and who will have time to conduct this follow-up.

Course competencies

This course is based on a set of competencies that every participant is expected to learn during the course and subsequent practice and follow-up at their place of work. To become competent at something, you need a certain amount of knowledge and to be proficient at certain skills. The following table lists the competencies (column 1), and the knowledge (column 2) and skills required (column 3) for each competency.

The "knowledge" part of the competencies will be taught during this course, and is contained in the *Participant's manual* for later referral and revision by participants. Most people find that they obtain the "knowledge" part of a competency more quickly than the "skills" part.

The "skills" part of the competencies will also be taught during this course. However, there may not be time for each participant to become proficient in every skill. This will depend on their previous experience. During the course, every participant should practise as many of the skills as possible, so that they know what to do when they return to their place of work. The skills will be practised further in the supervised follow-up session.

The competencies are arranged according to area/module and in a certain order. The competencies at the beginning of the table are those that are most commonly used, and on which later competencies depend. For example, the competency Use Listening and learning skills to counsel a mother or caregiver is used in many of the other competencies.

Competency	Knowledge	Skills
Counselling		
C1. Use Listening and learning skills to counsel a mother or caregiver	• List the six Listening and learning skills • Give an example of each skill	• Use the Listening and learning skills appropriately when counselling a mother or caregiver on feeding an infant or young child
C2. Use Skills for building confidence and giving support to counsel a mother or caregiver	• List the six Skills for building confidence and giving support • Give an example of each skill	• Use the Skills for building confidence and giving support appropriately when counselling a mother or caregiver on feeding an infant or young child
Breastfeeding basic		
BF1. Assess a breastfeed	• Describe the relevant anatomy and physiology of the breast and suckling action of the baby • Explain the contents and arrangement of the Job aid: Breastfeed observation	• Recognize signs of good and poor attachment and effective suckling, according to the Job aid: Breastfeed observation • Assess a breastfeed using the Job aid: Breastfeed observation • Recognize a mother who needs help, using the Job aid: Breastfeed observation
BF2. Help a mother to position herself and her baby for breastfeeding	• Explain The four key signs of good positioning • Describe how a mother should support her breast for feeding • Explain the main positions for the mother: sitting and lying down • Explain different ways to hold the baby: underarm and across	• Recognize good and poor positioning, according to The four key signs of good of positioning • Help a mother to position her baby using The four key signs of good positioning, in different positions
BF3. Help a mother to attach her baby to the breast	• Explain The four key signs of good attachment	• Help a mother to get her baby to attach to the breast once they are well positioned
BF4. Explain to a mother about the optimal pattern of breastfeeding	• Describe the physiology of breast-milk production and flow • Describe unrestricted (or demand) feeding, and implications for the frequency and duration of breastfeeds, and using both breasts alternately	• Explain to a mother about the optimal pattern of breastfeeding and demand feeding
BF5. Help a mother to express her breast milk by hand	• List the situations when expressing breast milk is useful • Describe the relevant anatomy of the breast and physiology of lactation • Explain how to stimulate the oxytocin reflex • Describe how to select and prepare a container for expressed breast milk • Describe how to store expressed breast milk	• Explain to a mother how to stimulate her oxytocin reflex • Rub a mother's back to stimulate her oxytocin reflex • Help a mother to learn how to prepare a container for expressed breast milk • Explain to a mother the steps of expressing breast milk by hand • Observe a mother expressing breast milk by hand, and help her if necessary
BF6. Help a mother to cup-feed her baby	• List the advantages of cup-feeding • Estimate the volume of milk to give a baby according to weight • Describe how to prepare a cup hygienically for feeding a baby	• Demonstrate to a mother how to prepare a cup hygienically for feeding • Practise with a mother how to cup-feed her baby safely • Explain to a mother the volume of milk to offer her baby and the minimum number of feeds in 24 hours
BF7. Take a feeding history for an infant aged from 0 up to 6 months	• Describe the contents and arrangement of the Job aid: Feeding history – 0 up to 6 months	• Take a feeding history, using the Job aid: Feeding history – 0 up to 6 months and appropriate counselling skills, according to the age of the child
BF8. Counsel a pregnant woman about breastfeeding	• Discuss why exclusive breastfeeding is important for the first 6 months • List the special properties of colostrum and reasons why it is important	• Use counselling skills appropriately with a pregnant woman, to discuss the advantages of exclusive breastfeeding • Explain to a pregnant woman how to initiate and establish breastfeeding after delivery, and the optimal breastfeeding pattern • Apply competencies C1, C2 and BF4
BF9. Help a mother to initiate breastfeeding	• Discuss the importance of early contact after delivery and of the baby receiving colostrum • Describe how health-care practices affect initiation of exclusive breastfeeding	• Help a mother to initiate skin-to-skin contact immediately after delivery and for at least 1 hour, and to recognize when her baby is ready to breastfeed • Apply competencies C1, C2, BF2 and BF3

Competency	Knowledge	Skills
BF10. Support exclusive breastfeeding for the first 6 months of life	• Describe why exclusive breastfeeding is important • Describe the support that a mother needs to sustain exclusive breastfeeding	• Apply competencies C1, C2, BF1 to BF7 and GA1 appropriately
BF11. Help a mother to sustain breastfeeding up to 2 years of age or beyond	• Describe the importance of breast milk in the second year of life	• Apply competencies C1, C2, BF7 and GA1, including explaining the value of breastfeeding up to 2 years and beyond
BF12. Help a mother with "not enough milk"	• Describe the common reasons why a baby may have a low intake of breast milk • Describe the common reasons for apparent insufficiency of milk • List the reliable signs that a baby is not getting enough milk	• Apply competencies C1, BF1, BF7 and GA1 to decide the cause • Apply competencies C2 and BF2 to BF6 to overcome the difficulty, including explaining the cause of the difficulty to the mother
BF13. Help a mother with a baby who cries frequently	• List the causes of frequent crying • Describe the management of a crying baby	• Apply competencies C1, BF1, BF7 and GA1 to decide the cause • Apply competencies C2 and BF2 to BF4 to overcome the difficulty, including explaining the cause of the difficulty to the mother • Demonstrate to a mother the positions to hold and carry a colicky baby
BF14. Help a mother whose baby is refusing to breastfeed	• List the causes of breast refusal • Describe the management of breast refusal	• Apply competencies C1, BF1, BF7 and GA1 to decide the cause • Apply competencies C2, BF2 and BF3 to overcome the difficulty, including explaining the cause of the difficulty to the mother • Help a mother to use skin-to-skin contact to help her baby accept the breast again • Apply competencies BF5 and BF6 to maintain production of breast milk and to feed the baby meanwhile
BF15. Help a mother who has flat or inverted nipples	• Explain the difference between flat and inverted nipples and about protractility • Explain how to manage flat and inverted nipples	• Recognize flat and inverted nipples • Apply competencies C2, BF2, BF3, BF5 and BF6 to overcome the difficulty • Show a mother how to use the syringe method for the treatment of inverted nipples
BF16. Help a mother with engorged breasts	• Explain the differences between full and engorged breasts • Explain the reasons why breasts may become engorged • Explain how to manage breast engorgement	• Recognize the difference between full and engorged breasts • Apply competencies C2 and BF2 to BF5 to manage the difficulty
BF17. Help a mother with sore or cracked nipples	• List the causes of sore or cracked nipples • Describe the relevant anatomy and physiology of the breast • Explain how to treat *Candida* infection of the breast	• Recognize sore and cracked nipples • Recognize *Candida* infection of the breast • Apply competencies C2, BF1 to BF3, BF5 and BF6 to manage these conditions
BF18. Help a mother with mastitis	• Describe the difference between engorgement and mastitis • List the causes of a blocked milk duct • Explain how to treat a blocked milk duct • List the causes of mastitis • Explain how to manage mastitis, including indications for antibiotic treatment and referral • List the antibiotics to use for infective mastitis • Explain what is different when treating mastitis in a mother living with HIV following the national health authority programme	• Recognize mastitis and refer if necessary • Recognize a blocked milk duct • Manage a blocked duct appropriately • Manage mastitis appropriately using competencies C1, C2 and BF1 to BF6, and rest, analgesics and antibiotics if indicated. Refer to the appropriate level of care • Refer mastitis in a mother living with HIV to the appropriate level of care, according to the national health authority programme

Competency	Knowledge	Skills
BF19. Help a mother to breastfeed a low-birth-weight or sick baby	• Explain why breast milk is important for a low-birth-weight or sick baby • Describe the different ways to feed breast milk to a low-birth-weight baby • Estimate the volume of milk to offer a low-birth-weight baby, per feed and per 24 hours	• Help a mother to feed her low-birth-weight baby appropriately • Apply competencies, especially BF5, BF6 and GA1, to manage these infants appropriately • Explain to a mother the importance of breastfeeding during illness and recovery
Breastfeeding advanced (competencies, knowledge and/or skills acquired in addition to those listed in **Breastfeeding basic**)		
BFA1. Assess a breastfeed	• Describe the physiology of the lactation hormones • Describe the suckling action of the baby when well attached and when poorly attached	• Recognize effective and ineffective suckling • Recognize signs of the oxytocin reflex
BFA2. Help a mother to position herself and her baby for breastfeeding	• Support the mother's breast for feeding	• Show a mother how to hold and position her baby, by demonstrating with a doll • Help a mother to find a comfortable position for breastfeeding, sitting or lying down
BFA3. Help a mother to attach her baby to the breast	• Explain the common mistakes of attachment	• Help the mother to recognize whether the baby is well attached or not
BFA4. Take a feeding history for an infant aged from 0 up to 6 months		• Use the feeding history to help decide whether the mother has a difficulty with breastfeeding, and how to counsel her
BFA5. Inform women about optimal infant feeding	• Explain the recommendations for optimal infant feeding up to 2 years or beyond • List the advantages of exclusive breastfeeding for 6 months and the risks of not breastfeeding • List the advantages of continued breastfeeding with complementary feeding for up to 2 years or beyond • Describe the differences between breast milk and infant formula milk	• Talk to women individually or in groups about optimal infant feeding and the risks of unnecessary artificial feeding
BFA6. Counsel a pregnant woman about breastfeeding	• Explain the importance of skin-to-skin contact immediately after delivery and the initiation of breastfeeding within 1 hour	• Discuss the importance of skin-to-skin contact immediately after delivery • Explain how a baby initiates breastfeeding within about an hour after birth, and about colostrum • Explain about good positioning and attachment and an optimal feeding pattern to establish breastfeeding • Explain about health-care practices and the help that the mother will receive after delivery • Apply competencies C1, C2 and parts of BFA2, BFA3 and BFA5
BFA7. Help a mother and baby to initiate breastfeeding within an hour after delivery	• Describe the procedure of putting the baby in skin-to-skin contact immediately after delivery • Describe how a baby moves to the breast and attaches by themself, and how to help the baby if needed	• Put a baby onto the mother's chest prone in skin-to-skin contact immediately after delivery, for at least 1 hour undisturbed • Explain to the mother how she can gently help the baby to the breast if needed • Apply competencies C1, C2, BFA2 and BFA3
BFA8. Support exclusive breastfeeding for the first 6 months of life	• Describe the concept of the SEVEN+ CONTACTS TO SUSTAIN BREASTFEEDING and the use of the JOB AID: POSTNATAL CONTACTS and the JOB AID: ONGOING CONTACTS • Describe how the child's growth chart can help you to support breastfeeding	• Ensure that a mother receives postnatal help within 6 hours after delivery (in hospital) or within 24 hours (after home delivery), to ensure good attachment and feeding pattern, using the JOB AID: POSTNATAL CONTACTS • Ensure at least three additional postnatal contacts within 8 weeks, using the JOB AID: POSTNATAL CONTACTS • Apply competencies C1, C2, BFA1 to BFA4 and GA1 appropriately

Competency	Knowledge	Skills
BFA9. Help a mother to continue breastfeeding up to 2 years of age or beyond	• Describe the importance of continuing breastfeeding, with complementary feeding, from the age of 6 to 24 months • Explain the pattern of continued breastfeeding – as often as the child wants, day and night • List the opportunities to support continued breastfeeding at all other contacts with the mother and child (growth monitoring, immunization, family planning)	• Explain the value of breastfeeding up to 2 years and beyond, while giving complementary foods • Counsel the mother about breastfeeding at all other contacts, using the JOB AID: ONGOING CONTACTS • Explain that the child should continue to breastfeed as often as they want, day and night • Apply competencies C1, C2, BFA4 and GA1
Complementary feeding		
CF1. Teach a mother the 10 KEY MESSAGES FOR COMPLEMENTARY FEEDING	• List and explain the six Key messages about what to feed to an infant or young child to fill the nutrition gaps (KEY MESSAGES 1–6) • Explain when to use the FOOD CONSISTENCY PICTURES, and what each picture shows • List and explain the two Key messages about quantities of food to give to an infant or young child (KEY MESSAGES 7 and 8) • List and explain the Key message about how to feed an infant or young child (KEY MESSAGE 9) • List and explain the Key message about how to feed an infant or young child during illness (KEY MESSAGE 10)	• Explain to a mother the six Key messages about what to feed to an infant or young child to fill the nutrition gaps (KEY MESSAGES 1–6) • Use the FOOD CONSISTENCY PICTURES appropriately during counselling • Explain to a mother the two Key messages about quantities of food to give to an infant or young child (KEY MESSAGES 7 and 8) • Explain to a mother the Key message about how to feed an infant or young child (KEY MESSAGE 9) • Explain to a mother the Key message about how to feed an infant or young child during illness (KEY MESSAGE 10)
CF2. Help mothers whose babies are aged over 6 months to give complementary feeds	• List the gaps that occur after 6 months when a child can no longer get enough nutrients from breast milk alone • List the foods that can fill the gaps • Describe how to prepare feeds hygienically • List recommendations for feeding a non-breastfed child, including the quantity, quality, consistency, frequency and method of feeding at different ages	• Apply competencies C1, C2, BF7 and GA1 • Use the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS to learn how a mother is feeding her infant or young child • Identify the gaps in the diet, using the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS and the REFERENCE TOOL: FOOD INTAKE – 6 UP TO 24 MONTHS • Explain to a mother what foods to feed her child to fill the gaps, applying competency CF1 • Demonstrate preparation of a meal for an infant or young child at different ages (8, 10, 15 months) • Practise with a mother how to prepare meals for her infant or young child • Show a mother how to prepare feeds hygienically • Explain to a mother how to feed a non-breastfed child
CF3. Help a mother with a breastfed child aged over 6 months who is not growing well	• Explain feeding during illness and recovery • Describe how to prepare feeds hygienically	• Apply competency BF11 to help a mother to sustain breastfeeding up to 2 years of age or beyond • Apply competencies C1, C2, BF7, CF1 and GA1 • Explain to a mother how to feed her child during illness and recovery • Demonstrate to a mother how to prepare feeds hygienically • Recognize when a child needs follow-up and when a child needs referral
CF4. Help a mother with a non-breastfed child aged over 6 months who is not growing well	• Explain about the special attention to give to children who are not receiving breast milk • List the recommendations for feeding a non-breastfed child, including the quantity, quality, consistency, frequency and method of feeding • Explain feeding during illness and recovery • Describe how to prepare feeds hygienically	• Apply competencies C1, C2, BF7, CF1 and GA1 • Explain to a mother how to feed a non-breastfed child • Explain to a mother how to feed her child during illness and recovery • Demonstrate to a mother how to prepare feeds hygienically • Recognize when a child needs follow-up and when a child needs referral

Competency	Knowledge	Skills
Growth assessment		
GA1. Plot and interpret a growth chart	• Explain the meaning of the standard curves • Describe where to find the age and the weight of a child on a growth chart • Describe where to find the age and the length/height of a child on a growth chart	• Plot the weight of a child on a growth chart • Plot the length/height of a child on a growth chart • Interpret a child's individual growth curve
GA2. Measure weight, length and height	• Describe how to measure weight, length and height • Determine when to measure length and when to measure height	• Measure the weight of a young child held by a mother and an older child alone • Measure length correctly • Measure height correctly
GA3. Plot single points on various growth charts	• Explain how to place a point on a graph combining information from two axes • Describe where to find the age, weight and length/height on various growth-indicator charts	• Plot weight and length/height points on weight-for-age and length/height-for-age charts • Plot weight points on weight-for-length/height charts
GA4. Interpret single points on various indicator charts	• Identify growth problems, based on points plotted on a single indicator chart • Define a growth problem, using a combination of indicator charts	• Identify children who are stunted, underweight, wasted and overweight, based on points plotted on several indicator charts
GA5. Interpret growth trends using a combination of indicators	• Interpret trends on growth charts	• Identify a child who is growing normally, has a growth problem or is at risk of a growth problem
GA6. Counsel a mother whose child has undernutrition	• Describe causes of stunting, wasting and underweight • Involve the mother in identifying possible causes of her child's undernutrition • Find age-appropriate advice for the problem identified • Set goals for improving the growth of an undernourished child	• Identify the key sections of the JOB AID: INVESTIGATING CAUSES OF UNDERNUTRITION • Use the JOB AID: INVESTIGATING CAUSES OF UNDERNUTRITION appropriately (find the correct pages for the child's age, complete the investigation before counselling, counsel using age-appropriate recommendations) • Check the mother's understanding, using checking questions • Involve the mother in setting goals for improved growth
GA7. Counsel a mother whose child is overweight	• Describe causes of overweight/obesity • Involve the mother in identifying possible causes of her child's overweight • Set goals for improving the growth of an overweight child	• Identify the key sections of the JOB AID: INVESTIGATING CAUSES OF OVERWEIGHT • Use the JOB AID: INVESTIGATING CAUSES OF OVERWEIGHT appropriately (find the correct pages for the child's age, complete the investigation before counselling, counsel using age-appropriate recommendations) • Check the mother's understanding, using checking questions • Involve the mother in setting goals for improved growth

Competency	Knowledge	Skills
HIV and infant feeding		
HIV1. Counsel a woman living with HIV antenatally about the infant-feeding practices recommended by the national health authority	• Explain the risk of mother-to-child transmission (MTCT) of HIV • Outline approaches that can prevent MTCT through safer infant feeding practices • State infant feeding recommendations for women living with HIV, those who are HIV negative or those who do not know their HIV status	• Apply competencies C1 and C2 to counsel a woman living with HIV
HIV2. Support a mother living with HIV to feed her infant according to national health authority recommendations	• Explain exclusive breastfeeding followed by continued breastfeeding while starting complementary foods • Explain how to heat-treat and store breast milk • Describe the criteria for selection of a wet nurse • Explain how to prepare replacement food • Describe hygienic preparation of feeds and hygienic management of utensils • Explain the volumes of replacement food to offer a baby according to weight	• Apply competencies C1, C2 and BF1 to BF4 to support a mother to breastfeed exclusively and optimally • Show a mother how to heat-treat breast milk and apply competencies BF5 and BF6 • Apply competencies C1, C2 and BF1 to BF4 to support the wet nurse • Help a mother to prepare the type of replacement feeding she requires • Apply competency BF6 • Show a mother how to prepare replacement feeds hygienically • Practise with a mother how to prepare replacement feeds hygienically • Show a mother how to measure milk and other ingredients to prepare feeds • Practise with a mother how to measure milk and other ingredients to prepare feeds • Explain to a mother the volume of milk to offer her baby and the number of feeds per 24 hours
HIV3. Promote appropriate use of nationally recommended antiretroviral therapy (ART) for women living with HIV	• Describe the ART regimes recommended by the national health authority • List the antiretroviral drugs included in the recommended regimes for use in women living with HIV	• Help women living with HIV to follow the recommended ART regime • Apply competencies C1 and C2
HIV4. Follow up the infant of a mother living with HIV who is receiving replacement feeding from 0 up to 6 months	• Describe hygienic preparation of feeds • Explain the volumes of milk to give to a baby according to weight • Explain when to arrange follow-up or when to refer • Explain about feeding during illness and recovery	• Show a mother how to prepare replacement feeds hygienically • Practise with a mother how to prepare replacement feeds hygienically • Apply competency BF6 • Recognize when a child needs follow-up and when a child needs to be referred • Explain to a mother how to feed her baby during illness or recovery • Use the Counselling cards and flyers appropriately
HIV5. Help a mother living with HIV in the event that she needs to stop breastfeeding	• Describe the difficulties a mother may encounter when she tries to stop breastfeeding over a short period of time • Explain how to manage engorgement and mastitis in a mother who stops breastfeeding over a short period of time • Show the ways to comfort a baby who is no longer breastfeeding • List what replacement feeds are available and how to prepare them • Explain when to arrange follow-up or when to refer	• Explain to a mother how she should prepare to stop breastfeeding early • Practise with a mother how to prepare replacement feeds hygienically • Apply competencies BF5 and BF6 • Manage breast engorgement and mastitis in an mother living with HIV who is stopping breastfeeding (competencies BF16 and BF18) • Explain to a mother ways to comfort a baby who is no longer breastfeeding

The course and the materials

Structure of the course

The course is divided into various modules and will take different times, according to the modules and sessions selected. The course can be conducted consecutively in a working week, or can be spread in other ways. The sessions use a variety of teaching methods, including lectures, demonstrations and work in smaller groups, with clinical practice sessions in wards and clinical facilities and classroom-based practicals and exercises.

Order of sessions

Sessions can be moved, but it is necessary for some aspects of the sequence to be maintained. The main requirement is that you conduct the sessions that prepare participants for a particular practical or clinical practice session before the practical session.

Course materials

Director's guide
The *Director's guide* contains all the information that the course director needs to plan and prepare for a course, to decide which modules and sessions will be included in the training, and to select trainers and participants, starting several months before the actual training. It contains lists of the materials and equipment needed, examples of timetables, and copies of the forms that need to be photocopied before a course. It also describes the director's role during the course itself.

Trainer's guide
The *Trainer's guide* contains what you, the trainer, need in order to lead participants through the course. The guide contains the information that you require, detailed instructions on how to conduct each session, the exercises that participants will do, together with answers, and the summary sheets, forms, checklists and stories used during the clinical practice and practical sessions of the course. This is your most essential tool as a trainer on the course. It is recommended that you use it at all times and add notes to it as you work. These notes will help you in future courses.

Slides
Many sessions use slides. Your director will inform you which you will use. It is important that you are familiar with the equipment beforehand. All the slides are shown in your *Trainer's guide*, so that you can make sure you understand the information, pictures or graphs for your sessions.

Participant's manual
A *Participant's manual* should be provided for each participant, using the modules selected. This contains summaries of information and copies of worksheets and checklists for the clinical practice and practical sessions and exercises participants will do during the course (without answers). This manual can be used for reference after the course, so it is not essential for participants to take detailed notes.

Guidance on the use of counselling cards
The Counselling cards are provided as a set and referred to in several modules; they are to be used during the training and when counselling mothers/caregivers/families.

Answer sheets
These are provided in your *Trainer's guide*, as well as separately for photocopying in the *Course handouts*, and they give answers to all the exercises. Give them to the participants after they have worked through the exercises.

Forms and checklists
Loose copies of the forms and checklists needed for clinical practice and practical sessions and counselling exercises are provided for photocopying either as separate publications or in the *Course handouts*. They are listed next.

For general use, or specifically for clinical practice sessions

- Listening and learning skills checklist
- Counselling skills checklist (includes Listening and learning skills and Skills for building confidence and giving support)
- How to use a Counselling card
- Clinical practice discussion checklist (for trainers only)
- Competency progress form

Job aids and reference tools

Items supplied as published materials

- Child age calculator (https://www.who.int/tools/child-growth-standards)
- Girl's growth record (https://apps.who.int/iris/bitstream/handle/10665/43601/9789241595070_GirlsGrowth_eng.pdf)
- Boy's growth record (https://apps.who.int/iris/bitstream/handle/10665/43601/9789241595070_BoysGrowth_eng.pdf)
- Blank WHO and/or local growth charts (https://www.who.int/toolkits/child-growth-standards/standards)
- Training course on child growth assessment: WHO child growth standards. Photo booklet. Geneva: World Health Organization; 2008 (http://www.who.int/childgrowth/training/module_e_photo_booklet.pdf).
- Job aid: Investigating causes of undernutrition and overweight (https://www.who.int/childgrowth/training/jobaid_investigating_causes.pdf)
- Counselling cards (https://apps.who.int/iris/bitstream/handle/10665/346567/WHO-HEP-NFS-21.24-eng.pdf)
- *Guidance on the use of counselling cards* (https://apps.who.int/iris/bitstream/handle/10665/346569/9789240035560-eng.pdf)

Items supplied in the *Course handouts*

- Job aid: Breastfeed observation
- Job aid: Feeding history – 0 up to 6 months
- Job aid: Postnatal contacts
- Job aid: Ongoing contacts
- Job aid: Food intake – 6 up to 24 months
- Instructions for completing the Job aid: Food intake – 6 up to 24 months
- Reference tool: Food intake – 6 up to 24 months
- Food consistency pictures
- Instructions for use of the Child age calculator
- Job aid: Weighing and measuring a child
- Growth problems chart

General assessment and follow-up

- Log of skills practised (for participants only)
- Difficulties experienced (for participants only)
- Self-assessment in infant and young child feeding: competency practice and progress tracking form

Story cards

Copies of the histories and counselling stories are provided for photocopying in the *Course handouts* for some of the sessions.

Other items of key information

For easy reference, and photocopying if required, other useful items and summaries of key information are also supplied in the *Course handouts*; they are presented in the order they appear in consecutive sessions, although some of them relate to several sessions.

Updates

Periodic updates on the topics covered on this course will be available on the WHO and UNICEF websites; these sites should be consulted when preparing a course.

Training aids

You will need a flipchart and blackboard and chalk, or white board and suitable markers for most sessions, and a means of fixing flipchart pages to the wall or notice board – such as masking tape. You will also need approximately one life-size baby doll and one model breast for each small working group of three or four participants.

If dolls and breasts are not available, some instructions follow for making them very simply and out of material that is readily available.

How to make a model doll

- Find any large fruit or vegetable, a towel or other strong thick cloth, and some rubber bands or string.
- Put the fruit or vegetable in the middle of the cloth, and tie the cloth around it to form the baby's "neck" and "head".
- Bunch the free part of the cloth together to form the baby's legs and arms, and tie them into shape.
- If the cloth is rather thin, you may like to stuff some other cloth inside to give the doll more of a "body".

How to make a model breast

- Use a pair of near skin-coloured socks, or stockings, or an old sweater or T-shirt.
- Make the cloth into a round bag shape, and stuff it with other cloth or foam rubber to make it breast shaped.
- Stitch a "purse string" around a circle in the middle of the breast to make a nipple.
- Stuff the nipple with foam or cotton.
- Colour the areola with a felt pen. You can also push the nipple in, to make an "inverted" nipple.
- If you wish to show the inside structure of the breast, with the larger ducts, make the breast with two layers, for example with two socks.
- Sew the nipple in the outer layer, and draw the large ducts and ducts on the inside layer beneath the nipple.
- You can remove the outer layer with the nipple to reveal the inside structure.

Reference materials

As a course trainer, you may wish to obtain the following reference materials to answer questions and provide additional information.

Breastfeeding

- Breastfeeding [videos]. Global Health Media (https://globalhealthmedia.org/videos/breastfeeding/, accessed 9 August 2021).
- Butte N, Lopez-Alarcon M, Garza C. Nutrient adequacy of exclusive breastfeeding for the term infant during the first six months of life. Geneva: World Health Organization; 2002 (https://apps.who.int/iris/handle/10665/42519, accessed 9 August 2021).
- Community-based strategies for breastfeeding promotion and support in developing countries. Geneva: World Health Organization; 2003 (https://apps.who.int/iris/handle/10665/42859, accessed 9 August 2021).
- Global nutrition targets 2025: breastfeeding policy brief. Geneva: World Health Organization; 2014 (WHO/NMH/NHD/14.7; https://apps.who.int/iris/handle/10665/149022, accessed 9 August 2021).
- Guideline: counselling of women to improve breastfeeding practices. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/handle/10665/280133, accessed 9 August 2021).
- Guideline: infant feeding in areas of Zika virus transmission. Geneva: World Health Organization; 2016 (https://apps.who.int/iris/handle/10665/208875, accessed 9 August 2021).
- Guideline: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services. Geneva: World Health Organization; 2017 (https://apps.who.int/iris/handle/10665/259386, accessed 9 August 2021).
- Kramer MS, Kakuma R. Optimal duration of exclusive breastfeeding. Cochrane Database Syst Rev. 2012;(8):CD003517. doi: 10.1002/14651858.CD003517.pub2.
- Mastitis: causes and management. Geneva: World Health Organization; 2000 (WHO/FCH/CAH/00.13; https://apps.who.int/iris/handle/10665/66230, accessed 9 August 2021).
- The optimal duration of exclusive breastfeeding: report of an expert consultation, Geneva, Switzerland, 28–30 March 2001. Geneva: World Health Organization; 2001 (WHO/FCH/CAH/01.24; https://apps.who.int/iris/handle/10665/67219, accessed 9 August 2021).

- Relactation: a review of experience and recommendations for practice. Geneva: World Health Organization; 1998 (WHO/CHS/CAH/98.14; https://apps.who.int/iris/handle/10665/65020, accessed 9 August 2021).
- Rollins NC, Bhandari N, Hajeebhoy N, Horton S, Lutter CK, Martines JC et al. Why invest, and what it will take to improve breastfeeding practices? Lancet. 2016;387:491–504. doi:10.1016/S0140-6736(15)01044-2.
- Special issue: Impact of breastfeeding on maternal and child health. Acta Paediatr. 2015;104:1–134 (https://onlinelibrary.wiley.com/toc/16512227/2015/104/S467, accessed 9 August 2021).
- Victora CG, Bahl R, Barros AJ, França GV, Horton S, Krasevec J et al. Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. Lancet. 2016;387:475–90. doi:10.1016/S0140-6736(15)01024-7.
- World Health Organization, United Nations Children's Fund. The Global Breastfeeding Collective [website]. New York: United Nations Children's Fund; 2021 (https://www.globalbreastfeedingcollective.org/, accessed 9 August 2021).
- World Health Organization, United Nations Children's Fund. Implementation guidance: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services – the revised Baby-friendly Hospital Initiative. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/handle/10665/272943, accessed 9 August 2021).
- World Health Organization, United Nations Children's Fund. Protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services: the revised Baby-friendly Hospital Initiative: 2018 implementation guidance: frequently asked questions. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/330824, accessed 9 August 2021).

Breast-milk substitutes

- Acceptable medical reasons for use of breast-milk substitutes. Geneva: World Health Organization; 2009 (https://apps.who.int/iris/handle/10665/69938, accessed 11 August 2021).
- The International Code of Marketing of Breast-milk Substitutes. Code and subsequent resolutions [website]. Geneva: World Health Organization; 2021 (https://www.who.int/teams/nutrition-and-food-safety/food-and-nutrition-actions-in-health-systems/netcode/code-and-subsequent-resolutions, accessed 11 August 2021).
- The International Code of Marketing of Breast-milk Substitutes: frequently asked questions. Geneva: World Health Organization; 2017 (https://apps.who.int/iris/handle/10665/254911, accessed 11 August 2021).
- The International Code of Marketing of Breast-milk Substitutes: frequently asked questions on the roles and responsibilities of health workers. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/332170, accessed 11 August 2021).
- WHO policy brief on international trade agreements and implementation of the International Code of Marketing of Breast-milk Substitutes. Geneva: World Health Organization and United Nations Children's Fund; 2020 (https://apps.who.int/iris/handle/10665/331897, accessed 11 August 2021).
- World Health Organization, United Nations Children's Fund, International Baby Food Action Network. Marketing of breast-milk substitutes: national implementation of the international code, status report 2020. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/332183, accessed 11 August 2021).

Complementary feeding

- Complementary feeding: family foods for breastfed children. Geneva: World Health Organization; 2000 (WHO/NHD/00.1; https://apps.who.int/iris/handle/10665/66389, accessed 11 August 2021).
- Five keys to safer food. Geneva: World Health Organization; 2001 (WHO/SDE/PHE/FOS/01.1; https://apps.who.int/iris/handle/10665/66735, accessed 11 August 2021).
- Five keys to safer food manual. Geneva: World Health Organization; 2006 (https://apps.who.int/iris/handle/10665/43546, accessed 11 August 2021).
- Guiding principles for complementary feeding of the breastfed child. Washington (DC): Pan American Health Organization; 2003 (https://iris.paho.org/handle/10665.2/752, accessed 11 August 2021).
- Guiding principles for feeding non-breastfed children 6–24 months of age. Geneva: World Health Organization; 2005 (https://apps.who.int/iris/handle/10665/43281, accessed 11 August 2021).

- World Health Organization, Food and Agriculture Organization of the United Nations. Safe preparation, storage and handling of powdered infant formula. Guidelines. Geneva: World Health Organization; 2007 (https://apps.who.int/iris/handle/10665/43659, accessed 11 August 2021).

Growth monitoring

- Childhood stunting: challenges and opportunities report: report of promoting healthy growth and preventing childhood stunting colloquium. Geneva: World Health Organization; 2014 (WHO/NMH/NHD/GRS/14.1; https://apps.who.int/iris/handle/10665/107026, accessed 11 August 2021).
- A critical link: interventions for physical growth and psychological development: a review. Geneva: World Health Organization; 1999 (WHO/CHS/CAH/99.3; https://apps.who.int/iris/handle/10665/66677, accessed 11 August 2021).
- de Onis M, Garza C, Victora CG, Bhan MK, Norum KR. WHO Multicentre Growth Reference Study (MGRS): rationale, planning and implementation. Food Nutr Bull. 2004; 25(Suppl. 1):S3–84 (https://journals.sagepub.com/toc/fnba/25/1_suppl_1, accessed 11 August 2021).
- WHO Child Growth Standards. Acta Paediatr. 2006; 95 (Suppl. 450):5–101 (https://www.who.int/childgrowth/publications/acta_supplement_pub/en/, accessed 11 August 2021).

HIV

- Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. 2016 update. Geneva: World Health Organization; 2016 (https://apps.who.int/iris/handle/10665/246200, accessed 11 August 2021).
- Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Recommendations for a public health approach, 2nd ed. Geneva: World Health Organization; 2016 (https://apps.who.int/iris/handle/10665/208825, accessed 11 August 2021).
- Counselling and voluntary HIV testing for pregnant women in high HIV prevalence countries. Elements and issues. Geneva: Joint United Nations Programme on HIV/AIDS; 2001 (UNAIDS/99.40E; https://www.unaids.org/sites/default/files/media_asset/jc245-couns_test_en_2.pdf, accessed 11 August 2021).
- World Health Organization, United Nations Children's Fund. Guideline: updates on HIV and infant feeding: the duration of breastfeeding, and support from health services to improve feeding practices among mothers living with HIV. Geneva: World Health Organization; 2016 (https://apps.who.int/iris/handle/10665/246260, accessed 11 August 2021).
- World Health Organization, United Nations Children's Fund. HIV and infant feeding in emergencies: operational guidance: the duration of breastfeeding and support from health services to improve feeding practices among mothers living with HIV. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/handle/10665/272862, accessed 11 August 2021).
- World Health Organization, United Nations Children's Fund, Food and Agriculture Organization of the United Nations, International Atomic Energy Agency, President's Emergency Plan for AIDS Relief, Joint United Nations Programme on HIV and AIDS et al. Guidelines on HIV and infant feeding 2010. An updated framework for priority action. Geneva: World Health Organization; 2012 (https://apps.who.int/iris/handle/10665/75152, accessed 11 August 2021).

General resources on infant and young child nutrition

- Community infant and young child feeding counselling package. New York: United Nations Children's Fund; 2013 (https://www.ennonline.net/iycfcommunityinterventions, accessed 11 August 2021).
- Comprehensive implementation plan on maternal, infant and young child nutrition. Geneva: World Health Organization; 2014 (WHO/NMH/NHD/14.1; https://apps.who.int/iris/handle/10665/113048, accessed 11 August 2021).
- Essential nutrition actions: mainstreaming nutrition through the life-course. Geneva: World Health Organization; 2019 (https://apps.who.int/iris/handle/10665/326261, accessed 11 August 2021).
- Global Nutrition Targets 2025. Childhood overweight policy brief. Geneva: World Health Organization; 2014 (WHO/NMH/NHD/14.6; https://apps.who.int/iris/handle/10665/149021, accessed 11 August 2021).
- Global Nutrition Targets 2025. Low birth weight policy brief. Geneva: World Health Organization; 2014 (WHO/NMH/NHD/14.5; https://apps.who.int/iris/handle/10665/149020, accessed 11 August 2021).
- Global Nutrition Targets 2025. Stunting policy brief. Geneva: World Health Organization; 2014 (WHO/NMH/NHD/14.3; https://apps.who.int/iris/handle/10665/149019, accessed 11 August 2021).

- Global Nutrition Targets 2025. Wasting policy brief. Geneva: World Health Organization; 2014 (WHO/NMH/NHD/14.8; https://apps.who.int/iris/handle/10665/149023, accessed 11 August 2021).
- Guidelines on optimal feeding of low birth-weight infants in low- and middle-income countries. Geneva: World Health Organization; 2011 (https://apps.who.int/iris/handle/10665/85670, accessed 11 August 2021).
- Infant and young child feeding: model chapter for textbooks for medical students and allied health professional. Geneva: World Health Organization; 2009 (https://apps.who.int/iris/handle/10665/44117, accessed 11 August 2021).
- World Health Organization, United Nations Children's Fund. Global strategy for infant and young child feeding. Geneva: World Health Organization; 2003 (https://apps.who.int/iris/handle/10665/42590, accessed 11 August 2021).

Maternal, newborn and young child care

- Beyond survival: integrated delivery care practices for long-term maternal and infant nutrition, health and development, 2nd ed. Washington (DC): Pan American Health Organization; 2013 (https://iris.paho.org/handle/10665.2/3464, accessed 11 August 2021).
- Convention No. 183. Convention concerning the Revision of the Maternity Protection Convention (Revised), 1952. Geneva: International Labour Organization; 2000 (http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_ILO_CODE:C183, accessed 11 August 2021).
- Improving early childhood development: WHO guideline. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/331306, accessed 11 August 2021).
- Kangaroo mother care: a practical guide. Geneva: World Health Organization; 2003 (https://apps.who.int/iris/handle/10665/42587, accessed 211 August 2021).
- Maternity protection resource package – from aspiration to reality for all. Module 3: Maternity protection at work: Why is it important? Geneva: International Labour Organization; 2012 (http://mprp.itcilo.org/allegati/en/m3.pdf, accessed 11 August 2021).
- World Health Organization, United Nations Children's Fund, World Bank Group. Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/handle/10665/272603, accessed 11 August 2021).
- World Health Organization, United Nations Population Fund, World Bank, United Nations Children's Fund. Pregnancy, childbirth, postpartum and newborn care: a guide for essential practice, 3rd ed. Geneva: World Health Organization; 2015 (https://apps.who.int/iris/handle/10665/249580, accessed 11 August 2021).

Making arrangements for the course

Where to hold the course

In order to hold a successful course, you need to arrange:

- classroom space for the course and for training the trainers
- lodgings and meals for the trainers and participants
- sites for the clinical practice sessions.

Ideally, a course should be residential, with the classroom and accommodation at the same site. If the course is not residential, allow adequate time for travel between the accommodation and the classroom.

It is essential that the course takes place near one or several facilities where participants can observe mothers, caregivers and young children.

Classroom facilities

You need one large room available for seating all facilitators, participants and visitors; and one small classroom per group. The small classroom should have space for each group of 6–8 participants and their trainers to sit at a table during the sessions. You need additional table space to lay out the materials used during the course.

The classrooms should be in a place where the participants are not disturbed by too much background noise and should have adequate lighting and ventilation.

During the training-of-trainers, one classroom is needed for the director(s) and 6–8 people to work in.

Accommodation and meals

For a residential course, it is necessary to arrange suitable accommodation near the classroom and the health facility. Unsatisfactory accommodation can hinder participants' learning. If needed, suitable transportation needs to be available, from the accommodation to the classroom and to the facilities for the clinical practice and practical sessions. If participants are travelling long distances, ensure the budget will cover the accommodation for the night before and the last night of the course.

Arrangements also need to be made for meals. This should include midday meals and refreshments, such as coffee and teas, near the classrooms.

Sites for clinical practice and practical sessions

The clinical practice and practical sessions should take place at the following sites.

- **Clinical practice session(s) on breastfeeding counselling (Sessions 21, 22, 41 and 42)**: a postnatal ward with enough breastfeeding mothers and babies for each participant to talk to at least one mother.
- **Clinical practice sessions on complementary feeding counselling (Sessions 53 and 54)**: a child health centre or paediatric outpatient service, with enough mothers/caregivers and children for each pair of participants to counsel the mother or caregiver of at least one child aged 6 months up to 2 years.
- **Clinical practice session on measuring children (Session 68)**:
  - Option 1: an area in the facility where the classroom sessions take place, with enough space to accommodate: scales, measuring boards, chairs for mothers or caregivers and, if possible, for each group of three or four participants and their trainer. For this option, mothers of children (aged under 2 years and 2–5 years) should be invited to the facility.
  - Option 2: a child health centre or paediatric outpatient service, with enough mothers/caregivers and children for each pair of participants to measure at least one child aged under 2 years and one aged 2–5 years.
- **Clinical practice session on nutrition counselling (Session 69)**: a child health centre or paediatric outpatient service, with enough mothers/caregivers and children for each pair of participants to measure a child and counsel the mother or caregiver of at least one child aged under 2 years and one aged 2–5 years.
- **Practical session on preparation of milk feeds (Session 78)**: an outside area where fires can be lit to prepare feeds – this may be in the grounds of the building where the course is being held, or the yard of a local home.

If there is no single facility in an area large enough to provide enough mothers, caregivers and children, you may use another nearby facility and send some of the small groups of three or four participants to each site. As discussed earlier, for participants to become competent in the necessary skills, it is important for them to practise, under supervision, as many of the skills as possible during the course. It is important, therefore, that there are enough caregiver/child pairs for each of the clinical practice sessions. Sometimes there seem to be plenty of mothers/caregivers and infants for the first clinical practice session, but the following day there are few new mothers/caregivers and infants for the second clinical practice session and some of these mothers/caregivers may not wish to be seen again.

If the facility is not close to the classrooms, make transport arrangements to ensure that the participants can commute between the classrooms and the health facility in the most efficient way, with minimal loss of time. Transport time may need to be included in the timetable for the sessions. Each clinical practice session takes approximately 3 hours.

The course timetable cannot be planned until the times of the clinical practice sessions are decided, so their organization is a high priority.

Visit the health facility

Visit one or more possible health facilities, to find out whether they are appropriate and to talk to the staff.

- Talk to the director of the health facility, and explain what the training consists of, what your needs are, and what you want to do.
- Ask whether they would be willing for the training to take place in the facility, and for their guidance on where different activities could take place.
- If the director agrees in principle, visit the outpatient department or other services. Check the approximate number of caregiver and child pairs you could expect to see on an average day. For about 20 participants, approximately 50 mother/caregiver/child pairs should be available.
- Ask what times of the day are most suitable for holding the clinical practice sessions. This depends on when caregivers and children are likely to be available, and convenience for the facility's routine.
- Talk to the staff, and try to find out whether they are interested in helping with the course; for example, if they are interested in infant feeding, would they be willing to share their experience with the course participants?
- Identify spaces or rooms near each clinic area where trainers and participants can have discussions out of caregivers' hearing.
- If the facility is suitable and the staff are interested and willing to help, arrange to make another visit nearer the time of the course to meet with the staff and prepare them.

Prepare the facility staff

It is important to prepare the health facility that will help during clinical practice sessions. If necessary, arrange to give them an appropriate orientation session, so that they understand the purpose of the course more clearly.

At the meeting, explain:

- about the course generally
- that you need their help to prepare mothers/caregivers and ask their permission before the participants arrive, and to introduce participants to mothers/caregivers to whom they can talk
- that you would like a responsible member of the facility staff to be available while the training team is there, in case a mother/caregiver needs a specific intervention; interventions will only take place with the permission and knowledge of facility staff; this will also enable staff to provide follow-up for the child
- when you would like to bring participants to the facility for the different sessions; check that these are convenient, and that mothers/caregivers are expected to be available at that time.

Leave some copies of reference materials for staff to read. An example of an information sheet is provided on the next page.

Example of an information sheet for a clinical practice site (to be adapted according to the content of the course)

Infant and young child feeding counselling course

After completing this course, participants will be able to assess breastfeeding and complementary feeding, measure children, plot measurements on growth charts, interpret growth indicators and counsel and support mothers, including those living with HIV, to carry out WHO/UNICEF-recommended feeding practices for their infants and young children.

On completion of the course, participants should be able to assess the growth of children aged 0–5 years; provide anticipatory feeding guidance, with emphasis on breastfeeding and complementary feeding; assist mothers living with HIV and those with breastfeeding difficulties; assess whether the child is at risk of or has a problem of undernutrition/overweight; and counsel mothers accordingly.

We would like your assistance with the clinical practice sessions of this course. During these sessions, participants practise counselling skills with mothers (or in some situations another caregiver) of children aged between 0 and 2 (or 0 and 5) years. In other clinical practice sessions, participants talk to mothers or caregivers of children aged 0–2 (or 0–5) years and measure the children; they also assess growth and provide counselling on appropriate feeding of children – with emphasis on complementary feeding, and management of undernutrition or overweight as appropriate. In the clinical practice sessions in the postpartum unit, participants talk with mothers and provide breastfeeding counselling and support.

Your help is needed to prepare mothers and caregivers, to ask their permission before the participants arrive, and to introduce participants to mothers and caregivers to whom they can talk.

If a child/mother/caregiver needs a specific intervention, this will only take place with the permission and knowledge of health-facility staff. This will also enable staff to provide follow-up for the child or caregiver.

The visit to your facility would be on: (date) . . . . . from (time) . . . . . .

Thank you for your assistance.

Course organizers:[1] . . . . . .

Course venue: . . . . . .

Course dates: . . . . . .

Course contact person's name and address: . . . . . .

[1] For example, child health service.

Selecting participants

Try to ensure that appropriate and motivated participants come to the course. This will make the training successful, and may stimulate the interest of others in infant feeding, so that they will also want to acquire the skills and do the work. Participants should be free of other work during the course, so that they may fully participate.

The number of participants who can be invited for a course depends on:

- your budget
- classroom and residential accommodation
- the number of trainers available (you need one trainer for each four participants)
- the number of mother/caregiver and young child pairs who can be seen on an average day in the health facility where you will conduct the clinical practice sessions (you need about eight pairs per session per group of four participants).

It is recommended that you do not invite more than 24 participants to a course. If possible, try to include one or more of the staff of the health facility in which the clinical practice sessions will be conducted. You may plan to train a number of people from a certain area, or to train all appropriate health workers in a given area or institution with a series of trainings. You may ask health facilities in an area each to select 1–3 participants to attend the course.

An example of a course announcement notice is provided below.

Example of a course announcement

Infant and young child feeding counselling course

Date: .....

Venue: .....

Course organizers:[1] .....

Objectives of the course: after completing this course, participants will be able to assess breastfeeding and complementary feeding, measure children, plot measurements on growth charts, interpret growth indicators and counsel and support mothers, including those living with HIV, to carry out WHO/UNICEF-recommended feeding practices for their infants and young children.

Who should attend: the course is for primary health-care nurses and doctors, clinicians at first referral level, lay counsellors and community health workers. They should be fluent in [state required language].
Outline of course: [section to be completed according to the content selected]

Accommodation: accommodation and meals will be available from [evening before course to morning after depending on travel arrangements]. Participants should arrive by 8 am on [first day of course] and are free to leave after 5 pm on [last day of course]. Travel costs will be refunded.

Registering for the course: send the names and contact details of candidates who wish to apply, to [name and address] before [date]. When participants have been selected, further information will be sent to them and to their health facility.

Certification: participants who complete the entire course will receive a certificate of completion.

[1] For example, child health service.

Checklists for planning

Overall planning checklist

Initial planning

1. Decide the course schedule. For example, a 5-day course or 1-day meeting each week for 5 weeks. Allocate 8 teaching hours per day, with meal times in addition.
2. Choose a training venue. This must include a large classroom, 2–3 smaller classrooms and a facility to conduct the clinical practice sessions. Ideally, these should be at the same site. Make sure that the following are available:
   - easy access from the classroom to the area for the clinical practice sessions
   - a large room and 2–3 smaller rooms that can seat all participants and trainers for sessions, including space for guests invited to the opening and closing ceremonies; there should be space for each group of 6–8 participants and their trainers to sit at a table, with enough space for each to open up their course materials
   - for training-of-trainers, one classroom that can accommodate 8–10 people
   - adequate lighting and ventilation, and wall space to post up large sheets of paper in each of the rooms
   - at least one table for each group of 6–8 participants and additional table space for materials
   - freedom from disturbances such as loud noises or music
   - arrangements for providing refreshments
   - space for at least one member of clerical or logistic support staff during training
   - a place where supplies and equipment can be safely stored and locked up if necessary.

When you have chosen a suitable site, book it in writing and subsequently confirm the booking some time before the course, and again shortly before the course.

3. Choose lodging for the participants. Ideally, the course should be residential. If lodging is at a different site from the course, make sure that the following are available:
   - reliable transportation to and from the course site
   - meal service that is convenient for the course timetable.

When you have identified suitable lodging, book it in writing and subsequently confirm the booking some time before the course, and again shortly before the course.

4. Visit the health facility or other facilities that you will use for the clinical practice sessions.
   - Confirm the hours during which it is possible to see mothers and young children (if you plan to visit more than one facility at each session, it is important to make sure they are available at the same time).

When you have chosen a suitable site, confirm it in writing and reconfirm shortly before the course.

5. Decide the exact dates of the course.
6. Arrange for a responsible authority (for example ministry of health, national nutrition programme) to send a letter to the district/regional office or to health facilities asking them to identify participants. This letter should:
   - explain that the course will be held, and explain the aims of the course
   - give the site and dates of the course
   - state the total number of places for participants on the course (12–24), and suggest the number of places to offer to participants from each facility (this depends on how many facilities are involved)
   - state clearly that nominated participants should be people who are responsible for measuring children and providing assistance on feeding young children aged 0–24 months
   - explain the duration of the course and that individuals should arrive in time and attend the entire course
   - give the date by which nominated course participants will be selected and contact details of the person to whom the names of nominated participants should be sent
   - say that a letter of invitation will be sent to participants once they are selected.

7. Identify suitable participants, and send them letters of invitation, stating:
   - the objectives of the training and a description of the course
   - the desired arrival and departure times for participants
   - that it is essential to arrive in time and to attend the entire course
   - administrative arrangements, such as accommodation, meals and payment of other costs.
8. Arrange to obtain enough copies of the course materials.
9. Arrange to obtain:
   - necessary supplies and equipment
   - the items needed for demonstrations
   - the necessary background information for the area.
10. Arrange to send materials, equipment and supplies to the training venue.
11. Arrange to send travel authorizations to trainers and participants.
12. Invite officials for the opening and closing ceremonies.

Arrangements at the training venue before the course begins

The course director (or a designated trainer) should arrive at the course site early, to ensure that the arrangements described next are made. Plan to arrive there at least a day or two before the preparatory period for trainers, and continue with the organization during the preparatory days. During the course, the course director needs to work with local staff to ensure that arrangements go well and that the trainers' and participants' work is not unduly interrupted.

13. Confirm arrangements for:
   - lodging for all trainers and participants
   - classrooms
   - daily transportation of participants from lodgings to their classroom and to and from the sites for clinical practice sessions; ensuring that clinic staff are briefed on the visits and that that children and their mothers/caregivers will be available when needed; and determining a suitable way of thanking the mothers/caregivers and children for their time – for example, small toys or fruit (bananas are easy to hand out) may be given to the children
   - meals and refreshments
   - opening and closing ceremonies with relevant authorities; check that invited guests are able to come
   - a Course-completion certificate (if one will be given) and when a group photograph will be taken in time to be printed before the closing ceremony (optional)
   - arrangements for typing and copying of materials during the course (for example, timetables, lists of addresses of participants and trainers).

Actions during the course

14. Post up the list of participants assigned to the different pairs of trainers where everyone can see it.
15. Provide all participants and trainers with a course directory, which includes the names and addresses of all participants and trainers and the course director.
16. Arrange for a group photograph, if desired, to be taken.
17. Prepare a Course-completion certificate for each participant.
18. Make arrangements to reconfirm or change airline, train or bus reservations for trainers and participants, if necessary.
19. Allocate a time for payment of per diem and for travel/lodging arrangements that does not take time from the course.

Trainers' meetings

- Trainers' meetings are usually conducted for about 30–60 minutes at the end of each day. Trainers will be tired, so keep the meetings brief. They should be led by the course director(s).
- Begin the meeting by encouraging the trainers – praising what they did well during the day. Trainers may become discouraged if they feel the session(s) they led did not go well.
- Continue by asking a trainer from each group to describe progress made by their group, to identify any difficulties impeding progress, and to identify any skill, exercise or any section of the sessions that participants found especially difficult to do or understand.
- Identify solutions to any problems related to any particular group's progress or related to difficult skills or sections of the sessions.
- Discuss teaching techniques that the trainers have found to be successful.
- Provide feedback to the trainers on their performance. Use the notes that you have taken while observing the groups during the day.
- Mention a few specific actions that were well done (for example, conducting a lecture session accurately and in an interesting way; keeping to time; providing participants with individual feedback; facilitating a practical session well; demonstrating practical skills carefully and accurately to the group).
- Mention a few actions that might be done better (for example, keeping to time; following the lecture sessions accurately without omitting any points; answering questions clearly; explaining more clearly which tasks should be practised during the practical or clinical practice session).

Remind trainers of certain actions that you consider important. Some examples are provided next.

- Discuss difficulties with a co-trainer. If co-trainers cannot solve problems together, go to the course director. The course director may be able to deal with these situations (for example, by discussing matters privately with the individuals concerned).
- Speak softly while giving feedback, to avoid disturbing others. Put chairs out in the hall, so that a participant and a trainer can talk without disturbing the rest of the group.
- Always be open to questions. Try to answer immediately, but if a question takes too long to answer, diverts the attention of the group from the main topic, or is not relevant at the moment, suggest that the discussion be continued later (for example, during free time or over dinner). If a question will be answered later in the course, explain this. If unsure of the answer to a question, offer to ask someone else and then come back later with an explanation.
- Interact informally with participants outside of scheduled class meetings.
- For participants who cannot read the sessions and/or do the exercises as quickly as others, the trainers should:
  - avoid doing exercises for them
  - reinforce small successes
  - be patient (or ask another facilitator to help).

Before closing the meeting:

- review important points to emphasize in the clinical practice session or in the sessions the next day
- remind the trainers to consult the *trainer's guide* and gather together any supplies needed for the next day
- make any necessary administrative announcements (for example, location of equipment for the demonstrations, room changes, transportation arrangements, etc.).

Checklists of course materials

The checklists give the materials needed for a course with 24 participants and 6 trainers plus a few spares. Some of the materials relate to specific modules and should be used only if the module is included in the training.

Items supplied as published materials

Item	Total copies	Director and trainers	Participants
Director's guides	8	✓	–
Trainer's guides	8	✓	–
Set of slides	1	per group	–
Participant's manuals	32	✓	✓
CHILD AGE CALCULATOR	32	✓	✓
GIRL'S GROWTH RECORD	32	✓	✓
BOY'S GROWTH RECORD	32	✓	✓
Blank WHO and/or local growth charts	32	✓	✓
Photo booklet[1]	32	✓	✓
JOB AID: INVESTIGATING CAUSES OF UNDERNUTRITION AND OVERWEIGHT	32	✓	✓
Counselling cards	32	✓	✓
Guidance on the use of counselling cards	32	✓	✓

[1] Training course on child growth assessment: WHO child growth standards. Photo booklet. Geneva: World Health Organization; 2008 (http://www.who.int/childgrowth/training/odule_e_photo_booklet.pdf).

Items to be photocopied

With the exception of the timetables, which need to be produced by the course director, the items in this table are supplied in the *Course handouts*.

Item	Total copies	Director and trainers	Participants
Course timetable for trainers	8	✓	–
Course timetable for participants	32	✓	✓
Course registration form	30	✓	✓
Summary participant list	1	✓	–
Evaluation questionnaire for participants	24	–	✓
Evaluation form for participants and trainers	32	✓	✓
Evaluation form for trainers	8	✓	–
Listening and learning skills checklist	32	✓	✓
Counselling skills checklist (including Listening and learning skills and Skills for building confidence and giving support)	32	✓	✓
How to use a Counselling card	32	✓	✓
Clinical practice discussion checklist (with counselling skills on back)	8	✓	–
Competency progress form	32	✓	✓
Job aid: Breastfeed observation	64	✓	✓
Job aid: Feeding history – 0 up to 6 months	64	✓	✓
Job aid: Postnatal contacts	32	✓	✓
Job aid: Ongoing contacts	32	✓	✓
Job aid: Food intake – 6 up to 24 months	90	–	3 per participant
Instructions for completing the Job aid: Food intake – 6 up to 24 months	32	✓	✓
Reference tool: Food intake – 6 up to 24 months*	32	✓	✓
Food consistency pictures*	32	✓	✓
Instructions for use of the Child age calculator	32	✓	✓
Job aid: Weighing and measuring a child	32	✓	✓
Growth problems chart	32	✓	✓
Log of skills practised	24	–	✓
Difficulties experienced	24	–	✓
Self-assessment in infant and young child feeding: competency practice and progress tracking form	24	–	✓
Copies of demonstrations	2 of each	–	For participants helping with demonstrations
Copies of scripts for role-play	2 of each	–	For participants helping with demonstrations
Materials for group exercises	8	–	1 per group of 4
Answer sheets	24	–	1 per participant
Course-completion certificate	32	✓	✓

*If possible, copy the Reference tool: Food intake – 6 up to 24 months with the Food consistency pictures on the back. Use card or heavy paper, if available.

Other items for photocopying are supplied in the *Course handouts*, under the heading Other items of key information, for use as required.

Checklist of equipment and stationery

Item(s) needed	Number needed for the course
Laptop	1
PowerPoint projector	1
Equipment for typing/word processing	Access needed
Photocopying equipment	Access needed
Photocopying paper	Two reams (200 sheets) just for timetables and other incidentals. More if worksheets, etc. are done at course
Flipchart stands or blackboards	3
Markers for flipchart	3 each of red, black and green
Chalk	2 boxes
Chalk erasers	2
Name tags and holders	32
Pads or notebooks of ruled paper	32
No 2 pencils	32
Erasers	32
Ballpoint pens – blue or black	32
Highlighters	32
Hand-held staplers	2
Staples	1 box
Scissors	2 pairs
Pencil sharpeners	5
Paper clips, large	Approx. 100
Masking tape to stick flipchart sheets onto walls or other surfaces	2 rolls
Simple files for trainers to store papers	10

Checklist of background information needed

- How does this course link to local programmes such as Integrated Management of Childhood Illnesses?
- What are the follow-up plans for course participants?
- What are the infant feeding indicators (breastfeeding, complementary feeding)?
- What is the breastfeeding/baby-friendly policy for local hospitals and clinics (if available)?
- Are there any locally used materials on feeding infants and young children?
- Are there any locally used materials on food hygiene?
- Are there local growth charts?
- Is generic infant formula milk available?
- Is a micronutrient supplement available in the local clinics? What is the policy for giving out these supplements?
- Is the percentage known of young children who are malnourished (wasted, underweight or stunted, overweight or obese, with micronutrient deficiencies)?
- Is the local culture vegetarian or meat eating?
- Are germinated flours or fermented porridge used in the area?
- Are there any local or national nutrition supplementation programmes and policies?
- Are there any local systems for providing food, vouchers or cash to families living in poverty?
- What is the prevalence of HIV? Are there regional differences?
- What is the national health authority infant feeding recommendation for mothers living with HIV?

Teaching the course

This section explains the teaching methodology used in the course. You should read it before you start conducting sessions.

Infant feeding and HIV are very emotive topics. Be aware that participants may have strong feelings about these topics. Help the group to accept that there will be strong feelings and that there is a need to respect them all, without judgement.

In areas where HIV is prevalent, it is possible that some participants are, themselves, living with HIV/AIDS, or have close family or friends who are living with HIV. Avoid comments that could sound critical of people with HIV.

Forming groups

Working in groups makes it possible for teaching to be more interactive and participatory, and it gives everybody more time to ask questions. Quieter participants have more chance to contribute.

As soon as possible after the introductory session, the course director and the trainers decide how the groups will be composed. Sometimes it is a good idea to make one participant who knows the others in the class responsible for arranging the groups.

Each group should have at least one person who can speak the local language. It may be appropriate to balance professional groupings and geographic areas.

Write the names of the trainer and participants in each group on a flipchart or board, and post it up where both trainers and participants can check which group they belong to.

The exercises are designed for groups of three or four people with a trainer. In this integrated course, where there are fewer practical sessions for each skill compared to the other WHO infant and young child feeding courses, it is essential that the maximum number of participants per group is four. If there are enough trainers to have groups of three people with each trainer, then this is even better, as it gives all participants more opportunity to practise their counselling and practical skills.

During the week, the trainers should try to spend as much time as possible with their groups, to learn what the participants feel competent at and where they need more help and practice.

Motivating participants

Encourage interaction

During the first day, interact at least once with every participant, and encourage them to interact with you. This will help them to overcome their shyness, and they will be more likely to interact with you for the remainder of the course.

Make an effort to learn participants' names early in the course, and use their names whenever it is appropriate. Use names when you ask participants to speak, or to answer questions, or when you refer to their comments, or thank them.

Be readily available at all times. Remain in the room and look approachable. For example, do not read magazines or talk constantly with other trainers. Talk to participants rather than trainers during tea breaks, and be available after a session has finished.

Get to know the participants who will be in your group, and encourage them to come and talk to you at any time, to ask questions or to discuss any difficulties, or even to tell you that they are interested and enjoying themselves.

Reinforce participants' efforts

Take care not to seem threatening. These techniques may help:

- be careful not to use facial expressions or comments that could make participants feel ridiculed
- sit or bend down to be on the same level as a participant to whom you are talking, particularly when you are going over individual written exercises
- do not be in a hurry, whether you are asking or answering questions
- show interest in what participants say. For example, say: "That is an interesting question/suggestion".

Praise or thank participants who make an effort, for example, when they:

- try hard
- ask for an explanation of a confusing point
- do a good job on an exercise
- participate in group discussion
- help other participants (without distracting them by talking about something irrelevant).

You may notice that many of the counselling skills taught during the course are also important for communicating with participants. In particular, you will find it helpful to use appropriate non-verbal communication, to ask open questions, and to praise them and help them to feel confident in their work with caregivers of young children. It is important that you, as a trainer, demonstrate these counselling skills throughout the course – not only during the relevant sessions, but also in your approach to the participants, mothers, caregivers, staff in the facilities, etc. This will demonstrate to the participants that counselling skills are useful in many situations and, with practice, become a way of life.

Be aware of language difficulties

Try to identify participants who have difficulty understanding or speaking the language in which the course is conducted. Speak slowly and clearly, so that you can be more easily understood. Encourage participants in their efforts to communicate.

If necessary, speak with a participant in their own language (or ask someone else to do so for you) to clarify a difficult point.

Discuss with the course director any language problems that seriously hinder the ability of a participant to understand the material. It may be possible to arrange help for the participant, or for them to do some of the exercises in a different way.

Using your *Trainer's guide*

Before you lead any session

Look at your *Trainer's guide* and read the OBJECTIVES, to find out what participants should be able to do by the end of the session. Read the SESSION OUTLINE, to find out what kind of session it will be, and what your responsibilities are.

Read the PREPARATION box at the beginning of the text, so that you know what you have to do in advance to prepare for the session, and what training aids (and other kind of help) you need.

Read the text for the session, so that you are clear what you will have to do. The text includes detailed point-by-point instructions about how to conduct the session.

Consider splitting the session between two or more trainers, particularly if the session is long. Trainers can also work together, with one trainer writing on the flipchart or assisting with a demonstration while the other trainer is conducting the session.

When you lead a session

Keep your *Trainer's guide* with you and use it all the time. You do not need to try to memorize what you have to do. It is extremely difficult to do so. Use the guide as your session notes, and follow it carefully.

The course director may explain at the beginning of the course that using the *Trainer's guide* is the correct method for this kind of teaching, in the same way that participants need to use their *Participant's manual*. You may wish to copy the necessary pages of the guide, to use as your notes during the session. This will not be so bulky as carrying the whole guide.

Remember that even the authors of the materials find it necessary to follow the *Trainer's guide* when they teach the course. If they do not, they find it difficult to keep to the planned sequence of teaching, and they miss out important steps.

If the participants seem tired, or their attention is wandering, pause for a short break. Encourage everyone to stretch and take some deep breaths. Perhaps a short activity, song or game may revive them.

Giving a lecture or demonstration

Preparing to give a lecture

Study the material

Before you give one of the lecture presentations, read the notes through carefully, and study the slides that go with it.

You do not have to give the lecture exactly as it is written. It is preferable not to read it out, though this is acceptable if you feel that there is no other way you can do it. However, it is important that you are thoroughly familiar with the contents of the lecture, and with the order of ideas in the presentation. This is necessary even if you are an experienced trainer and knowledgeable about infant feeding.

Go through the text, mark it and add your own notes to remind you about points to emphasize, or points of special local importance. Try to think of ways to present the information naturally, in your own way.

Read the Further information sections, which are provided at the end of some sessions. They give extra information about topics that are covered only briefly in the main text. You should not present them as part of the main presentation, but they may help you to answer questions that arise in the course of discussion.

Prepare your slides and flipcharts

Make sure that you have all the slides for the session. If you are projecting the slides, ensure that your projection equipment is working. If you are using overhead transparencies, arrange them in the correct order. If flipcharts need to be written beforehand, do this in plenty of time. During the session, when you are asking for responses from participants, another trainer can write items on the flipchart, thus allowing you to keep eye contact with the participants.

Shortly before the session, make sure that the audience will be able to see the images – that the room is dark enough, that the screen is well placed and that the chairs are arranged appropriately. You do not have to accept the arrangements from the previous session – it can be an advantage to move an audience around and present material in a new way. It may help to keep their attention.

Giving a lecture

Talk in a natural and lively way

- Present the information as in a conversation, instead of reading it.
- Speak clearly and try to vary the pitch and pace of your voice.
- Move around the room, and use natural hand gestures.

Explain the slides carefully

Remember that slides do not do the teaching for you. They are aids to help you to teach and to help participants to learn. Do not expect participants to learn from them without your help.

Explain to the audience exactly what each picture shows, and tell them clearly the main points that they should learn from it. As you explain the information in the text, point out on the slide where it shows what you are talking about. Do not assume that participants automatically see what you want them to look at.

Remember to face the audience as you explain – do not keep looking at the screen yourself. Do not turn your back on the audience for more than a short time. Keep looking at them, and maintain eye contact, so that they feel that you are talking to them personally.

Be careful not to block participants' view of the screen. Either stand to the side or sit down, and check that they can see clearly. Look out for participants bending to see the screen or demonstration because you are in the way. Stop and adjust your position before you continue.

When you are familiar with the material, and you have taught it a few times, you will be able to explain it in your own way. You will be able to make it appropriate for the participants and answer their questions in a way that is most helpful for them.

It is sometimes helpful, when presenting photographs, to ask participants to come to the screen to point things out to the others. This technique is recommended for Sessions 13 and 25: Assessing a breastfeed 1 and 2 and Sessions 19 and 28: Breast conditions 1 and 2.

Involve the participants

You will have to give much of the information in lecture form. This is necessary to cover enough material in the limited time available.

It is also helpful during lectures and other sessions to ask questions, to check that participants understand and to keep them thinking. This interactive technique helps to keep participants interested and involved, and is usually a more effective way of learning. Ask open questions (which you have learnt about in the sessions on counselling skills), so that participants have to give an answer that is more than a "yes" or "no".

A number of questions are indicated in the text. The questions are asked in such a way that participants should be able to decide the answer either by looking at the figure that is displayed, or from their own experience, or from what has been covered previously in the course, without requiring new information that they may not have.

Sometimes you may want to give participants a hint to help them to answer. Sometimes asking the question again, in another way, can help. However, do not help them or give them the answer too quickly. It is important to wait, and to give them a genuine chance to think of the answer themselves.

Ask participants to keep their *Participant's manual* closed while answering discussion questions, so that they think about possible answers rather than reading the information from their manual.

Do not get involved in discussions that are distracting and that waste a lot of time. Encourage participants to make a few suggestions; discuss their suggestions and then continue with the section. You do not have to wait until they have given all the answers listed in the text. Notes are included with many of the questions, to guide you.

Acknowledge all participants' responses, to encourage them to try again. Comment briefly on their answer, or say "Thank you", or "Yes". If participants give an incorrect answer, do not say "No – that is wrong!" or some may hesitate to make other suggestions. Accept all answers, and say something non-committal, such as "That is an interesting idea" or "I haven't heard that one before". Ask them to say more to clarify the idea, or say, "What does anyone else think?" or ask for other suggestions. Make participants feel that it is good to make a suggestion, even if it is not the "correct" answer. Then clarify the information so that participants have the correct information.

When someone answers correctly, "hold onto" their answer; expand it if necessary, and make sure that everyone else has understood.

Do not let several participants talk at once. If this occurs, stop the talkers, and give them an order to speak in. For example, say "Let's hear Mary's comment first, then Anastasia's, then Siti's". People will usually not interrupt if they know that they will have a turn to talk.

Do not let the same one or two people answer all the questions. If a talkative participant tries to answer several questions, ask them to wait for a minute, or move away and focus attention on others. Try to encourage quieter participants to talk. Ask by name someone who has not yet spoken to try to answer a question, or walk towards someone to bring attention toward that individual and make them feel that they are being asked to talk.

Thank participants whose answers are short and to the point.

Preparing to give a demonstration

Some sessions include a number of short demonstrations of counselling techniques and other skills. You should practise these beforehand, in order for them to be effective and to demonstrate the relevant points to the participants.

Study the instructions and collect the equipment

Some time before you give the demonstration, read through the instructions carefully, so that you are familiar with them and you do not forget any important steps. This is necessary even if you have already seen someone else give the demonstration. Make sure that you have the equipment that you need.

Prepare your assistant

You may need someone to help you to give the demonstration, for example, someone to role-play being a mother. It is usually a good idea to ask a participant to help you. This can be a good learning experience for them. It increases the participant's involvement, and helps them to learn about teaching methods. Ask for help the day before a demonstration, so that helpers have time to prepare themselves and discuss what you want them to do. If the participant will be taking part in one of the role-plays with a written scenario, give them the words to read the day before so that he or she can practise them.

If you feel that participants are not ready to demonstrate the counselling skills, do the demonstrations yourself with another trainer. This helps participants to understand what playing the part is about, and they can see that making mistakes does not matter, so they may feel more confident to try themselves next time.

Practise the demonstration

Practise giving the demonstration, by yourself, with your assistant, or with another trainer, so that you know how long it takes, what can go wrong, and if there is anything else that you need, such as an extra table or chairs. This will make the demonstration much more convincing, and it is a good idea even if you have done it before.

Giving a demonstration

Make sure that all the equipment is ready and together, and prepare the place where you will give the demonstration. Arrange tables and chairs as you will need them. Make sure that you can use a board or flipchart to write things on, or an overhead projector if you need to show a slide as part of the demonstration, without having to rearrange everything.

Demonstrate slowly, step-by-step, and make sure that the audience is able to see what you do. If necessary, ask them to move closer to you so that they can all see and hear clearly; or you can move closer to them, going to each part of the audience in turn.

As you give the demonstration, take every opportunity to let participants handle and examine the equipment that you use, and practise for themselves what you demonstrate. They will learn more if they try things out, rather than just watching you.

At the end of a lecture or demonstration

Leave time for participants to ask questions, and do your best to answer them. You do not need to know the answer to every question. Other participants may be able to offer information, or you can refer them to a local source of further information.

Ask participants to find the summary notes for the session in their *Participant's manual*. Ask them to read the notes later on the same day.

Facilitating other methods of learning

Group work for written exercises

Large groups of about eight participants with two trainers are used for some sessions that involve written exercises.

Work in groups of three or four with one trainer is mainly for the practice of skills, such as the clinical practice sessions. The smaller groups give everybody a chance to practise their skills.

Read the specific instructions for the group sessions that you will lead, and plan how you will conduct them.

Individual written exercises

A number of exercises are individual written exercises. This is an important way for individual participants to learn and to find out for themselves what they are and are not clear about. It helps you to discover who easily understands what has been taught, and who needs more help. The participants who are most in need of help may not ask for it, and you may not discover who they are until they do these exercises. In addition, you may find that someone who is very quiet in fact understands much more than you expect. Giving feedback also helps you to discover which topics are easy and which are difficult for the group.

For written exercises, participants stay in groups of eight, but work by themselves.

Make sure participants have found the correct page in their *Participant's manual*. Explain that they should read the questions and write the answers in their manuals. They should use pencil, so they can change their answer if needed.

Try to arrange for participants to sit a little away from each other, so they do not see or hear other people's answers and so that there is room for trainers to sit between them to give individual feedback. The two trainers circulate, and give individual feedback and personal attention to the participants as they do the exercises. Talk to each participant individually, and as confidentially as possible. Try not to let other participants overhear what you are saying. Compare their answers with the suggested answers in your *Trainer's guide*. Praise them if they have a good answer. If an answer is incorrect, do not make them feel ridiculed. Ask them whether they have any other ideas, and give them a chance to correct the answer. If they cannot do so, help them to decide the correct answer, and explain how they went wrong. Try not to give the answer too readily.

If a question causes difficulty for several participants, discuss it afterwards with the group together. At the end of the time, if there are unfinished questions in the exercise, suggest that they finish them in their own time and ask a trainer later to review the answers.

Clinical practice sessions

For clinical practice sessions, each trainer takes their group of three or four participants to a ward or clinic to practise with mothers, caregivers and infants the skills they have learnt in the previous sessions. Use the CLINICAL PRACTICE DISCUSSION CHECKLIST to help you to discuss each mother and baby with the participants. Remember to use your counselling skills when you give feedback to the participants. Encourage other participants to use their counselling skills when giving feedback, and to recognize and praise what the participant who is practising did well, in addition to making suggestions about what they could do better. They should not just criticize, but they should not give only praise either.

Detailed instructions are given with the notes for each clinical practice session.

Checklist of training skills

At the front of this *Trainer's guide*, there is a summary CHECKLIST OF TRAINING SKILLS. The course director may decide to demonstrate these skills at the time of preparing the trainers before a course, or you may be asked to study them for yourself. Refer to the list from time to time, to remind yourself how to make your session effective.

Additional training methodologies

Small working group

A small working group is a group of no more than 4–7 participants who work together to perform a task or activity and report back to larger group (plenary). This type of work:

- allows two-way communication
- allows group members to learn each other's views and sometimes makes consensus easier
- involves active participation
- allows participants to ask and learn about aspects that are unclear
- can produce a strong sense of sharing or camaraderie
- often lets people who feel inhibited share
- challenges participants to think, learn and solve problems.

Leading a small working group

- Outline the purpose and tasks clearly, to provide focus and structure.
- Allow enough time for all groups to finish the task and give feedback.
- Announce the remaining time at regular intervals.
- Ensure that participants share or rotate roles.
- Be aware of possible conflicts and anticipate their effect on the group's contribution in plenary.
- Reach conclusions but avoid repeating points already presented in plenary.

Example: rotation of flipcharts

- Divide participants into groups of four or five.
- Set up three or four flipcharts throughout the room, each with a different theme written at the top.
- Ask each group of four or five participants to present themselves in front of a flipchart.
- Allow each group 3 minutes to write as many points as they can think of to respond to the theme on the flipchart.
- Then ask the groups to rotate to the next flipchart (for 3 minutes) and repeat the exercise (without repeating the points already listed).
- Discuss and summarize in a large group or plenary.

Example: distribution of beans, pebbles, sticks or bottle caps, etc.

- Divide participants into groups, by region/district.
- Ask the groups to use beans, pebbles, sticks, or bottle caps to represent data of infant and young child feeding practices.
- After regions/districts have shared their data, get the whole group to discuss risk(s) according to each practice.

Example: ordering cards or illustrations

- Divide participants into groups of four.
- Give each group a set of cards (with words) or illustrations and ask each group to order them in terms of process: what comes first, second, etc.
- Ask each group to share their results in the large group.
- Facilitate discussion and summary in the large group.

Example: drawing

- Participants form four working groups in which each group is assigned to draw and label a specific object.
- In the large group, each group shares and explains their drawings.
- Facilitate discussion and summary in the large group.

Example: place an illustration or phrase into the appropriate box on a chart

- Divide the participants into two groups.
- Prepare two flipcharts with titles or illustrations on columns and rows.
- Distribute pieces of paper or illustrations with the chart content.
- Ask groups to fill in their flipchart content: taping/sticking their pieces of paper or illustration in the appropriate box on the flipchart.
- When groups have finished, get one group to explain their entries on the flipchart.
- Then ask the second group to make any additional comments and rearrange the content accordingly.
- Facilitate discussion and summary in the large group.

Example: sort foods into appropriate groupings, and prepare a meal

- Divide participants into four groups.
- Give each group locally, available, feasible, affordable and seasonal foods (pictures/ illustrations or local foods: animal-source foods, legumes and seeds, vitamin A-rich fruits and vegetables, other fruits and vegetables, staples) and oils.
- Ask each group to use the available foods to "prepare a meal" for a specified age group.
- Ask each group to show and explain the "prepared food" to the entire group, discussing age-appropriate characteristics of complementary feeding (age group, frequency, amount, texture, variety, responsive feeding, and hygiene).

Buzz group

A "buzz group" of two or three participants allows them to discuss their immediate reactions to information presented, give definitions and share examples and experiences. This type of work:

- gives everyone a chance and time to participate
- makes it easier to share opinions, experiences and information
- often creates a relaxed atmosphere that allows trust to develop and helps participants express opinions freely
- can raise energy levels by getting participants to talk after listening to information
- does not waste time moving participants.

Leading a buzz group

- Clearly state the topic or question to be discussed, along with the objectives.
- Encourage exchange of information and beliefs among different levels of participants.

Brainstorming

This is a spontaneous process through which group members' ideas and opinions on a subject are voiced and written for selection, discussion and agreement. All opinions and ideas are valid. This type of work:

- allows many ideas to be expressed quickly
- encourages open-mindedness (every idea should be acceptable, and judgement should be suspended)
- gives everyone an opportunity to contribute
- helps stimulate creativity and imagination
- can help make connections not previously seen
- is a good basis for further reflection
- helps build individual and group confidence by finding solutions within the group.

Leading a brainstorming session

- State clearly the brainstorming rule that there is no wrong or bad idea.
- Ensure a threat-free, non-judgemental atmosphere, so that everyone feels he or she can contribute.
- Ask for a volunteer to record brainstorming ideas.
- Record ideas in the speaker's own words.
- State that the whole group has ownership of brainstorming ideas.
- Give participants who haven't spoken a chance to contribute.

Plenary or whole-group discussion

The entire group comes together to share ideas. This type of work:

- allows people to contribute to the whole group
- enables participants to respond and react to contributions
- allows facilitators to assess group needs
- enables people to see what other group members think about an issue
- allows individuals or groups to summarize contents.

Leading a plenary or whole-group discussion

- Appoint someone to record the main points of the discussion.
- Appoint a timekeeper.
- Pose a few questions for group discussion.
- Use buzz groups to explore a topic in depth.
- Ask for contributions from participants who haven't shared their views.

Role-play

Role-play involves imitation of a specific life situation that involves giving participants details of the "person" they are asked to play. This type of work:

- helps start a discussion
- is lively and participatory, breaking down barriers and encouraging interaction
- can help participants improve skills, attitudes and perceptions in real situations
- is informal and flexible and requires few resources
- is creative
- can be used with all kinds of groups, regardless of their education levels.

Leading a role-play

- Structure the role-play well, keeping it brief and clear in focus.
- Give clear and concise instructions to participants.
- Carefully facilitate to deal with emotions that arise in the follow-up discussion.
- Make participation voluntary.

Drama

Unlike role-play, the actors are briefed in advance on what to say and do and can rehearse. As a result, the outcome is more predictable. Drama is often used to illustrate a point. This type of work:

- commands attention and interest
- clearly shows actions and relationships and makes them easy to understand
- involves the audience by letting them empathize with actors' feelings and emotions
- does not require many resources
- can bring people together almost anywhere.

Leading a drama presentation

- Encourage actors to include the audience in the drama.
- Follow the drama by discussion and analysis, to make it an effective learning tool.
- Keep it short, clear and simple.

Case study

Pairs or small groups are given, orally or in writing, a specific situation, event or incident and asked to analyse and solve it. This type of work:

- allows rapid evaluation of trainees' knowledge and skills
- provides immediate feedback
- increases analytical and thinking skills
- is the best realistic alternative to field practice.

Leading a case study

- Make the situation, event or incident real and focused on the topic.
- Initiate with simple case studies and gradually add more complex situations.
- Speak or write simply.

Example: mother, counsellor and observer

- The "counsellor" of each group asks the "mother" about her situation, and practises the ASSESS, ANALYSE and ACT steps with LISTENING AND LEARNING SKILLS and SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT.
- The "observer" records the skills of the "counsellor", using an observation checklist and then provides feedback after the case study.

Demonstration with return demonstration

A resource person performs a specific operation or job, showing others how to do it. The participants then practise the same task. This type of work:

- provides step-by-step process to participants
- allows immediate practice and feedback
- allows a checklist to be developed to observe participants' progress in acquiring the skill.

Leading a demonstration with return demonstration

- Explain the different steps of the procedure.
- The resource person demonstrates an inappropriate skill, then an appropriate skill, and discusses the differences.
- Participants practise the appropriate skill and provide feedback to each other.

Game

A person or group performs an activity characterized by structured competition that allows people to practise specific skills or recall knowledge. This type of work:

- entertains
- is competitive and stimulates interest and alertness
- is a good energizer
- helps recall of information and skills.

Leading a game

- Be prepared for "on the spot" questions because there is no script.
- Give clear directions and adhere to the allotted time.

Example: matching game

- Use illustrations cut into two pieces; each participant is given a picture portion and is asked to find his/her match; pairs of participants are then asked to answer a set of questions or perform some task.
- Participants are divided into groups. Each group is provided with terms and corresponding definitions. The task of the group is to match each term with one or more definitions.
  - Ask one group to report on the matching terms and definitions; do other groups agree or disagree? Continue until all groups agree on the definitions matched with each term.
  - Facilitate discussion and summary in the large group.

Example: fish game

- Divide the participants into two groups, assigning to each group a package of fish-shaped cards.
- On the back of each card write a common situation or condition related to local belief about infant and young child feeding (or paste an illustration). A paper clip can be attached to the "mouth" of the fish and another paper clip to the end of a string tied to a stick, so that participants might actually "fish" for a card.
- Cards (fish) should be placed face downward so participants can "fish" for a common situation or condition that can affect infant and young child feeding.
- Ask participants to fish (one card) and discuss:
  - how does this situation affect infant and young child feeding in your community?
  - what can be done about the situation?

Interactive presentation

This involves imparting information quickly, with engagement of participants, supplemented with audio or visual aids. This type of work:

- facilitates structuring of the presentation of ideas and information
- allows the facilitator to pose questions
- is ideal for factual topics
- stimulates ideas for informed group discussion.

Leading an interactive presentation

- Use a lead-off story or interesting visual.
- Present an initial case problem.
- Give examples using real-life illustrations and, if possible, comparing the material and the participants' knowledge and experience.
- Use visual backup (flipcharts, slides, brief handouts and demonstrations) to enable participants to see as well as hear what you are saying.
- Challenge participants to give examples of the concepts.
- Allow time for feedback, comments and questions.
- Apply the problem by posing a problem or question for participants to solve based on the information provided.

Small-group discussion

A small group of no more than seven participants discusses and summarizes a given subject or theme. The group selects a chairperson, a recorder and/or someone to report to plenary. This type of work:

- allows two-way communication
- allows group members to learn each other's views and sometimes makes consensus easier
- allows group members to take on different roles (e.g. leader, recorder), to practise facilitation techniques
- involves active participation
- allows participants to ask and learn about unclear aspects
- often lets people who feel inhibited share
- can produce a strong sense of sharing or camaraderie
- challenges participants to think, learn and solve problems.

Leading a small-group discussion

- Outline the purpose of the discussion and write questions and tasks clearly, to provide focus and structure.
- Establish ground rules (e.g. courtesy, speaking in turn, ensuring everyone agrees with conclusions) at the beginning.
- Allow enough time for all groups to finish the task and give feedback.
- Announce the remaining time at regular intervals.
- Ensure that participants share or rotate roles.
- Be aware of possible conflicts and anticipate their effect on the group's contribution in plenary.
- Reach conclusions but avoid repeating points already presented in plenary.

Module 1

Introduction to infant and young child feeding and growth assessment

Session 1

Introduction to infant and young child feeding

Objectives

After completing this session, participants will be able to:

- list evidence-based interventions targeting infants and young children
- describe global initiatives or strategies promoting nutrition interventions targeting the first 1000 days of life
- state the current recommendations for feeding children from 0 up to 24 months of age

Session outline . . . . . 20 minutes

Participants are all together for a lecture presentation by one trainer.

I. Introduce the session, present **Slide 1/1** . . . . . 3 minutes
II. Present **Slides 1/2** to **1/8** . . . . . 15 minutes
III. Summarize the session . . . . . 2 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides.
- Study the **Slides 1/1** to **1/8** and the text that goes with them, so that you are able to present them.
- Make sure that you have one copy of references for the group, for them to consult.
- Prepare electronic copies of all basic documents referred to in this session, and other key documents, including:
  - *WHO child growth standards*
  - *Essential nutrition actions: improving maternal, newborn, infant and young child health and nutrition*
  - *Global strategy for infant and young child feeding*
  - *Comprehensive implementation plan on maternal, infant and young child nutrition*
  - *International code of marketing of breast-milk substitutes* (1981) and subsequent relevant World Health Assembly (WHA) resolutions
  - *Baby-friendly Hospital Initiative*
  - International Labour Organization (ILO) *Maternity Protection Convention No. 183* (2000)
  - *Breastfeeding advocacy initiative*
  - *Guiding principles for complementary feeding of the breastfed child*
  - *Guiding principles for feeding non-breastfed children 6–24 months of age*
- Review the most up-to-date data on mortality, infant and young child feeding practices, and malnutrition, to present that information.
- Read the **Further information** sections, so that you are familiar with the ideas that they contain, so that you can answer participants' questions.

As you follow the text, remember:

- ► indicates an instruction to you, the trainer.
  - ¤ indicates what you say to participants.

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the session — 3 minutes

- ► Show **Slide 1/1 – Session 1 – objectives** and read out the objectives:

1/1

Session 1: Introduction to infant and young child feeding – objectives

After completing this session, participants will be able to:

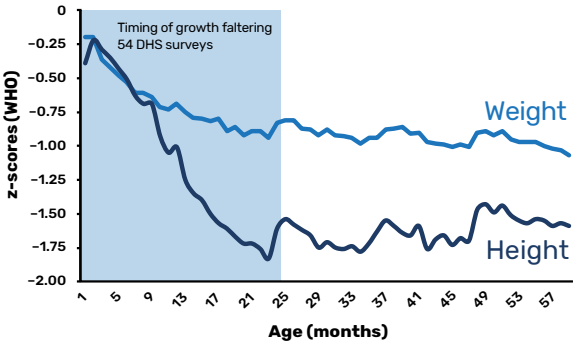
- list evidence-based interventions targeting infants and young children
- describe global initiatives or strategies promoting nutrition interventions targeting the first 1000 days of life
- state the current recommendations for feeding children from 0 up to 24 months of age

II. Present Slides 1/2 to 1/8 — 15 minutes

- ► Make these points:
  - ¤ We will start this course by looking at the global data supporting interventions in infancy and childhood.
- ► Show **Slide 1/2 – The window of opportunity: conception to 2 years.**
  - ¤ *Ask: How would you interpret this graph?*

1/2

The window of opportunity: conception to 2 years



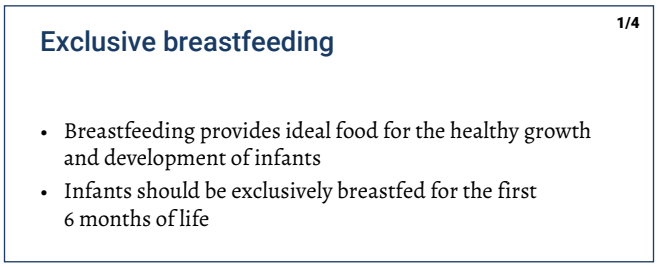
Source: Victora CG, de Onis M, Hallal PC, Blössner M, Shrimpton R. Worldwide timing of growth faltering: revisiting implications for interventions. Pediatrics. 2010;125(3):e473–80. doi:10.1542/peds.2009-1519.

- **Wait for a few responses and indicate:**
  - New analyses, using the *WHO child growth standards*, confirm the importance of pregnancy and the first 2 years of life as a window of opportunity for growth promotion. The findings highlight the need for prenatal and early-life interventions to prevent the growth failure that primarily happens during the first 2 years of life, including the promotion of appropriate infant feeding practices.
- **Make these points:**
  - We will now look at the *Essential nutrition actions: improving maternal, newborn, infant and young child health and nutrition.*
  - *Ask: Is there anyone who has heard of this and knows what it contains?*
- **Wait for a few replies and then continue.**
  - This document is a compilation of current guidelines targeting mothers, infants and young children. Infant and young child feeding is a core element of the guidelines.
  - The *Essential nutrition actions* document starts reviewing data related to the health and nutrition of children, to highlight the importance of appropriate infant and young child feeding practices.
  - 5.9 million children under the age of 5 years died in 2015. More than half of these early child deaths are due to conditions that could be prevented or treated with access to simple, affordable interventions. About 45% of all child deaths are linked to malnutrition and inadequate feeding practices.[1]
  - Globally, in 2016, out of 667 million children under the age of 5 years worldwide, 159 million were stunted, 50 million were wasted and 41 million were overweight.[2]
  - Appropriate breastfeeding and complementary feeding practices not only play a significant role in improving the health and nutrition of young children, they also confer long-term benefits during adolescence and adulthood, including the prevention of overweight/obesity.
  - Scaling up breastfeeding to near universal level could prevent 823 000 annual deaths in children younger than 5 years and 20 000 annual deaths from breast cancer.
  - The nutrition interventions are divided by age group targeted. We will look at those targeting young infants (0 up to 6 months of age) and infants and young children (6 up to 24 months of age), with details referring to infant and young child feeding.
- **Show Slide 1/3 – Nutrition interventions targeted at young infants (0 up to 6 months) and ask participants to read out the interventions:**

  - We will address all these interventions during this course.

[1] Children: improving survival and well-being [website]. Geneva: World Health Organization; 2020 (https://www.who.int/en/news-room/fact-sheets/detail/children-reducing-mortality, accessed 31 July 2021).
[2] Global nutrition report 2016: from promise to impact: ending malnutrition by 2030. Washington (DC): International Food Policy Research Institute; 2016 (https://globalnutritionreport.org/reports/2016-global-nutrition-report/, accessed 31 July 2021).

▸ Show **Slide 1/4 – Exclusive breastfeeding** and make the points that follow:



- Breastfeeding provides ideal food for the healthy growth and development of infants, and it is all that a child needs for the first 6 months of life.
- As a global public health recommendation, infants should be **exclusively** breastfed for the first 6 months of life.
- We will be talking a lot about exclusive breastfeeding during this course.
- *Ask: What does the term "exclusive breastfeeding" mean?*

▸ Wait for a few replies and then ask participants to turn to page 7 of their *Participant's manual* and find the box DEFINITION OF EXCLUSIVE BREASTFEEDING.

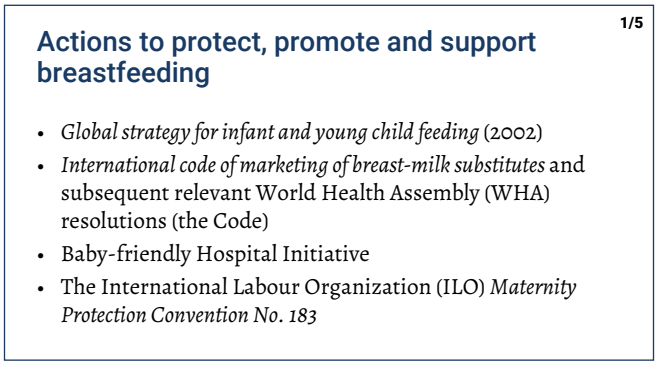
▸ Ask one participant to read out the definition below.

DEFINITION OF EXCLUSIVE BREASTFEEDING

Exclusive breastfeeding means giving a baby only breast milk, and no other liquids or solids, not even water. Drops or syrups consisting of vitamins, mineral supplements or medicines, including oral rehydration solution (ORS), are permitted.

- Virtually all mothers can breastfeed exclusively, provided they have accurate information and support within their families and communities.
- They should have access to skilled practical help from people trained in breastfeeding counselling who can help to build their confidence, improve feeding technique and prevent or resolve breastfeeding difficulties.
- During this course, you will start to develop these skills, or build on skills you are already using in your daily work.

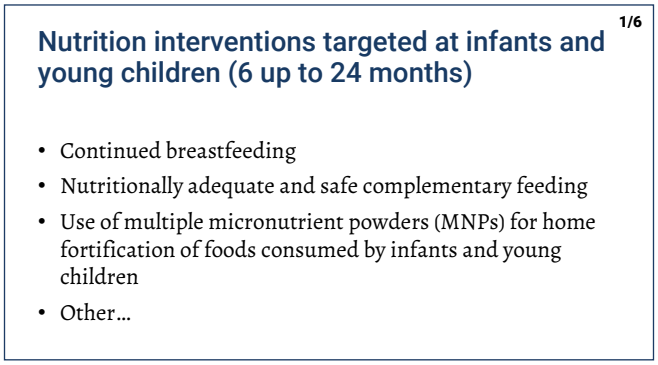
▸ Show **Slide 1/5 – Actions to protect, promote and support breastfeeding** and make the points that follow:



- The *Global strategy for infant and young child feeding*, launched in 2002, was developed by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) jointly, to revitalize world attention to the impact that feeding practices have on the nutritional status, growth, development and health, and thus the very survival, of infants and young children.

- The *Global strategy* builds on key global instruments, including:
  - the *International code of marketing of breast-milk substitutes* (1981) and subsequent relevant World Health Assembly (WHA) resolutions (the Code)
  - the Baby-Friendly Hospital Initiative (BFHI), launched in 1991
  - the International Labour Organization (ILO) *Maternity Protection Convention No. 183* (2000).
- We will be discussing some of these important initiatives later in the course.

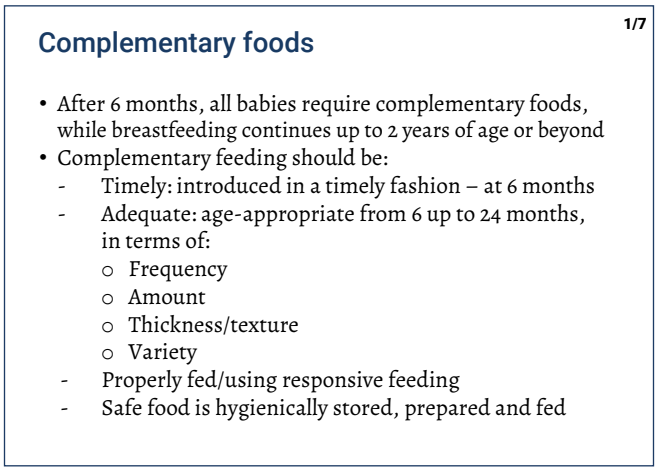
► Show **Slide 1/6 – Nutrition interventions targeted at infants and young children (6 up to 24 months)** and make the points that follow:



- Recommended interventions for this age group for appropriate health, nutrition, growth and development include the three included in the slide, which we will address in the course; additionally, we have the following interventions for this age group:
  - vitamin A supplementation for children under 5 years of age
  - vitamin A supplementation for children with measles
  - daily or intermittent iron supplementation for children aged 6–23 months
  - zinc supplementation for management of diarrhoea
  - reaching optimal iodine nutrition in young children
  - management of children with severe acute malnutrition
  - management of children with moderate acute malnutrition
  - nutritional care and support of children aged 6 months or older who are living with HIV
  - nutritional care and support during emergencies
  - early stimulation.[1]

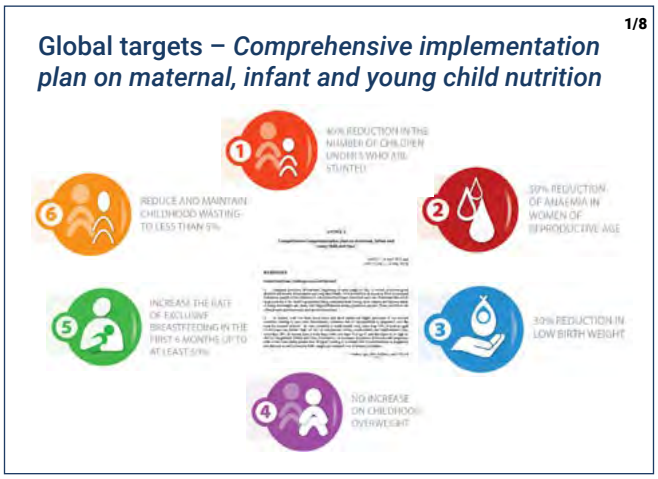
[1] WHO, UNICEF. Integrating early childhood development (ECD) activities into nutrition programmes in emergencies. Why, what and how. Geneva: World Health Organization; 2012 (http://www.who.int/mental_health/emergencies/ecd_note.pdf); Mental health and psychosocial well–being among children in severe food shortage situations. Geneva: World Health Organization; 2006 (http://www.who.int/mental_health/mental_health_food_shortage_children2.pdf); WHO, UNICEF. Care for child development: improving the care for young children. Geneva: World Health Organization; 2012 (https://apps.who.int/iris/handle/10665/75149).

► Show **Slide 1/7 – Complementary foods** and make the points that follow:



- After 6 months of age, all babies require other foods to complement breast milk – we call these foods complementary foods.
- When complementary foods are introduced, breastfeeding should still continue up to 2 years of age or beyond.
- Infants are particularly vulnerable during the transition period when complementary feeding begins. Ensuring that their nutritional needs are met requires that complementary foods should be:
  - **timely:** introduced in a timely fashion – i.e. at 6 months, when the need for energy and nutrients exceeds what can be provided through exclusive and frequent breastfeeding
  - **adequate:** i.e. age-appropriate in terms of feeding frequency, amount, thickness/texture and variety from 6 up to 24 months
  - **properly fed:** given in response to a child's signals of hunger, engaging the child in a manner that makes eating/feeding a positive experience, and with a meal frequency and feeding methods that are suitable for the child's age
  - **safe:** food is hygienically stored, and prepared and fed with clean hands, using clean utensils.

► Show **Slide 1/8 – Global targets – *Comprehensive implementation plan on maternal, infant and young child nutrition*** and make the points that follow:



- In yet another commitment to address global nutrition challenges, the WHA endorsed a *Comprehensive implementation plan on maternal, infant and young child nutrition* in 2012. The plan includes six global targets to identify priority areas and catalyse global change. Global target 5 increases the target for exclusive breastfeeding in the first 6 months, from the estimated global average of 37% during the period 2006–2010 to 50% by 2025.

► **If national policies and programmes related to the global targets, essential nutrition actions, or infant and young child feeding exist, refer to them now.**

III. Summarize the session 2 minutes

- **Ask participants whether they have any questions, and try to answer them.**
- **Make these points:**
  - During this course, we will be learning more about how to offer mothers and caregivers the skilled practical help they need to feed their children optimally.
- **Explain that a summary of this session can be found on pages 7–8 of the *Participant's manual*.**

Further information

Comprehensive implementation plan on maternal, infant and young child nutrition

There is greater understanding on how combined actions in the health, food, water and sanitation, education and social support sectors are contributing to improved nutrition, and countries are increasingly focusing on the development of multisectoral plans to improve nutrition. WHO has prepared and updated guidance in several areas, including provision of vitamins and minerals in different age groups, fortification of staple foods, management of acute malnutrition, and dietary goals for preventing obesity and diet-related noncommunicable diseases. Specialized agencies of the United Nations, together with the World Bank and academics, have indicated that agricultural policies and programmes can be made nutrition sensitive if they are designed to increase the availability, affordability and consumption of diverse, safe, nutritious foods; align with dietary recommendations and ensure environmental sustainability; empower women; and include nutrition-promotion messages.

Progress has therefore been documented in all five action areas of this plan:

- to create a supportive environment for the implementation of comprehensive food and nutrition policies;
- to include all required effective health interventions with an impact on nutrition in national nutrition plans;
- to stimulate development policies and programmes outside the health sector that recognize and include nutrition;
- to provide sufficient human and financial resources for the implementation of nutrition interventions;
- to monitor and evaluate the implementation of policies and programmes.

Healthy growth

- In a special issue of *Maternal and Child Nutrition* on healthy growth (2013),[1] de Onis et al.[2] describe the background and rationale for the global goal on reduction of stunting, present forecasts of the prevalence and numbers of stunted children to 2025, and propose a methodology to adapt the global target at the national level, taking into account current levels and trends of stunting, population growth and the availability of resources. The paper also reviews what can be done to reduce stunting, what inputs are required, and where and when they should be invested for highest returns.
- Although the target for reduction of stunting refers to children aged under 5 years, the literature abounds with evidence that a large proportion of the linear growth deficits that make up the under-5 stunting burden are accumulated in the first 1000 days.[3] The critical period, the age between 6 and 24 months – when the child transitions from exclusive breastfeeding to full dependence on the household diet – poses particular challenges for infant and young child nutrition programmes. The paper by Stewart et al. in the *Maternal and Child Nutrition* supplement[4] presents a conceptual framework centred on stunted growth and development, with special emphasis on the contribution of inadequate complementary feeding to childhood stunting. **Many of the contextual factors being addressed by nutrition-sensitive development efforts will help reduce stunting if they positively impact complementary feeding.** The most critical investments for healthy growth and development are made at the household level, and these include the care and nurturing that the home environment affords for the mother and child.
- The **risk of stunting is affected by interdependent influences rooted in the political economy, health and health care, education, society and culture, agriculture and food systems, water and sanitation, and the environment.** Therefore, the interventions required to prevent stunting are anchored in many different sectors. This reality is acknowledged by the multiplicity of actors attempting to address stunting. What presents some challenge is establishing a common agenda within which different sectors recognize their roles and how each can contribute synergistically to prevention of stunting.

[1] Special issue: promoting healthy growth and preventing childhood stunting. Matern Child Nutr. 2013;9(Suppl. S2):1–149.
[2] de Onis M, Dewey KG, Borghi E, Onyango AW, Blössner M, Daelmans B, Piwoz E et al. The World Health Organization's global target for reducing childhood stunting by 2025: rationale and proposed actions. Matern Child Nutr. 2013;9(Suppl. S2):6–26. doi:10.1111/mcn.12075.
[3] Dewey KG, Huffman SL. Maternal, infant, and young child nutrition: combining efforts to maximize impacts on child growth and micronutrient status. Food Nutr Bull. 2009 Jun;30(2 Suppl.):S187-9; Victora CG, de Onis M, Hallal PC, Blossner M, Shrimpton R. Worldwide timing of growth faltering: revisiting implications for interventions. Pediatrics. 2010;125: e473–e480.
[4] Stewart CP, Iannotti L, Kathryn G. Dewey KG, Kim F. Michaelsen KF, Onyango AW. Contextualising complementary feeding in a broader framework for stunting prevention. Matern Child Nutr. 2013;9(Suppl. S2):27–45. doi:10.1111/mcn.12088.

- Lutter and colleagues[1] **propose a set of principles that should be applied in a programme planning, implementation and evaluation cycle to improve complementary feeding interventions.** The authors provide useful reflections on dissemination, replication and scaling up of successful programmes. These processes require political commitment and dedicated budgets – an indication of the need for programme-integrated capacity for advocacy to secure these inputs in support of programme scalability and sustainability.
- The programming-support tools presented by Daelmans et al. in the *Maternal and Child Nutrition* supplement[2] provide a **systematic approach to understanding local food choices and complementary feeding practices – a critical first step to identifying nutrient gaps – and then developing and testing appropriate, context-specific feeding recommendations.** The ProPAN and Optifood tools complement each other and are available to inform programming decisions on feasible, acceptable and affordable options for complementary feeding. They also provide reliable assessments of contexts in which nutrient supplementation and other measures are essential to complement local diets, in order that children's nutritional needs are met.

The composition of human, animal and artificial milks

There is some casein in human milk, but less than in cow's milk, and it forms soft curds that are easier to digest.

The whey proteins in animal and human milks are different. Human milk contains alpha-lactalbumin and cow's milk contains beta-lactoglobulin.

In addition, the proteins in animal milks and formula milk contain a different balance of amino acids from breast milk, which may not be ideal for a baby. Animal milk and formula milk may lack the amino acid cystine, and formula milk may lack taurine, which neonates need especially for brain growth. Taurine is now sometimes added to formula milks.

The anti-infective proteins in human milk include lactoferrin (which binds iron, and prevents the growth of bacteria which need iron) and lysozyme (which kills bacteria), as well as antibodies (immunoglobulin, mostly IgA).

Other important anti-infective factors include the bifidus factor (which promotes the growth of *Lactobacillus bifidus. L. bacillus* inhibits the growth of harmful bacteria, and gives breastfed babies' stools their yoghurty smell). Breast milk also contains antiviral and antiparasitic factors.

Babies who develop intolerance to animal proteins may develop diarrhoea that becomes persistent. Babies who are fed animal milks or formula milk are also more likely than breastfed babies to develop allergies, which may cause eczema. A baby may develop intolerance or allergy after only a few artificial feeds given in the first few days of life.

Vitamins

The amounts of vitamins are different in breast milk and animal milks. Cow's milk has plenty of the B vitamins, but does not contain as much vitamin A and vitamin C as human milk. Breast milk contains plenty of vitamin A, if the mother has enough in her diet. Breast milk can supply much of the vitamin A that a child needs, even in the second year of life.

Vitamin A supplements for post-partum mothers

Do not give a mother high-dose capsules of vitamin A (over 10 000 units daily) for more than 4–6 weeks after she has given birth. After 6 weeks, there is a slight possibility that she could be pregnant, and if a high dose of vitamin A is given in early pregnancy, it could damage the fetus. High-dose vitamin A supplementation for post-partum mothers is no longer recommended by WHO.

B vitamins in different milks

For some B vitamins, the amount in human milk is the same as or more than in cow's milk, but for most of them the amount in cow's milk is 2–3 times higher than in breast milk. These high levels are more than a baby needs. Goat's milk lacks the B vitamin folic acid (vitamin B_{12}), and this can cause anaemia.

Vitamin C

Health workers often recommend giving babies fruit juice from a very early age, to provide vitamin C. This may be necessary for artificially fed babies, but it is not necessary for breastfed babies.

[1] Lutter CK, Ianotti L, Creed-Kanashiro H, Guyon A, Daelmans B, Robert R et al. Key principles to improve programmes and interventions in complementary feeding. Matern Child Nutr. 2013;9(Suppl. S2):101–15. doi:10.1111/mcn.12087.

[2] Daelmans B, Ferguson E, Lutter CK, Singh N, Pachón H, Creed-Kanashiro H et al. Designing appropriate complementary feeding recommendations: tools for programmatic action. Matern Child Nutr. 2013;9(Suppl. S2):116–30. doi:10.1111/mcn.12083.

Iron

Different milks contain similar very small amounts of iron. However, only about 10% of the iron in cow's milk is absorbed, but about 50% of the iron from breast milk is absorbed. Babies fed on cow's milk may not get enough iron, and they often become anaemic.

Some brands of formula milk have iron added. This added iron is not well absorbed, so a large amount has to be added to ensure that a baby gets enough iron to protect against anaemia.

Added iron may make it easier for some kinds of bacteria to grow, which may increase the chances of some kinds of infection, for example, meningitis and septicaemia.

Notes

Notes (contd)

Notes (contd)

Session 2

Introduction to the *WHO child growth standards*

Objectives

After completing this session, participants will be able to:

- describe the significance of the *WHO child growth standards*
- list the benefits of the *WHO child growth standards*

Session outline . . . . . 15 minutes

Participants are all together for a lecture presentation by one trainer.

I. Introduce the session, present **Slide 2/1** . . . . . 2 minutes
II. Present **Slides 2/2** to **2/5** . . . . . 12 minutes
III. Summarize the session . . . . . 1 minute

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides.
- Study the **Slides 2/2** to **2/5** and the text that goes with them, so that you are able to present them.
- Review the most up-to-date data on mortality, infant and young child feeding practices, and malnutrition, to present that information.
- Read the **Further information** sections, so that you are familiar with the ideas that they contain, so that you can answer participants' questions.

As you follow the text, remember:

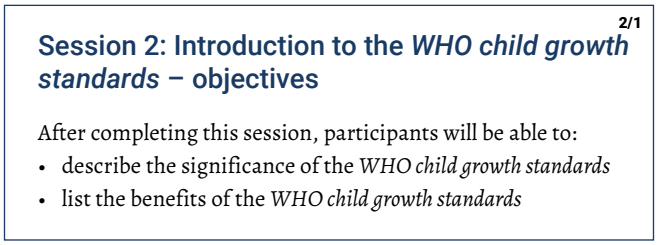
► **indicates an instruction to you, the trainer.**

¤ indicates what you say to participants.

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the session — 2 minutes

► Show **Slide 2/1 – Session 2 – objectives** and read out the objectives:



II. Present Slides 2/2 to 2/5 — 12 minutes

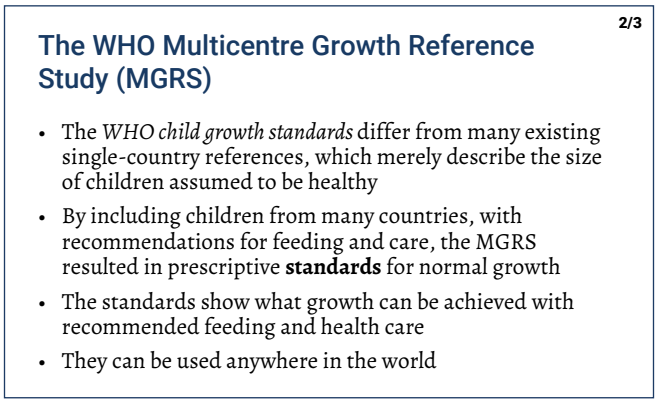
► Show **Slide 2/2 – Development of the *WHO child growth standards*** and make the points that follow:

► Make these points:

- Now we will look at the *WHO child growth standards*.
- The World Health Organization (WHO) developed growth standards based on a sample of children from six countries: Brazil, Ghana, India, Norway, Oman and the United States of America (USA).
- The WHO Multicentre Growth Reference Study (MGRS)[1] was designed to provide data describing how children should grow, by including in the study's selection criteria certain recommended health behaviours (for example, breastfeeding, providing standard paediatric care and not smoking).
- The study followed term babies from birth to 2 years of age, with frequent observations in the first weeks of life.
- Another group of children, aged 18 to 71 months, were measured once, and data from the two samples were combined to create the growth standards for birth to 5 years of age.

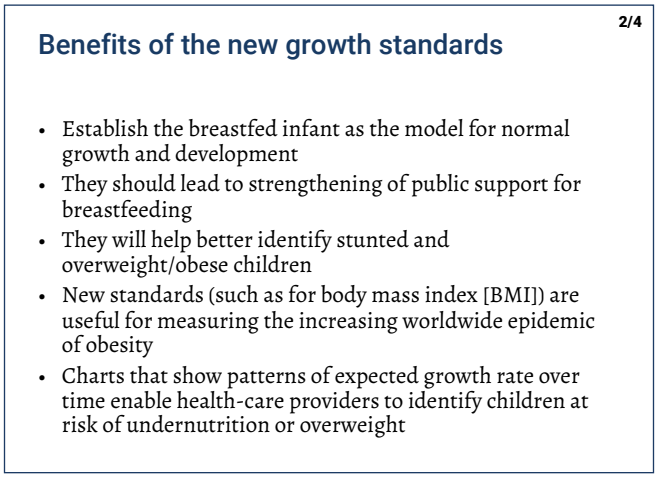
[1] de Onis M, Garza C, Victora CG, Bhan MK, Norum KR, editors. WHO Multicentre Growth Reference Study: rationale, planning and implementation. Food Nutr Bull. 2004;25 (Suppl. 1):S15–26. doi:10.1177/15648265040251S103.

► Show **Slide 2/3 – The WHO Multicentre Growth Reference Study (MGRS)** and make the points that follow:



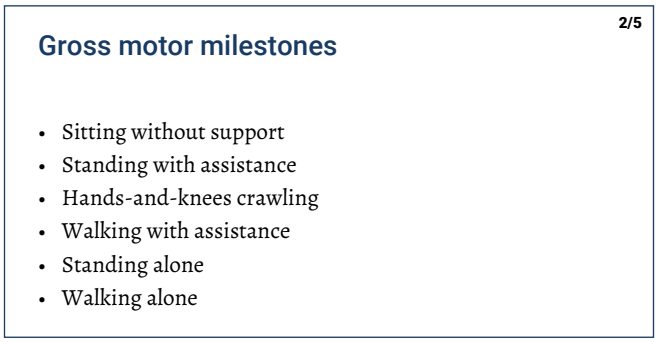
- The *WHO child growth standards* differ from many existing single-country references, which merely describe the size of children assumed to be healthy.
- By including children from many countries who were receiving recommended feeding and care, the MGRS resulted in prescriptive standards for normal growth, as opposed to simply descriptive references.
- The standards show what growth can be achieved with recommended feeding and health care (e.g. immunizations, care during illness).
- The standards can be used anywhere in the world, since the study also showed that children everywhere grow in similar patterns when their nutrition, heath and care needs are met.

► Show **Slide 2/4 – Benefits of the new growth standards** and make the points that follow:



- Benefits of the new growth standards include the following:
  - The new standards establish the breastfed infant as the model for normal growth and development. As a result, health policies and public support for breastfeeding will be strengthened.
  - The new standards will help better identify stunted and overweight/obese children.
  - New standards, such as for body mass index (BMI), are useful for measuring the increasing worldwide epidemic of obesity.
  - Charts that show standard patterns of the expected growth rate over time enable health-care providers to identify children at risk of becoming undernourished or overweight early, rather than waiting until a problem level is reached.

► Show **Slide 2/5 – Gross motor milestones** and make the points that follow:



- In addition to standards for physical growth, the *WHO child growth standards* include six gross motor-development milestones: sitting without support, standing with assistance, hands-and-knees crawling, walking with assistance, standing alone and walking alone.
- All healthy children are expected to achieve these milestones during specified age ranges between 4 and 18 months.
- The expected age ranges for achieving these milestones (or "windows of achievement") are included in the WHO Boy's growth record and Girl's growth record provided with this course. This course, however, focuses on assessment of physical growth and does not provide training on assessing motor development.

III. Summarize the session — 2 minutes

► Ask participants whether they have any questions, and try to answer them.

► Make these points:

- During this course we will be learning more about how to offer mothers and caregivers the skilled practical help they need to feed their children optimally.
- We will be discussing and practising how to help mothers to breastfeed exclusively, and how to prepare and feed complementary foods while sustaining breastfeeding.
- We will learn how to measure children from birth to 5 years of age, how to assess the growth of children in relation to the *WHO child growth standards* and how to counsel mothers about feeding and growth.

► Explain that a summary of this session can be found on page 11 of the *Participant's manual*.

Further information

Healthy growth

- In a special issue of *Maternal and Child Nutrition* on Healthy Growth (2013),[1] de Onis et al.[2] describe the background and rationale for the global goal on reduction of stunting, present forecasts of the prevalence and numbers of stunted children to 2025, and propose a methodology to adapt the global target at the national level, taking into account current stunting levels and trends, population growth and the availability of resources. The paper also reviews what can be done to reduce stunting, what inputs are required, and where and when should they be invested for highest returns.
- Although the target for reduction of stunting refers to children aged under 5 years, the literature abounds with evidence that a large proportion of the linear growth deficits that make up the under-5 stunting burden are accumulated in the first 1000 days.[3] The critical period, the age between 6 and 24 months – when the child transitions from exclusive breastfeeding to full dependence on the household diet – poses particular challenges for infant and young child nutrition programmes. The paper by Stewart et al. in the *Maternal and Child Nutrition* supplement[4] presents a conceptual framework centred on stunted growth and development, with special emphasis on the contribution of inadequate complementary feeding to childhood stunting. **Many of the contextual factors being addressed by nutrition-sensitive development efforts will help reduce stunting if they positively impact complementary feeding.** The most critical investments for healthy growth and development are made at the household level, and these include the care and nurturing that the home environment affords for the mother and child.
- The **risk of stunting is affected by interdependent influences rooted in the political economy, health and health care, education, society and culture, agriculture and food systems, water and sanitation, and the environment.** Therefore, the interventions required to prevent stunting are anchored in many different sectors. This reality is acknowledged by the multiplicity of actors attempting to address stunting. What presents some challenge is establishing a common agenda within which different sectors recognize their roles and how each can contribute synergistically to prevention of stunting.
- Lutter and colleagues[5] **propose a set of principles that should be applied in a programme planning, implementation and evaluation cycle to improve complementary feeding interventions.** The authors provide useful reflections on dissemination, replication and scaling up of successful programmes. These processes require political commitment and dedicated budgets – an indication of the need for programme-integrated capacity for advocacy to secure these inputs in support of programme scalability and sustainability.
- The programming-support tools presented by Daelmans et al. in the *Maternal and Child Nutrition* supplement[6] provide a **systematic approach to understanding local food choices and complementary feeding practices – a critical first step to identifying nutrient gaps – and then developing and testing appropriate, context-specific feeding recommendations.** The ProPAN and Optifood tools complement each other and are available to inform programming decisions on feasible, acceptable and affordable options for complementary feeding. They also provide reliable assessments of contexts in which nutrient supplementation and other measures are essential to complement local diets, in order that children's nutritional needs are met.

[1] Special Issue: Promoting Healthy Growth and Preventing Childhood Stunting. Matern Child Nutr. 2013;9(Suppl. S2):1–149.
[2] de Onis M, Dewey KG, Borghi E, Onyango AW, Blössner M, Daelmans B, Piwoz E et al. The World Health Organization's global target for reducing childhood stunting by 2025: rationale and proposed actions. Matern Child Nutr. 2013;9(Suppl. S2):6–26. doi:10.1111/mcn.12075.
[3] Dewey KG, Huffman SL. Maternal, infant, and young child nutrition: combining efforts to maximize impacts on child growth and micronutrient status. Food Nutr Bull. 2009 Jun;30(2 Suppl):S187-9; Victora CG, de Onis M, Hallal PC, Blossner M, Shrimpton R. Worldwide timing of growth faltering: revisiting implications for interventions. Pediatrics. 2010;125: e473–e480.
[4] Stewart CP, Iannotti L, Kathryn G. Dewey KG, Kim F. Michaelsen KF et al. Contextualising complementary feeding in a broader framework for stunting prevention. Matern Child Nutr. 2013;9(Suppl. S2):27–45. doi:10.1111/mcn.12088.
[5] Lutter CK, Ianotti L, Creed-Kanashiro H, Guyon A, Daelmans B, Robert R et al. Key principles to improve programmes and interventions in complementary feeding. Matern Child Nutr. 2013;9(Suppl. S2):101–15. doi:10.1111/mcn.12087.
[6] Daelmans B, Ferguson E, Lutter CK, Singh N, Pachón H, Creed-Kanashiro H et al. Designing appropriate complementary feeding recommendations: tools for programmatic action. Matern Child Nutr. 2013;9(Suppl. S2):116–30. doi:10.1111/mcn.12083.

Notes

Session 3

Local infant and young child feeding situation

Objectives

After completing this session, participants will be able to:

- describe the infant and young child feeding trends in the country
- list the common infant and young child feeding practices in the country

Session outline . . . . . 30 minutes

Participants are all together for a lecture presentation by one trainer or a local expert, OR for a discussion led by one trainer or a local expert, OR for a discussion led by one trainer.

I. Introduce the session, present **Slide 3/1** . . . . . 2 minutes
II. Option I: Present local infant and young child feeding data . . . . . 25 minutes
III. Option II: Discuss participants' experience of infant and young child feeding practices . . . . . 25 minutes
IV. Summarize the session . . . . . 3 minutes

Preparation

Before the course:

- Decide which alternative (Option I or Option II) you will use for this session. Option II is recommended if there are not enough data, so you elicit information from what the participants know/have experience with.
- Try to obtain information about infant and young child feeding in the country; for example, the results of any surveys or studies that have been done, or any information available from health service information system, or demographic and health survey (DHS) surveys. Consult with local experts.
- Try to find data on:
  - breastfeeding: early initiation; exclusive breastfeeding; the use of water, teas, cereals, animal milk, formula in the first 6 months of life; use of feeding bottles, and any other feeding methods; continued breastfeeding – all in both rural and urban areas
  - complementary feeding: age of initiation of solid/semi-solid foods, quantity, variety, frequency of feeds from 6 up to 24 months of age; any other feeding pattern in this age group
  - feeding of low-birth-weight infants, feeding of malnourished children
  - HIV rates. What effect has this had on breastfeeding-promotion activities? Is there a prevention of mother-to-child transmission of HIV (PMTCT) programme? What is the HIV and infant feeding policy in the country?
  - how many baby-friendly hospitals there are. Have any of them been reassessed?
  - what community breastfeeding-promotion initiatives there are.
- Find out also what is being done, or what has been done, to promote breastfeeding.
- You may decide to invite an expert from the ministry of health to give this presentation. If you do this, give them a copy of the course materials, so that they can see what the course is about.
- Alternatively, the course director or one of the trainers can conduct the session.

Before the session for Option I

- Prepare slides using the data collected. You can use the slides from Session 1 when discussing recommended infant and young child feeding practices.
- Refer to the Introduction for guidance on giving a presentation with slides.
- Study the slides and the text that goes with them, so that you are able to present them.

Before the session for Option II

- Read the Introduction for guidance on facilitating group discussion.
- Prepare a flipchart copying the list of questions and choice of answers: "few", "half", "most", from the text provided, for the participants to discuss.

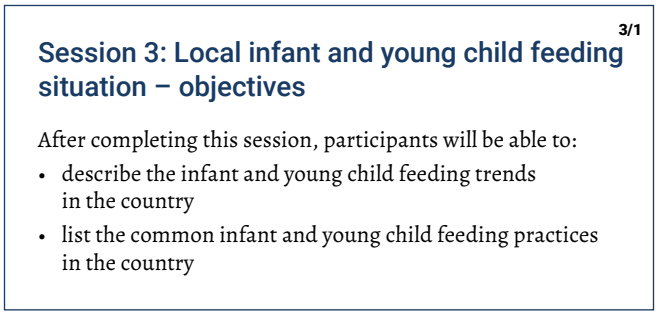
As you follow the text, remember:

► **indicates an instruction to you, the trainer.**

¤ indicates what you say to participants.

I. Introduce the session — 2 minutes

► Show **Slide 3/1 – Session 3 – objectives** and read out the objectives:



II. Option I: Present local infant and young child feeding data 25 minutes

- **Present data that answer as many of the following key questions as possible, using the slides you prepared before the session.**
- **If possible, present data from rural and urban areas, or from different areas/regions.**
  - What percentage of babies start breastfeeding within 1 hour after delivery?
  - What percentage of babies breastfeed exclusively for 6 months?
  - What percentage of babies have other drinks or food between 0 and 6 months of age?
  - What percentage of babies continue to breastfeed for 1 year, for 2 years?
  - What percentage of babies start complementary foods at 6 up to 9 months?
  - What percentage of children aged 6 up to 24 months receive an appropriate frequency of foods per age group? Appropriate variety of foods? An appropriate quantity of foods? An appropriate consistency of foods?[1]
- **Point out that these questions relate to the recommendations presented in Session 1.**
- **Present data on the relationship between feeding practices and illnesses such as diarrhoea. These might indicate whether particular practices cause health problems.**
- **Present data related to health-care practices at the time of delivery.**
  - What percentage of babies are born at home, in hospitals, or other health facilities?
  - What percentage of babies are born in baby-friendly hospitals or baby-friendly facilities?
  - What percentage of babies in each place have skin-to-skin contact after delivery?
  - What percentage of babies in each place are given other food or drink before breastfeeding is established?
  - What postnatal support is available? What is available in the community and in health centres?
  - What percentage of children aged 6 up to 24 months have access to counselling on complementary feeding?
- **Present data on reasons that mothers give for introducing other feeds, or for giving up breastfeeding early. This should include some information on sociocultural beliefs and practices.**
- **Present this information briefly. Make a list to post on the wall. Remember to discuss it again when the particular situations and difficulties are discussed in later sessions.**
- **Present information about the rate of HIV infection among mothers, and how this is affecting infant feeding practices.**
- **Present the data on infant and young child feeding practices in special situations.**

[1] See footnotes to the table for Option II.

III. Option II: Discuss participants' experience of infant and young child feeding practices 25 minutes

- **Ask participants to find pages 13–14 in their *Participant's manual*, where they will find a list of questions.**
- **Explain what to do:**
  - In your manuals, next to each question, there are three alternative answers: "few", "half", "most".
  - Choose the answer to each question that fits best with your experience, by putting a circle round it.
- **Allow 5 minutes to answer.**
- **Post your flipchart on which you copied the same list, where the class can see it.**

	Few	Half	Most
How many babies have immediate skin-to-skin contact?			
How many breastfeed within 1 hour after delivery?			
How many have other foods or drinks before they start breastfeeding?			
How many breastfeed exclusively for 6 months?			
How many have other foods or drinks before:			
1 day?			
1 month?			
2 months?			
3 months?			
4 months?			
6 months?			
How many continue to breastfeed for more than:			
6 months?			
12 months?			
24 months?			
How many children start solid/semi-solid foods:			
Before 6 months of age?			
Between 6 and 8 months of age?			
After 8 months of age?			
How many children aged 6 up to 24 months:			
Receive an appropriate variety of foods?[1]			
Receive an appropriate frequency of foods?[2]			
Receive an appropriate amount of food for each meal?[3]			
Receive an appropriate consistency of foods?[4]			

[1] Children should receive foods from 4 or more out of 7 foods groups. The 7 foods groups are: (1) grains, roots and tubers, (2) legumes and seeds, (3) dairy products (milk, yogurt, cheese), (4) flesh foods (meat, poultry, fish, liver), (5) eggs, (6) vitamin-A rich fruits and vegetables (mango, papaya, passion fruit, oranges, dark green leaves, carrots, yellow sweet potato, pumpkin), (7) other fruits and vegetables.

[2] rom 6 up to 9 months: 2–3 meals per day; depending on the child's appetite, 1–2 snacks may be offered. From 9 up tp 12 months: 3–4 meals per day; depending on the child's appetite, 1–2 snacks may be offered. From 12 up to 24 months: 3–4 meals per day; depending on the child's appetite, 1–2 snacks may be offered.

[3] From 6 up to 9 months: start with 2–3 tablespoonfuls per feed, increasing gradually to ½ of a 250 mL cup. From 9 up to 12 months: ½ of a 250 mL cup/bowl. From 12 up to 24 months: ¾ to 1 250 mL cup/bowl.

[4] From 6 up to 9 months: start with thick porridge, well-mashed foods, continue with mashed family foods with finger foods that baby can pick up from 8 months. From 9 up to 12 months: finely chopped or mashed foods, and finger foods. From 12 up to 24 months: family foods, chopped or mashed if necessary.

- Discuss with the class, for each practice, which answer most of them marked, and whether the practice generally follows the recommendations from Session 1.
- Decide with the class whether the practice should be marked overall as "few", "half", "most". Mark the box on your list on the flipchart.
- If participants come from different areas, you may want to make separate lists from separate areas.
- Develop a list of common reasons why mothers:
  - give a baby other drinks or foods before breastfeeding is established
  - give a baby other drinks or foods before 6 months
  - stop breastfeeding early (before 12 months, before 24 months).
- Write on a flipchart the heading: REASONS FOR STOPPING BREASTFEEDING OR GIVING OTHER DRINKS OR FOODS EARLY.
- Ask participants to suggest common reasons from their experience.
- Write their suggestions on the list (try not to have more than 10 reasons).
- Post the list on the wall.
- Refer back to the list later, and remind participants what they included in it, when you discuss:
  - BREAST CONDITIONS (Sessions 19 and 28)
  - REFUSAL TO BREASTFEED (Session 30)
  - NOT ENOUGH MILK (Session 34)
  - CRYING (Session 35)
  - FEEDING LOW-BIRTH-WEIGHT AND SICK BABIES (Session 38)
  - SUSTAINING BREASTFEEDING (Session 40)
- Ask participants to summarize their conclusions about the local infant feeding situation, and whether they think that it is satisfactory or in need of improvement.

IV. Summarize the session 3 minutes

- Ask participants whether they have any questions, and try to answer them.
- Explain that a summary of this session can be found on pages 13–14 of the *Participant's manual*.

Notes

Session 4

Local nutrition situation

Objectives

After completing this session, participants will be able to:

- describe the nutrition trends in the country
- list the common nutritional problems in the country

Session outline . . . . . 30 minutes

Participants are all together for a lecture presentation and discussion led by one trainer.

I. Introduce the session, present **Slide 4/1** . . . . . 2 minutes
II. Present the local nutrition situation . . . . . 15 minutes
III. Discuss participants' experience of nutrition problems . . . . . 12 minutes
IV. Summarize the session . . . . . 1 minute

Preparation

Before the course:

- Try to obtain information about the nutrition situation in the country; for example, the results of any surveys or studies that have been done, or any information available from the health service information system, or demographic and health survey (DHS) surveys. Consult with local experts.
- Try to find data on:
  - acute and chronic undernutrition among children aged 0 up to 24 months, and children aged less than 5 years
  - overweight/obesity among children aged 0 up to 24 months, children aged less than 5 years and women of childbearing age
  - anaemia among children aged less than 5 years and women of childbearing age.
- Find out also what is being done, or what has been done, to address these nutritional problems.
- You may decide to invite an expert from the ministry of health to give this presentation. If you do this, give them a copy of the course materials, so that they can see what the course is about.
- Alternatively, the course director or one of the trainers can conduct the session.

Before the session:

- Prepare slides using the data collected.
- Refer to the Introduction for guidance on giving a presentation with slides and facilitating group discussion.
- Study the slides and the text that goes with them, so that you are able to present them.
- Prepare a flipchart copying the list of questions and choice of answers: "few", "half", "most", from the text provided, for the participants to discuss.

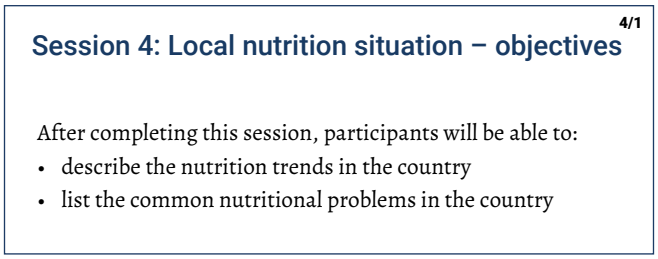
As you follow the text, remember:

► **indicates an instruction to you, the trainer.**

¤ indicates what you say to participants.

I. Introduce the session — 2 minutes

- Show **Slide 4/1 – Session 4 – objectives** and read out the objectives:



II. Present local nutrition data — 15 minutes

- **Present data that answer as many of the following key questions as possible, using the slides you prepared before the session.**
- **If possible, present data from rural and urban areas, or from different areas/regions.**
  - What percentage of children aged 0 up to 24 months are undernourished?
  - What percentage of children aged 0 up to 24 months have marasmus?
  - What percentage of children aged 0 up to 24 months have kwashiorkor?
  - What percentage of children aged 0 up to 24 months are overweight or obese?
  - What percentage of children aged less than 5 years are undernourished?
  - What percentage of children aged less than 5 years have marasmus?
  - What percentage of children aged less than 5 years have kwashiorkor?
  - What percentage of children aged less than 5 years have anaemia?
  - What percentage of children aged less than 5 years are overweight or obese?
  - What percentage of women of childbearing age are overweight or obese?
  - What percentage of women of childbearing age have anaemia?
- **Try to get information that will help you answer the following questions:**
  - Does the country have a programme for management of acute severe malnutrition?
  - If yes, is the programme available throughout the country?
  - Does the country have a programme for management of acute moderate malnutrition?
  - If yes, is the programme available throughout the country?
  - Does the country have a programme for management of overweight/obesity among women of childbearing age? If yes, is the programme available throughout the country?
  - Does the country have a programme for anaemia management? If yes, what is/are the target group(s)? If yes, is the programme available throughout the country?

III. Discuss participants' experience of nutrition problems — 12 minutes

- Ask participants to find page 17 in their *Participants manual*, where they will find a list of questions.
- Explain what to do:
  - In your manuals, next to each question there are three alternative answers: "few", "half", "most".
  - Choose the answer to each question that fits best with your experience, by putting a circle round it.
- Allow 5 minutes to answer.
- Post your flipchart on which you copied the same list, where the class can see it.

	Few	Half	Most
How many children aged under 5 years have acute severe malnutrition?			
How many children aged under 5 years have acute moderate malnutrition?			
How many children aged under 5 years are overweight/obese?			
How many women of childbearing age are overweight/obese?			
How many children aged under 5 years of age have anaemia?			
How many women of childbearing age have anaemia?			
How many children start solid/semi-solid foods at 6 months of age?			

- Discuss with the class, for each of the issues mentioned, which answer most of them marked; emphasize in your discussion those issues that seem to be more frequent.
- Discuss with them about the programmes mentioned in the previous section, their knowledge about those programmes and the availability of supplies/facilities to implement the programmes.
- Ask participants to summarize their conclusions about the local nutrition situation, and whether they think that it is satisfactory or in need of improvement.

IV. Summarize the session — 1 minute

- Ask participants whether they have any questions, and try to answer them.
- Explain that a summary of this session can be found on page 17 of the *Participant's manual*.

Notes

Notes (contd)

Module 2

Counselling skills

SESSION 5

Listening and learning

Objectives

After completing this session, participants will be able to:

- list the six LISTENING AND LEARNING SKILLS
- give an example of each skill
- demonstrate the appropriate use of the skills when counselling on infant and young child feeding

Session outline . . . . . 70 minutes

Participants are all together for a demonstration by one trainer.

I. Introduce the session, present **Slide 5/1** . . . . . 15 minutes
II. Demonstrate LISTENING AND LEARNING SKILLS (DEMONSTRATIONS 5.A–5.O) . . . . . 50 minutes
III. Summarize the session . . . . . 5 minutes

Preparation

- Refer to the Introduction for guidance on giving a demonstration.
- Study the notes for the session, so that you are clear about what to do.
- You need two boards or two flipcharts with two summary lists: LISTENING AND LEARNING SKILLS and HELPFUL NON-VERBAL COMMUNICATION.
- If it is difficult to get two flipchart boards, stick flipchart sheets to the wall. Make sure that participants can see them. Make sure you are clear about the lists that will go onto each flipchart.
- Make copies of all the DEMONSTRATIONS 5.B to 5.O. (An alternative would be to use another copy of this guide.) Study the instructions for DEMONSTRATIONS 5.B to 5.O, so that you are clear about the ideas they illustrate, and you know what to do.
- Ask different participants to help you to give the demonstrations. Explain what you want them to do. One way to involve several participants is to use a different participant for each skill. For DEMONSTRATIONS 5.B to 5.G, the participants read out the words of the mother. For DEMONSTRATIONS 5.H to 5.O, participants read out the words of the mother and the health worker.
- For DEMONSTRATION 5.A, the participant has to sit and breastfeed a doll while you demonstrate different ways of talking to her. She can respond to your greetings, but need not say anything else. Discuss and agree with her before the demonstration what you can do to demonstrate "appropriate touch" and "inappropriate touch".
- Give each of the participants a copy of the demonstrations that they have to read.
- If it is difficult for participants to help with the demonstrations for some reason, another trainer can play the part of the mother. However, try to involve participants as much as possible, because it helps them to learn.
- Make sure that **Slide 5/1** is ready. Alternatively, as there is only one slide in this session, you might prefer to read aloud the objectives on **Slide 5/1** without projecting them onto the screen.
- Read through the Suggested alternative methodologies section and decide whether this is appropriate for your group.

As you follow the text, remember:

- ► indicates an instruction to you, the trainer.
  - ¤ indicates what you say to participants.

I. Introduce the session — 15 minutes

► Show **Slide 5/1 – Session 5 – objectives** and read out the objectives:

> 5/1
>
> **Session 5: Listening and learning – objectives**
>
> After completing this session, participants will be able to:
> - list the six LISTENING AND LEARNING SKILLS
> - give an example of each skill
> - demonstrate the appropriate use of the skills when counselling on infant and young child feeding

► Introduce the idea of counselling with these points:

- ¤ Counselling is a way of working with people in which you try to understand how they feel and help them to decide what they think is best to do in their situation.
- ¤ In this course, we look at counselling mothers who are feeding infants and young children. They may be breastfeeding, giving complementary feeds or, in some cases, giving replacement feeds.
- ¤ Although we talk about "mothers" in this session, remember that these skills should be used when talking to other caregivers about infant feeding, for example fathers or grandmothers.
- ¤ Counselling mothers about feeding their infants is not the only situation in which counselling is useful.
- ¤ Counselling skills are useful when you talk to patients or clients in other situations. You may also find them helpful with your family and friends, or your colleagues at work. Practise some of the techniques with them – you may find the result surprising and helpful.
- ¤ A mother may not talk easily about her feelings, especially if she is shy, and with someone whom she does not know well. You will need the skill to listen and to make her feel that you are interested in her. This will encourage her to tell you more. She will be less likely to "turn off" and say nothing.

► Conduct an activity with participants:

► Pair participants. Ask them to tell a story to each other at the same time for 2 minutes. Then, *ask* the large group:

- ¤ *How did you feel talking at the same time with another person?*
- ¤ *Did you catch anything of the story?*

► In the same pairs, repeat the activity, but this time listen to one another with lots of concentration (do not take notes, but listen carefully). Then, tell each other's stories (each member of the pair speaks for 1 minute). In the large group, *ask*:

- ¤ *How much of your story did your partner get right?*
- ¤ *How did it make you feel inside to tell a story and see someone listening to you?*
- ¤ *What things did you do to make sure that your partner was listening to you?*

II. Demonstrate Listening and learning skills — 50 minutes

- Tell participants that in this session you will explain and demonstrate six Listening and learning skills.
- Write the heading Listening and learning skills on a board or flipchart, with room for a list of six points below it (Flipchart 1). List the six skills underneath, as you demonstrate them.

Skill 1. Use helpful non-verbal communication

- Write Use helpful non-verbal communication on the list of Listening and learning skills (Flipchart 1).
- Write Helpful non-verbal communication on **another** board or flipchart, with room for a list of five points below it (Flipchart 2).
- Explain the skill:
  - *Ask: What do you think we mean by "non-verbal communication"?*
- Wait for a few replies and then continue.
  - Non-verbal communication means showing your attitude through your posture, your expression, everything except through speaking. Helpful non-verbal communication makes a mother feel that you are interested in her, so it helps her to talk to you.
- Demonstrate the skill. Tell participants that you will demonstrate five different kinds of non-verbal communication.
- Ask the participant whom you have prepared to help you. She sits with a doll, pretending to be a mother. She can respond to your greeting, but does not have to say anything else. It is important that you say the **same** words, in the **same** tone of voice, with each demonstration. It is tempting to change your tone of voice to sound kinder in the demonstration that shows "helpful non-verbal communication". However, this will confuse the participants, who may start to comment on verbal instead of non-verbal communication.
- Give the five pairs of demonstrations in Demonstration 5.A. With each pair, you approach the "mother" in two ways – one way helps communication and the other way hinders communication. Demonstrate the way that helps sometimes first, and sometimes second, so that the participants who are observing cannot guess which is which just from the order of the demonstrations. Demonstrate "appropriate touch" (socially acceptable) and "inappropriate touch" (not socially acceptable) in the way that you agreed with the participant before the session.
- Ask other participants to:
  - identify the form of non-verbal communication that you demonstrate
  - say which form helps communication and which hinders it.

Demonstration 5.A Non-verbal communication

- With each demonstration, say **exactly the same** few words, and try to say them in the same way, for example:
  - *"Good morning, Susan. How is feeding going for you and your baby?"*

1. Posture:

Hinders: Stand with your head higher than the other person's.
Helps: Sit so that your head is level with hers.

- Write – Keep your head level with the mother/caregiver on the flipchart (Flipchart 2).

2. Eye contact:

Hinders: Look away at something else, or down at your notes.
Helps: Look at her and pay attention as she speaks.

- Write – Pay attention on the flipchart.

(Note: eye contact may have different meanings in different cultures. Sometimes when a person looks **away,** it means that they are ready to listen. If necessary, adapt this to your own situation.)

3. Barriers:

Hinders: Sit behind a table, or write notes while you talk.
Helps: Remove the table or the notes.

- Write – Remove physical barriers on the flipchart.

4. Taking time:

Hinders: Be in a hurry. Greet her quickly, show signs of impatience, look at your watch.
Helps: Make the mother feel that you have time. Sit down and greet her without hurrying; then just stay quietly smiling at her, watching her breastfeed, and waiting for her to answer.

- Write – Take time/allow the mother or caregiver time to talk on the flipchart.

5. Touch:

Hinders: Touch her in an inappropriate way.
Helps: Touch the mother appropriately.

- Write – Use Appropriate touch on the flipchart.

(Note: If you cannot demonstrate an inappropriate touch, simply demonstrate not touching.)

- **Discuss appropriate touch in this community.**
  - *Ask:*
    - *What kinds of touch are appropriate and inappropriate in this situation in this community?*
    - *Does touch make a mother feel that you care about her?*
    - *For a man, if it is not appropriate to touch the woman, is it appropriate to touch the baby?*
- **Wait for a few replies and then continue.**
- **You now have the following list written on Flipchart 2. Post it up on the wall.**

HELPFUL NON-VERBAL COMMUNICATION

- Keep your head level with the mother/caregiver
- Pay attention
- Remove physical barriers
- Take time/allow the mother or caregiver time to talk
- Use appropriate touch

- **Make the following point:**
  - Our non-verbal communication often demonstrates to a mother or caregiver our approval or disapproval of a situation. We should be careful to avoid allowing our own views on certain subjects, e.g. religion, to be expressed in a counselling situation, where it might appear as though we are judging a mother.
- **Introduce Skills 2–6 by making the following points:**
  - The next skills deal with what we say to mothers. In other words, verbal communication.
  - Remember that the tone of our voice is important during verbal communication. We should always try to sound gentle and kind when talking to mothers.
  - During counselling, we are trying to find out how people feel. We need to be interested and to probe beneath the surface if we wish to learn their real worries and their concerns.

Skill 2. Ask open questions

- **Write ASK OPEN QUESTIONS on the list of LISTENING AND LEARNING SKILLS (Flipchart 1).**
- **Explain the skill:**
  - To start a discussion with a mother, or to take a history from her, you need to ask some questions.
  - It is important to ask questions in a way that encourages a mother to talk to you and to give you information. This saves you from asking too many questions, and enables you to learn more in the time available.
  - Open questions are usually the most helpful. To answer them, a mother must give you some information.
  - Open questions usually start with "How?", "What?", "When?", "Where?", "Why?", "Who?"; for example, "How are you feeding your baby?"
  - Closed questions are usually less helpful. They tell a mother the answer that you expect, and she can answer them with a "Yes" or "No".
  - Closed questions usually start with words such as: "Are you?" or "Did he?" or "Has he?" or "Does she?"; for example: "Did you breastfeed your last baby?"
  - If a mother says "Yes" to this question, you still do not know whether she breastfed exclusively, or whether she also gave some artificial feeds.
  - If you continue to ask questions to which the mother can only answer "Yes" or "No", you can become quite frustrated, and think that the mother is not willing to talk, or that she is not telling the truth.

- **Demonstrate the skill. Ask a participant to read the words of the mother in DEMONSTRATIONS 5.B and 5.C, while you read the part of the health worker. After each demonstration, comment on what the health worker learnt.**
- **Introduce the role-plays by making these points:**
  - We will now see this skill being demonstrated in two role-plays. The health worker is talking to a mother who has a young baby whom she is breastfeeding.

DEMONSTRATION 5.B CLOSED QUESTIONS TO WHICH THE MOTHER CAN ANSWER "YES" OR "NO"

Health worker: *Good morning, (name). I am (name), the community midwife. Is (child's name) well?*
Mother: *Yes, thank you.*

Health worker: *Are you breastfeeding him?*
Mother: *Yes.*

Health worker: *Are you having any difficulties?*
Mother: *No.*

Health worker: *Is he breastfeeding very often?*
Mother: *Yes.*

- *Ask:* *What did the health worker learn from this mother?*

Comment: The health worker got "yes" and "no" for answers and didn't learn much. It can be difficult to know what to say next.

DEMONSTRATION 5.C OPEN QUESTIONS

Health worker: *Good morning, (name). I am (name), the community midwife. How is (child's name)?*
Mother: *She is well, and she is very hungry.*

Health worker: *Tell me, how are you feeding her?*
Mother: *She is breastfeeding. I just have to give her one bottle feed in the evening.*

Health worker: *What made you decide to do that?*
Mother: *She wants to feed too much at that time, so I thought that my milk is not enough.*

- *Ask:* *What did the health worker learn from this mother?*

Comment: The health worker asked open questions. The mother could not answer with a "yes" or a "no", and she had to give some information. The health worker learnt much more.

- **Explain how to use questions to start and to continue a conversation:**
  - A very general open question is useful to start a conversation. This gives the mother an opportunity to say what is important to her. For example, you might ask a mother of a 9-month-old baby: "How is your child feeding?"
  - Sometimes a general question like this receives an answer such as, "Oh, very well thank you".
  - So then you need to ask questions to continue the conversation.
  - For this, more specific questions are helpful. For example: "Can you tell me what your child ate for the main meal yesterday?"
  - Sometimes you might need to ask a closed question. For example: "Did your child have any fruit yesterday?"
  - After you have received an answer to this question, try to follow up with another open question.
- **Demonstrate the skill. Ask a participant to read the part of the mother in DEMONSTRATION 5.D. You read the part of the health worker.**

- **Introduce the role-play by making these points:**
  - We will now see a role-play demonstrating using questions to start and continue a conversation.
  - The health worker is talking to a mother who has a young baby whom she is breastfeeding.

DEMONSTRATION 5.D STARTING AND CONTINUING A CONVERSATION

Health worker: *Good morning, (name). How are you and (child's name) getting on?*
Mother: *Oh, we are both doing well, thank you.*

Health worker: *How old is (child's name) now?*
Mother: *He is 2 days old today.*

Health worker: *What are you feeding him on?*
Mother: *He is breastfeeding, and having drinks of water.*

Health worker: *What made you decide to give the water?*
Mother: *There is no milk in my breasts, and he doesn't want to suck.*

- *Ask:* *What did the health worker learn from this mother?*

Comment: The health worker asked an open question, which did not help much. Then she asked two specific questions, and then followed up with an open question. Although the mother said at first that she and the baby were well, the health worker later learnt that the mother needed help with breastfeeding.

Skill 3. Use responses and gestures that show interest

- **Write USE RESPONSES AND GESTURES THAT SHOW INTEREST on the list of LISTENING AND LEARNING SKILLS (Flipchart 1).**
- **Explain the skill:**
  - If you want a mother to continue talking, you must show that you are listening, and that you are interested in what she is saying.
  - Important ways to show that you are listening and interested are:
    - With gestures; for example, look at her, nod and smile
    - With simple responses, for example, you say "Aha", "Mmm", "Oh dear!".
- **Demonstrate the skill. Ask a participant to read the words of the mother in DEMONSTRATION 5.E, while you play the part of the health worker. You give simple responses, and nod, and show by your facial expression that you are interested and want to hear more.**
- **Introduce the role-play by making these points:**
  - We will now see a role-play demonstrating this skill.
  - The health worker is talking to a mother who has a 1-year-old child.

Demonstration 5.E Using responses and gestures that show interest

Health worker: *Good morning, (name). How is (child's name) now that she has started solids?*
Mother: *Good morning. She's fine, I think.*

Health worker: *Mmm. (nods, smiles)*
Mother: *Well, I was a bit worried the other day, because she vomited.*

Health worker: *Oh dear! (raises eyebrows, looks interested)*
Mother: *I wondered if it was something in the stew that I gave her.*

Health worker: *Aha! (nods sympathetically).*

- *Ask:* *How did the health worker encourage the mother to talk?*

Comment: The health worker asked a question to start the conversation. Then she encouraged the mother to continue talking, with responses and gestures.

- **Discuss locally appropriate responses:**
  - In different countries, people use different responses.
  - *Ask: What responses do people use locally?*
- **Wait for a few replies and then continue.**

Skill 4. Reflect back what the mother/caregiver says

- **Write Reflect back what the mother/caregiver says on the list of Listening and learning skills (Flipchart 1).**
- **Explain the skill:**
  - Health workers sometimes ask mothers a lot of factual questions. However, the answers to factual questions are often not helpful. The mother may say less and less in reply to each question.
  - For example, if a mother says: "My baby was crying too much last night", you might want to ask: "How many times did he wake up?" But the answer is not helpful.
  - It is more useful to repeat back or reflect what a mother says. This is another way to show you are listening and encourages the mother or caregiver to continue talking and to say what is important to her. It is best to say it in a slightly different way, so that it does not sound as though you are copying her.
  - For example, if a mother says: "I don't know what to feed my child, she refuses everything", you could reflect back by saying: "Your child is refusing all the food you offer her?"
- **Demonstrate the skill. Ask a participant to read the words of the mother in Demonstrations 5.F and 5.G, while you read the part of the health worker.**
- **Introduce the role-plays by making these points:**
  - We will now watch two role-plays to demonstrate this skill.
  - The health worker is talking to a mother who has a 6-week-old baby whom she is breastfeeding.

Demonstration 5.F Continuing to ask for facts

Health worker: *Good morning, (name). How are you and (child's name) today?*
Mother: *He wants to feed too much – he is taking my breast all the time!*

Health worker: *About how often would you say?*
Mother: *About every half an hour.*

Health worker: *Does he want to suck at night too?*
Mother: *Yes.*

- *Ask:* *What did the health worker learn from the mother?*

Comment: The health worker asked factual questions, and the mother gave less and less information.

Demonstration 5.G Reflecting back

Health worker: *Good morning, (name). How are you and (child's name) today?*
Mother: *She wants to feed too much – she is taking my breast all the time!*

Health worker: *(Child's name) is feeding very often?*
Mother: *Yes. This week she is so hungry. I think that my milk is drying up.*

Health worker: *She seems more hungry this week?*
Mother: *Yes, and my sister is telling me that I should give her some bottle feeds as well.*

Health worker: *Your sister says that she needs something more?*
Mother: *Yes. Which formula is best?*

- *Ask:* *What did the health worker learn from the mother?*

Comment: The health worker reflected back what the mother said, so the mother gave more information.

Skill 5. Empathize – show that you understand how the mother/caregiver feels

- Write EMPATHIZE – SHOW THAT YOU UNDERSTAND HOW THE MOTHER/CAREGIVER FEELS on the list of LISTENING AND LEARNING SKILLS.
- Explain the skill:
  - Empathy is a difficult skill to learn. It is difficult for people to talk about feelings. It is easier to talk about facts.
  - When a mother says something that shows how she feels, it is helpful to respond in a way that shows that you heard what she said, and that you understand her feelings from her point of view.
  - For example, if a mother says: "My baby wants to feed very often and it makes me feel so tired!", you respond to what she **feels**, perhaps like this: "You are feeling very tired all the time then?"
  - Empathy is different from sympathy. When you sympathize you are sorry for a person, but you look at it from **your** point of view.
  - If you sympathize, you might say: "Oh, I know how you feel. My baby wanted to feed often too, and I felt exhausted". This brings the attention back to you, and does not make the mother feel that you understand her.
  - You could reflect back what the mother says about the baby.
  - For example: "He wants to feed very often?", but this reflects back what the mother said about the baby's behaviour, and it misses what she said about how she feels. She feels tired.
  - So empathy is more than reflecting back what a mother says to you.
  - It is also helpful to empathize with a mother's good feelings. Empathy is not only to show that you understand her bad feelings.

- **Demonstrate the skill. Ask the two participants whom you have prepared to give DEMONSTRATIONS 5.H to 5.K to read the words of the mother and health worker.**
- **Introduce the role-plays by making these points:**
  - We will see a demonstration of this skill.
  - The health worker is talking to a mother of a 10-month-old child.
  - As you watch, look for empathy – is the health worker showing she understands the mother's point of view?

DEMONSTRATION 5.H SYMPATHY

Health worker: *Good morning, (name). How are you and (child's name) today?*
Mother: *(Child's name) is not feeding well, I am worried he is ill.*

Health worker: *I understand how you feel. When my child was ill, I was so worried. I know exactly how you feel.*
Mother: *What was wrong with your child?*

- *Ask:* *Do you think the health worker showed sympathy or empathy?*

Comment: Here the focus moved from the mother to the health worker. This was sympathy, not empathy. Let us hear this again, with the focus on the mother and empathizing with her feelings.

DEMONSTRATION 5.I EMPATHY

Health worker: *Good morning, (name). How are you and (child's name) today?*
Mother: *(Child's name) is not feeding well, I am worried he is ill.*

Health worker: *You are worried about him?*
Mother: *Yes, some of the other children in the village are ill and I am frightened he may have the same illness.*

Health worker: *It must be very frightening for you.*

- *Ask:* *Do you think the health worker showed sympathy or empathy?*

Comment: Here the health worker used the skill of empathy twice. She said "You are worried about him" and "It must be very frightening for you". In this second version, the mother and her feelings are the focus of the conversation.

- Now let us see two more demonstrations. This time, the mother is HIV positive and pregnant and is coming to talk to the health worker about how she will feed her baby after birth. Again, listen for empathy – is the health worker showing she understands the mother's point of view?

DEMONSTRATION 5.J SYMPATHY

Health worker: *Good morning, (name). You wanted to talk to me about something? (smiles)*
Mother: *I tested for HIV last week and am positive. I am worried about my baby.*

Health worker: *Yes, I know how you feel. My sister has HIV.*

- *Ask:* *Do you think the health worker showed sympathy or empathy?*

Comment: Here the focus moved from the mother to the sister of the health worker. This was sympathy, not empathy. Let us hear this again, with the focus on the mother and empathizing with her feelings.

Demonstration 5.K Empathy

Health worker: *Good morning, (name). You wanted to talk to me about something? (smiles)*
Mother: *I tested for HIV last week and am positive. I am worried about my baby.*

Health worker: *You're really worried about what's going to happen.*
Mother: *Yes I am. I don't know what I should do?*

- *Ask:* *Do you think the health worker showed sympathy or empathy?*

Comment: In the second version, the health worker concentrated on the mother's concerns and worries. The health worker responded by saying "You're really worried about what's going to happen". This was empathy.

- Ask the two participants whom you have prepared to give Demonstrations 5.L to 5.O.
- Introduce the next role-play by making these points:
  - Now we will see another demonstration. Watch to see whether the health worker is really listening to the mother.
  - The health worker is talking to a mother of a 7-month-old child who has recently started complementary feeds.

Demonstration 5.L Asking facts

Health worker: *Good morning, (name). How are you and (child's name) today?*
Mother: *She is refusing to breastfeed since he started eating porridge and other foods last week – she just pulls away from me and doesn't want me!*

Health worker: *How old is (child's name) now?*
Mother: *She is 7 months old.*

Health worker: *And how much porridge does she eat during a day?*

- *Ask:* *What did the health worker learn about the mother's feelings?*

Comment: The health worker asked about facts and ignored the mother's feelings. The information the health worker learnt did not help the health worker to assist the mother with her worry that the baby won't breastfeed since other foods were offered. The health worker did not show empathy. Let us hear this again, with the focus on listening to the mother.

Demonstration 5.M Empathy

Health worker: *Good morning, (name). How are you and (child's name) today?*
Mother: *She is refusing to breastfeed since she started eating porridge and other foods last week – she just pulls away from me and doesn't want me!*

Health worker: *It's very upsetting when your baby doesn't want to breastfeed.*
Mother: *Yes, I feel so rejected.*

- *Ask:* *What did the health worker learn about the mother's feelings this time?*

Comment: In this second version, the mother's feelings were listened to at the beginning. Then the health worker was able to focus on what the mother sees as the problem.

Skill 6. Avoid using words that sound judging

- Write AVOID USING WORDS THAT SOUND JUDGING on the list of LISTENING AND LEARNING SKILLS.
- Explain the skill:
  - "Judging words" are words such as: right, wrong, well, badly, good, enough, properly.
  - If you use judging words when you talk to a mother about feeding, especially when you ask questions, you may make her feel that she is wrong, or that there is something wrong with the baby. A breastfeeding mother may feel there is something wrong with her breast milk.
  - For example: Do not say: "Are you feeding your child **properly**?"; instead say: "How are you feeding your child?"
  - Do not say: "Do you give her **enough** milk?"; instead say: "How often do you give your child milk?"
- Introduce the role-play by making these points:
  - We will see a demonstration of this skill. The health worker is talking to a mother of a 5-month-old baby. As you watch, look for judging words.

DEMONSTRATION 5.N USING JUDGING WORDS

Health worker: *Good morning. Is (name) breastfeeding **normally**?*
Mother: *Well – I think so.*

Health worker: *Do you think that you have **enough** breast milk for him?*
Mother: *I don't know ... I hope so, but maybe not ... (she looks worried)*

Health worker: *Has he gained weight **well** this month?*
Mother: *I don't know...*

Health worker: *May I see his growth chart?*

- *Ask:* *What did the health worker learn about the mother's feelings?*

Comment: The health worker has not learnt anything useful, but has made the mother very worried.

DEMONSTRATION 5.O AVOIDING JUDGING WORDS

Health worker: *Good morning. How is breastfeeding going for you and (child's name)?*
Mother: *It's going very well. I haven't needed to give her anything else.*

Health worker: *How is her weight? Can I see her growth chart?*
Mother: *Nurse said that she gained more than half a kilo this month. I was pleased.*

Health worker: *She is obviously getting all the breast milk that she needs.*

- *Ask:* *What did the health worker learn about the mother's feelings?*

Comment: This time the health worker learnt what she needed to know without making the mother worried. The health worker used open questions to avoid using judging words.

- Make these additional points:
  - Mothers may use judging words about their own situation. You may sometimes need to use them yourself, especially the positive ones, when you are building a mother's confidence. But practise avoiding them as much as possible, unless there is a really important reason to use one.
  - You may have noticed that judging questions are often closed questions. Using open questions often helps to avoid using a judging word.

III. Summarize the session 5 minutes

- Ask participants whether they have any questions, and try to answer them.
- You now have a list of the six skills on Flipchart 1. Post it on the wall. Read the list through, to remind participants of the six skills.
- Explain that a summary of this session can be found on pages 21 and 22 of the *Participant's manual*.
- Ask participants to find the list of HELPFUL NON-VERBAL COMMUNICATION and LISTENING AND LEARNING SKILLS on page 22 of their *Participant's manual*. Ask them to try to memorize it. Explain that they will use the list for CLINICAL PRACTICE SESSION 1: LISTENING AND LEARNING – ASSESSING A BREASTFEED (Session 21).

HELPFUL NON-VERBAL COMMUNICATION

- Keep your head level with the mother/caregiver
- Pay attention
- Remove physical barriers
- Take time/allow the mother or caregiver time to talk
- Use appropriate touch

LISTENING AND LEARNING SKILLS

1. Use helpful non-verbal communication
2. Ask open questions
3. Use responses and gestures that show interest
4. Reflect back what the mother/caregiver says
5. Empathize – show that you understand how the mother/caregiver feels
6. Avoid using words that sound judging

Suggested alternative methodologies

In **Section II**, you can use the following methodology.

Before starting the demonstration of LISTENING AND LEARNING SKILLS

Skill 2. Ask open questions

- **Tell participants that you want them to ask you questions, no more than one question per participant; answer truthfully.**
  - *Ask: What did you get from this exercise?* (Some types of questions bring out more information than others.)
- **Wait for a few replies and then continue.**
  - Asking about age gets you a specific piece of information (which is what you sometimes want).
  - Open-ended questions usually begin with "Why?", "How?", "When?" or "Where?"

Notes

Notes (contd)

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Session 6

Listening and learning: exercises 1

Participants will now practise the six LISTENING AND LEARNING SKILLS that they learnt about in Session 5.

Session outline . . . . . 60 minutes

Participants work in groups of 8–10 with two trainers.

I. Introduce the session . . . . . 5 minutes
II. Facilitate the written exercises (EXERCISES 6.A to 6.C) . . . . . 40 minutes
III. Conduct the group exercise (EXERCISE 6.D) . . . . . 15 minutes

Preparation

- Refer to the Introduction for guidance on facilitating written exercises and group work.
- Study the notes for the session, so that you are clear about what to do.
- For EXERCISES 6.A to 6.C, make sure that Answer sheets are available to give to participants at the end of the session.
- For EXERCISE 6.D, prepare translations of the judging words, and of the examples of judging and non-judging questions. Work with the other trainers to do this. Write your translations in the spaces in the box USING AND AVOIDING JUDGING WORDS.

As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

I. Introduce the session — 5 minutes

- Ask participants to turn to pages 25–29 of their *Participant's manual*, and to find EXERCISES 6.A to 6.D.
- Explain what they will do:
  - You will now practise the six LISTENING AND LEARNING SKILLS that you learnt about in Session 5.
  - EXERCISES 6.A to 6.C are individual written exercises.
  - For each exercise, read the instructions **How to do the exercise** and the **Example** of what to do.
  - Then write your answers to the questions in the section that says **To answer**.
  - If possible, use pencil, so that it is easier to correct the answers.
  - When you are ready, discuss your answers with the trainer. Trainers will give feedback individually as you do the exercises, and will give you Answer sheets at the end of the session.

EXERCISE 6D is a group exercise on judging words.

II. Facilitate the written exercises — 40 minutes

EXERCISE 6.A ASKING OPEN QUESTIONS

How to do the exercise:

Questions 1–4 are "closed" and it is easy to answer "yes" or "no".
Write a new "open" question, which requires the mother to tell you more.

Example:

"Closed" question	"Open" question
Do you breastfeed your baby?	*How are you feeding your baby?*

To answer:

"Closed" questions	Suggested answers for "open" questions
1. Does your baby sleep with you?	*Where does your baby sleep?*
2. Are you often away from your baby?	*How much time do you spend away from your baby?*
3. Does Sara eat porridge?	*What kinds of foods does Sara eat?*
4. Do you give fruit to your child often?	*How often does your child eat fruit?*

Exercise 6.B Reflecting back what a mother/caregiver says

How to do the exercise:

Statements 1–3 are some things that mothers might tell you.

Underneath statements 1–3 are three responses. Mark the response that "reflects back" what the statement says. For statement 4, make up your own response that "reflects back" what the mother says.

Example:

"My mother says that I don't have enough milk."

	a. Do you think you have enough?
	b. Why does she think that?
✓	c. She says that you have a low milk supply?

To answer:

1. "Mika does not like to take thick porridge."

✓	a. Mika does not seem to enjoy thick foods?
	b. What foods have you tried?
	c. It is good to give Mika thick foods as he is over 6 months old.

2. "He doesn't seem to want to suckle from me."

	a. Has he had any bottle feeds?
	b. How long has he been refusing?
✓	c. He seems to be refusing to suckle?

3. "I tried feeding her from a bottle, but she spat it out."

	a. Why did you try using a bottle?
✓	b. She refused to suck from a bottle?
	c. Have you tried to use a cup?

4. "My husband says our baby is old enough to stop breastfeeding now."

Your husband wants you to stop breastfeeding your baby?

EXERCISE 6.C EMPATHIZING – SHOWING THAT YOU UNDERSTAND HOW THE MOTHER/CAREGIVER FEELS

How to do the exercise:

Statements 1–4 are things that mothers might say.

Underneath statements 1–4 are three responses that you might make.

Underline the words in the mother's statement that show something about how she feels. Mark the response that is most empathetic.

For stories 5 and 6, underline the feeling words, then make up your own empathizing response.

Example:

My baby wants to feed so often at night that I feel exhausted.

	a. How many times does he feed altogether?
	b. Does he wake you every night?
✓	c. You are really tired with the night feeding.

To answer:

1. James has not been eating well for the past week. I am very worried about him.

✓	a. You are anxious because James is not eating?
	b. What did James eat yesterday?
	c. Children often have times when they do not eat well.

2. My breast milk looks so thin – I am afraid it is not good.

	a. That's the foremilk – it always looks rather watery.
✓	b. You are worried about how your breast milk looks?
	c. Well, how much does the baby weigh?

3. I feel there is no milk in my breasts, and my baby is a day old already.

✓	a. You are upset because your breast milk has not come in yet?
	b. Has she started suckling yet?
	c. It always takes a few days for breast milk to come in.

4. I am anxious that if I breastfeed I will pass HIV on to my baby.

✓	a. I can see you are worried about breastfeeding your baby.
	b. Would you like me to explain to you about how the HIV virus is passed from mothers to babies?
	c. What have you heard about other options for feeding your baby?

5. Angelique brings Sammy to see you. He is 9 months old. Angelique is worried. She says "Sammy is still breastfeeding and I feed him three other meals a day, but *I am so upset*, he still looks so thin".

What would you say to Angelique to empathize with how she feels?

(Possible answers include:
You are worried because Sammy looks thin to you?
You are worried about Sammy?)

6. Catherine comes to the clinic. She is pregnant with her first baby and has found out she has HIV. She says: "I am frightened that my mother-in-law might find out".

What would you say to Catherine to empathize with how she feels?

(Possible answers include:
You are frightened about what your mother-in-law will think?
You are worried about your mother-in-law finding out?)

- Give participants the Answer sheets for EXERCISES 6.A to 6.C.
- If some participants are having difficulties with the exercises, or have not finished them, arrange to help them later.

III. Conduct the group exercise — 15 minutes

EXERCISE 6.D TRANSLATING JUDGING WORDS

- Ask participants to look at the list of JUDGING words on page 29 of their *Participant's manual*.

JUDGING WORDS

Well	Normal	Enough	Problem
good	correct	adequate	fail
bad	proper	inadequate	failure
badly	right	satisfied	succeed
	wrong	plenty of	success
		sufficient	

- Make these points about the list:
  - The words in bold at the top of each group are words that are used most commonly. These are the words that we will work with in the exercises.
  - Below each of the common words is a list of other words with similar meanings.
  - For example, "adequate" and "sufficient" appear below "enough".
  - Words with opposite meanings are in the same group. For example "good" and "bad".
  - All of these are judging words, and it is important to avoid them.
- Ask participants to look at the box USING AND AVOIDING JUDGING WORDS, also on page 29 of their *Participant's manual*.
- Ask them to suggest translations of the four common words in the local language. Discuss their suggestions as a group.
- Ask them to write the agreed translations into the box in their manuals.
- For each word, read out the judging question, and give your translation of it.
- Then ask participants to think of a non-judging question. This should be a similar question that does not use the judging word. Remind them that judging questions are often closed questions, and that they can often avoid using a judging word if they use an open question.
- Discuss their suggestions as a group.
- Ask them to write the agreed non-judging question into the box in their *Participant's manual*.

USING AND AVOIDING JUDGING WORDS

English	Local language	Judging question	Non-judging question
Well	. . . . .	Does he suckle well?	How is he suckling?
Normal	. . . . .	Are his stools normal?	What are his stools like?
Enough	. . . . .	Is he gaining enough weight?	How is your baby growing?
Problem	. . . . .	Do you have any problems breastfeeding?	How is breastfeeding going for you?

► Ask participants whether they have any questions about the exercises, and try to answer them.

Notes

Notes (contd)

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Session 7

Listening and learning: exercises 2 – breastfeeding

Participants will now practise the six LISTENING AND LEARNING SKILLS that they learnt about in Session 5, with an emphasis on breastfeeding.

Session outline . . . . . 60 minutes

Participants work in groups of 8–10 with two trainers.

I. Introduce the session . . . . . 5 minutes
II. Facilitate the written exercises (EXERCISES 7.A to 7.C) . . . . . 40 minutes
III. Conduct the group exercise (EXERCISE 7.D) . . . . . 15 minutes

Preparation

- Refer to the Introduction for guidance on facilitating group work and written exercises.
- Study the notes for the session, so that you are clear about what to do.
- For EXERCISES 7.A to 7.C, make sure that Answer sheets are available to give to participants at the end of the session.
- For EXERCISE 7.D, prepare translations of the judging words, and of the examples of judging and non-judging questions. Work with the other trainers to do this. Write your translations in the spaces in the box USING AND AVOIDING JUDGING WORDS.

As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

I. Introduce the session — 5 minutes

- Ask participants to turn to pages 31–36 of their *Participant's manual*, and to find EXERCISES 7.A to 7.D.
- Explain what they will do:
  - You will now practise the six LISTENING AND LEARNING SKILLS that you learnt about in Session 5.
  - EXERCISES 7.A to 7.C are individual written exercises.
  - For each exercise, read the instructions **How to do the exercise** and the **Example** of what to do.
  - Then write your answers to the questions in the section that says **To answer**.
  - If possible, use pencil, so that it is easier to correct the answers.
  - When you are ready, discuss your answers with the trainer. Trainers will give feedback individually as you do the exercises and will give you Answer sheets at the end of the session.
  - EXERCISE 7.D is a group exercise on judging words.

II. Facilitate the written exercises — 40 minutes

EXERCISE 7.A ASKING OPEN QUESTIONS

How to do the exercise:

Questions 1–4 are "closed" and it is easy to answer "yes" or "no".
Write a new "open" question, which requires the mother to tell you more.

Example:

"Closed" question	"Open" question
Do you breastfeed your baby?	*How are you feeding your baby?*

To answer:

"Closed" questions	Suggested answers for "open" questions
1. Does your baby sleep with you?	*Where does your baby sleep?*
2. Are you often away from your baby?	*How much time do you spend away from your baby?*
3. Are your nipples sore?	*How do your breasts and nipples feel?*

4. Optional short story exercise

(To do if you have time, or need more practice)

Joseph and Mabel bring 3-month-old Johnny to the clinic. They want to talk to you because he is not gaining weight.

Write two open questions that you would ask Joseph and Mabel. The questions must be ones that they cannot say just "yes" or "no" to.

(Possible answers include:
How are you feeding Johnny?
What illnesses has Johnny had?
How is Johnny behaving?
Tell me how Johnny is feeding?)

EXERCISE 7.B REFLECTING BACK WHAT A MOTHER/CAREGIVER SAYS

How to do the exercise:

Statements 1–3 are some things that mothers might tell you.

Underneath statements 1–3 are three responses. Mark the response that "reflects back" what the statement says. For statements 4 and 5, make up your own response that "reflects back" what the mother says.

Example:

My mother says that I don't have enough milk.

	a. Do you think you have enough?
	b. Why does she think that?
✓	c. She says that you have a low milk supply?

To answer:

1. My baby is passing a lot of stools – sometimes eight in a day.

✓	a. He is passing many stools each day?
	b. What are the stools like?
	c. Does this happen every day, or only on some days?

2. He doesn't seem to want to suckle from me.

	a. Has he had any bottle feeds?
	b. How long has he been refusing?
✓	c. He seems to be refusing to suckle?

3. I tried feeding her from a bottle, but she spat it out.

	a. Why did you try using a bottle?
✓	b. She refused to suck from a bottle?
	c. Have you tried to use a cup?

For statements 4 and 5, make up your own response that "reflects back" what the mother says.

4. Sometimes he doesn't pass a stool for 3 or 4 days.
   (He doesn't pass a stool some days?) or *(for 3 or 4 days?)*

5. My husband says our baby is old enough to stop breastfeeding now.
   (*Your husband wants you to stop breastfeeding your baby?*)

6. Optional short story exercise

(To do if you have time, or need more practice)

You meet Cora in the market with her 2-month-old baby. You say how well the baby looks, and ask how she and the baby are doing. She says "Oh, we're doing fine. But she needs a bottle feed in the evening".

What do you say, to reflect back what Cora says?

(Possible answers include:
She seems to need more in the evening?
She seems very hungry sometimes?
She needs a bottle?)

EXERCISE 7.C EMPATHIZING – SHOWING THAT YOU UNDERSTAND HOW THE MOTHER/CAREGIVER FEELS

How to do the exercise:

Statements 1–4 are things that mothers might say.

Underneath statements 1–4 are three responses that you might make.

Underline the words in the mother's statement that show something about how she feels. Mark the response that is most empathetic.

For statements 5 and 6 and stories 7 and 8, underline the feeling words, and then make up your own empathizing response.

Example:

My baby wants to feed so often at night that I feel exhausted.

	a. How many times does he feed altogether?
	b. Does he wake you every night?
✓	c. You are really tired with the night feeding.

To answer:

1. James has not been eating well for the past week. I am very worried about him.

✓	a. You are anxious because James is not eating?
	b. What did James eat yesterday?
	c. Children often have times when they do not eat well.

2. My breast milk looks so thin – I am afraid it is not good.

	a. That's the foremilk – it always looks rather watery.
✓	b. You are worried about how your breast milk looks?
	c. Well, how much does the baby weigh?

3. I feel there is no milk in my breasts, and my baby is a day old already.

✓	a. You are upset because your breast milk has not come in yet?
	b. Has she started suckling yet?
	c. It always takes a few days for breast milk to come in.

4. I am anxious that if I breastfeed I will pass HIV on to my baby.

✓	a. I can see you are worried about breastfeeding your baby.
	b. Would you like me to explain to you about how the HIV virus is passed from mothers to babies?
	c. What have you heard about other options for feeding your baby?

5. My breasts leak milk all day at work – it is so embarrassing.

   (*It must be embarrassing if it happens at work.*)

6. I have bad pains in my stomach when he is breastfeeding.

   (*You are really having strong pains, aren't you?*)

7. Edna brings baby Sammy to see you. She looks worried. She says "Sammy breastfeeds very often, but he still looks so thin!"

   What would you say to Edna to empathize with how she feels?

   (Possible answers include:
   You are worried because Sammy looks thin to you?

You are worried about how Sammy looks?)

8. Catherine comes to the clinic. She is pregnant with her first baby and has found out she has HIV. She says: "I am frightened that my mother-in-law might find out".

   What would you say to Catherine to empathize with how she feels?

   (Possible answers include:
   You are frightened about what your mother-in-law will think?
   You are worried about your mother-in-law finding out?)

- Give participants the Answer sheets for EXERCISES 7.A to 7.C.
- If some participants are having difficulties with the exercises, or have not finished them, arrange to help them later.

III. Conduct the group exercise — 15 minutes

EXERCISE 7.D TRANSLATING JUDGING WORDS

- Ask participants to look at the list of JUDGING words on page 36 of their *Participant's manual*.

JUDGING WORDS

Well	Normal	Enough	Problem
good	correct	adequate	fail
bad	proper	inadequate	failure
badly	right	satisfied	succeed
	wrong	plenty of	success
		sufficient	

- Make these points about the list:
  - The words in bold at the top of each group are words that are used most commonly. These are the words that we will work with in the exercises.
  - Below each of the common words is a list of other words with similar meanings.
  - For example, "adequate" and "sufficient" appear below "enough".
  - Words with opposite meanings are in the same group. For example "good" and "bad".
  - All of these are judging words, and it is important to avoid them.
- Ask participants to look at the box USING AND AVOIDING JUDGING WORDS, also on page 36 of their *Participant's manual*.
- Ask them to suggest translations of the four common words in the local language.Discuss their suggestions as a group.
- Ask them to write the agreed translations into the box in their manuals.
- For each word, read out the judging question, and give your translation of it.
- Then ask participants to think of a non-judging question. This should be a similar question that does not use the judging word. Remind them that judging questions are often closed questions, and that they can often avoid using a judging word if they use an open question.
- Discuss their suggestions as a group.
- Ask them to write the agreed non-judging question into the box in their *Participant's manual*.

USING AND AVOIDING JUDGING WORDS

English	Local language	Judging question	Non-judging question
Well	. . . . .	Does he suckle well?	How is he suckling?
Normal	. . . . .	Are his stools normal?	What are his stools like?
Enough	. . . . .	Is he gaining enough weight?	How is your baby growing?
Problem	. . . . .	Do you have any problems breastfeeding?	How is breastfeeding going for you?

► Ask participants whether they have any questions about the exercises, and try to answer them.

Notes

Notes (contd)

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Session 8

Building confidence and giving support

Objectives

After completing this session, participants will be able to:

- list the six SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT
- give an example of each skill
- demonstrate the appropriate use of the skills when counselling on infant and young child feeding

Session outline . . . . . 45 minutes

Participants are all together for a demonstration led by one trainer.

I. Introduce the session, present **Slide 8/1** . . . . . 5 minutes
II. Demonstrate six SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT (**Slides 8/2** to **8/9**, DEMONSTRATIONS 8A–D) . . . . . 35 minutes
III. Summarize the session . . . . . 5 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides and on giving a demonstration.
- You need one board or flipchart.
- Study the **Slides 8/1** to **8/9** and the text that goes with them, so that you are able to present them.
- Make copies of all the DEMONSTRATIONS 8.A to 8.D. Study the instructions for DEMONSTRATIONS 8.A to 8.D, so that you are clear about the ideas they illustrate, and you know what to do.
- Ask different participants to help you to give the DEMONSTRATIONS 8.A to 8.D. Explain what you want them to do.
- Give each of the participants a copy of the demonstration that they have to read.

As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

I. Introduce the session — 5 minutes

► Show **Slide 8/1 – Session 8 – objectives** and read out the objectives:

8/1

Session 8: Building confidence and giving support – objectives

After completing this session, participants will be able to:

- list the six SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT
- give an example of each skill
- demonstrate the appropriate use of the skills when counselling on infant and young child feeding

► Make these introductory points:

- In this session, you will learn about the next counselling skills: building confidence and giving support.
- A mother easily loses confidence in herself. This may lead her to feel that she is a failure and to give in to pressure from family and friends.
- You may need these skills to help her to feel confident and good about herself.
- It is important not to make a mother feel that she has done something wrong.
- A mother easily believes that there is something wrong with herself, with how she is feeding her child, or with her breast milk if she is breastfeeding. This reduces her confidence.
- It is important to avoid telling a mother what to do.
- Help each mother to decide for herself what is best for her and her baby. This increases her confidence.

II. Demonstrate the six SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT — 35 minutes

► Tell participants that you will now explain and demonstrate SIX SKILLS FOR BUILDING A MOTHER'S CONFIDENCE AND GIVING HER SUPPORT.

► Explain that these skills are also important when counselling caregivers and other family members.

► Write the heading SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT on a board or flipchart. List the skills on the board as you demonstrate them.

Skill 1. Accept what a mother/caregiver thinks and feels

- Write ACCEPT WHAT A MOTHER/CAREGIVER THINKS AND FEELS on the list of SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT.
- Explain the skill:
  - Sometimes a mother thinks something that you do not agree with – that is, she has a mistaken idea.
  - Sometimes a mother feels very upset about something that you know is not a serious problem.
  - Ask: *How will she feel if you disagree with her, or criticize, or tell her that it is nothing to be upset or to worry about?*
- Wait for a few replies and then continue.
  - You may make her feel that she is wrong. This reduces her confidence. She may not want to say any more to you.
  - So it is important not to disagree with a mother.
  - It is also important not to agree with a mistaken idea. You may want to suggest something quite different. That can be difficult if you have already agreed with her.
  - Instead, you just accept what she thinks or feels. Accepting means responding in a neutral way, and not agreeing or disagreeing.
- Give an example of accepting what a mother **thinks**. Ask the two participants whom you have prepared to give DEMONSTRATION 8.A to read out the words of the mother and health worker. After each response from the health worker, ask the participants whether the response was agreeing, disagreeing or accepting.
- Introduce the role-play by making the following points:
  - We will now see a role-play showing acceptance of what a mother thinks. This mother has a 1-week-old baby.

DEMONSTRATION 8.A ACCEPTING WHAT A MOTHER THINKS

Mother: *My milk is thin and weak, and so I have to give bottle feeds.*
Health worker: *Oh no! Milk is never thin and weak. It just looks that way. (nods, smiles)*

- *Ask:* *Did the health worker agree, disagree or accept?*

Comment: This is an inappropriate response, because it is disagreeing.

Mother: *My milk is thin and weak, so I have to give bottle feeds.*
Health worker: *Yes – thin milk can be a problem.*

- *Ask:* *Did the health worker agree, disagree or accept?*

Comment: This is an inappropriate response because it is agreeing.

Mother: *My milk is thin and weak, so I have to give bottle feeds.*
Health worker: *I see. You are worried about your milk.*

- *Ask:* *Did the health worker agree, disagree or accept?*

Comment: This is an appropriate response because it shows acceptance.

- **Make these additional points:**
  - Reflecting back and simple responses are useful ways to show acceptance. Later in the discussion, you can give information to correct a mistaken idea.
  - In a similar way, empathizing can show acceptance of a mother's feelings.
  - If a mother is worried or upset, and you say something such as, "Oh, don't be upset, it is nothing to worry about", she may feel that she was wrong to be upset.
  - This reduces a mother's confidence in her ability to make her own decisions.
- **Ask the two participants whom you have prepared to give DEMONSTRATION 8.B to read out the words of the mother and health worker.**
- **Introduce the role-play by making the following points:**
  - The last role-play showed acceptance of what a mother thinks. We will now see a role-play showing acceptance of what a mother feels. This mother has a 9-month-old baby.

DEMONSTRATION 8.B ACCEPTING WHAT A MOTHER FEELS

Mother (in tears): *It is terrible, (child's name) has a cold and his nose is completely blocked and he can't breastfeed. He just cries and I don't know what to do.*

Health worker: *Don't worry, your baby is doing very well.*

- *Ask:* *Was this an appropriate response?*

Comment: This is an inappropriate response. By saying things such as, "don't worry" or "don't cry", you make a mother feel it is wrong to be upset and this reduces her confidence.

Mother (in tears): *It is terrible, (child's name) has a cold and his nose is completely blocked and he can't breastfeed. He just cries and I don't know what to do.*

Health worker: *You are upset about (child's name) aren't you?*

- *Ask:* *Was this an appropriate response?*

Comment: This is an appropriate response because it accepted how the mother felt and made her feel that it was alright to be upset. Notice how, in this example, empathizing was used to show acceptance. So this is another example of using a Listening and learning skill to show acceptance.

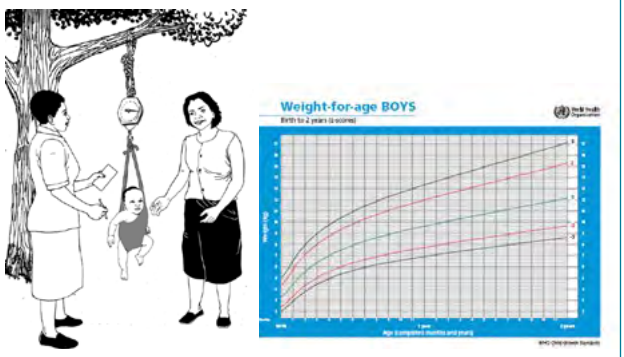
Skill 2. Recognize and praise what a mother/caregiver and baby are doing right

- **Write RECOGNIZE AND PRAISE WHAT A MOTHER/CAREGIVER AND BABY ARE DOING RIGHT on the list of SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT.**
- **Explain the skill:**
  - As health workers, we are trained to look for problems. Often, this means that we see only what we think people are doing wrong, and try to correct them.
  - Ask: *How does it make a mother feel if you tell her that she is doing something wrong, or that her baby is not doing well?*
- **Wait for a few replies and then continue.**
  - It may make her feel bad, and this can reduce her confidence.
  - As counsellors, we must look for what mothers and babies are doing right.
  - We must first recognize what they do right; and then we should praise or show approval of the good practices.

- Praising good practices has these benefits:
  - It builds a mother's confidence.
  - It encourages her to continue those good practices.
  - it makes it easier for her to accept suggestions later.
- In some situations, it can be difficult to recognize what a mother is doing right. But any mother whose child is living must be doing some things right, whatever her socioeconomic status or education.

▶ Show **Slide 8/2** and explain the situation that it illustrates:

8/2



▶ Explain **Slide 8/2**:

- Here is a baby being weighed, and his mother. The baby is exclusively breastfed. Beside the mother and baby is the baby's growth chart. His growth chart shows that he has gained a little weight over the last month. However, his growth line is not following the reference curves. It is rising too slowly. This shows that the baby's growth is slow.

▶ Show **Slide 8/3** and read out the remarks:

8/3

Which of these remarks will help to build the mother's confidence?

- "Your baby's growth line is going up too slowly."
- "I don't think your baby is gaining enough weight."
- "Your baby gained weight last month just on your breast milk."

▶ Ask participants to say which one helps to build the mother's confidence.

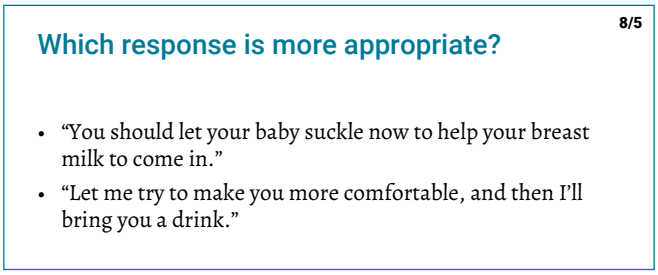
- The correct response is the last one: "Your baby gained weight last month just on your breast milk".

Skill 3. Give practical help

- **Write GIVE PRACTICAL HELP on the list of SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT.**
- **Explain the skill:**
  - Sometimes, practical assistance is more effective in helping the mother than speaking. For example:
    - when a mother feels tired or dirty or uncomfortable
    - when she is hungry or thirsty
    - when she has had a lot of information already
    - when she has a clear practical problem.
  - *Ask: What kind of practical help might you offer?*
- **Wait for a few replies and then continue.**
  - Some ways to give practical help are these:
    - help to make her clean and comfortable
    - give her a drink, or something to eat
    - hold the baby yourself, while she gets comfortable, or washes, or goes to the toilet.
  - Practical help also includes showing caregivers how to prepare feeds, rather than just giving them a list of instructions. It further includes practical help with feeding – such as helping a mother with positioning and attachment, expressing breast milk, relieving engorgement or preparing complementary feeds.
- **Show Slide 8/4 and explain the situation that it illustrates:**

- **Explain Slide 8/4:**
  - This mother is lying in bed soon after delivery. She looks miserable and depressed. She is saying to the health worker: "No, I haven't breastfed my baby yet. My breasts are empty and it is too painful to sit up".

- Then show **Slide 8/5** and read out the remarks:
- Ask participants to say which response is the more appropriate.



- Give this explanation:
  - The appropriate response is the second one, in which the health worker offers to give practical help. She will make the mother comfortable before she helps her to breastfeed.
  - Of course it is important for the baby to breastfeed soon. But it is more likely to be successful if the mother feels comfortable.

Skill 4. Give a little, relevant information

- Write GIVE A LITTLE, RELEVANT INFORMATION on the list of SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT.
- Explain the skill:
  - Mothers often need information about feeding. It is important to share your knowledge with them. It may also be important to correct mistaken ideas.
  - However, sometimes health workers know so much information that they think they need to tell it all to the mother.
  - It is a skill to be able to listen to the mother and choose just two or three pieces of the most relevant information to give at this time.
  - Try to give information that is relevant to her situation now. Tell her things that she can use today, not in a few weeks' time.
  - Explaining the reason for a difficulty is often the most relevant information when it helps a mother to understand what is happening.
  - Try to give only one or two pieces of information at a time, especially if a mother is tired and has already received a lot of information.
  - Give information in a positive way, so that it does not sound critical, or make the mother think that she has been doing something wrong: this is especially important if you want to correct a mistaken idea.
  - For example, instead of saying "Thin porridge is not good for your baby", you could say: "Thick foods help the baby to grow".
  - Before you give information to a mother, build her confidence. Accept what she says and praise what she does well; you do not need to give new information or to correct a mistaken idea immediately.

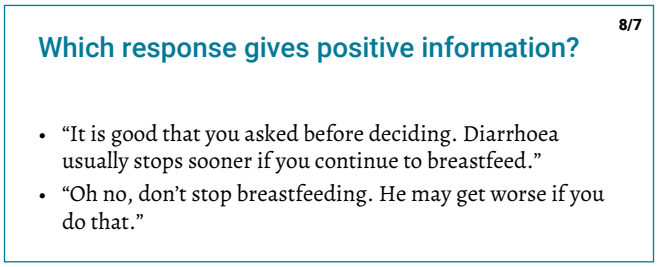
► Show **Slide 8/6** and explain the situation that it illustrates:

► Explain **Slide 8/6**:

- This baby is 3 months old. His mother has recently started giving some formula feeds in a bottle, in addition to breastfeeding. The baby has developed diarrhoea. The mother is saying to the health worker: "He has started to have loose stools. Should I stop breastfeeding?"

► Then show **Slide 8/7**: and read out the responses:

► Ask participants to say which one gives information in a positive way.



► Give this explanation:

- Response 2 is critical, and may make her feel wrong and lose confidence. Response 1 is positive, and should not make her feel wrong or lose confidence.

Skill 5. Use simple language

► Write USE SIMPLE LANGUAGE on the list of SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT.

► Explain the skill:

- Health workers learn about diseases and treatments using technical or scientific terms. When these terms become familiar, it is easy to forget that people who are not health workers may not understand them.
- It is important to use simple, familiar terms, to explain things to mothers.
- We will now see a demonstration. The health worker is talking to a mother of a 6-month-old child.

► Ask the two participants whom you have prepared to give DEMONSTRATION 8.C to read the words of the mother and health worker. Discuss briefly what the participants have observed after each section.

DEMONSTRATION 8.C USING SIMPLE LANGUAGE

Health worker: *Good morning (name). What can I do for you today?*
Mother: *Can you tell me what foods to give my baby, now that she is 6 months old?*

Health worker: *I'm glad that you asked. Well now, the situation is this. Most children need more nutrients than breast milk alone when they are 6 months old because breast milk has less than 1 mg of absorbable iron and breast milk has about 450 calories, so less than the 700 calories that are needed. The vitamin A needs are higher than what is provided by breast milk and also the zinc and other micronutrients.*

However, if you add foods that aren't prepared in a clean way, it can increase the risk of diarrhoea and if you give too many poor-quality foods the child won't get enough calories to grow well.

- *Ask:* *What did you observe?*

Comment: The health worker provided too much information. It was not relevant to the mother at this time. She used words that were unlikely to be familiar.

- Now we will see another mother receiving information in a different way. Again, listen for the skills listed.

▸ **Ask the two participants whom you have prepared to give DEMONSTRATION 8.D to read the words of the mother and health worker.**

DEMONSTRATION 8.D USING SIMPLE LANGUAGE

Health worker: *Good morning (name). How can I help you?*
Mother: *Can you tell me what foods to give my baby, now that she is 6 months old?*

Health worker: *You are wondering about what is best for your baby. I'm glad you have come to talk about it. It is usually a good idea to start with a little porridge to get him used to the taste of different foods. Just two spoons twice a day to start with.*

- *Ask:* *What did you observe this time?*

Comment: The health worker explained about starting complementary foods in a simple way.

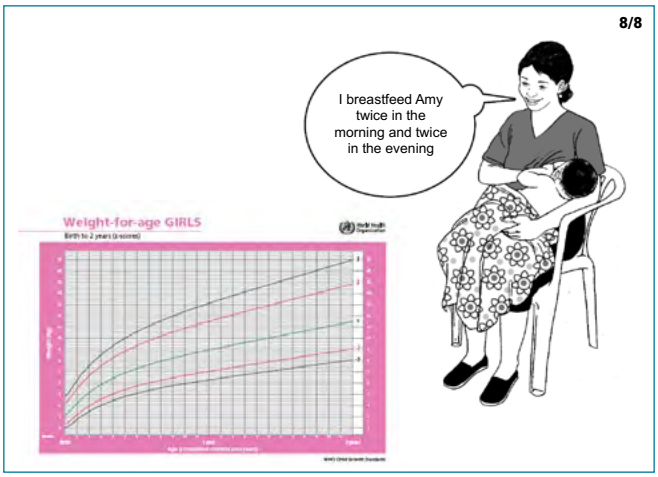
Skill 6. Make one or two suggestions, not commands

▸ **Write MAKE ONE OR TWO SUGGESTIONS, NOT COMMANDS on the list of SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT.**

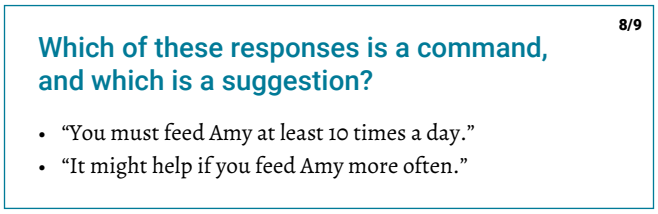
▸ **Explain the skill:**

- You may decide that it would help a mother if she does something differently – for example, if she feeds the baby more often, or holds them in a different way.
- However, you must be careful not to tell or command her to do something. This does not help her to feel confident.
- When you counsel a mother, you suggest what she could do. Then she can decide whether she will try it or not. This leaves her feeling in control, and helps her to feel confident.

- Show **Slide 8/8** and explain the situation that it illustrates:



- Make one or two suggestions.
- Explain **Slide 8/8**:
  - Amy breastfeeds only four times a day, and she is gaining weight too slowly. Her mother thinks that she does not have enough breast milk.
- Then show **Slide 8/9** and read out the responses:
  - Ask participants to say which is a command and which a suggestion.



- Give this explanation:
  - Response 1 is a command. It tells Amy's mother what she must do. She will feel bad and lose confidence if she cannot do it.
  - The second response is a suggestion. It allows Amy's mother to decide whether she will feed Amy more often or not.
  - Another way to make a suggestion is to ask a question, for example, "Have you thought of feeding her more often? Sometimes that helps".

III. Summarize the session — 5 minutes

- Ask participants whether they have any questions, and try to answer them.
- You now have a list of six skills on the flipchart. Post it on the wall. Read the list through, to remind participants of the six skills.
- Explain that a summary of the session can be found on pages 39–41 of the *Participant's manual*.
- Ask participants to find the list on page 41 of their *Participant's manual*. Ask them to try to memorize it. Explain that they will use these skills for CLINICAL PRACTICE SESSION 2: BUILDING CONFIDENCE AND GIVING SUPPORT – POSITIONING A BABY AT THE BREAST (Session 22).
- Orient participants to the COUNSELLING SKILLS CHECKLIST, which includes both LISTENING AND LEARNING SKILLS and SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT.

SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT

1. Accept what a mother/caregiver thinks and feels
2. Recognize and praise what a mother/caregiver and baby are doing right
3. Give practical help
4. Give a little, relevant information
5. Use simple language
6. Make one or two suggestions, not commands

COUNSELLING SKILLS CHECKLIST

Name of counsellor:

Name of observer:

Date of visit:

(✓ for Yes and X for No)

Did the counsellor:

Use LISTENING AND LEARNING SKILLS:

- ☐ Keep the head level with mother/parent/caregiver?
- ☐ Pay attention (eye contact)?
- ☐ Remove barriers (tables and notes)?
- ☐ Take time? Allow the mother/caregiver time to talk?
- ☐ Use appropriate touch?
- ☐ Ask open questions?
- ☐ Use responses and gestures that showed interest?
- ☐ Reflect back what the mother/caregiver said?
- ☐ Empathize – showing that he or she understood how the mother/caregiver feels?
- ☐ Avoid using words that sound judging?

Use SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT:

- ☐ Accept what the mother/caregiver thinks and feels?
- ☐ Recognize and praise what the mother/caregiver and baby are doing right?
- ☐ Give practical help?
- ☐ Give a little, relevant information?
- ☐ Use simple language?
- ☐ Make one or two suggestions, not commands?

Notes

Session 9

Building confidence and giving support: exercises 1 – breastfeeding

Participants will now practise the six SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT that they learnt about in Session 8, with an emphasis on breastfeeding.

Session outline . . . . . 45 minutes

Participants work in groups of 8–10 with two trainers.

I. Introduce the session . . . . . 5 minutes
II. Facilitate the written exercises (EXERCISES 9.A to 9.F) . . . . . 40 minutes

Preparation

- Refer to the Introduction for guidance on facilitating written exercises and group work.
- Study the notes for the session, so that you are clear about what to do.
- For EXERCISES 9.A to 9.F, make sure that Answer sheets are available to give to participants at the end of the session.

As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

I. Introduce the session — 5 minutes

- Ask participants to turn to pages 43–49 of their *Participant's manual* and to find EXERCISES 9.A to 9.F.
- Explain what they will do:
  - You will now practise the six SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT that you learnt about in Session 8.
  - The examples in this session are mostly about infants who are breastfeeding. Later in the course, you will do more exercises using examples of children who are receiving complementary feeds.
  - All the exercises are individual written exercises.
  - For each exercise, read the instructions **How to do the exercise** and the **Example** of what to do.
  - Then write your answers to the questions in the section that says **To answer**.
  - If possible use pencil, so that it is easier to correct the answers.
  - When you are ready, discuss your answers with a trainer. Trainers will give feedback individually as you do the exercises and will give you Answer sheets at the end of the session.

II. Facilitate the written exercises — 40 minutes

EXERCISE 9.A ACCEPTING WHAT A MOTHER THINKS

How to do the exercise:

Statements 1 and 2 are mistaken ideas that mothers might hold.

Beside each mistaken idea are three responses. One agrees with the idea, one disagrees and one accepts the idea, without either agreeing or disagreeing.

Below each response write whether the response agrees, disagrees or accepts.

Example:

Mother of a 6-month-old baby:"My baby has diarrhoea so it is not good to breastfeed now."

You do not like to give him breast milk just now?	*It is quite safe to breastfeed a baby when he has diarrhoea.*	*It is often better to stop breastfeeding a baby when he has diarrhoea.*
Accepts	**Disagrees**	**Agrees**

To answer:

1. Mother of a 1-month-old baby: "I give him drinks of water, because the weather is so hot now."

Oh, that is not necessary! Breast milk contains plenty of water.	*Yes, babies may need extra drinks of water in this weather.*	*You feel that he needs drinks of water sometimes.*
Disagrees	**Agrees**	**Accepts**

2. Mother of a 9-month-old baby: "I have not been able to breastfeed for 2 days, so my milk is sour."

Breast milk is not very nice after a few days.	*You are worried that your breast milk may be sour?*	*But milk never goes sour in the breast!*
Agrees	**Accepts**	**Disagrees**

How to do the exercise:

Statements 3–5 are some more mistaken ideas that mothers might hold.

Make up a response that accepts what the mother says, without disagreeing or agreeing.

Example:

Mother of a 1-week-old baby: "I don't have enough milk because my breasts are so small".
Mm. Mothers often worry about the size of their breasts. *I see you are worried about the size of your breasts.* *Ah ha.*

To answer:

3. "The first milk is not good for a baby – I cannot breastfeed until it has gone."
You do not want him to have the first milk?

4. "I don't let her suckle for more than 10 minutes, because it would make my nipples sore."
You are frightened that you might have sore nipples?

5. "I need to give him formula milk now that he is 2 months old. My breast milk is not enough for him now."
I see…

EXERCISE 9.B ACCEPTING WHAT A MOTHER FEELS

How to do the exercise:

After the Stories 1 and 2 below, there are three responses.
Mark with a ✓ the response that shows acceptance of how the mother feels.

Example:

Purla's baby boy has a cold and a blocked nose, and is finding it difficult to breastfeed. As Purla tells you about it, she bursts into tears.

Mark with a ✓ the response that shows that you accept how Purla feels.

	a. Don't worry – he is doing very well.
	b. You don't need to cry – he will soon be better.
✓	c. It's upsetting when a baby is ill, isn't it?

To answer:

Story 1
Marion is in tears. She says that her breasts have become soft again, so her milk must be less, but the baby is only 3 weeks old.

	a. Don't cry – I'm sure you still have plenty of milk.
✓	b. You are really upset about this, I know.
	c. Breasts often become soft at this time – it doesn't mean that you have less milk!

Story 2
Dora is very bothered. Her baby sometimes does not pass a stool for 1 or 2 days. When she does pass a stool, she pulls up her knees and goes red in the face. The stools are soft and yellowish brown.

	a. You needn't be so bothered – this is quite normal for babies.
	b. Some babies don't pass a stool for 4 or 5 days.
✓	c. It really bothers you when she doesn't pass a stool, doesn't it?

Exercise 9.C Praising what a mother and baby are doing right

How to do the exercise:

For Story 3 below, there are three responses. They are all things that you might want to say to the mother.

Mark with a ✓ the response that praises what the mother and baby are doing right, to build the mother's confidence.

For Story 4, make up your own response that praises the mother.

Example:

A mother is breastfeeding her 3-month-old baby, and giving drinks of fruit juice. The baby has slight diarrhoea.

Mark the response that praises what she is doing right.

	a. You should stop the fruit juice – that's probably what is causing the diarrhoea.
✓	b. It is good that you are breastfeeding – breast milk should help him to recover.
	c. It is better not to give babies anything but breast milk until they are about 6 months old.

To answer:

Story 3

The mother of a 3-month-old baby says that he is crying a lot in the evenings, and she thinks that her milk supply is decreasing. The baby gained weight well last month.

	a. Many babies cry at that time of day – it is nothing to worry about.
✓	b. He is growing very well – and that is on your breast milk alone.
	c. Just let him suckle more often – that will soon build up your milk supply.

Story 4

A 4-month-old baby is completely fed on replacement feeds from a bottle. She has diarrhoea. The growth chart shows that she weighed 3.5 kg at birth, and that he has only gained 200 g in the last 2 months. The bottle smells very sour.

(Possible answer: *I am glad that you came to the clinic, and it is very helpful that you brought her weight chart*.)

Exercise 9.D Giving a little, relevant information

How to do the exercise:

Below is a list of six mothers with babies of different ages.

Beside them are six pieces of information (a, b, c, d, e and f) that those mothers may need, but the information is not opposite the mother who needs it most.

Match the piece of information with the mother and baby in the same set for whom it is **most relevant at that time.**

After the description of each mother there are six letters.

Put a circle round the letter that corresponds to the information that is most relevant for her. As an example, the correct answer for Mother 1 is already marked in brackets.

To answer:

1. Mother returning to work	a b c d (e) f	a. Foremilk normally looks watery, and hindmilk is whiter
2. Mother with a 12-month-old baby	a b c d e (f)	b. Exclusive breastfeeding is best until a baby is 6 months old
3. Mother who thinks that her milk is too thin	(a) b c d e f	c. More suckling makes more milk
4. Mother who thinks that she does not have enough breast milk	a b (c) d e f	d. Colostrum is all that a baby needs at this time
5. Mother with a 2-month-old baby who is exclusively breastfed	a (b) c d e f	e. Night breastfeeds are good for a baby and help to keep up the milk supply
6. A newly delivered mother who wants to give her baby prelacteal feeds	a b c (d) e f	f. Breastfeeding is valuable for 2 years or more

Exercise 9.E Using simple language

How to do the exercise:

Below are two pieces of information that you might want to give to mothers.

The information is correct, but it uses technical terms that a mother who is not a health worker might not understand.

Rewrite the information in simple language that a mother could easily understand.

Example:

Information	Using simple language
Colostrum is all that a baby needs in the first few days.	*The first yellowish milk that comes is exactly what a baby needs for the first few days.*

To answer:

Information	Using simple language
1. Exclusive breastfeeding is best up to 6 months of age.	*Breast milk alone is all a baby needs until he is about 6 months old.*
2. To suckle effectively, a baby needs to be well attached to the breast.	*To get the milk, your baby needs to take a big mouthful of breast.*

EXERCISE 9.F GIVING A LITTLE, RELEVANT INFORMATION

How to do the exercise:

Below are some commands that you might want to give to a breastfeeding mother.

Rewrite the commands as suggestions. In your answer, you only need to give ONE answer.

The box below gives some examples of ways to make suggestions, not commands. You may find this helpful when doing the exercises.

MAKING SUGGESTIONS, NOT COMMANDS

Commands use the imperative form of verbs (give, do, bring) and words such as *always, never, must, should*.

Suggestions include:

- Have you considered...?
- Would it be possible...?
- What about trying... to see if it works for you?
- Would you be able to?
- Have you thought about...? Instead of...?
- You could choose between... and... and...
- It may not suit you, but some mothers... a few women...
- Perhaps... might work.
- Usually... Sometimes... Often...

Example:

Command	Suggestions
Keep the baby in bed with you so that he can feed at night!	*It might be easier to feed him at night if he slept in bed with you.* *Would it be easier to feed him at night if he slept with you?*

To answer:

Command	Suggestions
Do not give your baby any drinks of water or glucose water, before he is at least 6 months old!	*You may find that breastfeeding is all that she needs – extra water is not usually necessary.* *Have you thought of giving her just breastfeeds? Babies can get all the water that they need from breast milk.*
Feed him more often, whenever he is hungry, then your milk supply will increase!	*A good way to build up your milk supply is to breastfeed your baby more often.* *Would you be able to breastfeed him more often? That is a good way to build up your milk supply.*

- ► Give participants the Answer sheets for EXERCISES 9.A to 9.F.
- ► If some participants are having difficulties with the exercises, or have not finished them, arrange to help them later.
- ► Ask participants whether they have any questions about the exercises, and try to answer them.

Notes

Session 10

Building confidence and giving support: exercises 2 – complementary feeding

Participants will now practise the SIX SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT that they learnt about in Session 8, with an emphasis on complementary feeding of children aged 6 up to 24 months.

Session outline . . . . . 45 minutes

Participants work in groups of 8–10 with two trainers.

I. Introduce the session . . . . . 3 minutes
II. Facilitate the written exercises (EXERCISES 10.A to 10.F) . . . . . 42 minutes

Preparation

- Refer to the Introduction for general guidance on facilitating written exercises and group work.
- Make sure that Answer sheets for Exercises 10.A to 10.F are available to give to participants at the end of the session.

As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

I. Introduce the session — 3 minutes

- Ask participants to turn to pages 51–56 of their *Participant's manual* and to find EXERCISES 10.A to 10.F.
- Explain what they will do:
  - In Session 9 we practised the six SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT with examples of breastfeeding mothers. We will now use these skills with mothers whose children are over 6 months of age and receiving complementary foods.
  - EXERCISES 10.A to 10.F are individual written exercises.
  - For each exercise, read the instructions **How to do the exercise** and the **Example** of what to do.
  - Then write your answers to the questions in the section that says **To answer**.
  - If possible use pencil, so that it is easier to correct the answers.
  - When you are ready, discuss your answers with the trainer. Trainers will give feedback individually as you do the exercises and will give you Answer sheets at the end of the session.

II. Facilitate the written exercises — 42 minutes

EXERCISE 10.A ACCEPTING WHAT A MOTHER THINKS

How to do the exercise:

Statements 1 and 2 are mistaken ideas that mothers might hold.

Beside each mistaken idea are three responses. One agrees with the idea, one disagrees and one accepts the idea, without either agreeing or disagreeing.

Beside each response write whether the response agrees, disagrees or accepts.

Example:

Mother of a healthy 19-month-old baby whose weight is on the median: "I am worried that my child will become a fat adult so I will stop giving him milk."

You are worried about giving him milk?	*It is important that children have some milk in their diet until they are at least 2 years of age.*	*Yes, fat babies tend to turn into fat adults.*
Accepts	**Disagrees**	**Agrees**

To answer:

1. Mother of a 7-month-old baby: "My child is not eating any food that I offer, so I will have to stop breastfeeding so often. Then he will be hungry and will eat the food."

Oh, no, you must not give him less breast milk. That is a bad idea.	*I see...*	*Yes, sometimes babies do get full up on breast milk.*
Disagrees	**Accepts**	**Agrees**

2. Mother of a 12-month-old child: "My baby has diarrhoea, so I must stop giving her any solids."		
Yes, often foods can make the diarrhoea worse.	*You are worried about giving foods at the moment?*	*But solids help a baby to grow and gain weight again – you must not stop them now.*
Agrees	**Accepts**	**Disagrees**

How to do the exercise:

Statements 3 and 4 are some more mistaken ideas that mothers might hold.

Make up a response that accepts what the mother says, without disagreeing or agreeing.

To answer:

3. "My neighbour's child eats more than my child and he is growing much bigger. I must not be giving my child enough food."
You feel unsure whether your child is getting enough to eat?

4. "I am worried about giving my 1-year-old child family foods in case he chokes."
Mmm. You are concerned that she might choke.

Exercise 10.B Accepting what a mother FEELS

How to do the exercise:

After the stories 1 and 2 below, there are three responses.

Mark with a ✓ the response that shows acceptance of how the mother feels.

Example:

Edith's baby boy has not gained much weight over the past 2 months. As Edith tells you about it, she bursts into tears.

Mark with a ✓ the response that shows that you accept how Edith feels.

	a. Don't worry – I am sure he will gain weight soon.
	b. Shall we talk about what foods to give your baby?
✓	c. You're really upset about this aren't you?

To answer:

Story 1

Agnes is in tears. Her baby is refusing to eat vegetables and she is worried.

	a. Don't cry – many children do not eat vegetables.
✓	b. You are really worried about this?
	c. It is important that your baby eats vegetables for the vitamins he needs.

Story 2

Susan is crying. Since starting complementary foods, her baby has developed a rash on her buttocks. The rash looks like a nappy rash.

	a. Don't cry – it is not serious.
	b. Lots of babies have this rash – we can soon make it better.
✓	c. You are really upset about this rash, aren't you?

Exercise 10.C Praising what a mother and baby are doing right

How to do the exercise:

For stories 3 and 4 below, make up a response that praises something the mother and baby are doing right. In your answer, you only need to give ONE answer.

Example:

A mother is giving her 9-month-old baby fizzy drinks. She is worried that he is not eating his meals well. He is growing well at the moment. She offers him three meals and one snack per day.	*It is good that you are offering him three meals and one snack per day.* *Your child is growing well on the food you are giving him.*

To answer:

Story 3 A 15-month-old child is breastfeeding and having thin porridge and sometimes tea and bread. She has not gained weight for 6 months, and is thin and miserable.	*It is good that you are continuing to breastfeed her at this age.*
Story 4 A 9-month-old baby and his mother have come to see you. Here is the growth chart of the baby. 	*Your baby gained weight last month on the food that you are offering him.*

Exercise 10.D Giving a little, relevant information

How to do the exercise:

Below is a list of four mothers with babies of different ages.

Beside them are four pieces of information (a, b, c and d) that those mothers may need; but the information is not opposite the mother who needs it most.

Match the piece of information with the mother and baby in the same set for whom it is **most relevant at that time**.

After the description of each mother there are four letters.

Put a circle round the letter that corresponds to the information that is most relevant for her.

To answer:

1. Mother with a 7-month-old baby.	a (b) c d	a. Children need extra water at this age – about 4–5 cups in a hot climate.
2. Mother with a 15-month-old baby who is getting two meals per day.	a b (c) d	b. Children who start complementary feeding at 6 completed months of age grow well.
3. Mother with a 12-month-old baby who thinks that the baby is too old to breastfeed any longer.	a b c (d)	c. Growing children of this age need 3–4 meals per day, plus 1–2 snacks if hungry, in addition to milk.
4. Mother of a non-breastfed child who is 11 months old.	(a) b c d	d. Breastfeeding to at least 2 years of age helps a child to grow strong and healthy.

Exercise 10.E Using simple language

How to do the exercise:

Below are two pieces of information that you might want to give to mothers.

The information is correct, but it uses technical terms that a mother who is not a health worker might not understand.

Rewrite the information in simple language that a mother could easily understand.

Example:

Information	Using simple language
Dark-green leaves and yellow- coloured fruit and vegetables are rich in vitamin A.	*Dark-green leaves and yellow-coloured vegetables help the child to have healthy eyes and fewer infections.*

To answer:

Information	Using simple language
1. Breastfeeding beyond 6 months of age is good, as breast milk contains absorbable iron, calories and zinc.	*Breastfeeding to at least 2 years of age helps a child to grow strong and healthy.*
2. Non-breastfed children aged 14 months should receive protein, zinc and iron in appropriate quantities.	*For children who are not breastfeeding, it is helpful to give an animal-source food each day.*

Exercise 10.F Making one or two suggestions, not commands

How to do the exercise:

Below are some commands that you might want to give to a mother.

Rewrite the commands as suggestions. In your answer, you only need to give ONE answer.

The box below gives some examples of ways to make suggestions, not commands. You may find this helpful when doing the exercises.

Making suggestions, not commands

Commands use the imperative form of verbs (give, do, bring) and words such as *always, never, must, should*.

Suggestions include:

- Have you considered…?
- Would it be possible…?
- What about trying… to see if it works for you?
- Would you be able to?
- Have you thought about…? Instead of…?
- You could choose between… and…and…
- It may not suit you, but some mothers… a few women…
- Perhaps… might work.
- Usually… Sometimes… Often…

Example:

Command	Suggestions
"You must start complementary foods when your baby is 6 completed months old."	*Children who start complementary foods at 6 completed months grow well and are active and content.* *Could you start some foods in addition to milk now that your baby is 6 completed months old?*

To answer:

Command	Suggestions
"You must use thick foods."	*Family foods with a thick consistency nourish and fill the child.* *Would you be able to use thicker foods?*
"Your child should be eating a full bowl of food by 1 year of age."	*Increasing amounts of food helps a child grow.* *Could you give your child a full bowl of food at mealtimes?*

- Give participants the Answer sheets for EXERCISES 10.A to 10.F.
- If some participants are having difficulties with the exercises, or have not finished them, arrange to help them later.
- Ask participants whether they have any questions about the exercises, and try to answer them.

Notes

Notes (contd)

Module 3

Breastfeeding

Session 11

Why breastfeeding is important 1

Objectives

After completing this session, participants will be able to:

- state the advantages of exclusive breastfeeding
- list the risks of artificial feeding
- describe the main differences between breast milk and artificial milks

Session outline . . . . . 60 minutes

Participants are all together for a lecture presentation by one trainer, followed by group work with all trainers.

I. Introduce the session, present **Slide 11/1** . . . . . 3 minutes
II. Facilitate group work and plenary discussion . . . . . 15 minutes
III. Present **Slides 11/2** to **11/11** . . . . . 25 minutes
IV. Present COUNSELLING CARDS 1 and 2 . . . . . 15 minutes
V. Summarize the session . . . . . 2 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides and facilitating group discussion.
- Study the **Slides 11/1** to **11/11** and the text that goes with them, so that you are able to present them.
- Set three flipcharts out round the room, with the titles IMPORTANCE OF BREASTFEEDING TO INFANT, IMPORTANCE OF BREASTFEEDING TO MOTHER and RISKS OF NOT BREASTFEEDING.
- Have ready COUNSELLING CARD 1: DURING THE FIRST 6 MONTHS, YOUR BABY NEEDS ONLY BREAST MILK; COUNSELLING CARD 2: THE IMPORTANCE OF EXCLUSIVE BREASTFEEDING DURING THE FIRST 6 MONTHS, and the *Guidance on the use of counselling cards*.
- You will introduce the cards before presenting **Slide 11/10**.
- Read the *Guidance on the use of counselling cards*, so you are familiar with the methodology to introduce the Counselling cards to participants.
- Read the **Further information** sections, so that you are familiar with the ideas that they contain, so that you can answer participants' questions.

As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the session — 3 minutes

- **Make these points:**
  - The World Health Organization (WHO) and United Nations Children's Fund (UNICEF) recommend that infants should be exclusively breastfed for the first 6 months of life, starting within 1 hour after birth, and to continue breastfeeding up to 2 years of age or beyond.
  - You need to understand why breastfeeding is important, so you can help to support mothers who may have doubts about the value of breast milk.
  - You also need to know the differences between breast milk and artificial milks.
- **Show Slide 11/1 – Session 11 – objectives and read out the objectives:**

> 11/1
>
> **Session 11: Why breastfeeding is important 1 – objectives**
>
> After completing this session, participants will be able to:
> - state the advantages of optimal breastfeeding
> - list the risks of artificial feeding
> - describe the main differences between breast milk and artificial milks

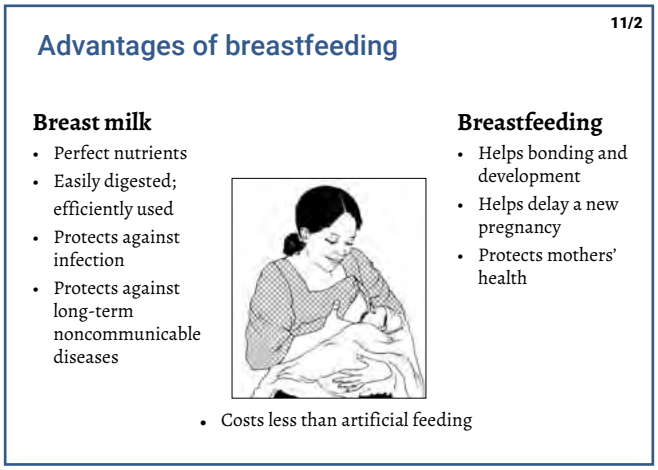
- **Make the following points:**
  - We will review the rationale for the breastfeeding recommendations, with emphasis on exclusive breastfeeding for the first 6 months of life.
  - To do that, you will have workgroup discussions, followed by plenary discussion and a presentation to share up-to-date evidence on breastfeeding.

II. Facilitate group work and plenary discussion — 15 minutes

- **Divide participants into three groups. Each group will be with one trainer/facilitator.**
- **Make the following points:**
  - Now you will work in groups.
  - You will find three flipcharts set throughout the room (*let them know where the flipcharts are*).
  - One flipchart has the title IMPORTANCE OF BREASTFEEDING TO INFANT, the second IMPORTANCE OF BREASTFEEDING TO MOTHER and the last RISKS OF NOT BREASTFEEDING.
  - Each group will have about 3 minutes at each flipchart, to write as many points as you can think of; you should not repeat what is already listed.
  - Groups will rotate to the next flipchart and repeat the exercise until the three groups have written something on each of the three flipcharts.
  - At the end of the exercise, you will get back to your places, so we can continue with the plenary session.
- **Ask a representative of group 1 to present the list on the first flipchart (IMPORTANCE OF BREASTFEEDING TO INFANT) and ask the other groups to contribute or make clarifications they consider necessary.**
- **Then ask a representative of group 2 to present the list on the second flipchart (IMPORTANCE OF BREASTFEEDING TO MOTHER) and ask the other groups to contribute or make clarifications they consider necessary.**

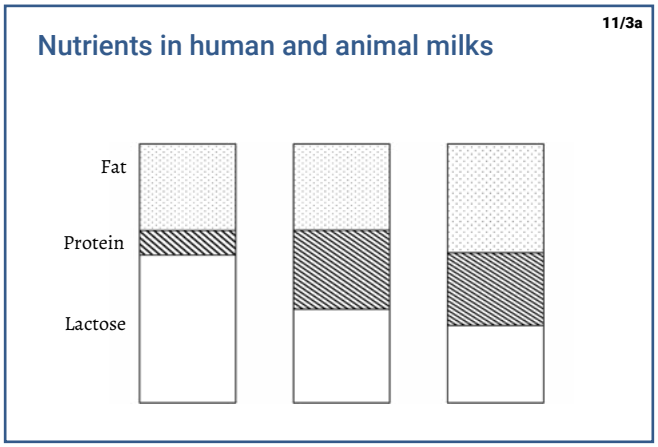
III. Present **Slides 11/2** to **11/11** 25 minutes

► Show **Slide 11/2 – Advantages of breastfeeding** and make the points that follow, considering the participants' contribution and avoiding repetitions:

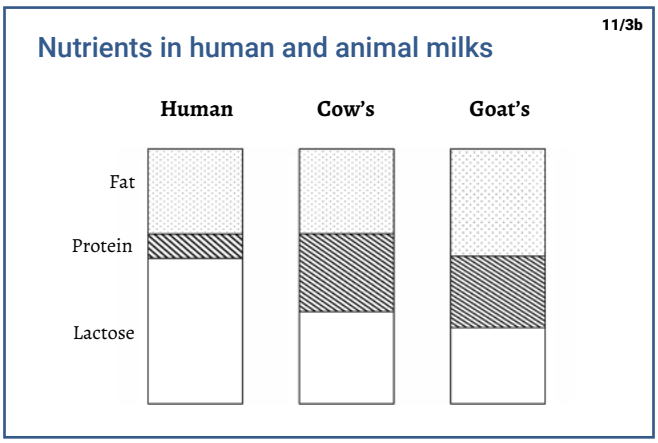


- This diagram summarizes the main advantages of breastfeeding.
- It is useful to think of the advantages of both breast milk (listed on the left) and the process of breastfeeding (listed on the right) (*refer to what the participants mentioned*).
- The advantages of a baby having breast milk are that:
  - it contains exactly the nutrients that a baby needs
  - it is easily digested and efficiently used by the baby's body
  - it protects a baby against infection
  - it provides long-term protection against chronic noncommunicable diseases such as obesity, hypertension and diabetes.
- The other advantages of breastfeeding are that:
  - it costs less than artificial feeding
  - it helps a mother and baby to bond – that is, to develop a close, loving relationship
  - it helps a baby's development
  - it can help to delay a new pregnancy
  - it protects a mother's health:
    - it helps the uterus to return to its previous size; this helps to reduce bleeding, and may help to prevent anaemia
    - it also reduces the risk of ovarian cancer and breast cancer in the mother.
- In the next few slides, we will look at some of these advantages in more detail.

- Show **Slide 11/3a – Nutrients in human and animal milks** and ask participants which one represents human, cow's and goat's milk:

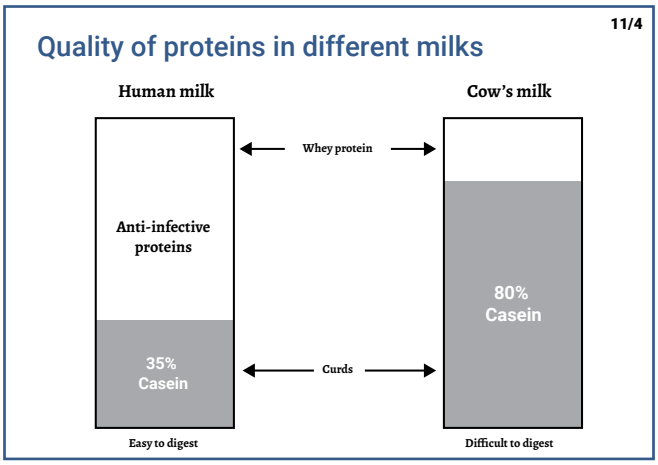


- If answered correctly, congratulate the participant(s) and continue.
- Show **Slide 11/3b – Nutrients in human and animal milks** and make the points that follow:



  - First, we will look at the nutrients in breast milk, to see why they are perfect for a baby.
  - Formula milks are made from a variety of products, including animal milks, soybean and vegetable oils. Although they have been adjusted so that they are more like human milk, they are still far from perfect for babies.
  - In order to understand the composition of formula milk, we need to understand the differences between animal and human milk and how animal milks need to be modified to produce formula milk.
  - This chart compares the nutrients in breast milk with the nutrients in fresh cow's and goat's milk.
  - All the milks contain fat, which provides energy, protein for growth and a milk sugar called lactose, which also provides energy.
  - *Ask: What is the difference between the amount of protein in human milk and the amount in animal milks?*
- Wait for a few replies and then continue.
  - The animal milk contains more protein than human milk.
  - It is difficult for a baby's immature kidneys to excrete the extra waste from the protein in animal milks.
  - Human milk also contains essential fatty acids that are needed for a baby's growing brain and eyes, and for healthy blood vessels. These fatty acids are not present in animal milks, but may have been added to formula milk.
  - *Ask: What are the differences in milk proteins between human and cow's milk?*
- Wait for a few answers and then continue. Refer to the correct responses when reviewing the slide.

► Show **Slide 11/4 – Quality of proteins in different milks** and make the points that follow:

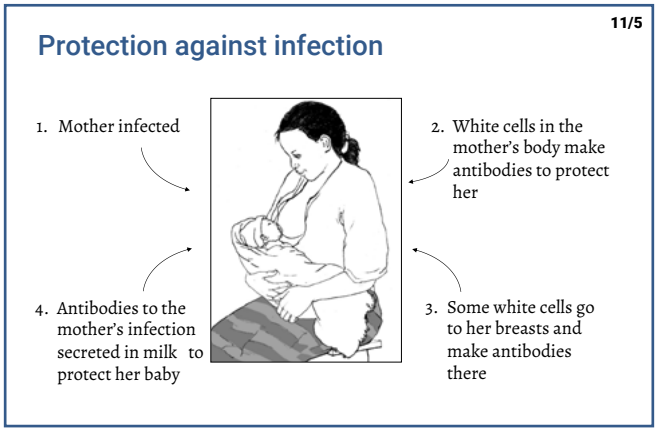


- The protein in different milks varies in quality, as well as in quantity. While the quantity of protein in cow's milk can be modified to make formula milk, the quality of proteins cannot be changed.
- This chart shows that much of the protein in cow's milk is casein.
- *Ask: What happens if human babies consume too much casein?*

► Wait for a few replies and then continue.

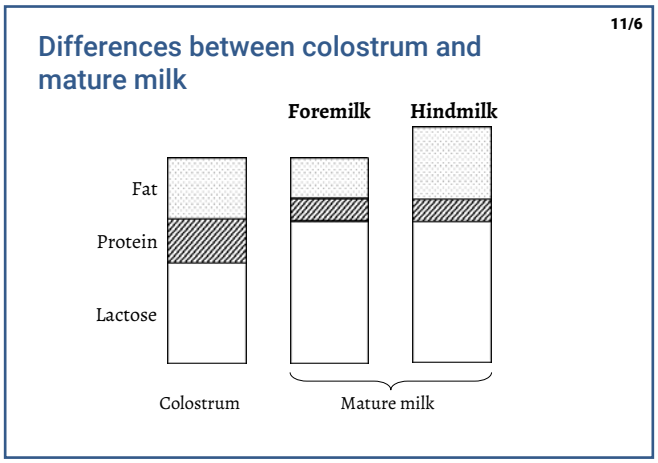
- Casein forms thick, indigestible curds in a baby's stomach.
- You can see in the diagram that human milk contains more whey proteins.
- The whey proteins contain anti-infective proteins, which help to protect a baby against infection.
- Artificially fed babies may develop intolerance to protein from animal milk. They may develop diarrhoea, abdominal pain, rashes and other symptoms when they have feeds that contain the different kinds of protein.

► Show **Slide 11/5 – Protection against infection** and make the points that follow:



- Breast milk contains white blood cells, and a number of anti-infective factors, which help to protect a baby against many infections. Breastfeeding protects babies against diarrhoeal and respiratory illness and also ear infections, meningitis and urinary tract infections.
- Breast milk also contains antibodies against infections that the mother has had in the past.
- This diagram shows that when a mother develops an infection (1), white cells in her body become active, and make antibodies against the infection to protect her (2).
- Some of these white cells go to her breasts and make antibodies (3), which are secreted in her breast milk to protect her baby (4).
- So a baby should not be separated from their mother when she has an infection, because her breast milk protects the baby against the infection.

► Show **Slide 11/6 – Differences between colostrum and mature milk** and make the points that follow:



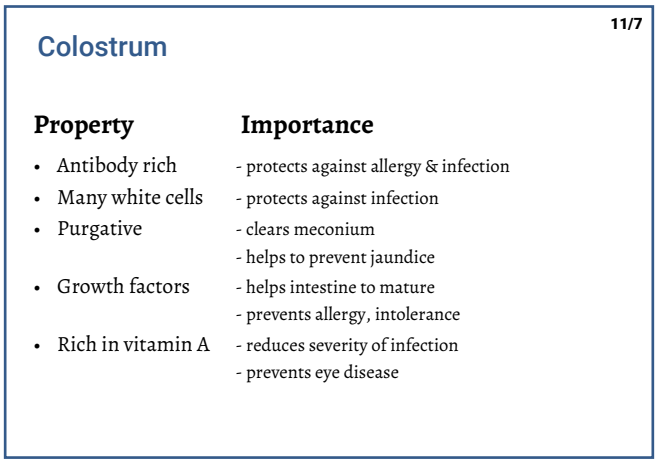
- The composition of breast milk is not always the same. It varies according to the age of the baby, and from the beginning to the end of a feed. This chart shows some of the main variations.
- *Ask: What differences do you notice between the different types of breast milk?*

► Wait for a few replies and then continue.

- Colostrum is the special breast milk that women produce in the first few days after delivery. It is thick, and yellowish or clear in colour. It contains more protein than later milk (*point to the area on the graph*).
- After a few days, colostrum changes into mature milk. There is a larger amount of mature milk, and the breasts feel full, hard and heavy. Some people call this the milk "coming in".
- Foremilk is the thinner milk that is produced early in a feed. It is produced in large amounts and provides plenty of protein, lactose, water and other nutrients. Babies do not need other drinks of water before they are 6 months old, even in a hot climate.
- Hindmilk is the whiter milk that is produced later in a feed. It contains more fat than foremilk, which is why it looks whiter (*point to the area on the graph*). This fat provides much of the energy of a breastfeed, which is why it is important not to take the baby off a breast too quickly.
- Mothers sometimes worry that their milk is "too thin". Milk is never "too thin". It is important for a baby to have both foremilk and hindmilk to get a complete "meal" that includes all the water that they need.
- *Ask: Why is colostrum so important?*

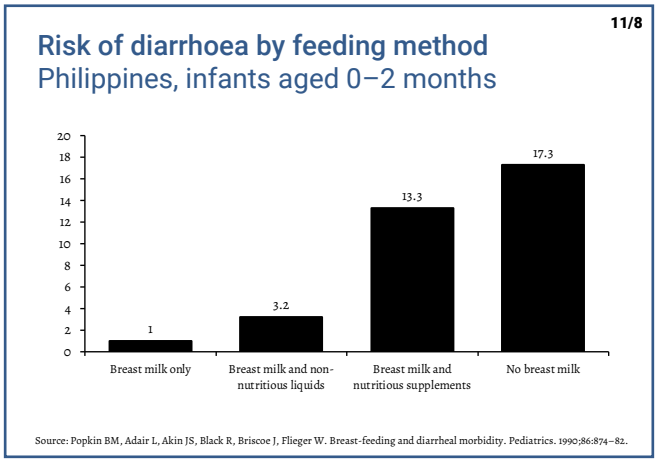
► Wait for a few answers and continue with **Slide 11/7**.

► Show **Slide 11/7 – Colostrum** and make the points that follow:



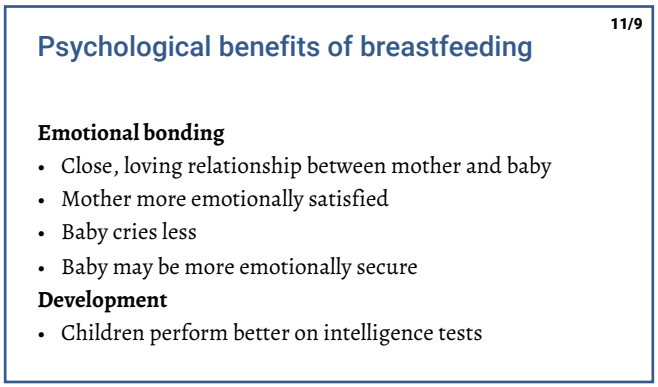
- This chart shows the special properties of colostrum, and why it is important.
- Colostrum contains more antibodies and other anti-infective proteins than mature milk. This is part of the reason why colostrum contains more protein than mature milk.
- It contains more white blood cells than mature milk.
- Colostrum helps to prevent the bacterial infections that are a danger to newborn babies and provides the first immunization against many of the diseases that a baby meets after delivery.
- Colostrum has a mild purgative effect, which helps to clear the baby's gut of meconium (the first dark stools). This clears bilirubin from the gut, and helps to prevent jaundice from becoming severe.
- Colostrum contains many growth factors that help a baby's immature intestine to develop after birth. This helps to prevent the baby from developing allergies and intolerance to other foods.
- Colostrum is rich in vitamin A, which helps to reduce the severity of any infections the baby might have.
- So it is very important for babies to have colostrum for their first few feeds. Colostrum is ready in the breasts when a baby is born.
- Babies should not be given any drinks or foods before they start breastfeeding. Artificial feeds given before a baby has colostrum are likely to cause allergy and infection.

► Show **Slide 11/8 – Risk of diarrhoea by feeding method** and make the points that follow:



- This chart shows how breastfeeding protects a baby against diarrhoea.
- The chart shows the main findings of a study from the Philippines. It compares how often babies fed in different ways get diarrhoea.
- The bar on the left is for babies who were exclusively breastfed. The bar is small, because very few babies who are exclusively breastfed get diarrhoea.
- The bar on the right is for artificially fed babies, who received no breast milk. This column is 17 times taller, because these babies were 17 times more likely to get diarrhoea than babies fed only on breast milk.
- Some of the babies were given breast milk and other feeds or fluids, here called "nutritious supplements". These babies were more likely to have diarrhoea than exclusively breastfed babies, but less likely than babies who received no breast milk at all (*point to the two bars in the middle of the chart*).
- Artificially fed babies get diarrhoea more often, partly because artificial feeds lack anti-infective factors, and partly because artificial feeds are often contaminated with harmful bacteria. Breast milk is not contaminated,
- Breastfeeding also protects against respiratory illness. Mortality from pneumonia is increased in babies who are not exclusively breastfed.
- Other studies have shown that breastfeeding also protects babies against other infections, for example ear infections, meningitis and urinary tract infections.

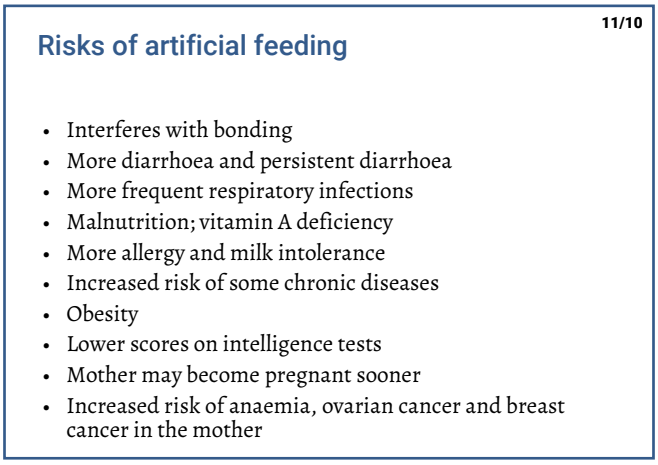
► Show **Slide 11/9 – Psychological benefits of breastfeeding** and make the points that follow:



- Breastfeeding has important psychological benefits for both mothers and babies.
- Close contact from immediately after delivery helps the mother and baby to bond and helps the mother to feel emotionally satisfied. Babies tend to cry less if they are breastfed and may be more emotionally secure.
- Some studies suggest that breastfeeding may help a child to develop intellectually. Low-birth-weight babies fed breast milk in the first weeks of life perform better on intelligence tests in later childhood than children who are artificially fed.
- If mothers are not breastfeeding, for a medical reason, it is important to help them to bond with their babies in other ways apart from breastfeeding.

► Ask a representative of group 3 to present the list of the third flipchart (RISKS OF NOT BREASTFEEDING) and ask the other groups to contribute or make clarifications they consider necessary.

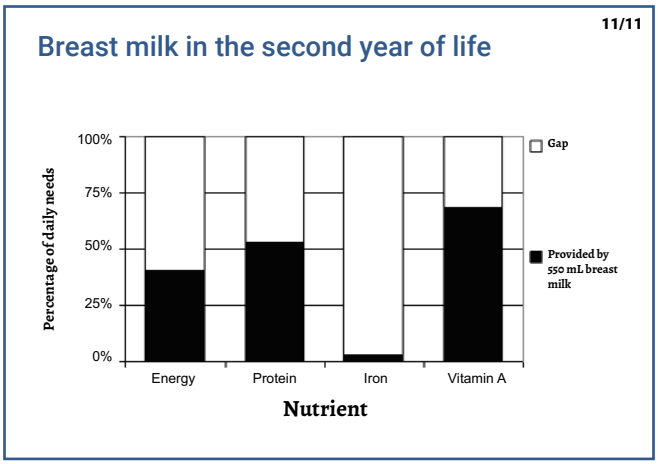
► Show **Slide 11/10 – Risks of artificial feeding** and make the points that follow, referring to what was mentioned by participants and avoiding repetitions:



- This slide summarizes the risks of artificial feeding.
- Artificial feeding may interfere with bonding. The mother and baby may not develop such a close, loving relationship.
- An artificially fed baby is more likely to become ill with diarrhoea, respiratory and other infections. The diarrhoea may become persistent.
- The baby may get too little milk and become malnourished because they receive too few feeds or because the feeds are too dilute. The baby is more likely to suffer from vitamin A deficiency.
- The baby is more likely to develop allergic conditions such as eczema, and possibly asthma.
- The baby may become intolerant of animal milk, so that the milk causes diarrhoea, rashes and other symptoms.
- The risk of some chronic diseases in the child, such as diabetes, is increased.
- A baby may get too much artificial milk, and become obese.

- The baby may not develop so well mentally, and may score lower on intelligence tests.
- A mother who does not breastfeed may become pregnant sooner. She is more likely to become anaemic after childbirth, and later to develop cancer of the ovary or the breast.
- So, artificial feeding may be harmful for children and their mothers.

▶ Show **Slide 11/11 – Breast milk in the second year of life** and make the points that follow:



- For the first 6 months of life, exclusive breastfeeding can provide all the nutrients and water that a normal, full-term baby needs.
- From the age of 6 months, breast milk is no longer sufficient by itself. In Session 1, we learnt that all babies need complementary foods from 6 months, in addition to breast milk.
- However, breast milk continues to be an important source of energy and high-quality nutrients beyond 6 months of age. We will discuss this in more detail in the sessions on complementary feeding.
- This chart shows how much of a child's daily energy and nutrient needs can be supplied by breast milk during the second year of life.
- *Ask: How much of the protein that a child needs in the second year can breast milk provide? How much of the energy that a child needs in the second year can breast milk provide?*

▶ Wait for a few replies and then continue.

- Breast milk can provide up to 40% of the energy needs of a young child in second year of life and half of the protein a child needs.
- *Ask: How much of the vitamin A that a child needs can breast milk provide?*

▶ Wait for a few replies and then continue.

- Breast milk can provide about 75% of the vitamin A that a child needs, provided the mother is not deficient in vitamin A herself.

IV. Present Counselling cards 1 and 2 — 15 minutes

- Tell participants that they will review Counselling card 1: During the first 6 months, your baby needs ONLY breast milk and Counselling card 2: The importance of exclusive breastfeeding during the first 6 months.
- Model the use of Counselling card 1 to the entire group of participants – applying the steps: Assess, Analyse and Act.
- Write on a flipchart the word Assess and *ask* the following questions to the group:
  - *What do you see in this card?*
  - *What does each image represent?*
  - *What recommended practice(s) is/are shown?*
- Write on a flipchart the word Analyse and *ask* the following questions to the group:
  - *What do you think about this card?*
  - *Is there anything you disagree with – or think would not be possible? Please explain.*
  - *What are the advantages of adopting the recommended practice(s)?*
- If mothers/caregivers in this community were in the same situation, would they be willing to try the recommended practice(s)? Why? Why not?
  - If YOU were the mother/caregiver in the Counselling card, would YOU be willing to try the new practice(s)?
  - What difficulties might you experience?
  - How would you be able to overcome them?
- Write on a flipchart the word Act and *ask* the following questions to the group:
- Distribute and discuss How to use a counselling card from the *Guidance on the use of counselling cards*.
- Ask participants to form pairs; one participant from each pair will act as "counsellor" and demonstrate the use of Counselling card 1 to the other participant "mother", applying the steps: Assess, Analyse and Act.
- After 10 minutes, ask pairs to switch their roles and the "counsellor" will demonstrate the use of Counselling card 2 to the other participant "mother", applying the steps: Assess, Analyse and Act.
- Refer participants to the sections in the *Guidance on the use of counselling cards* on Key practices and discussion points for Counselling cards 1 and 2, and Positive counselling skills.

V. Summarize the session — 2 minutes

- Ask participants whether they have any questions, and try to answer them.
- Explain that a summary of this session can be found on pages 59–63 of the *Participant's manual*.

Further information

Sugar

The sugar lactose is the main carbohydrate in milk. None of the milks contain the carbohydrate starch. Starch is a very important nutrient for older children and adults – it is the main nutrient in staple foods, and in many complementary foods. But young babies cannot digest starch easily, so it is not appropriate to give them starchy foods in the first few months of life. Breast milk contains more lactose than other milks.

Protein

There is some casein in human milk, but less than in cow's milk, and it forms soft curds that are easier to digest.

The whey proteins in animal and human milks are different. Human milk contains alpha-lactalbumin and cow's milk contains beta-lactoglobulin.

In addition, the proteins in animal milks and formula milk contain a different balance of amino acids from breast milk, which may not be ideal for a baby. Animal milk and formula milk may lack the amino acid cystine, and formula milk may lack taurine, which neonates need especially for brain growth. Taurine is now sometimes added to formula milks.

The anti-infective proteins in human milk include lactoferrin (which binds iron, and prevents the growth of bacteria which need iron) and lysozyme (which kills bacteria), as well as antibodies (immunoglobulin, mostly IgA).

Other important anti-infective factors include the bifidus factor (which promotes the growth of Lactobacillus bifidus. L. bacillus inhibits the growth of harmful bacteria, and gives breastfed babies' stools their yoghurty smell). Breast milk also contains antiviral and antiparasitic factors.

Babies who develop intolerance to animal proteins may develop diarrhoea that becomes persistent. Babies who are fed animal milks or formula milk are also more likely than breastfed babies to develop allergies, which may cause eczema. A baby may develop intolerance or allergy after only a few artificial feeds given in the first few days of life.

Vitamins

The amounts of vitamins are different in breast milk and animal milks. Cow's milk has plenty of the B vitamins, but does not contain as much vitamin A and vitamin C as human milk. Breast milk contains plenty of vitamin A, if the mother has enough in her diet. Breast milk can supply much of the vitamin A that a child needs, even in the second year of life.

Vitamin A supplements for post-partum mothers

Do not give a mother high-dose capsules of vitamin A (over 10 000 units daily) for more than 4–6 weeks after she has given birth. After 6 weeks, there is a slight possibility that she could be pregnant, and if a high dose of vitamin A is given in early pregnancy, it could damage the fetus. High-dose vitamin A supplementation for post-partum mothers is no longer recommended by WHO.

B vitamins in different milks

For some B vitamins, the amount in human milk is the same as or more than in cow's milk, but for most of them the amount in cow's milk is 2–3 times higher than in breast milk. These high levels are more than a baby needs. Goat's milk lacks the B vitamin folic acid, and this can cause anaemia.

Vitamin C

Health workers often recommend giving babies fruit juice from a very early age, to provide vitamin C. This may be necessary for artificially fed babies, but it is not necessary for breastfed babies.

Iron

Different milks contain similar very small amounts of iron. However, only about 10% of the iron in cow's milk is absorbed, but about 50% of the iron from breast milk is absorbed. Babies fed on cow's milk may not get enough iron, and they often become anaemic.

Some brands of formula milk have iron added. This added iron is not well absorbed, so a large amount has to be added to ensure that a baby gets enough iron to protect against anaemia.

Added iron may make it easier for some kinds of bacteria to grow, which may increase the chances of some kinds of infection, for example, meningitis and septicaemia.

Foremilk and hindmilk

There is no sudden change from "fore" to "hind"milk. The fat content increases gradually from the beginning to the end of a feed.

Protection against infection

The main immunoglobulin in breast milk is IgA – often called "secretory" immunoglobulin A. It is secreted within the breast into the milk, in response to the mother's infections.

This is different from other immunoglobulins (such IgG), which are carried in the blood.

Intolerance and allergies to milk proteins

Colostrum and breast milk contain many hormones and growth factors. The function of all of them is not certain. However, epidermal growth factor, which is present in both, has been shown to stimulate growth and maturation of the intestinal villi. Undigested cow's milk proteins can pass through the immature infant gut into the blood, and may cause intolerance and allergy to milk protein. Epidermal growth factor helps to prevent the absorption of large molecules by stimulating rapid development of the gut. This "seals" the baby's intestine, so that it is more difficult for proteins to be absorbed without being digested.

Antibodies probably help to prevent allergies by coating the intestinal mucosa, and preventing the absorption of larger molecules.

Vitamin A from breast milk in the second year of life

There are different estimates of how much of a child's vitamin A requirements can be provided by breastfeeding in the second year, ranging from 38% to 75%. The amount depends on the mother's vitamin A status, and the volume of breast milk consumed. However, what we do know is that breastfeeding in the second year provides useful protection to the child against vitamin A deficiency.

Vitamin C from breast milk in the second year of life

Breast milk can provide almost all of the vitamin C that a child needs, provided the mother herself is not deficient.

Colostrum and breast milk contain many hormones and growth factors. The function of all of them is not certain. However, epidermal growth factor, which is present in both, has been shown to stimulate growth and maturation of the intestinal villi. Undigested cow's milk proteins can pass through the immature infant gut into the blood, and may cause intolerance and allergy to milk protein. Epidermal growth factor helps to prevent the absorption of large molecules by stimulating rapid development of the gut. This "seals" the baby's intestine, so that it is more difficult for proteins to be absorbed without being digested. Antibodies probably help to prevent allergies by coating the intestinal mucosa, and preventing the absorption of larger molecules. Bacteria also can pass through the immature gut into the tissues more easily than they can pass through the mature gut.

The *Lancet* series on Breastfeeding (2016)[1]

The *Lancet* Breastfeeding series shows why breastfeeding is one of the highest-impact interventions, providing benefits for children, women, and society. Breastfeeding reduces infant morbidity and mortality and is associated with increased intelligence quotient (IQ) score, improved school achievement, and higher adult earnings – all essential for reducing poverty. It also contributes to equity by giving all children a nutritional head start for success in life. For many people living in poverty, malnutrition remains a prime contributor to stunted development, and this *Lancet* series documents how breastfeeding can make a lasting difference. This series suggests that, alongside other factors, breastfeeding could have an important role in addressing inequality, by providing equal opportunity to all children to grow and contribute to national economies, and countries such as Bangladesh and Brazil show that it is possible to increase breastfeeding rates with comprehensive strategies. The evidence on breastfeeding leaves no doubt that it is a smart and cost-effective investment in a more prosperous future.

[1] Lancet series: Breastfeeding. Lancet. 2016;387:404–504.

Special issue of *Acta Paediatrica*: Impact of breastfeeding on maternal and child health (2015)[1]

The papers presented here clearly demonstrate that breastfeeding protects against a spectrum of adverse health outcomes, over and above these traditional perspectives. In one of the papers, the authors document substantially higher rates of mortality among infants who were never breastfed, compared to those who were exclusively breastfed in the first 6 months of life and receiving continued breastfeeding beyond. Otitis media occurs nearly twice as frequently among those who are not exclusively breastfed in the first 6 months. The papers in this supplement demonstrate that many of the benefits of breastfeeding are experienced well beyond the period that breastfeeding is stopped. Children who were breastfed have a lower risk of obesity, higher IQs, reduced malocclusion and less asthma. Breastfeeding mothers likewise benefit from having breastfed, with lower rates of breast cancer, ovarian cancer, type 2 diabetes and postpartum depression. These multiple benefits of breastfeeding demonstrate the contribution and relevance of breastfeeding as a global public health issue, for low- and high-income populations alike. The mechanisms by which breastfeeding affect health are extremely varied; for example, many of the maternal benefits of breastfeeding are probably related to the hormonal effects of producing milk over a long period. For some outcomes in the child, the composition of the milk itself is probably important. Long-chain polyunsaturated fatty acids may be important for intellectual development; ghrelin and leptin in the milk may be important for appetite regulation; pathogen-specific antibodies may be important for protection against otitis media; and nonspecific immune factors may be important for asthma. On the other hand, the feeding of breast milk from a bottle or cup, rather than feeding directly from the breast, may be more important for outcomes such as malocclusion or obesity. Even when most of the infant's diet comes from breastfeeding, small amounts of breast-milk substitutes can substantially alter the intestinal flora, with health outcomes yet to be fully elucidated. Breastfeeding practices are responsive to interventions delivered in health systems, communities and homes. The largest effects are achieved when interventions are delivered in combination.

Notes

[1] Special issue: Impact of breastfeeding on maternal and child health. Acta Paed. 2015;104(Suppl. 467):1–134.

Notes (contd)

Session 12

How breastfeeding works 1

Objectives

After completing this session, participants will be able to:

- name the main parts of the breast and describe their function
- describe the hormonal control of production and ejection of breast milk
- describe the difference between good and poor attachment of a baby at the breast
- describe the difference between effective and ineffective suckling

Session outline . . . . . 60 minutes

Participants are all together for a lecture presentation by one trainer.

I. Introduce the session, present **Slide 12/1** . . . . . 5 minutes

II. Present **Slides 12/2** to **12/11** and COUNSELLING CARD 3 . . . . . 50 minutes

III. Summarize the session . . . . . 5 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides and facilitating group discussion.
- Study the **Slides 12/1** to **12/11** and the text that goes with them, so that you are able to present them.
- Have ready COUNSELLING CARD 3: GOOD ATTACHMENT, and the *Guidance on the use of counselling cards*.
- Read the *Guidance on the use of counselling cards*, so you are familiar with the methodology to introduce the Counselling cards to participants.
- Read the **Further information** sections, so that you are familiar with the ideas that they contain, so that you can answer participants' questions.

As you follow the text, remember:

▶ indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the session — 5 minutes

► Show **Slide 12/1 – Session 12 – objectives** and read out the objectives:

12/1

Session 12: How breastfeeding works 1 – objectives

After completing this session, participants will be able to:

- name the main parts of the breast and describe their function
- describe the hormonal control of production and ejection of breast milk
- describe the difference between good and poor attachment of a baby at the breast
- describe the difference between effective and ineffective suckling

► Make the following points:

- In order to help mothers, you need to understand how breastfeeding works.
- You cannot learn a specific way of counselling for every situation, or every difficulty. But if you understand how breastfeeding works, you can work out what is happening, and help each mother to decide what is best for her.

II. Present **Slides 12/2** to **12/11** and COUNSELLING CARD 3 — 50 minutes

► Ask participants to form four working groups, in which each group draws and labels:

- The breast as it looks on the outside
- The breast as it looks from the inside

In the large group:

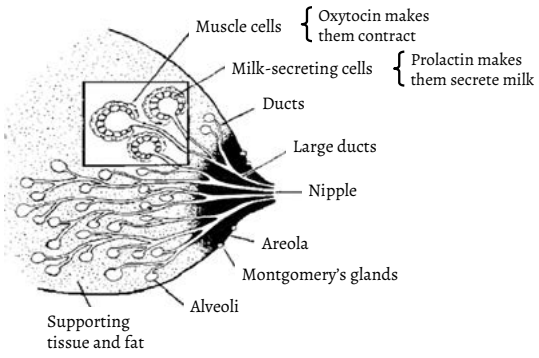
► Ask one group to explain the outside drawing and others to comment.

► Ask another group to explain the inside drawing and others to comment.

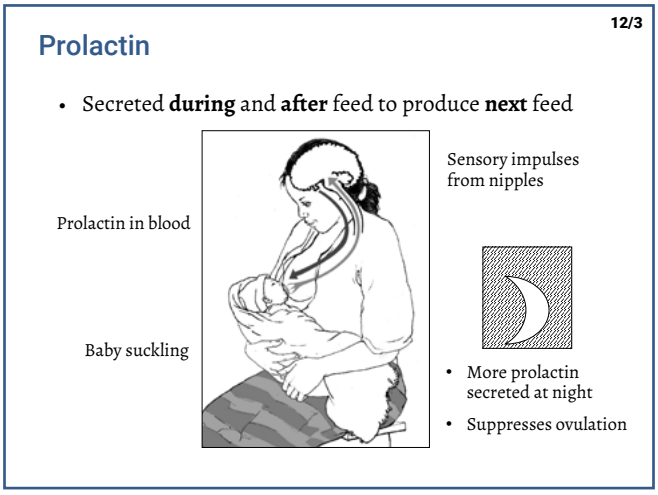
► Show **Slide 12/2 – Anatomy of the breast** and compare drawings with the slide, noting similarities and correcting misinformation:

12/2

Anatomy of the breast



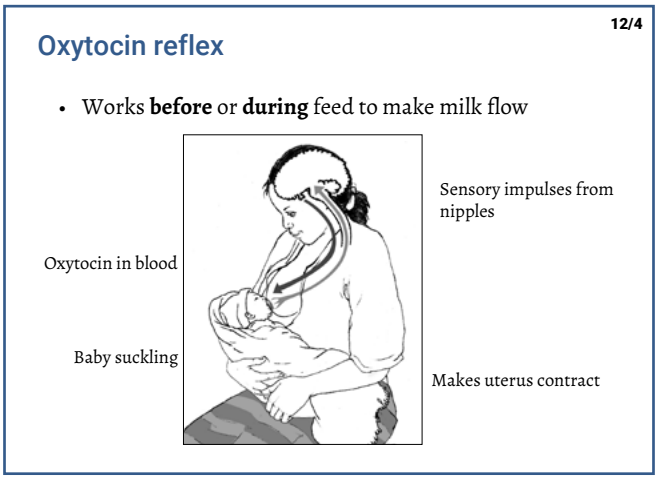
- **Make the points that follow, as appropriate and to complement what was discussed in the large group:**
  - This diagram shows the anatomy of the breast.
  - First, look at the nipple and the dark skin called the areola that surrounds it. In the areola are small glands called Montgomery's glands, which secrete an oily fluid to keep the skin healthy (clean and lubricated) (*point to the relevant parts of the diagram on the slide as you explain them*).
  - Inside the breast are the alveoli, which are very small sacs made of milk-secreting cells. There are millions of alveoli – the diagram shows only a few. The box shows three of the alveoli enlarged. A hormone called prolactin makes these cells produce milk.
  - Around the alveoli are muscle cells, which contract and squeeze out the milk. A hormone called oxytocin makes the muscle cells contract.
  - Small tubes, or ducts, carry milk from the alveoli to the outside. Between feeds, milk is stored in the alveoli and small ducts.
  - The larger ducts beneath the areola dilate during feeding and hold the breast milk temporarily during the feed.
  - The secretory alveoli and ducts are surrounded by supporting tissue and fat.
  - *Ask: Some mothers think their breasts are too small to produce enough milk. What is the difference between large breasts and small breasts?*
- **Wait for a few replies and then continue.**
  - It is the fat and other tissue that give the breast its shape, and that make most of the difference between large and small breasts.
  - Small breasts and large breasts both contain about the same amount of gland tissue, so they can both make plenty of milk.
- **Ask one of the working groups to explain how milk is produced; ask the other groups to add additional points.**
- **Show Slide 12/3 – Prolactin and make the points that follow:**



  - This diagram explains about the hormone prolactin.
  - When a baby suckles at the breast, sensory impulses go from the nipple to the brain. In response, the pituitary gland at the base of the brain secretes prolactin.
  - Prolactin goes in the blood to the breast, and makes the milk-secreting cells produce milk.
  - Most of the prolactin is in the blood about 30 minutes after the feed – so it makes the breast produce milk for the next feed. For this feed, the baby takes the milk that is already in the breast.
  - *Ask: What does this suggest about how to increase a mother's milk supply?*
- **Wait for a few replies and then continue.**
  - It tells us that if her baby suckles more, her breasts will make more milk. So, suckling makes more milk.

- If a mother has two babies, and they both suckle, her breasts make milk for two. If a baby stops suckling, the breasts soon stop making milk.
- Sometimes people suggest that to make a mother produce more milk, we should give her more to eat, more to drink, more rest or medicines. It is important for a mother to eat and drink enough, but these things do not help her to produce milk if her baby does not suckle.
- Some special things to remember about prolactin are:
  - More prolactin is produced at night, so breastfeeding at night is especially helpful for keeping up the milk supply.
  - Hormones related to prolactin suppress ovulation, so breastfeeding can help to delay a new pregnancy. Breastfeeding at night is important for this.

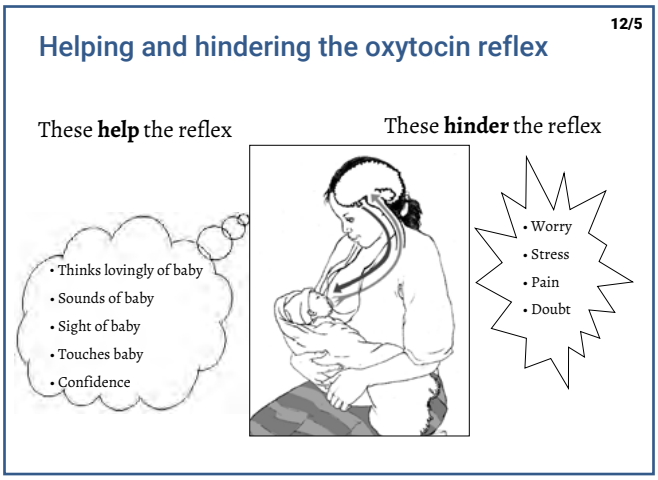
▶ Show **Slide 12/4 – Oxytocin reflex** and make the points that follow:



▶ Make the points that follow, as needed:

- This diagram explains about the hormone oxytocin.
- When a baby suckles, sensory impulses go from the nipple to the brain. In response, the pituitary gland at the base of the brain secretes the hormone oxytocin.
- Oxytocin goes in the blood to the breast, and makes the muscle cells around the alveoli contract.
- This makes the milk that has collected in the alveoli flow along the ducts to the larger ducts beneath the areola. Here the milk is stored temporarily during the feed. This is the oxytocin reflex, the milk-ejection reflex or the "let-down" reflex.
- Oxytocin is produced more quickly than prolactin. It makes the milk in the breast flow for **this** feed. Oxytocin can start working before a baby suckles, when a mother learns to expect a feed.
- If the oxytocin reflex does not work well, the baby may have difficulty in getting the milk. It may seem as if the breasts have stopped producing milk. However, the breasts are producing milk, but it is not flowing out.
- Another important point about oxytocin is that it makes a mother's uterus contract after delivery. This helps to reduce bleeding, but it sometimes causes uterine pain and a rush of blood during a feed for the first few days. The pains can be quite strong.

► Show **Slide 12/5 – Helping and hindering the oxytocin reflex** and make the points that follow:



- This diagram shows how the oxytocin reflex is easily affected by a mother's thoughts and feelings.
- Good feelings, for example feeling pleased with her baby, or thinking lovingly of them, and feeling confident that her milk is the best for the baby, can help the oxytocin reflex to work and her milk to flow. Sensations such as touching or seeing her baby, or hearing them cry, can also help the reflex.
- But bad feelings, such as pain, or worry, or doubt that she has enough milk, can hinder the reflex and stop her milk from flowing. Fortunately, this effect is usually temporary.
- *Ask: Why is it important to understand the oxytocin reflex in the way we care for mothers after delivery?*

► Wait for a few replies and then continue.

- A mother needs to have her baby near her all the time, so that she can see, touch and respond to them. If a mother is separated from her baby between feeds, her oxytocin reflex may not work so easily.
- You need to remember a mother's feelings whenever you talk to her. Try to make her feel good and build her confidence. Try not to say anything that may make her doubt her supply of breast milk.
- Mothers are often aware of their oxytocin reflex. There are several signs of an active reflex that they, or you, may notice.

► Ask participants to turn to page 68 of their *Participant's manual*, and find the box SIGNS AND SENSATIONS OF AN ACTIVE OXYTOCIN REFLEX.

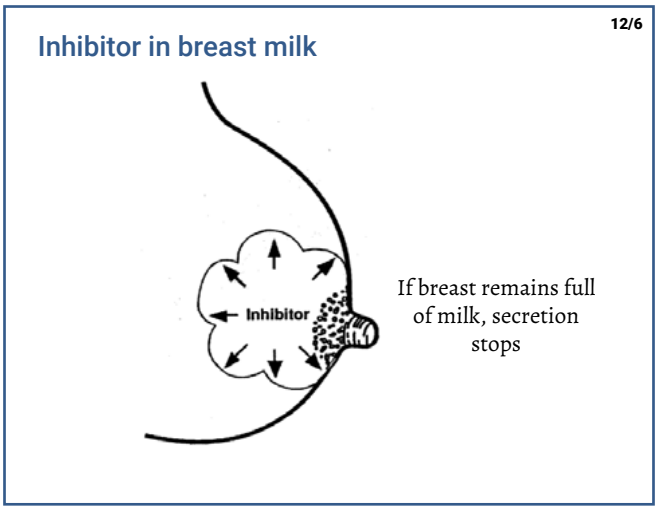
► Ask participants to take it in turns to read out the signs.

SIGNS AND SENSATIONS OF AN ACTIVE OXYTOCIN REFLEX

A mother may notice:

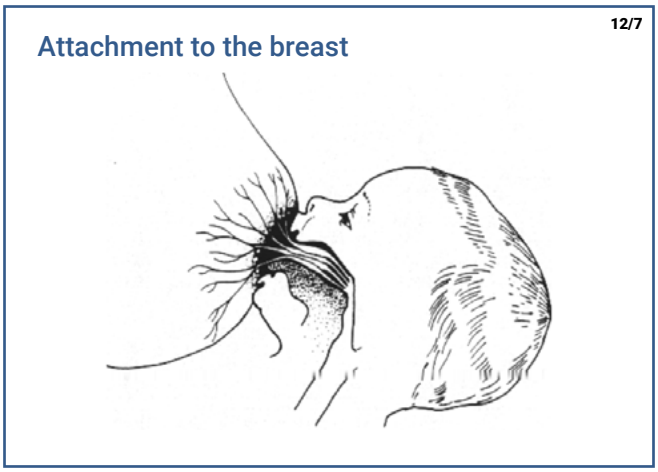
- A squeezing or tingling sensation in her breasts just before she feeds her baby, or during a feed
- Milk flowing from her breasts when she thinks of her baby, or hears him crying
- Milk dripping from her other breast, when her baby is suckling
- Milk flowing from her breasts in fine streams, if her baby comes off the breast during a feed
- Pain from uterine contractions, sometimes with a rush of blood, during feeds in the first week
- Slow deep sucks and swallowing by the baby, which show that breast milk is flowing into the baby's mouth

► Show **Slide 12/6 – Inhibitor in breast milk** and make the points that follow:



- Production of breast milk is also controlled within the breast itself.
- You may wonder why sometimes one breast stops making milk, while the other breast continues to make milk – although oxytocin and prolactin go equally to both breasts. This diagram shows why.
- There is a substance in breast milk that can reduce or inhibit milk production.
- If a lot of milk is left in a breast, the inhibitor stops the cells from secreting any more. This helps to protect the breast from the harmful effects of being too full. This is obviously necessary if a baby dies or stops breastfeeding for some other reason.
- If breast milk is removed, by suckling or expression, the inhibitor is also removed. Then the breast makes more milk.
- This helps you to understand why:
  - If a baby stops suckling from one breast, that breast stops making milk.
  - If a baby suckles more from one breast, that breast makes more milk and becomes larger than the other.
- It also helps you to understand why:
  - For a breast to continue making milk, the milk must be removed.
  - If a baby cannot suckle from one or both breasts, the breast milk must be removed by expression, to enable production to continue. This is an important point that we will discuss later in the course when we talk about expressing breast milk.

▸ Show **Slide 12/7 – Attachment to the breast** and make the points that follow:

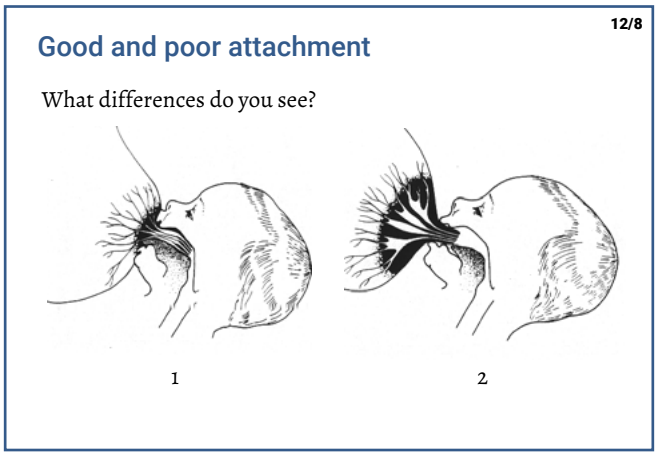


- This diagram shows how a baby takes the breast into his mouth to suckle.
- *Ask: What do you see?*

▸ Ask one participant to come to the screen to show how the baby takes the breast into his mouth.

- Notice these points:
  - The baby has taken much of the areola and the underlying tissues into his mouth.
  - The larger ducts are included in these underlying tissues.
  - He has stretched the breast tissue out to form a long "teat".
  - The nipple forms only about one third of the "teat".
  - The baby is suckling from the breast, not the nipple.
- Notice the position of the baby's tongue:
  - The baby's tongue is forward, over the lower gums, and beneath the larger ducts.
  - His tongue is cupped round the "teat" of breast tissue. You cannot see that in this drawing, though you may see it when you observe a baby.
  - The tongue presses milk out of the larger ducts into the baby's mouth.
- If a baby takes the breast into their mouth in this way, we say that the baby is well attached to the breast. The baby can remove breast milk easily and we say that they are suckling effectively.
- When a baby suckles effectively, the baby's mouth and tongue do not rub the skin of the breast and nipple.

► Show **Slide 12/8 – Good and poor attachment** and make the points that follow:



- Here you see two pictures. Picture 1 is the same baby as in **Slide 12/7**. He is well attached to the breast. Picture 2 shows a baby suckling in a different way.
- *Ask: In what way is picture 2 different from picture 1?*

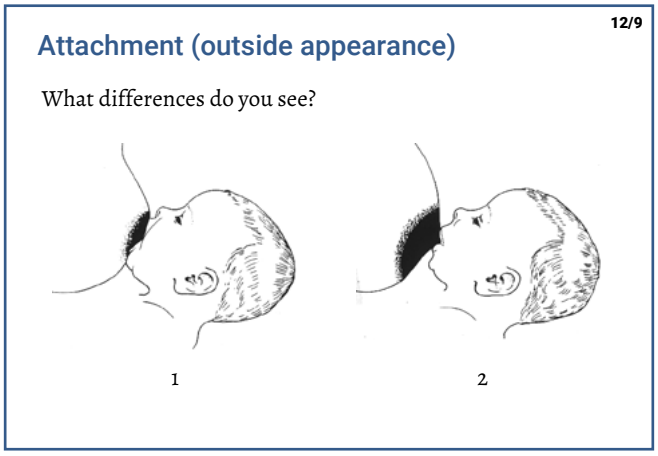
► Wait for a few replies and then continue.

► Make sure that the points below are clear.

► If participants notice signs that are described with **Slide 12/9**, accept their observations, but do not repeat or emphasize them yet.

- The most important differences to see in picture 2 are:
  - Only the nipple is in the baby's mouth, not the underlying breast tissue.
  - The larger ducts are outside the baby's mouth, where his tongue cannot reach them.
  - The baby's tongue is back inside his mouth, and not pressing on the larger ducts.
- The baby in picture 2 is poorly attached. He is "nipple sucking" and cannot suckle effectively.

► Show **Slide 12/9 – Attachment (outside appearance)** and make the points that follow:



- This picture shows the same two babies from the outside.
- *Ask: What differences do you see between pictures 1 and 2?*

► Wait for a few replies and then continue.

- In picture 1, you can see more of the areola above the baby's top lip and less below his bottom lip. This shows that he is reaching with his tongue under the larger ducts to press out the milk. In picture 2, you can see the same amount of areola above his top lip and below his bottom lip, which shows that he is not reaching the larger ducts.
- In picture 1, his mouth is wide open. In picture 2, his mouth is not wide open and points forward.

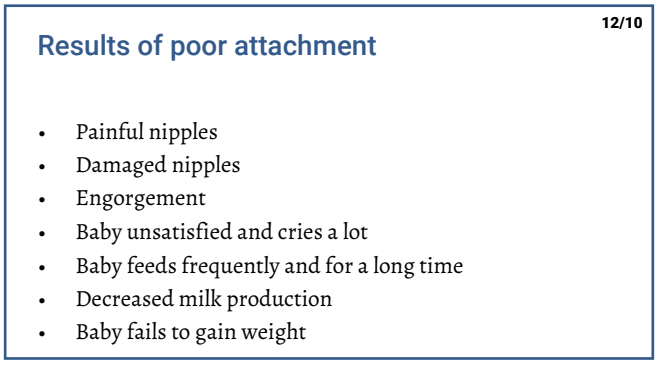
- In picture 1, his lower lip is turned outwards. In picture 2, his lower lip is not turned outwards.
- In picture 1, the baby's chin touches the breast. In picture 2, his chin does not touch the breast.
- These are some of the signs that you can see from the outside that tell you that a baby is well attached to the breast.
- Seeing a lot of areola is not a reliable sign of poor attachment. Some mothers have a very large areola, and you can see a lot even if the baby is well attached. It is more reliable to compare how much areola you see above the baby's top lip and below his bottom lip.
- THE FOUR KEY SIGNS OF GOOD ATTACHMENT are:
  1. The baby's mouth is wide open.
  2. The baby's lower lip is turned outwards.
  3. The baby's chin is touching the mother's breast.
  4. More areola is seen above the baby's top lip than below the bottom lip.
- There are other differences that you can see when you look at a real baby, which you will learn about in SESSION 14: POSITIONING A BABY AT THE BREAST.
- Take out COUNSELLING CARD 3: GOOD ATTACHMENT and look at the figure. How could you use the card to explain attachment to the mother?

► **Wait for a few replies and then remind them of the steps ASSESS, ANALYSE and ACT and using them when counselling a mother. Ask them to look at the sections in the *Guidance on the use of counselling cards* on KEY PRACTICES AND DISCUSSION POINTS for COUNSELLING CARD 3 and POSITIVE COUNSELLING SKILLS.**

- *Ask: What do you think might be the results of poor attachment?*

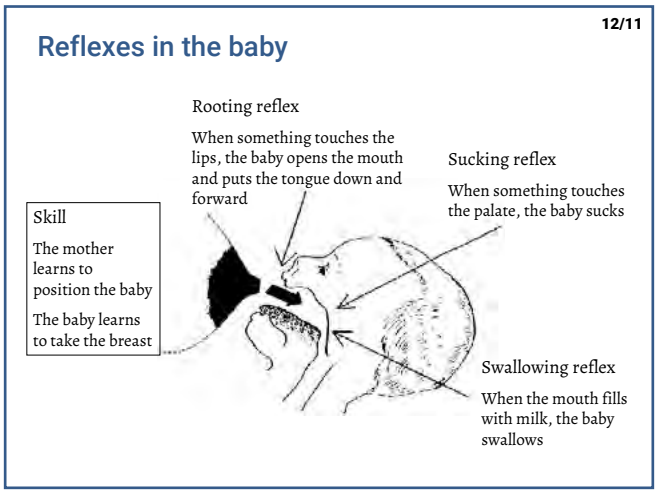
► **Wait for a few responses before showing the next slide.**

► **Show Slide 12/10 – Results of poor attachment and make the points that follow:**



- If a baby is poorly attached, and "nipple sucks", it is painful for the mother. Poor attachment is the most important cause of sore nipples.
- As the baby sucks hard to try to get milk, they pull the nipple in and out. This makes the nipple skin rub against the baby's mouth. If a baby continues to suck in this way, it can damage the nipple skin and cause cracks (also known as fissures).
- As the baby does not remove breast milk effectively, the breasts may become engorged.
- Because the baby does not get enough breast milk, they may be unsatisfied and cry a lot. The baby may want to feed often or for a very long time at each feed.
- Eventually, if breast milk is not removed, the breasts may make less milk.
- A baby may fail to gain weight and the mother may feel she is a breastfeeding failure.
- To prevent this happening, all mothers need skilled help to position and attach their babies.
- Also, babies should not be given feeding bottles. If a baby feeds from a bottle before breastfeeding is established, they may have difficulty suckling effectively. Even babies who start bottle feeds after a few weeks may also begin to suckle ineffectively.

- Show **Slide 12/11 – Reflexes in the baby** and make the points that follow:



- Earlier slides showed reflexes in a mother, but it is also useful to know about the reflexes in a baby.
- There are three main reflexes – the rooting reflex, the sucking reflex and the swallowing reflex.
- When something touches a baby's lips or cheek, the baby opens their mouth and may turn the head to find it. The baby puts the tongue down and forward. This is the "rooting" reflex. It should normally be the breast that the baby is "rooting" for.
- When something touches a baby's palate, they start to suck it. This is the sucking reflex.
- When the baby's mouth fills with milk, they swallow. This is the swallowing reflex.
- All these reflexes happen automatically, without the baby having to learn to do them.
- Notice in the drawing that the baby is not coming straight towards the breast. He is coming up to it from below the nipple. This helps the baby to attach well because:
  - The nipple is aiming towards the baby's palate, so it can stimulate his sucking reflex.
  - The baby's lower lip is aiming well below the nipple, so he can get his tongue under the larger ducts.

III. Summarize the session 5 minutes

- Ask participants whether they have any questions, and try to answer them.
- Explain that a summary of this session can be found on pages 65–69 of the *Participant's manual*.

Further information

Attachment

The amount of areola that you see outside a baby's mouth may help you to compare the attachment of the same baby before and after you correct it. However, the first time that you see a baby, it is not a reliable sign. A mother may have a very small areola, which all goes inside the baby's mouth easily, or a very large areola, so that you can always see a lot outside.

Causes of poor attachment

Use of a feeding bottle: the action of sucking from a bottle is different from suckling from the breast. Babies who have had some bottle feeds may try to suck on the breast as if it is a bottle, and this makes them "nipple suck". When this happens, it is sometimes called "suckling confusion" or "nipple confusion". So, giving a baby feeds from a bottle can interfere with breastfeeding. Skilled help is needed to overcome this problem.

Inexperienced mother: if a mother has not had a baby before, or if she bottle fed or had difficulties breastfeeding previous babies, she may have difficulty getting her baby well attached to her breast. However, even mothers who have previously breastfed successfully sometimes have difficulties.

Functional difficulty: some situations can make it more difficult for a baby to attach well to the breast. For example, if a baby is very small or weak; if a mother's nipples and the underlying tissue are poorly protractile; if her breasts are engorged; or if there has been a delay in starting to breastfeed. Mothers and babies can breastfeed in all these situations, but they may need extra skilled help to succeed.

Lack of skilled support: a very important cause of poor attachment is lack of skilled help and support. Some women are isolated and lack support from the community. They may lack help from experienced women such as their own mothers, or from traditional birth attendants, who often are very skilled at helping with breastfeeding. Women in "bottle-feeding" cultures may be unfamiliar with how a breastfeeding mother holds and feeds her baby. They may never have seen a baby breastfeeding. Health workers who look after mothers and babies, for example doctors and midwives, may not have been trained to help mothers to breastfeed.

Sucking/suckling

The term "suckling" is usually used when referring to a baby feeding from the breast. The term "sucking" is used when referring to a baby feeding from a bottle. However, note that the reflex referred to on page 156 (page 69 of the *Participant's manual*) is known as the "sucking reflex", as it refers to anything that touches the baby's palate.

Notes

Notes (contd)

Session 13

Assessing a breastfeed 1

Objectives

After completing this session, participants will be able to:

- explain THE FOUR KEY SIGNS OF GOOD ATTACHMENT
- assess a breastfeed by observing a mother and baby
- identify a mother who may need help
- recognize signs of good and poor attachment and positioning
- explain the contents and arrangement of the JOB AID: BREASTFEED OBSERVATION

Session outline . . . . . 60 minutes

Participants are all together for a lecture presentation by one trainer.

I. Introduce the session, present **Slide 13/1** . . . . . 5 minutes
II. Explain the JOB AID: BREASTFEED OBSERVATION (DEMONSTRATION 13.A) . . . . . 20 minutes
III. Present **Slides 13/2** to **13/7**. . . . . 20 minutes
IV. Practise using the JOB AID: BREASTFEED OBSERVATION (EXERCISE 13.A, **Slides 13/8** and **13/9**) . . . . . 10 minutes
V. Summarize the session . . . . . 5 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides and giving a demonstration.
- Study the **Slides 13/1** to **13/9** and the text that goes with them, so that you are able to present them.
- For demonstration of the General section of the JOB AID: BREASTFEED OBSERVATION:
  - Ask two participants to help you with the DEMONSTRATION 13.A.
  - Give them a copy of the scenarios for mothers A and B for them to act.
  - Explain what you want them to do, and help them to practise.
  - Make sure that they have dolls for the demonstration (see page 12 for instructions on HOW TO MAKE A MODEL DOLL), and that you have pillows and a blanket and somewhere for the "mother" to lie down, e.g. a bed or a table.
  - If you feel on the first day of the course that participants cannot do this, ask other trainers to help instead.
- For demonstration of how to hold a breast – (General section of the JOB AID: BREASTFEED OBSERVATION):
  - Make sure that you have a model breast available (see page 12 for instructions on HOW TO MAKE A MODEL BREAST).
- At the beginning of the session, ask participants to arrange their seats so that they are sitting in a half circle near to the screen, without tables or other obstruction in front of them. They need to be able to go to the screen to point out appearances on the slides.
- Put a seat for yourself to sit with the participants, so that you do not stand up in front to lecture.
- Have ready COUNSELLING CARD 3: GOOD ATTACHMENT, and the *Guidance on the use of counselling cards*.
- Read the **Further information** sections, so that you are familiar with the ideas that they contain, so that you can answer participants' questions.

As you follow the text, remember:

- ► indicates an instruction to you, the trainer.
  - ¤ indicates what you say to participants.

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the session — 5 minutes

► Show **Slide 13/1 – Session 13 – objectives** and read out the objectives:

13/1

Session 13: Assessing a breastfeed 1 – objectives

After completing this session, participants will be able to:

- explain THE FOUR KEY SIGNS OF GOOD ATTACHMENT
- assess a breastfeed by observing a mother and baby
- identify a mother who may need help
- recognize signs of good and poor attachment and positioning
- explain the contents and arrangement of the JOB AID: BREASTFEED OBSERVATION

► Make these points:

- ¤ Assessing a breastfeed helps you to decide whether a mother needs help or not, and how to help her.
- ¤ You can learn a lot about how well or badly breastfeeding is going by observing, before you ask questions.
- ¤ There are some things you can observe when a baby is not breastfeeding. Other things you can only observe if a baby is breastfeeding.

II. Explain the JOB AID: BREASTFEED OBSERVATION — 20 minutes

► Ask participants to turn to page 72 of their *Participant's manual* and find the JOB AID: BREASTFEED OBSERVATION.

Job aid: Breastfeed observation

Mother's name: **Date:**

Baby's name: **Baby's age:**

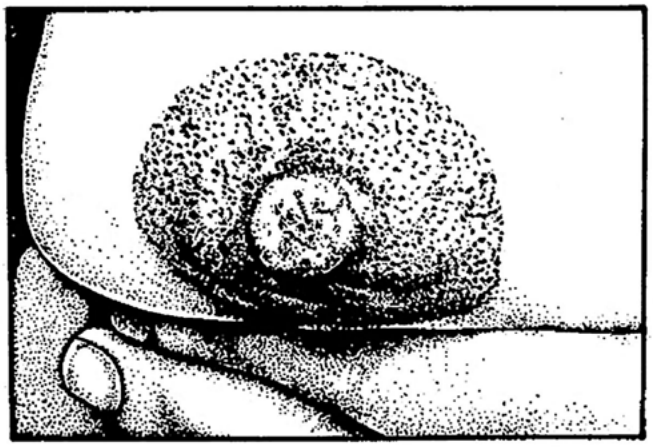
Signs that breastfeeding is going well:	Signs of possible difficulty:
GENERAL	
Mother:	**Mother:**
☐ Mother looks healthy	☐ Mother looks ill or depressed
☐ Mother relaxed and comfortable	☐ Mother looks tense and uncomfortable
☐ Signs of bonding between mother and baby	☐ No mother/baby eye contact
Baby:	**Baby:**
☐ Baby looks healthy	☐ Baby looks sleepy or ill
☐ Baby calm and relaxed	☐ Baby is restless or crying
☐ Baby reaches or roots for breast if hungry	☐ Baby does not reach or root
BREASTS	
☐ Breasts look healthy	☐ Breasts look red, swollen, or sore
☐ No pain or discomfort	☐ Breast or nipple painful
☐ Breast well supported with fingers away from nipple	☐ Breasts held with fingers on areola
BABY'S POSITION	
☐ Baby's head and body in line	☐ Baby's neck and head twisted to feed
☐ Baby held close to mother's body	☐ Baby not held close
☐ Baby's whole body supported	☐ Baby supported by head and neck only
☐ Baby approaches breast, nose to nipple	☐ Baby approaches breast, lower lip/chin to nipple
BABY'S ATTACHMENT	
☐ Baby's mouth open wide	☐ Baby's mouth not open wide
☐ Lower lip turned outwards	☐ Lips pointing forward or turned in
☐ Baby's chin touches breast	☐ Baby's chin not touching breast
☐ More areola seen above baby's top lip	☐ More areola seen below bottom lip
SUCKLING	
☐ Slow, deep sucks with pauses	☐ Rapid shallow sucks
☐ Cheeks round when suckling	☐ Cheeks pulled in when suckling
☐ Baby releases breast when finished	☐ Mother takes baby off the breast
☐ Mother notices signs of oxytocin reflex	☐ No signs of oxytocin reflex noticed

- **Make these points:**
  - This form will help you to remember what to look for when you assess a breastfeed.
  - The form is arranged in five sections: GENERAL, BREASTS, BABY'S POSITION, BABY'S ATTACHMENT, SUCKLING.
  - The signs on the left all show that breastfeeding is going well. The signs on the right indicate a possible difficulty.
  - Beside each sign is a box to mark with a tick if you have seen the sign in the mother that you are observing.
  - As you observe a breastfeed, mark a tick in the box for each sign that you observe. **If you do not observe a sign, you should make no mark.**
  - When you have completed the form, if all the ticks are on the left-hand side of the form, breastfeeding is probably going well. If there are some ticks on the right-hand side, then breastfeeding may not be going well. This mother may have a difficulty and she may need your help.
  - We looked at THE FOUR KEY POINTS OF ATTACHMENT in the last session. We will talk about positioning in a later session.
- **Ask one participant to read aloud the points in the first section of the form (GENERAL), reading the point from the left-hand column and then the corresponding point from the right-hand column. Then ask another participant to read the next section (BREASTS). Do not read the other sections at this stage – they will be read later.**
  - **Figs. 13.1** to **13.3** illustrate correct and incorrect ways to hold a baby for breastfeeding (**Fig. 13.1**), for how the mother should hold her breast (**Fig. 13.2**) and for how the baby attaches to the breast for feeding (**Fig. 13.3**).

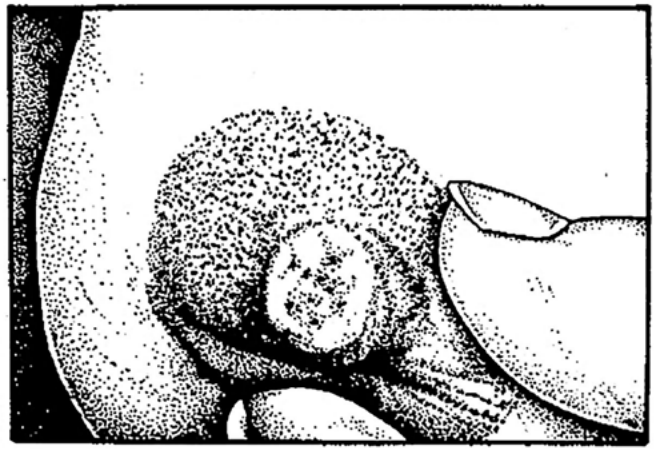
a. Baby's body close, facing breast
Face-to-face attention from mother

b. Baby's body away from mother, neck twisted
No mother/baby eye contact

Fig. 13.1 How does the mother hold her baby?

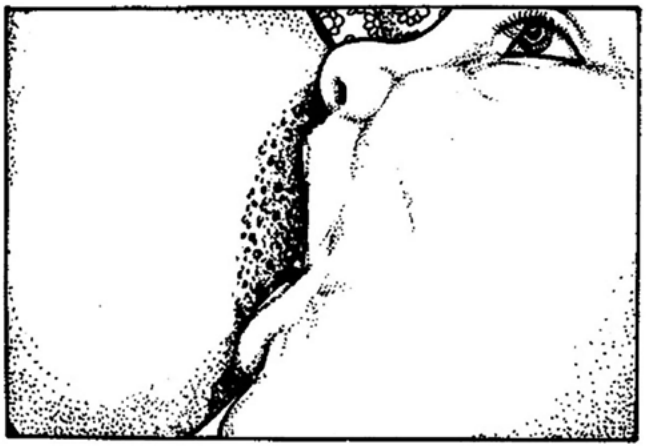


a. Resting her fingers on her chest wall so that her first finger forms a support at the base of the breast

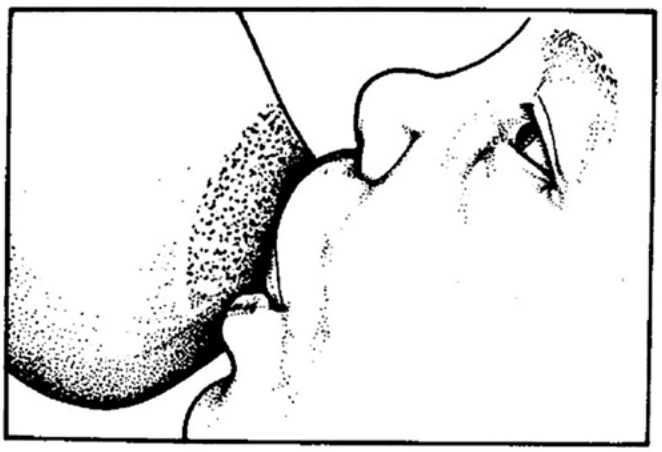


b. Holding her breast too near the nipple

Fig. 13.2 How does the mother hold her breast?



a. A baby who is well attached to the mother's breast



b. A baby who is poorly attached to the mother's breast

Fig. 13.3 How is the baby attached to the breast?

Explain the first two sections: General and Breasts

- Ask participants to keep their *Participant's manual* open at the Job aid: Breastfeed observation during the rest of the session.
- Ask two participants to play the roles of mothers and babies in the following demonstration. Let them choose names for themselves and their babies.

Demonstration 13.A Assessing a breastfeed

Mother A	Mother B
Sits comfortably and relaxed	Uncomfortable and tense
Happy and pleased with the baby	Sad and not interested in the baby
Looks at the baby, talks to her	Looks away from the baby, does not talk to her
Fondles and touches the baby lovingly	Does not touch the baby lovingly
Holds the baby close, facing her breast	Holds the baby loosely, turned away, neck twisted
Supports the baby's whole body	Supports only the baby's head and shoulders
Holds the baby calmly and securely and looks confident	Holds the baby nervously, not looking confident
	May shake or prod the baby to make her suckle

- Ask the other participants to start observing the "mothers and babies". (Do not let this role-play last more than 2 minutes.) As they are observing, ask what they have observed from the first two sections of the Job aid: Breastfeed observation.
- Make the following points. Ensure that the participants are clear about which point on the Job aid: Breastfeed observation you are referring to:
  - Look at the mother to see whether she looks well. Her expression may tell you something about how she feels – for example she may be in pain.
  - Observe whether the mother looks relaxed and comfortable. If a mother holds her baby securely and feels confident, it is easier for her baby to suckle effectively, and her milk will flow more easily. If a mother is nervous and lacks confidence, she may show this by shaking or prodding the baby to make him go on feeding. This can upset her baby and interfere with suckling and the flow of breast milk.
  - Observing how a mother interacts with her baby while feeding is important. Remember from the last session that if a mother feels good about breastfeeding, this will help her oxytocin reflex to work well, and this will help her milk to flow.
  - Look at the baby's general health, nutrition and alertness. Look for conditions that may interfere with breastfeeding, such as a blocked nose or difficult breathing.
  - Notice whether the breasts look healthy. You may notice a cracked nipple, or may see that the breast is inflamed. We will talk about breast conditions in more detail later in the course.
  - If breastfeeding feels comfortable and pleasant for the mother, her baby is probably well attached. Ask a mother how breastfeeding feels.
  - Notice how the mother is holding her breast.
- Demonstrate these points with a model breast and doll, or on your own body, or ask another trainer to demonstrate while you talk (it is only possible to demonstrate the responses partially, but it helps participants to understand the points you are making):
  - How a mother holds her breast during feeding is important.
  - Does the mother lean forward and try to push the nipple into the baby's mouth; or does she bring her baby to the breast, supporting her whole breast with her hand?
  - Does she hold the breast close to the areola? This makes it more difficult for a baby to suckle. It may also block the milk ducts, so that it is more difficult for the baby to get the breast milk.

- Does the mother hold her breast back from her baby's nose with her finger? This is not necessary.
- Does the mother use the "scissor" hold – when she holds the nipple and areola between her index finger above and middle finger below. This can make it more difficult for a baby to take enough breast into their mouth.
- Does the mother support her breast in an appropriate way:
  - with her fingers against the chest wall?
  - with her first finger supporting the breast?
  - with her thumb above, away from the nipple?

Explain the section: Baby's position

- Ask one participant to read aloud the points in the third section of the Job aid: Breastfeed Observation (Baby's position), reading each point from the left-hand column and then the corresponding point from the right-hand column. Ask the participants what they observed from the third section of the form during the previous role-play. Then make these points:
  - Observe how the mother holds her baby. Notice whether the baby's head and body are in line.
  - Notice whether she holds the baby close to the breast and facing it, making it easier for the baby to suckle effectively. If she holds the baby loosely, or turned away so that the baby's neck is twisted, it is more difficult for them to suckle effectively.
  - If the baby is young, observe whether the mother supports the baby's whole body or only the head and shoulders.

Explain the section: Baby's attachment

- Ask one participant to read aloud the points in the fourth section of the Job aid: Breastfeed observation (Baby's attachment), reading each point from the left-hand column and then the corresponding point from the right-hand column. These points will not have been observed during the role-play with the doll. The four key points of attachment were covered in the last session.
- Review Counselling card 3: Good attachment and the four signs of good attachment: Ask participant "mothers" to point to themselves and name in sequence: (1) the baby's mouth is wide open; (2) the baby's lower lip is turned outwards; (3) the baby's chin is touching the mother's breast; and (4) more of the darker skin (**areola**) is seen above the baby's top lip than below the bottom lip.

Explain the section: Suckling

- Ask one participant to read aloud the points in the fifth section of the Job aid: Breastfeed observation (Suckling), reading each point from the left-hand column and then the corresponding point from the right-hand column. These points will not have been observed during the role-play with the doll.
- Make the following points:
  - Look and listen for the baby taking slow deep sucks. This is an important sign that the baby is getting breast milk and is suckling effectively. If a baby takes slow, deep sucks, then they are probably well attached.
  - If the baby is taking quick shallow sucks all the time, this is a sign that the baby is not suckling effectively.
  - If the baby is making smacking sounds as they suck, this is a sign that the baby is not well attached.
  - Notice whether the baby releases the breast themself after the feed, and looks sleepy and satisfied.
  - If a mother takes the baby off the breast before they have finished; for example, if the baby pauses between sucks, the baby may not get enough hindmilk. The baby may want to feed again soon.

III. Present **Slides 13/2** to **13/7** 20 minutes

- You will now see a series of slides of babies breastfeeding.
- You will practise recognizing the signs of good and poor attachment that the slides show, and you will practise using the JOB AID: BREASTFEED OBSERVATION. There are also some signs of good and poor positioning, but not in all the slides.
- You will not be able to see all of the signs in the slides. For example, you cannot see signs with movement in slides.
- Observe the signs that are clear, and do not worry about signs that you cannot see.
- However, when you see real mothers and babies, you should look for all the signs.
- As you look at each slide:
  - decide which signs of good or poor attachment you see
  - decide whether you think the baby's attachment is good or poor
  - notice whether there are any signs of good or poor positioning shown.

▸ **Ask a different participant to come forward for each of the Slides 13/2 to 13/7.**

▸ **As you show each slide:**

- *Ask: What do you think of this baby's attachment (and positioning, if signs are visible)?*

▸ **Give the participant at the screen a few moments to study the picture, and to describe and point to the signs that they see. Then ask other participants to describe the signs that they see.**

▸ **Then point out any signs that they have missed. Try not to repeat signs that they have already mentioned.**

▸ **The text below lists the signs that each slide illustrates particularly well, and which can help the observer to make a decision. Try to encourage participants to go through THE FOUR KEY POINTS OF GOOD ATTACHMENT first and then to list points from the other sections of the JOB AID: BREASTFEED OBSERVATION. This will help them to think more systematically as they assess a breastfeed.**

▸ **Participants may describe more signs than are given in the text. There are other signs in the slides, but most of them are not very helpful. Accept participants' observations, or gently correct them if they are incorrect.**

▸ **Show Slide 13/2.**

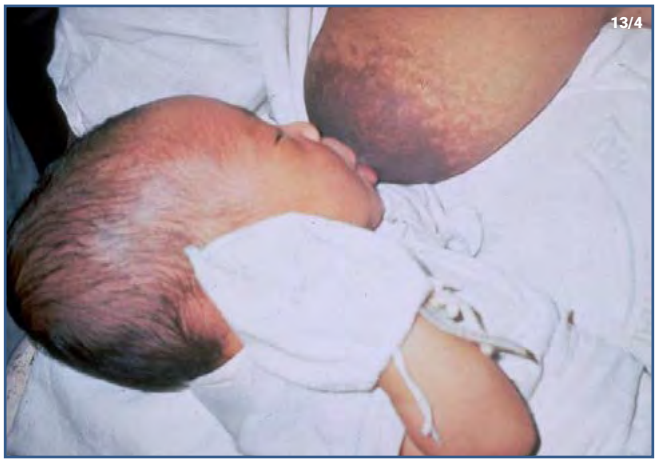
- Signs that you can see clearly are:
  - The baby's mouth is quite wide open.
  - The baby's lower lip is turned outwards.
  - The baby's chin is almost touching the breast.
  - There is more areola above the baby's top lip than below the bottom lip.

- These signs show that the baby is well attached to the breast.
- In addition, the baby is close to the breast and facing it.
- The baby is breathing quite well without the mother holding her breast back with her finger.

▶ Show **Slide 13/3**.

- Signs that you can see clearly are:
  - The baby's mouth is pointing forward.
  - The baby's chin is not touching the breast.
- This baby is poorly attached.
- In addition, the baby's cheeks are pulled in when suckling.
- The mother is holding her breast with the "scissor" hold.

▶ Show **Slide 13/4**.

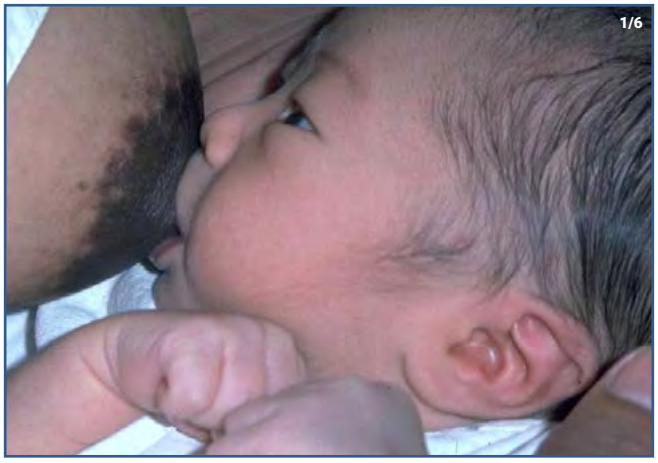


- Signs that you can see clearly are:
  - The baby's mouth is not wide open and the lips are pointing forward.
  - The baby's chin is not touching the breast.
  - There is as much areola below the baby's bottom lip as above the top lip.
- This baby is poorly attached to the breast.
- The baby's body is not close to the mother's.
- This mother's areola is very large, so it is likely that you would see a lot of it even if her baby was well attached. However, you should see more above the baby's top lip than below the bottom lip.

► Show **Slide 13/5**.

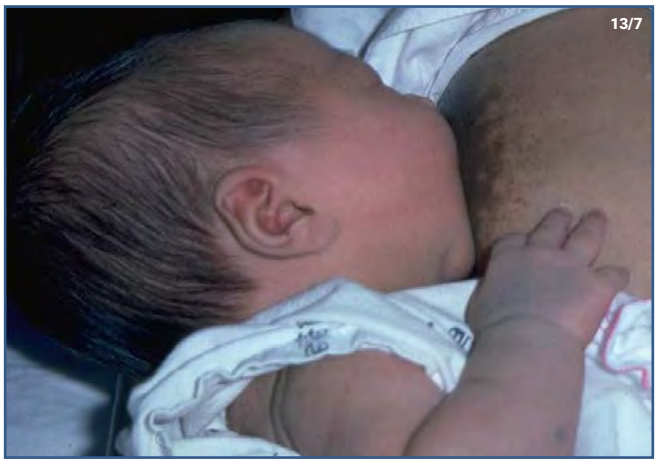
- ¤ Signs that you can see clearly are:
  - The baby's mouth is quite wide open.
  - The baby's lower lip is turned in and not outwards.
  - The baby's chin is touching the breast.
  - There is more areola above the baby's top lip than below the bottom lip.
- ¤ This baby is not well attached.
- ¤ The baby's lower lip is turned in, so the baby is not well attached, even if the other signs are not bad.
- ¤ In addition, the baby's head and body are straight and he is facing the breast.

► Show **Slide 13/6**.



- ¤ Signs that you can see clearly are:
  - The baby's mouth is not wide open and the lips are pointing forward.
  - The baby's chin is not touching the breast.
  - There is as much or more areola below the baby's mouth as above it.
- ¤ This baby is poorly attached and looks as though he is feeding from a bottle.
- ¤ In addition, the baby is twisted and is not close to the breast.

► Show **Slide 13/7**.



- Signs that you can see clearly are:
  - The baby's chin is touching the breast.
  - As the baby is very close to the breast, it makes it difficult to see many other signs.
  - There is a little areola above the baby's top lip.
- This baby is well attached.
- Additional point: this is the same baby as in slide 13/6 after the health worker has helped the mother to position the baby better. In a better position, a baby can attach more easily.

IV. Practise using the Job aid: Breastfeed observation — 10 minutes

Exercise 13.A Using the Job aid: Breastfeed observation

► Explain what to do:

- With **Slides 13/8** and **13/9**, you will use your observations to practise filling in the Job aid: Breastfeed observation.
- There are two copies of the form for this exercise in the *Participant's manual* on pages 75 and 76. Fill in one form for each slide.
- If you see a sign, make a tick in the box next to the sign. If you do not see a sign, leave the box empty.
- Concentrate on the sections on the baby's position and attachment. However, when you see mothers and babies in the practical sessions, you should fill in all sections of the form. Remember, you may not see all the signs with every baby.

► Ask all the trainers to help. They should circulate and make sure that participants understand what to do. They should give individual feedback on participants' observations of the slides.

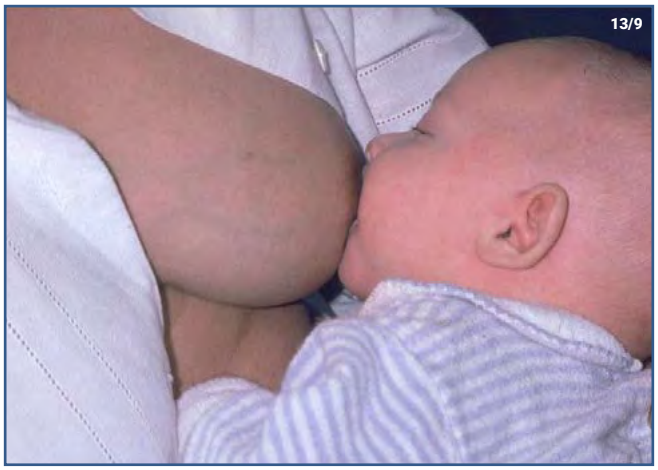
► Show **Slides 13/8** and **13/9.**

► Show each slide for about 4 minutes.

► In the *Trainer's guide*, on pages 171 and 172, for each of the **Slides 13/8** and **13/9**, the Job aid: Breastfeed observation is copied. The copies have been marked with ticks for the signs that participants should see in these slides. Boxes have only been ticked if the signs are clear. Remember, it is difficult in slides to see all the signs. Use these answers to give individual feedback.

► Show **Slide 13/8**.

► Show **Slide 13/9**.



Job aid: Breastfeed observation – Slide 13/8

Mother's name: **Date:**

Baby's name: **Baby's age:**

Signs that breastfeeding is going well:	Signs of possible difficulty:
GENERAL	
Mother:	**Mother:**
☐ Mother looks healthy	☐ Mother looks ill or depressed
☐ Mother relaxed and comfortable	☐ Mother looks tense and uncomfortable
☐ Signs of bonding between mother and baby	☐ No mother/baby eye contact
Baby:	**Baby:**
☐ Baby looks healthy	☐ Baby looks sleepy or ill
☐ Baby calm and relaxed	☐ Baby is restless or crying
☐ Baby reaches or roots for breast if hungry	☐ Baby does not reach or root
BREASTS	
☐ Breasts look healthy	☐ Breasts look red, swollen, or sore
☐ No pain or discomfort	☐ Breast or nipple painful
☐ Breast well supported with fingers away from nipple	☑ Breasts held with fingers on areola
BABY'S POSITION	
☐ Baby's head and body in line	☑ Baby's neck and head twisted to feed
☐ Baby held close to mother's body	☑ Baby not held close
☐ Baby's whole body supported	☑ Baby supported by head and neck only
☐ Baby approaches breast, nose to nipple	☐ Baby approaches breast, lower lip/chin to nipple
BABY'S ATTACHMENT	
☐ Baby's mouth open wide	☑ Baby's mouth not open wide
☐ Lower lip turned outwards	☑ Lips pointing forward or turned in
☐ Baby's chin touches breast	☑ Baby's chin not touching breast
☐ More areola seen above baby's top lip	☑ More areola seen below bottom lip
SUCKLING	
☐ Slow, deep sucks with pauses	☐ Rapid shallow sucks
☐ Cheeks round when suckling	☑ Cheeks pulled in when suckling
☐ Baby releases breast when finished	☐ Mother takes baby off the breast
☐ Mother notices signs of oxytocin reflex	☐ No signs of oxytocin reflex noticed

JOB AID: BREASTFEED OBSERVATION – SLIDE 13/9

Mother's name: **Date:**

Baby's name: **Baby's age:**

Signs that breastfeeding is going well:	Signs of possible difficulty:
GENERAL	
Mother:	**Mother:**
☐ Mother looks healthy	☐ Mother looks ill or depressed
☐ Mother relaxed and comfortable	☐ Mother looks tense and uncomfortable
☐ Signs of bonding between mother and baby	☐ No mother/baby eye contact
Baby:	**Baby:**
☐ Baby looks healthy	☐ Baby looks sleepy or ill
☐ Baby calm and relaxed	☐ Baby is restless or crying
☐ Baby reaches or roots for breast if hungry	☐ Baby does not reach or root
BREASTS	
☐ Breasts look healthy	☐ Breasts look red, swollen, or sore
☐ No pain or discomfort	☐ Breast or nipple painful
☐ Breast well supported with fingers away from nipple	☐ Breasts held with fingers on areola
BABY'S POSITION	
☑ Baby's head and body in line	☐ Baby's neck and head twisted to feed
☑ Baby held close to mother's body	☐ Baby not held close
☑ Baby's whole body supported	☐ Baby supported by head and neck only
☐ Baby approaches breast, nose to nipple	☐ Baby approaches breast, lower lip/chin to nipple
BABY'S ATTACHMENT	
☐ Baby's mouth open wide	☐ Baby's mouth not open wide
☐ Lower lip turned outwards	☐ Lips pointing forward or turned in
☑ Baby's chin touches breast	☐ Baby's chin not touching breast
☑ More areola seen above baby's top lip	☐ More areola seen below bottom lip
SUCKLING	
☐ Slow, deep sucks with pauses	☐ Rapid shallow sucks
☑ Cheeks round when suckling	☐ Cheeks pulled in when suckling
☐ Baby releases breast when finished	☐ Mother takes baby off the breast
☐ Mother notices signs of oxytocin reflex	☐ No signs of oxytocin reflex noticed

V. Summarize the session 5 minutes

- Ask participants whether they have any questions, and try to answer them.
- Explain that a summary of this session can be found on pages 71–74 of the *Participant's manual*.

Further information

If a mother says that breastfeeding is going well, but you see signs that indicate a possible difficulty, you must decide what to do.

In the days soon after delivery, while the mother is still learning, you may want to offer to help her. Even if she is not aware of any difficulty now, you may prevent one occurring later.

If breastfeeding seems to be well established, you probably do not want to intervene immediately. It is usually more helpful to see her again soon, and follow the baby's growth, to make sure that breastfeeding continues to go well. Intervene only if a difficulty arises.

Notes

Notes (contd)

Session 14

Positioning a baby at the breast 1

Objectives

After completing this session, participants will be able to:

- explain THE FOUR KEY SIGNS OF GOOD POSITIONING
- describe how a mother should support her breast for feeding
- demonstrate the main positions – sitting, lying, underarm and across
- help a mother to position her baby at the breast, using THE FOUR KEY SIGNS OF GOOD POSITIONING in different positions

Session outline . . . . . 75 minutes

Participants are all together for a demonstration led by one trainer. Another trainer helps with the demonstrations. For the practical session on positioning using dolls, participants are in groups of 3–4, with one trainer per group.

I. Introduce the session, present **Slide 14/1** . . . . . 5 minutes
II. Demonstrate helping a mother to position her baby (DEMONSTRATIONS 14.A–14.C) . . . . . 35 minutes
III. CLASSROOM PRACTICAL: POSITIONING A BABY USING DOLLS (small groups) . . . . . 30 minutes
IV. Summarize the session . . . . . 5 minutes

Preparation

- Refer to the Introduction for guidance on giving a demonstration.
- The demonstrations in this session need a lot of practice if they are to be effective. One trainer leads the session. Another trainer helps with the demonstration of helping a mother who is sitting and lying.
- The day before the demonstration:
  - Ask a trainer to help you with the demonstration.
  - Explain that you want her to play a mother who needs help to position her baby. Ask her to decide on a name for herself and her "baby". She can use her real name if she likes.
  - Explain what you want to happen as follows:

1. You will demonstrate how to help a mother who is sitting.
   - She will sit holding the doll in the common way, with the doll across the front.
   - You will greet her and ask how breastfeeding is going, and she will say that it is painful and that she has sore nipples.
   - You will ask her to "breastfeed" the doll, while you observe.
   - She will hold it in a poor position: loosely, supporting only its head, with its body away from hers, so that she has to lean forward to get her breast to its mouth. She will pretend that breastfeeding is painful. You will then help her to sit more comfortably and to improve the doll's position.
   - When the position is better, she should say "Oh! That feels better", and look happier. She can rub the other breast, to show that now she is feeling the ejection reflex.

2. You will demonstrate how to help a mother who is lying down.
   - She will lie down, propped on her arm, with the doll far from her body, loosely held on the bed.
   - Practise giving the demonstration with the participant, so that you know how to follow the steps.
   - Decide the "comfortable" position that you will help her to lie in.
   - Ask her to wear clothes such as a long skirt or trousers, so that she feels comfortable lying down for this demonstration.
   - Find a cloth to cover the table, and a cloth to cover the "mother's" legs. Find some pillows if these are appropriate in this community.

Early on the day of the demonstration:

- Arrange chairs, a footstool and a bed, or a table that can be used for a bed, to demonstrate breastfeeding lying down.
- You will need a doll and a model breast for the demonstration of common mistakes in positioning.
- Make sure that you have **Slide 14/1** ready. Alternatively, as there is only one slide in this session, you might prefer to read aloud the objectives on **Slide 14/1** without projecting them onto the screen.
- Have ready COUNSELLING CARD 3: GOOD ATTACHMENT, COUNSELLING CARD 4: BREASTFEEDING POSITIONS, and the *Guidance on the use of counselling cards*.

As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

I. Introduce the session — 5 minutes

► Show **Slide 14/1 – Session 14 – objectives** and read out the objectives:

14/1

Session 14: Positioning a baby at the breast 1 – objectives

After completing this session, participants will be able to:

- explain THE FOUR KEY SIGNS OF GOOD POSITIONING
- describe how a mother should support her breast for feeding
- demonstrate the main positions – sitting, lying, underarm and across
- help a mother to position her baby at the breast, using THE FOUR KEY SIGNS OF GOOD POSITIONING in different positions

► Ask participants to turn to page 72 of their *Participant's manual*, and find the JOB AID: BREASTFEED OBSERVATION.

► Make these points:

¤ We are going to learn how to position a baby at the breast.

¤ We will be using the four key points from the section on BABY'S POSITION on the JOB AID: BREASTFEED OBSERVATION.

¤ There are several steps to follow when helping a mother to position her baby at the breast.

- Now ask participants to turn to page 80 of their *Participant's manual* and find the box HOW TO HELP A MOTHER TO POSITION HER BABY. Ask participants to take it in turns to read out the points.
- After participants have read the four points of positioning, review the steps 1, 2, 3 and 4, using either the right or left hand and arm to show them: (1) slap the hand on the opposite forearm (demonstrating where the baby's head lies); (2) slap the palm and whole arm against the stomach (demonstrating that the baby is close to the mother and turns towards the mother); (3) slap the arm on the opposite palm (demonstrating that the mother supports the buttocks, not holds); and (4) swing the hand and arm behind the waist (demonstrating that the baby's hand and arm should be behind the mother).
- After participants have looked for the four points of good attachment, ask the participant "mothers" to point to themselves, and name in sequence: (1) the baby's mouth is wide open; (2) the lower lip is turned outwards; (3) the baby's chin is touching the mother's breast; and (4) more of the darker skin (areola) is seen above the baby's top lip than below the bottom lip.

HOW TO HELP A MOTHER TO POSITION HER BABY

- Greet the mother and ask how breastfeeding is going.
- Assess a breastfeed.
- Explain what might help, and ask whether she would like you to show her.
- Make sure that she is comfortable and relaxed.
- Sit down yourself in a comfortable, convenient position.
- Explain how to hold her baby, and show her if necessary.
  The **four key points** are:
  - Baby's head and body in line
  - Baby held close to mother's body
  - Baby's whole body supported
  - Baby approaches breast, nose to nipple
- Show her how to support her breast:
  - With her fingers against her chest wall below her breast
  - With her first finger supporting the breast
  - With her thumb above
  - Her fingers should not be too near the nipple
- Explain or show her how to help the baby to attach:
  - Touch her baby's lips with her nipple
  - Wait until her baby's mouth is opening wide
  - Move her baby quickly onto her breast, aiming the lower lip below the nipple
- Notice how she responds and ask her how her baby's suckling feels.
- Look for signs of good attachment. If the attachment is not good, try again.

Fig. 14.1 illustrates the correct way to position a baby for breastfeeding.

Fig. 14.1 The mother's nipple is touching her baby's lips; the baby is opening his mouth and putting his tongue forward ready to take the breast

- Now we will look at these points in more detail.
- Always observe a mother breastfeeding before you help her, using the points from the JOB AID: BREASTFEED OBSERVATION.
- In Session 13, we talked about the importance of observing a mother interacting with her baby and breastfeeding. Take time to see what she does, so that you can understand her situation clearly. Do not rush to make her do something different.
- Give a mother help only if she has difficulty. Some mothers and babies breastfeed satisfactorily in positions that would make difficulties for others.
- This is especially true with babies that are more than about 2 months old. There is no point trying to change a baby's position if they are getting breast milk effectively, and the mother is comfortable.
- Let the mother do as much as possible herself. Be careful not to "take over" from her. Explain what you want her to do. If possible, demonstrate on your own body to show her what you mean.
- Make sure that she understands what you do, so that she can do it herself. Your aim is to help her to position her own baby. It does not help if you can get a baby to suckle, if the mother cannot.

II. Demonstrate helping a mother to position her baby 35 minutes

DEMONSTRATION 14.A DEMONSTRATE HOW TO HELP A MOTHER WHO IS SITTING

- Demonstrate how to help a mother to position her baby, going through the points in the box HOW TO HELP A MOTHER TO POSITION HER BABY on page 177 of the *Trainer's guide*. Ask one of the other trainers to be a mother. You will demonstrate each of the points in the box in turn. When you have demonstrated a point, make sure that it is clear to the participants before you move to the next point.
- **Greet the mother and ask how breastfeeding is going**
  When you have greeted the "mother" and asked how breastfeeding is going, she should respond by saying that breastfeeding is painful.
- **Assess a breastfeed**
  Ask whether you may see how (child's name) breastfeeds, and ask the "mother" to put him to her breast in the usual way. She holds him loosely, away from her body, with his neck twisted, as you practised. Observe her breastfeeding for a few minutes.

- **Explain what might help and ask whether she would like you to show her**
  Say something encouraging such as: "He really wants your breast milk, doesn't he?"

  Then say: "Breastfeeding might be less painful if (child's name) took a larger mouthful of breast when he suckles. Would you like me to show you how?" If she agrees, you can start to help her.

- **Make sure that she is comfortable and relaxed**
  Make sure the "mother" is sitting in a comfortable and relaxed position – as you decided when you practised this demonstration beforehand.

- **Sit down yourself in a comfortable, convenient position**
  - You cannot help a mother satisfactorily if you are in an awkward or uncomfortable position yourself or if you are bending over her.

- Demonstrate the following points to the participants using a doll, a high chair, a low chair and a stool. Make sure the following points are clear:
  - A low seat is usually best, if possible one that supports the "mother's" back.
  - If the seat is rather high, find a stool for her to put her feet onto. However, be careful not to make her knees so high that her baby is too high for her breast.
  - If she is sitting on the floor, make sure that her back is supported.
  - If she supports her baby on her knee, help her to hold the baby high enough so that she does not lean forward to put the baby onto her breast.

- **Explain how to hold her baby, and show her if necessary**
  Demonstrate how to help the mother to position her baby, making sure that THE FOUR KEY SIGNS OF GOOD POSITIONING are clear to the mother and to the participants.

  When you have finished helping the "mother" to position her baby, make these points to the participants, using a doll to demonstrate:
  - These four key points are the same as the points that you learnt to observe in the JOB AID: BREASTFEED OBSERVATION.
  - **For point 1– Baby's head and body in line:** a baby cannot suckle or swallow easily if the head is twisted or bent.
  - **For point 2 – Baby held close to mother's body:** a baby cannot attach well to the breast if they are far away from it. The baby's whole body should almost face the mother's body. The baby should be turned away just enough to be able to look at her face. This is the best position for the baby to take the breast, because most nipples point down slightly. If the baby faces the mother completely, they may fall off the breast.
  - **For point 3 – Baby's whole body supported:** the whole body should be supported, with the mother's arm along the baby's back. This is particularly important for neonates and young babies. For older babies, support of the upper part of the body is usually enough. A mother needs to be careful about using the hand of the same arm, which supports her baby's back, to hold their bottom. Holding the baby's bottom may result in her pulling them too far out to the side, so that their head is in the crook (bend) of her arm. The baby then has to bend their head forward to reach the nipple, which makes it difficult for them to suckle.
  - **For point 4 – Baby approaches breast, nose to nipple:** we will talk about this a little later when we discuss how to help a baby to attach to the breast.
  - Try not to touch the mother or baby if possible. But if you need to touch them to show the mother what to do, put your hand over her hand or arm, so that you hold the baby through her.

- **Show her how to support her breast**

  Demonstrate how to help the mother to support her breast.

  When you have finished helping the "mother" to support her breast, make these points to the participants, demonstrating on your own body or on a model breast:

  - It is important to show a mother how to support her breast with her hand, to offer it to her baby.
  - If she has small and high breasts, she may not need to support them.
  - She should place her fingers flat on her chest wall under her breast, so that her first finger forms a support at the base of the breast.
  - She can use her thumb to press the top of her breast slightly. This can improve the shape of the breast, so that it is easier for her baby to attach well.
  - She should not hold her breast too near to the nipple.
  - Holding the breast too near the nipple makes it difficult for a baby to attach and suckle effectively. The "scissor" hold can block milk flow.

- Demonstrate to participants these ways of holding a breast, and explain that they make it difficult for a baby to attach:
  - holding the breast with the fingers and thumb close to the areola
  - pinching up the nipple or areola between your thumb and fingers, and trying to push the nipple into a baby's mouth
  - holding the breast in the "scissor" hold – index finger above and middle finger below the nipple.

- **Explain or show her how to help the baby to attach**

  Demonstrate how to help the "mother" to attach her baby.

  When you have finished helping the "mother" to attach her baby, make these points to the participants, using a doll and your own body or a model breast:

  - Explain that she first holds the baby with their nose opposite her nipple, so that they approach the breast from underneath the nipple.
  - Explain how she should touch her baby's lips with her nipple, so that the baby opens the mouth, puts out the tongue, and reaches up.
  - Explain that she should wait until her baby's mouth is opening wide, before she moves the baby onto her breast. The baby's mouth needs to be wide open to take a large mouthful of breast.
  - It is important to use the baby's reflexes, so that they open their mouth wide to take the breast themself. You cannot force a baby to suckle, and the mother should not try to open her baby's mouth by pulling the chin down.
  - Explain or show her how to quickly move her baby to her breast, when they are opening their mouth wide.
  - She should keep her back straight and bring her baby to her breast. She should not move herself or her breast to her baby.
  - As she brings the baby to her breast, she should aim her baby's lower lip below her nipple, with the nose opposite the nipple, so that the nipple aims towards the baby's palate, the tongue goes under the areola, and the chin will touch her breast.
  - Hold the baby at the back of the shoulders – not the back of the head. Be careful not to push the baby's head forward.

- **Notice how she responds and ask her how her baby's suckling feels**
  Ask the "mother" how she feels. She should say something such as: "Oh, much better thank you." Then explain to the participants:
  - Notice how the mother responds.
  - Ask the mother how suckling feels.
  - If suckling is comfortable for the mother, and she looks happy, her baby is probably well attached.
- **Look for signs of good attachment. If the attachment is not good, try again.**
  Make these points to the participants:
  - Look for all the signs of good attachment (which you cannot see with a doll). If the attachment is not good, try again.
  - It often takes several tries to get a baby well attached. You may need to work with the mother again at a later time, or the next day, until breastfeeding is going well.
  - Make sure that the mother understands about her baby taking enough breast into their mouth.
  - If she is having difficulty in one position, try to help her to find a different position that is more comfortable for her.
  - Use COUNSELLING CARD 3: GOOD ATTACHMENT, to review with the "mother" the signs of good attachment.

DEMONSTRATION 14.B OTHER WAYS FOR A MOTHER WHO IS SITTING TO POSITION HER BABY

- Ask participants to turn to page 82 of their *Participant's manual* to look at other ways that mothers can position their babies (see **Figs. 14.2** and **14.3**).
- Demonstrate these positions using a doll.

Fig. 14.2 A mother holding her baby in the underarm position

Useful for:
- twins
- blocked duct
- difficulty attaching the baby
- very small or low-birth-weight babies

Fig 14.3 A mother holding her baby with the arm opposite the breast

Useful for:
- very small or low-birth-weight babies
- sick babies
- blocked duct

Demonstration 14.C How to help a mother who is lying down

- Ask the other trainer who is helping to lie in the way that you practised. The "mother" should lie down propped on one elbow, with the doll far from her body, loosely held on the bed.
- Demonstrate helping the "mother" to lie down in a comfortable, relaxed position. Explain that the same steps are followed in the box How to help a mother to position her baby.
- During or after the demonstration, make these points clear to participants:
  - To be relaxed, the mother needs to lie down on her side, in a position in which she can sleep. Being propped on one elbow is not relaxing for most mothers.
  - If she has pillows, a pillow under her head and another under her chest may help.
  - Exactly the same four key points on positioning are important for a mother who is lying down.
  - She can support her baby with her lower arm. She can support her breast if necessary, with her upper arm.
  - If she does not support her breast, she can hold her baby with her upper arm.
  - A common reason for difficulty attaching when lying down is that the baby is too "high" near the mother's shoulders, and the baby's head has to bend forward to reach the breast.
  - Breastfeeding lying down (see **Fig. 14.4**) is useful:
    - when a mother wants to sleep, so that she can breastfeed without getting up
    - soon after a caesarian section, when lying on her back or side may help her to breastfeed her baby more comfortably.

Fig. 14.4 A mother breastfeeding her baby lying down

- Make these points:
  - There are many other positions in which a mother can breastfeed. In any position, the important thing is for the baby to take enough of the breast into their mouth so that they can suckle effectively.
  - Some useful positions that you may want to show mothers are:
    - the underarm position
    - holding the baby with the arm opposite the breast.
- Review positions using Counselling card 4: Breastfeeding positions. Refer participants to the section in the *Guidance on the use of counselling cards* on Key practices and discussion points for that Counselling card. Ask one of them to read aloud the information included in this section.

III. Classroom practical: Positioning a baby using dolls — 30 minutes

- Divide the participants into their small groups of 3–4 participants with one trainer. Each group will need one doll. The participants should take it in turns to be the "counsellor", the "mother" and "observers". The "mother" should pretend to be having difficulties positioning her baby. Encourage the participants to practise all the skills they have learnt so far. Encourage them to follow the steps on page 80 of their *Participant's manual*, in the box How to help a mother to position her baby. These steps can be found on page 177 of the *Trainer's guide*.

IV. Summarize the session — 5 minutes

- Ask participants whether they have any questions, and try to answer them.
- Explain that a summary of this session can be found on pages 79–83 of the *Participant's manual*.

The four key signs of good positioning

1. The baby's head and body are in line.
2. The baby is held close to the mother's body.
3. The baby's whole body is supported.
4. The baby approaches the breast, nose to nipple.

The four key signs of good attachment

1. The baby's mouth is wide open.
2. The baby's lower lip is turned outwards.
3. The baby's chin is touching the mother's breast.
4. More areola is seen above the baby's top lip than below the bottom lip.

Notes

Notes (contd)

Session 15

Taking a feeding history – 0 up to 6 months 1

Objectives

After completing this session, participants will be able to:

- take a feeding history of an infant aged 0 up to 6 months
- demonstrate appropriate use of the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS

Session outline . . . . . 30 minutes

Participants are all together for a demonstration led by one trainer. .

I. Introduce the session, present **Slide 15/1** . . . . . 3 minutes
II. Explain how to take a feeding history . . . . . 5 minutes
III. Explain the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS . . . . . 5 minutes
IV. Demonstrate how to use the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS (DEMONSTRATION 15.A, **Slides 15/2** and **15/3**) . . . . . 15 minutes
V. Summarize the session . . . . . 2 minutes

Preparation

- Refer to the Introduction for guidance on giving a demonstration.
- Study the session notes, so that you are clear about what to do.
- For DEMONSTRATION 15.A, ask a participant to play the part of Mrs Green and ask one of the other trainers to play the part of Nurse Jane. Plot two local growth charts for Lucy: one for the demonstration, and one to be passed around the participants during the demonstration. Make sure that you have practised this demonstration beforehand. If local charts do not include length, use the charts provided in **Slide 15/3** for the example, making an additional copy to be passed around.

As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

I. Introduce the session — 3 minutes

▸ Show **Slide 15/1 – Session 15 – objectives** and read out the objectives:

> 15/1
>
> **Session 15: Taking a feeding history – 0 up to 6 months of age 1 – objectives**
>
> After completing this session, participants will be able to:
> - take a feeding history of an infant aged 0 up to 6 months
> - demonstrate appropriate use of the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS

▸ Explain why it is necessary to take a history.

- In this session, you will learn how to take a feeding history of a child aged 0 up to 6 months. The baby may be breastfeeding or receiving another form of milk, and may or may not be receiving complementary feeds.
- The JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS will help you to remember the main questions to ask for any infant.
- As you become more experienced, your counselling skills will help you to learn more about different situations.

II. Explain how to take a feeding history — 5 minutes

▸ Ask participants to turn to page 85 of their *Participant's manual* and find the box HOW TO TAKE A FEEDING HISTORY – 0 UP TO 6 MONTHS.

▸ Ask participants to take turns to read out the points.

HOW TO TAKE A FEEDING HISTORY – 0 UP TO 6 MONTHS

- Greet the woman in a kind and friendly way.
- Use the mother's name and the baby's name (if appropriate).
- Ask her to tell you about herself and her baby in her own way, starting with the things that she feels are important.
- Look at the child's growth chart. It may tell you some important facts and save you asking some questions.
- Ask the questions that will tell you the most important facts.
  The JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS is a guide to the facts that you may need to learn about.
  Decide what you need to know from each of the six sections.
- Be careful not to sound critical.
- Use SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT.
- Try not to repeat your questions.
  If you need to repeat a question, first say: "Can I make sure that I have understood clearly?" and then, for example, "You said that (name) had both diarrhoea and pneumonia last month?"
- Take time to learn about more difficult, sensitive things.
  For example:
  - What does the baby's father say? Her mother? Her mother-in-law?
  - Is the mother happy about having the baby now? About the baby's sex?

Some mothers tell you these things spontaneously. Others tell you when you empathize, and show that you understand how they feel. Others take longer. If a mother does not talk easily, wait, and ask again later, or on another day, perhaps somewhere more private.

III. Explain the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS 5 minutes

► **Ask participants to look at the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS, on page 86 of their *Participant's manual*. Notice that the Job aid has six sections. Ask participants to make themselves familiar with the form. Make these points:**

- ¤ Try to memorize the headings:
  - Feeding
  - Health
  - Pregnancy, birth and early feeds (where applicable)
  - Mother's condition and family planning
  - Previous infant feeding experience
  - Family and social situation
- ¤ When you know the headings, you will find it easier to remember the different points in each section.
- ¤ Remember to use your counselling skills when you are taking a history from a mother. Try to ask questions in an open way, although you may also have to ask some closed questions if you need specific information.
- ¤ Remember to use other counselling skills, such as reflecting back, empathy and praise, in between questions, so that the mother is encouraged to talk more and to feel confident.

Job aid: Feeding history – 0 up to 6 months

Mother's name: **Date:**

Baby's name: **Baby's age:**

Particular concerns about feeding of child:

FEEDING

- Milk (breast milk, formula, cow's milk, other)
- Frequency of milk feeds
- Length of breastfeeds/quantity of other milks
- Night feeds
- Other foods in addition to milk (when started, what, frequency)
- Other fluids in addition to milk (when started, what, frequency)
- Use of bottles and how cleaned
- Feeding difficulties (breastfeeding/other feeding)

HEALTH

- Growth chart (birth weight, weight now; length at birth, length now)
- Urine frequency per day (6 times or more)
- Stools (frequency, consistency)
- Illnesses

PREGNANCY, BIRTH AND EARLY FEEDS (where applicable)

- Antenatal care
- Feeding discussed at antenatal care
- Delivery experience
- Rooming-in
- Prelacteal feeds
- Postnatal help with feeding

MOTHER'S CONDITION AND FAMILY PLANNING

- Age
- Health – including nutrition and medications
- Breast health
- Family planning

PREVIOUS INFANT FEEDING EXPERIENCE

- Number of previous babies
- How many breastfed and for how long
- If breastfed – exclusive or mixed fed
- Other feeding experiences

FAMILY AND SOCIAL SITUATION

- Work situation
- Economic situation
- Family's attitude to infant feeding practices

IV. Demonstrate how to use the Job aid: Feeding history – 0 up to 6 months Job 15 minutes

- Explain that you will demonstrate how to use the Job aid: Feeding history – 0 up to 6 months. Ask the participants whom you have prepared to read the words of the health worker and the mother. Show Lucy's growth chart (**Slides 15/2** and **15/3**) to the participants during the demonstration.
  - Ask participants to follow the Job aid: Feeding history – 0 up to 6 months on page 86 of their *Participant's manual* as you give the demonstration.
  - Ask them to listen for counselling skills.

Demonstration 15.A Taking a feeding history – 0 up to 6 months

Health worker: *Good morning, I am Nurse Jane. May I ask your name, and your baby's name?*
Mother: *Good morning, nurse; I am Mrs Green and this is my daughter Lucy.*

Health worker: *She is lovely – how old is she?*
Mother: *She is 5 months now.*

Health worker: *Yes – and she is taking an interest in what is going on, isn't she? Tell me, what milk have you been giving her?*
Mother: *Well, I started off breastfeeding her, but she is so hungry and I never seemed to have enough milk, so I had to give her bottle feeds as well.*

Health worker: *Oh dear, it can be very worrying when a child is always hungry. You decided to start bottle feeds? What are you giving her?*
Mother: *Well, I put some milk in the bottle and then mix in a spoonful or two of cereal.*

Health worker: *When did she start these feeds?*
Mother: *Oh, when she was about 2 months old.*

Health worker: *About 2 months. How many bottles do you give her each day?*
Mother: *Oh, usually two – I mix up one in the morning and one in the evening, and then she just sucks it when she wants to – each bottle lasts quite a long time.*

Health worker: *So she just takes the bottle little by little? What kind of milk do you use?*
Mother: *Yes – well, if I have formula, I use some of that; or else I just use cow's milk and mix in some water, or sweetened milk, because they are cheaper. She likes the sweet milk!*

Health worker: *Formula is very expensive isn't it? Tell me more about the breastfeeding. How often is she doing that now?*
Mother: *Oh she breastfeeds when she wants to – quite often in the night, and about 4 or 5 times in the day – I don't count. She likes it for comfort.*

Health worker: *She breastfeeds at night?*
Mother: *Yes she sleeps with me.*

Health worker: *Oh that makes it easier, doesn't it? Did you have any other difficulties with breastfeeding, apart from worrying about not having enough?*
Mother: *No, it wasn't difficult at all.*

Health worker: *Do you give her anything else yet? Any other foods or drinks?*
Mother: *No – I won't give her food for a long time yet. She is quite happy with the bottle feeds.*

Health worker: *Can you tell me how you clean the bottles?*
Mother: *I just rinse them out with hot water. If i have soap I use that, but otherwise just water.*

Health worker: *OK. Now can you tell me about how Lucy is. Has she got a growth chart? Can I see it? [mother hands over growth chart] Thank you, now let me see ... She was 3.5 kg and 51 cm when she was born, she was 5.5 kg and 59 cm when she was 2 months old, and now she is 6.0 kg and 66 cm. You can see that she gained weight fast for the first 2 months, but it is a bit slower since then. Can you tell me whether Lucy has had any illnesses?*
Mother: *Well, she had diarrhoea twice last month, but she seemed to get better. Her stools are normal now.*

Health worker: *Can I ask about the earlier days – how was your pregnancy and delivery?*
Mother: *They were normal.*

Health worker: *What did they tell you about feeding her when you were pregnant, and soon after she was born? Did anyone show you what to do?*
Mother: *Nothing - they told me to breastfeed her, but that was all. The nurses were so busy, and I came home after 1 day.*

Health worker: *They just told you to breastfeed?*
Mother: *Yes – but I didn't have any milk in my breasts even then, so I gave her some glucose water until the milk started.*

Health worker: *It is confusing isn't it when your breasts feel soft after delivery? You need help then, don't you?*
Mother: *Yes.*

Health worker: *Can I ask about you? How old are you?*
Mother: *Sure - I am 22.*

Health worker: *And how is your health?*
Mother: *I am fine.*

Health worker: *How are your breasts?*
Mother: *I have had no trouble with my breasts.*

Health worker: *May I ask whether you are thinking about another pregnancy at any time? Have you thought about family planning?*
Mother: *No – I haven't thought about it – I thought that you can't get pregnant when you are breastfeeding.*

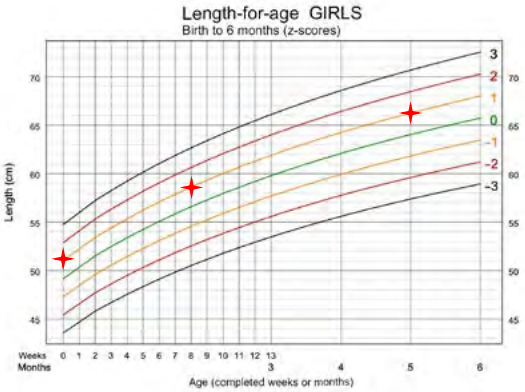
Health worker: *Well, it is possible if you are also giving other feeds. We will talk about it more later if you like. Is Lucy your first baby?*
Mother: *Yes. And I do not want another one just yet.*

Health worker: *Tell me about how things are at home – are you going out to work?*
Mother: *No – I am a housewife now. I may try to find a job later when Lucy is older.*

Health worker: *Who else do you have at home to help you?*
Mother: *Lucy's father is with me. He has a job as a driver and he is very fond of Lucy, but he thinks she should not breastfeed at night – he thinks she breastfeeds too much and he wants her to sleep in another bed. But I am not sure ... He says that too much breastfeeding is what gives her diarrhoea.*

15/2

15/3



- **Discuss the demonstration. Ask the group to think about the technique of taking a feeding history. Participants may look at the demonstration on pages 87–88 of their *Participant's manual*, to help them to answer the following questions:**
  - Did Nurse Jane use LISTENING AND LEARNING SKILLS to obtain information – can you give some examples? (Encourage participants to give specific examples of open questions and reflection.)
  - What examples of empathy did you hear the health worker use? (Examples of empathy included: Oh dear, it can be very worrying when a child is always hungry and It is confusing isn't it when your breasts feel soft after delivery.)
  - Did Nurse Jane ask some questions from all six sections of the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS?
  - Did she leave out any important questions?
  - Did asking questions from each section of the form help her to understand the difficulties?
  - What were the feeding difficulties in this situation? (These included: perceived milk insufficiency at 2 months, leading to introduction of bottle feeds; giving cereal in the bottles; use of non-modified cow's milk and sweetened milk if the formula milk runs out; inappropriate cleaning of the feeding bottles; two episodes of diarrhoea; poor growth since 2 months; no help with early breastfeeds; early introduction of glucose water; attitude of Lucy's father).

V. Summarize the session 2 minutes

- **Ask the participants whether they have any questions, and try to answer them.**
- **Explain that a summary of this session can be found on pages 85-88 of the *Participant's manual*.**

Notes

Notes (contd)

Session 16

Common breastfeeding difficulties

Objectives

After completing this session, participants will be able to identify the causes of, and help mothers with, the following difficulties:

- "not enough milk"
- a crying baby
- breast refusal

Session outline . . . . . 90 minutes

Participants are all together for a lecture presentation by one, two or three trainers.

I. Introduce the session, present **Slide 16/1** . . . . . 5 minutes
II. Analysis of the most common difficulties . . . . . 20 minutes
III. "Not enough milk" (**Slides 16/2** to **16/4**) . . . . . 20 minutes
IV. Crying baby . . . . . 20 minutes
V. Refusal to breastfeed (**Slide 16/5**) . . . . . 20 minutes
VI. Summarize the session . . . . . 5 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides and facilitating group work.
- Study the **Slides 16/1** to **16/5** and the text that goes with them, so that you are able to present them.
- This is a long session, which divides easily into three sections: "not enough milk", "crying baby" and "refusal to breastfeed". Trainers can divide the session.
- Prepare three flipcharts, each with one of the following headings: NOT ENOUGH MILK, CRYING BABY and REFUSAL TO BREASTFEED.
- If you do not have enough flipchart stands, post up sheets of flipchart paper of the wall to write on. Make sure that the room is arranged so that participants can see the lists.
- There is a lot of information in the **Further information** sections. Make sure that you have read this, so that you are familiar with the ideas that they contain, so that you can answer participants' questions.

As you follow the text, remember:

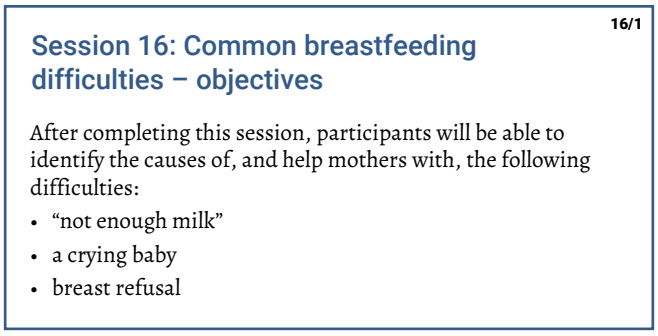
► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the session — 5 minutes

- Show **Slide 16/1 – Session 16 – objectives** and read out the objectives:



- Make these introductory points:
  - In previous sessions, we have looked at ways to find out how mothers are managing with breastfeeding.
  - These include:
    - good counselling skills to encourage a mother to tell you what is worrying her
    - assessing a breastfeed, using your skills of observation to see whether a baby is well positioned and well attached
    - taking a detailed feeding history.
  - There are many reasons why mothers stop breastfeeding or start to mix feed, even if they decided antenatally to breastfeed exclusively.
  - When helping mothers with difficulties, you will need to use all the skills you have learnt so far. Lay counsellors and community health workers have important roles to support mothers through these difficulties, as mothers may not visit a health facility to seek help.

II. Analysis of the most common difficulties — 20 minutes

- Divide participants into three groups and assign each group a difficulty: (1) NOT ENOUGH MILK; (2) CRYING BABY; and (3) REFUSAL TO BREASTFEED.
- Tell the participants that each group will be facilitated by one trainer, who will give them the instructions for the working group.
- Ask each group to nominate a facilitator, a recorder and a presenter of results of the group discussion.
- Ask each group to prepare the demonstration and/or drama relevant to its topic.

Working group "Not enough milk"

- Ask group participants to discuss the following, recording the results of their discussion in three columns on the flipchart:

Column 1:	HOW TO DECIDE WHETHER A BABY IS GETTING ENOUGH MILK OR NOT
Column 2:	REASONS A BABY MAY NOT GET ENOUGH BREAST MILK
Column 3:	WHAT TO DO – HOW TO HELP A MOTHER WITH "NOT ENOUGH BREAST MILK"

- **Participants should prepare the demonstration, using the case of Mrs Singh:**

> Mrs Singh says she does not have enough milk. Her baby is 3 months old and crying "all the time". Her baby gained 200 g last month. Mrs Singh manages the family farm by herself, so she is very busy. She breastfeeds her baby about 2–3 times at night, and about twice during the day when she has the time. She does not give her baby any other food or drink.

Working group "Crying baby"

- **Ask group participants to discuss the following, recording the results of their discussion in three columns on the flipchart:**

  Column 1: Reasons why babies cry

  Column 2: Contributors to those reasons

  Column 3: What to do – how to help a mother with a "baby who cries a lot"

- **Participants should prepare the demonstration, using the case of Mrs Biyela:**

> Mrs Biyela's baby is 3 months old. She says that for the last few days he has suddenly started crying to be fed very often. She thinks that her milk supply has suddenly decreased. Her baby has breastfed exclusively until now and has gained weight well.

Working group "Refusal to breastfeed"

- **Ask group participants to discuss the following, recording the results of their discussion in three columns on the flipchart:**

  Column 1: Types of refusal

  Column 2: Reasons why a baby refuses to breastfeed

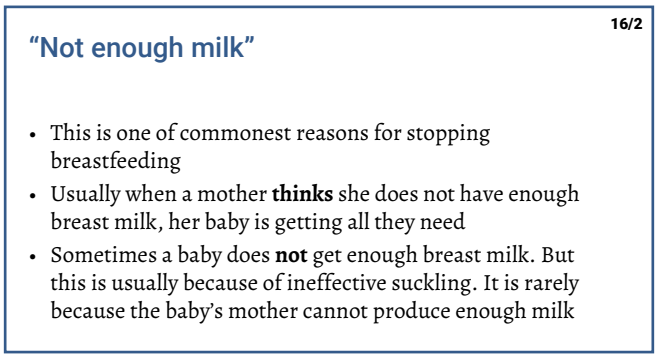
  Column 3: What to do – how to help a mother and her baby to breastfeed again

- **Participants should prepare the demonstration, using the case of Mrs Barlow:**

> Mrs Barlow delivered a baby by vacuum extraction 2 days ago. The baby has a bruise on her head. When Mrs Barlow tries to feed her, she screams and refuses. Mrs Barlow is very upset and feels that breastfeeding will be too difficult for her. You watch her trying to feed her baby, and you notice that her hand is pressing on the bruise.

III. "Not enough milk" 20 minutes

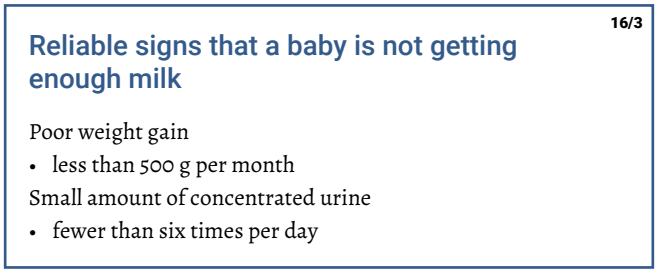
- Ask the working group discussing the subject to present the results of their flipchart.
- Ask participants of the other groups to add anything they consider is missing.
- Proceed with the review of "not enough milk", filling any gaps and avoiding repetitions.
- Show **Slide 16/2 – "Not enough milk"** and make the points that follow:



- One of the most common reasons for a mother to stop breastfeeding is that she thinks she does not have enough milk.
- Usually, even when a mother thinks that she does not have enough breast milk, her baby is, in fact, getting all that they need.
- Almost all mothers can produce enough breast milk for one or even two babies.
- They can almost all produce more than their babies need.
- Sometimes a baby does not get enough breast milk. But it is usually because they are not suckling enough, or not suckling effectively. It is rarely because the mother cannot produce enough.
- So it is important to think not about how much milk a mother can produce, but about how much milk a baby is getting.

Discuss how to decide whether a baby is getting enough milk or not

- Fill any gaps not covered by the working group.
  - The first step in helping mothers with insufficient milk is to confirm whether the baby is receiving enough breast milk or not.
  - There are only two **reliable** signs that a baby is not receiving enough breast milk.
- Show **Slide 16/3 – Reliable signs that a baby is not getting enough milk** and read out the signs from the slide:



- Make these points:
  - For the first 6 months of life, a baby should gain at least 500 g in weight each month; 1 kg is not necessary, and not usual.
  - If a baby does not gain 500 g in a month, they are not gaining enough weight.
  - Look at the baby's growth chart if available, weigh the baby now, and arrange to weigh them again in 1 week's time.
  - An exclusively breastfed baby who is getting enough milk usually passes dilute urine at least 6–8 times in 24 hours.

- A baby who is not getting enough breast milk passes urine fewer than six times a day (often less than four times a day).
- The baby's urine is also concentrated, and may be strong smelling and dark orange in colour.
- If a baby is having other drinks, for example water, as well as breast milk, you cannot be sure they are getting enough milk if they are passing lots of urine.

▶ Show **Slide 16/4 – Possible signs that a baby is not getting enough breast milk** and read out any sign not mentioned by the working group:

16/4

Possible signs that a baby is not getting enough breast milk

- Baby is not satisfied after breastfeeds
- Baby cries often
- Very frequent breastfeeds
- Very long breastfeeds
- Baby refuses to breastfeed
- Baby has hard, dry or green stools
- Baby has infrequent small stools
- No milk comes out when the mother tries to express
- The breasts did not enlarge (during pregnancy)
- Milk did not "come in" (after delivery)

- Although these signs may worry a mother, there may be other reasons for them, so they are not reliable. For example, a baby may cry often because they have colic, although they might be getting plenty of milk (we will discuss colic later in this session).

▶ Explain that participants can find the complete list of **Reliable** and **Possible** signs on pages 91 and 92 of their *Participant's manuals*.

Discuss the reasons why a baby may not get enough breast milk

▶ Fill any gaps left after the presentation of the working group and make these points:

- Once you have decided, using the reliable signs, that a baby is not getting enough breast milk, it is important to find out why, before you can help the mother.
- *Ask: Can you think of any reasons why a baby may not get enough breast milk?*

▶ Wait for a few replies. Continue if possible until they have suggested at least one "breastfeeding factor" and at least one "psychological factor".

▶ Tell participants that on page 92 of their *Participant's manual*, they can find the box REASONS WHY A BABY MAY NOT GET ENOUGH BREAST MILK.

▶ Make the following points:

- The reasons are arranged in four columns:
  - BREASTFEEDING FACTORS
  - MOTHER: PSYCHOLOGICAL FACTORS
  - MOTHER: PHYSICAL CONDITION
  - BABY'S CONDITION

► Refer to what the working group presented and ask one participant to read out the reasons not included in the flipchart.

REASONS WHY A BABY MAY NOT GET ENOUGH BREAST MILK			
BREASTFEEDING FACTORS	**MOTHER: PSYCHOLOGICAL FACTORS**	**MOTHER: PHYSICAL CONDITION**	**BABY'S CONDITION**
Delayed start Feeding at fixed times Infrequent feeds No night feeds Short feeds Poor attachment Bottles, pacifiers Other foods Other fluids (water, teas)	Lack of confidence Worry, stress Dislike of breastfeeding Rejection of baby Tiredness	Contraceptive pill (estrogen), diuretics Pregnancy Severe malnutrition Alcohol Smoking Retained piece of placenta (rare) Poor breast development (very rare)	Illness Abnormality
These are COMMON		**These are NOT COMMON**	

► Make these points:

- The reasons in the first two columns (BREASTFEEDING FACTORS and MOTHER: PSYCHOLOGICAL FACTORS) are common.
- Psychological factors are often behind the breastfeeding factors; for example, lack of confidence causes a mother to give artificial feeds; tiredness results in a mother feeding her baby less often.
- Look for these common reasons first.
- The reasons in the second two columns (MOTHER: PHYSICAL CONDITION and BABY'S CONDITION) are not common.
- So it is not common for a mother to have a physical difficulty in producing enough breast milk.
- Think about these uncommon reasons only if you cannot find one of the common reasons.

Discuss how to help mothers with "not enough milk"

► Fill any gaps left after the group presentation, making these points, as needed:

- We have already found out whether the baby is really getting enough breast milk or not.
- If the baby is not getting enough breast milk you need to find out **why**, so that you can help the mother.
- If the baby is getting enough breast milk, but the mother thinks that they aren't, you need to find out **why** she doubts her milk supply, so that you can build her confidence.

Babies who are *not* getting enough milk: low milk intake

- Use your counselling skills to take a good feeding history.
- Assess a breastfeed to check positioning and attachment and to look for bonding or rejection.
- Use your observation skills to look for illness or physical abnormality in the mother or baby.
- What you suggest to the mother as solutions will depend upon the cause of the insufficient milk.
- Always remember to arrange to see the mother again soon. If possible, see the mother and baby daily until the baby is gaining weight and the mother feels more confident. It may take 3–7 days for the baby to gain weight.

Babies who *are* getting enough milk but whose mother *thinks* they are not:

- Use your counselling skills to take a good feeding history.
- Try to learn what may be causing the mother to doubt her milk supply.
- Explore the mother's ideas and feelings about her milk and pressures she may be experiencing from other people regarding breastfeeding.
- Assess a breastfeed, to check positioning and attachment and to look for bonding or rejection.
- Praise the mother about good points about her breastfeeding technique and good points about her baby's development.
- Correct mistaken ideas without sounding critical (see **Fig. 16.1**).
- Always arrange to see the mother again soon. These mothers are at risk of introducing other foods and fluids and need a lot of support until their confidence is built up again.

Fig. 16.1 If a baby passes plenty of urine, it usually means that they are getting plenty of breast milk

- Ask participants of the working group to discuss the case of Mrs Singh. Ask them to turn to page 94 of their *Participant's manual*, to find the story about Mrs Singh. Below the story are questions and spaces for participants to fill in answers. First read out the story. Then ask the participants to fill in the answers to the questions. They may refer to page 92 of their manual to remind them of the reasons why a baby may not get enough breast milk. After a few minutes, go through the questions with the group and ask the participants to write in the answers so they have them to refer to later. Make sure the "mother" is sitting in a comfortable and relaxed position – as you decided when you practised this demonstration beforehand.
  - *Ask: What could you say to empathize with Mrs Singh?*
- Wait for a few replies. A possible response is given below but praise participants if they have an alternative response that empathizes with the mother.
  - *You are very busy. It must be difficult to find time to feed your baby.*
  - *Ask: Mrs Singh says she does not have enough breast milk – do you think her baby is getting enough milk?*
- Wait for a few replies.

- Mrs Singh's baby only gained 200 g last month, so she is not getting enough breast milk.
- *Ask: What do you think is the cause of Mrs Singh's baby not getting enough milk?*

► **Wait for a few replies – encourage participants to refer to the list of causes on page 92 of their *Participant's manual*.**

- Mrs Singh is not breastfeeding her often enough.
- *Ask: Can you suggest how Mrs Singh could give her baby more breast milk?*

► **Wait for a few replies.**

- Could she take her baby to the farm with her so she could breastfeed her more often?
- Could someone bring her baby to her where she is working?
- Could she express her breast milk to leave for her baby?

IV. "Crying babies" 20 minutes

► **Make these points:**

- We will now look at another common reason for a mother to stop breastfeeding – the crying baby.
- Many mothers start unnecessary foods or fluids because of their baby's crying. These additional foods and drinks often do not make a baby cry less. Sometimes a baby cries more.
- A baby who cries a lot can upset the relationship between the baby and their mother, and can cause tension among other members of the family.
- An important way to help a breastfeeding mother is to counsel her about her baby's crying.

Discuss the reasons why babies cry

► **Develop a list of reasons why babies may cry a lot:**

- *Ask: What reasons can you think of why babies may cry a lot?*

► **Write the replies up on a flipchart.**

► **Ask participants to turn to page 95 of their *Participant's manual* and find the box REASONS WHY BABIES CRY. Ask them to look briefly at the list. There is no need to read it aloud.**

REASONS WHY BABIES CRY

Discomfort	(dirty, hot, cold)
Tiredness	(too many visitors)
Illness or pain	(changed pattern of crying)
Hunger	(not getting enough milk, growth spurt)
Mother's food	(any food, sometimes cow's milk)
Drugs mother takes	(caffeine, cigarettes, other drugs)
Colic	
"High-needs" babies	

► **Make the following points:**

- Some of these causes may be new to you, so we will discuss them briefly.
- Hunger due to growth spurt:
  - In this situation, a baby seems very hungry for a few days, possibly because they are growing faster than before.
  - The baby demands to be fed very often.
  - This is commonest at the ages of about 2 weeks, 6 weeks and 3 months, but can occur at other times.
  - If the baby suckles often for a few days, the breast-milk supply increases, and the baby breastfeeds less often again.
- Mother's food:
  - Sometimes a mother notices that her baby is upset when she eats a particular food.
  - This is because substances from the food pass into her milk.
  - It can happen with any food, and there are no special foods to advise mothers to avoid, unless she notices a problem.
- Colic:
  - Some babies cry a lot without one of the above causes.
  - Sometimes the crying has a clear pattern.
  - The baby cries continuously at certain times of day, often in the evening.
  - The baby may pull up their legs as if they have abdominal pain.
  - The baby may appear to want to suckle, but it is very difficult to comfort them.
  - Babies who cry in this way may have a very active gut, or wind, but the cause is not clear.
  - This is called "colic".
  - Colicky babies usually grow well, and the crying usually becomes less after the baby is 3 months old.
- "High-needs" babies:
  - Some babies cry more than others, and they need to be held and carried more.
  - In communities where mothers carry their babies with them, crying is less common than in communities where mothers like to put their babies down to leave them, or where they put them to sleep in separate cots.

Discuss how to help mothers whose babies cry a lot

► **Make these points:**

- As with "not enough milk", you have to try to find the cause of the crying, so that you can help the mother. Use your counselling skills to take a good history.
- Help the mother to talk about how she feels and empathize with her. She may be tired, frustrated and angry. Accept her ideas about the cause of the problem and how she feels about the baby.
- Try to learn about pressures from other people and what they think the cause of the crying is.
- Assess a breastfeed, to check the baby's suckling position and attachment, and the length of a feed.
- Make sure the baby is not ill or in pain. Check the growth and refer if necessary.
- Where relevant, praise the mother that her baby is growing well and is not ill or bad or naughty.
- Demonstrate ways to carry and comfort a crying baby – holding them close, with gentle movement and pressure on the baby's abdomen. We will discuss this a little later.

- Give relevant information where appropriate:
- *Ask: What relevant information could you give to a mother whose baby is 6 weeks old with colic?*

▸ **Wait for a few replies and then continue.**

- Explain that the baby has a real need for comfort when they are crying, but that the crying will become less when the baby is 3–4 months old. Artificial feeds or medicines do not solve the problem.
- *Ask: What relevant information could you give to a mother whose baby is at the age when they might be going through a growth spurt?*

▸ **Wait for a few replies and then continue.**

- Encourage the mother to feed more frequently for a few days to increase her milk supply.
- *Ask: What practical help could you offer to a mother whose family thinks her well-grown 3-month-old baby is crying too much and needs to start cereals.*

▸ **Wait for a few replies and then continue.**

- Offer to talk to the family. It is important to help reduce tensions, so that the mother does not feel under pressure to give unnecessary foods in addition to breast milk.

Demonstrate how to hold and carry a colicky baby

▸ **Make this introductory point:**

- Babies are most often comforted with closeness, gentle movement and gentle pressure on the abdomen. There are several ways to provide this.

▸ **Give the demonstration:**

- Hold a doll along your forearm, pressing on its back with your other hand.
- Move gently backwards and forwards (see **Fig.16.2a**; show the slide).
- Sit down and hold the doll lying face down across your lap. Gently rub the doll's back.
- Sit down and hold the doll sitting on your lap, with its back to your chest.
- Hold it round the abdomen, gently pressing on the abdomen (see **Fig.16.2b**; show the slides).
- Ask a man to help with this demonstration if possible (see **Fig.16.2c**; show the slides).
- Ask him to hold the doll upright against his chest, with the doll's head against his throat. He should hum gently, so that a baby would hear his deep voice.

a. Holding the baby along your forearm

b. Holding the baby round his abdomen, on your lap

c. Father holding the baby against his chest

Fig. 16.2 Some different ways to hold a colicky baby

- **Ask participants of the working group to discuss the case of Mrs Biyela. Ask them to turn to page 96 of their *Participant's manual*, to find the story about Mrs Biyela. Below the story are questions and spaces for participants to fill in answers. First read out the story. Then ask the participants to fill in the answers to the questions. They may refer to page 95 of their manual to remind them of the reasons why a baby may cry. After a few minutes, go through the questions with the group and ask the participants to write in the answers so they have them to refer to later.**
  - *Ask: What could you say to empathize with Mrs Biyela?*
- **Wait for a few replies. A possible response is given below but praise participants if they have an alternative response that empathizes with the mother.**
  - *You are worried that he is crying more than before.*
  - *Ask: What could you praise to build Mrs Biyela's confidence?*
- **Wait for a few replies. A possible response is given below but participants may offer other suitable replies.**
  - *He has grown so well on your breast milk.*
  - *Ask: What relevant information could you give to Mrs Biyela?*
- **Wait for a few replies. Encourage participants to give the information in a positive way.**
  - At this age, many babies have a growth spurt and become very hungry. If you're feeding him more often for a few days, your milk supply will increase, and he will settle down again.

V. Refusal to breastfeed — 20 minutes

- **Make these points:**
  - Finally, we will look at babies who refuse to breastfeed or are unwilling to suckle (see **Fig. 16.3**; show the slide).

Fig. 16.3 A baby may be unable to suckle because they are sick

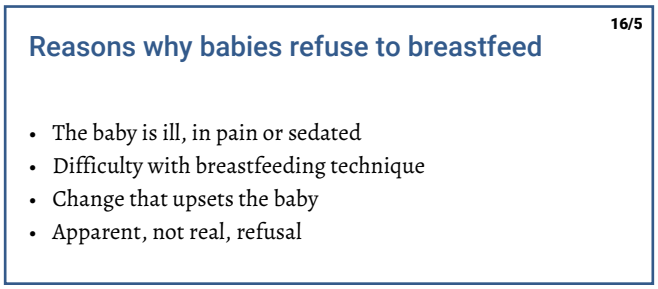
- In some communities, refusal is a common reason for stopping breastfeeding. However, it need not lead to complete cessation of breastfeeding, and can often be overcome.
- Refusal can cause great distress to the baby's mother. She may feel rejected and frustrated by the experience.
- There are different kinds of refusal.
  - Sometimes a baby attaches to the breast, but then does not suckle or swallow, or suckles very weakly.
  - Sometimes a baby cries and fights at the breast, when their mother tries to breastfeed them.
  - Sometimes a baby suckles for a minute and then comes off the breast, choking or crying. The baby may do this several times during a single feed.
  - Sometimes a baby takes one breast, but refuses the other.
- You need to know why a baby is refusing to breastfeed, before you can help the mother and baby to enjoy breastfeeding again.

▶ **Discuss causes of refusal to breastfeed**

- *Ask: What reasons can you think of why babies may refuse to breastfeed?*

▶ **Write the replies up on a flipchart**

▶ **Show Slide 16/5 – Reasons why babies refuse to breastfeed and make the points that follow:**



- Most reasons why babies refuse to breastfeed fall into one of these categories:
  - The baby is ill, in pain or sedated
  - Difficulty with breastfeeding technique
  - Change that upsets the baby
  - Apparent, not real, refusal.

▶ **Ask participants to turn to page 98 of their *Participant's manual* and find the box CAUSES OF REFUSAL TO BREASTFEED. Ask participants to look at this briefly. Explain any cause they do not understand but do not read out the whole list, as this will take too much time.**

CAUSES OF REFUSAL TO BREASTFEED

Illness, pain, discomfort or sedation (especially in the first week)	• Difficult delivery (e.g. brain damage) • Infection • Pain from bruise (vacuum, forceps) • Sedation (drugs given to mother) • Blocked nose • Sore mouth (thrush, teething)
Difficulty with breastfeeding technique (especially in the first month)	• Separation from mother after delivery • Use of bottles and pacifiers while breastfeeding • Not getting much milk (e.g. poor attachment) • Pressure on back of head when positioning • Delay "coming in", engorgement • Mother shaking her breast • Restricting the length of feeds • Difficulty coordinating suckle
Change that upsets the baby (especially aged 3–12 months)	• Separation from mother (e.g. if mother returns to work) • New carer or too many carers • Change in the family routine • Mother ill • Mother has breast problem (e.g. mastitis) • Mother menstruating • Change in smell of mother
Apparent refusal	• Neonate – rooting • Age 4–8 months – distraction • Above 1 year – self-weaning

Discuss how to help mothers whose babies refuse the breast

► Ask participants to turn to page 99 of their *Participant's manual* and find the box HELPING A MOTHER AND BABY TO BREASTFEED AGAIN. Ask participants to take it in turns to read out the points.

HELPING A MOTHER AND BABY TO BREASTFEED AGAIN

Help the mother to do these things:

- Keep her baby close – no other carers
  - Give plenty of skin-to-skin contact at all times, not just at feeding times
  - Sleep with her baby
  - Ask other people to help in other ways
- Offer her breast whenever her baby is willing to suckle
  - When her baby is sleepy, or after a cup feed
  - When she feels her ejection reflex working
- Help her baby to take the breast
  - Express breast milk into the baby's mouth
  - Position the baby so that they can attach easily to the breast – try different positions
  - Avoid pressing the back of the baby's head or shaking the mother's breast
- Feed her baby by cup
  - Express her breast milk to keep the supply and keep her breasts healthy
  - Give her own expressed breast milk if possible; if necessary, give artificial feeds
  - Avoid using bottles, teats or pacifiers

► Ask participants of the working group to discuss the case of Mrs Barlow. Ask them to turn to page 99 of their *Participant's manual*, to find the story about Mrs Barlow. Below the story are questions and spaces for participants to fill in answers. First read out the story. Then ask the participants to fill in the answers to the questions. They may refer to page 98 of their manual to remind them of the reasons why a baby may refuse to breastfeed. After a few minutes, go through the questions with the group and ask the participants to write in the answers so they have them to refer to later.

- *Ask: What could you say to empathize with Mrs Barlow?*

► Wait for a few replies. A possible response is given below but praise participants if they have an alternative response that empathizes with the mother.

- *You are really upset, aren't you?*
- *Ask: What praise and relevant information could you give to build Mrs Barlow's confidence?*

► Wait for a few replies.

- Praise: *It is lovely that you want to breastfeed your baby.*
- Relevant information: *At the moment, the bruise is making breastfeeding painful for your baby. That is why she is crying and refusing to feed.*
- *Ask: What practical help could you give to Mrs Barlow?*

► Wait for a few replies.

► Offer to help to find a way for Mrs Barlow to hold her baby that is not painful for her.

VI. Summarize the session — 5 minutes

- Ask participants whether they have any questions, and try to answer them.
- Make the following points to summarize the session:
  - Notice how all the skills you have learnt so far can be used to help mothers in different situations: LISTENING AND LEARNING SKILLS; SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT; assessing a breastfeed; helping a mother to position and attach her baby; taking a detailed feeding history.
- In many situations, there may be no treatment, so giving the mother relevant information and suggestions is very important.
- Explain that a summary of this session can be found on pages 91–100 of the *Participant's manual*.

Further information

Insufficient milk

The problem of "not enough milk" may arise before breastfeeding has been established, in the first few days after delivery. Then the mother needs help to establish breastfeeding.

The problem may arise after breastfeeding has been established, after the baby is about one month of age. Then the mother needs help to maintain breast-milk production.

Some mothers worry that they do not have milk at a certain time of day, usually in the evening.

The causes of the problem and the needs of mothers in these different situations are sometimes different. It is important to be aware of this. However, the same principles of management apply to all situations.

Stool frequency

The stool frequency of infants is very variable. A baby may not pass a stool for several days, and this is quite normal. However, when the baby does pass a stool, it is usually large and semi-liquid. Small dry stools may be a sign that a baby is not getting enough milk.

It is also normal for a baby to pass eight or more semi-liquid stools in a day. If the baby has diarrhoea, the stools are watery.

Disposable nappies

These absorb urine and make it difficult to decide whether a baby has passed enough urine. If a mother is worried about her milk supply, it is better to use towelling nappies.

Unreliable signs of "not enough milk"

Participants may have suggested some of the following signs that make a mother think that she does not have enough milk. They are all unreliable and do not indicate that her baby is not getting enough:

- Baby sucks fingers
- Baby sleeps longer after bottle feed
- Baby's abdomen is not rounded after feeds
- Breasts are not full immediately after delivery
- Breasts are softer than before
- Breast milk is not dripping out
- The mother is not feeling her oxytocin reflex
- Family members ask whether there is enough milk
- A health worker said there is not enough milk
- The mother is told she is too young or too old to breastfeed
- The mother is told her baby is too small or too big
- Poor previous experience of breastfeeding
- Breast milk looks thin

Guidelines, not rules

The signs of weight gain and urine output as reliable signs that a baby is not getting enough breast milk are guidelines, not rules. They can help you to diagnose and correct a clinical breastfeeding problem. However, do not apply them rigidly to all mothers – especially if there is no problem. Experience will guide you.

Weight changes in newborn babies

A newborn baby may lose a little weight in the first few days of life. The baby she should regain the birth weight by the age of 2 weeks. If babies demand feed from the first day, they start gaining weight more quickly than babies who delay. A baby who weighs less than their her birth weight at 2 weeks of age is not gaining enough weight.

These notes may help you to explain the reasons why a baby may not get enough milk.

Breastfeeding factors

Delayed start

If a baby does not start to breastfeed on the first day, their mother's breast milk may take longer to come in, and the baby may take longer to start gaining weight.

Infrequent feeds

Breastfeeding fewer than 8 times a day in the first 4 weeks, or fewer than 5–6 times a day at an older age, is a common reason why a baby does not get enough milk. Sometimes a mother does not respond to her baby when they cry, or she may miss feeds, because she is too busy or at work. Some babies are content and do not show that they are hungry often enough. In this case, a mother should not wait for her baby to "demand", but should encourage/wake the baby to breastfeed every 3–4 hours. This is commonest in the first few months of life.

No night feeds

If a mother stops night breastfeeds before her baby is ready, her milk supply may decrease.

Short feeds

Breastfeeds may be too short or hurried, so that the baby does not get enough fat-rich hindmilk.

Sometimes a mother takes her baby off her breast after only a minute or two. This may be because the baby pauses, and the mother decides that the baby has finished. Or she may be in a hurry, or she may believe that her baby should stop in order to suckle from the other breast.

Sometimes a baby stops suckling too quickly, for example if they are too hot, because they are wrapped in too many clothes.

Poor attachment

If a baby suckles ineffectively, they may not get enough milk. This is one of the most important reasons for poor weight gain, especially in the first few weeks of life. So ensuring that babies are well attached at the breast soon after birth is an important way to ensure an adequate milk supply.

Bottles and pacifiers

A baby who feeds from a bottle or who sucks on a pacifier may suckle less at the breast, so the supply of breast milk decreases.

Complementary feeds

A baby who has complementary feeds (artificial milks, solids, or drinks including plain water), before 6 months suckles less at the breast, so the supply of breast milk decreases.

Mother: psychological factors

Lack of confidence

Mothers who are very young, or who lack support from family and friends, often lack confidence. Mothers may lose confidence because their baby's behaviour worries them. Lack of confidence may lead a mother to give unnecessary supplements.

Worry, stress

If a mother is worried or stressed or in pain, her oxytocin reflex may temporarily not work well. If she is comforted and her stress relieved, the reflex will recover.

Dislike of breastfeeding, rejection of the baby and tiredness

In these situations, a mother may have difficulty in responding to her baby. She may not hold the baby close enough to attach well; she may breastfeed infrequently, or for a short time. She may give her baby a pacifier when they cry, instead of breastfeeding them.

Mother: physical condition

Contraceptive pill

Contraceptive pills, which contain estrogens, may reduce the secretion of breast milk. Progestagen-only pills and Depo-Provera should not reduce the supply of breast milk, but should not be given before the baby is 4 weeks old. Diuretics may reduce the supply of breast milk.

Pregnancy

If a mother becomes pregnant again, she may notice a decrease in her supply of breast milk.

Severe malnutrition

Severely malnourished women may produce less milk. However, a woman who is mildly or moderately undernourished continues to produce milk at the expense of her own tissues, provided her baby suckles often enough.

Alcohol and smoking

Alcohol and cigarettes can reduce the amount of breast milk that a baby takes.

Retained piece of placenta

This is RARE. A small piece of placenta remains in the uterus, and makes hormones that prevent milk production. The woman bleeds more than usual after delivery, her uterus does not decrease in size and her milk does not "come in". After the placenta is removed by curettage, her milk supply increases.

Poor breast development

This is VERY RARE. Occasionally a woman's breasts do not develop and increase in size during pregnancy, and she does not produce much milk. If the mother noticed an increase in the size of her breasts during pregnancy, then poor breast development is not her problem. It is not necessary to ask about this routinely. Ask only if there is a problem.

Baby's condition

Illness

A baby who is ill and unable to suckle strongly does not get enough breast milk. If this continues, the mother's milk supply will decrease.

Abnormality

A baby who has a congenital problem, such as a heart abnormality, may fail to gain weight. This is partly because they take less breast milk, and partly because of other effects of the condition.

Babies with a deformity such as a cleft palate, or with a neurological problem, or mental disability, often have difficulty in suckling effectively, especially in the first few weeks.

Occasionally, you may not be able to find the cause of a poor milk supply; or the milk supply does not improve (the baby does not gain weight) even though you have done everything you can to help the mother increase her supply of breast milk. A very small proportion of women may have an unexplained low milk supply – perhaps about 1–2% of women. Then you may need to look for one of the less common causes, and help or refer the mother accordingly.

Occasionally you may need to help a mother to find a suitable additional source of milk for her baby. We use the term **supplements** to refer to extra milk given to a baby in the first few months. This is different from complementary feeding.

Encourage her to:

- continue breastfeeding as much as possible
- give only the amount of complement that her baby needs for adequate growth
- give the complement by cup
- give the complement only once or twice a day, so that her baby suckles often at the breast.

Remember that the need for complements before 6 months of age should be RARE.

Crying

A baby who is "crying too much" may really be crying more than other babies, or their family may be less tolerant of the crying, or less skilled at comforting the baby. Families' response to crying is different in different societies. So also is the way in which parents handle children. For example, in societies where babies are carried around more, they cry less. If babies sleep with their mothers, they are less likely to cry at night. Yet babies themselves vary a lot in how much they cry. So it is impossible to say that some patterns are "normal", and some are not.

Allergies

Babies can become allergic to the protein in some foods in their mother's diet. Cow's milk, soy, egg and peanuts can all cause this problem. Babies may become allergic to cow's milk protein after only one or two prelacteal feeds of formula.

Drugs the mother takes

Caffeine in coffee, tea and colas can pass into breast milk and upset a baby. If a mother smokes cigarettes, or takes other drugs, her baby is more likely to cry than other babies. If someone else in the family smokes, that also can affect the baby.

Breast refusal

These notes will help you to explain the reasons why babies may refuse the breast.

Is the baby ill, in pain or sedated?

Illness:

- The baby may attach to the breast, but suckle less than before

Pain:

- Pressure on a bruise from forceps or vacuum extraction
- The baby cries and fights as their mother tries to breastfeed them

Blocked nose:

- Sore mouth (*Candida* infection [thrush], an older baby teething)
- The baby suckles a few times, and then stops and cries

Sedation:

A baby may be sleepy because of:

- drugs that the mother was given during labour
- drugs that she is taking for psychiatric treatment

Is there a difficulty with the breastfeeding technique?

Sometimes breastfeeding has become unpleasant or frustrating for a baby.

Possible causes:

- Feeding from a bottle, or sucking on a pacifier (dummy)
- Not getting much milk, because of poor attachment or engorgement
- Pressure on the back of the baby's head, by the mother or a helper positioning the baby roughly, with poor technique. The pressure makes the baby want to "fight"
- The mother holding or shaking the breast, which interferes with attachment
- Restriction of breastfeeds; for example, breastfeeding only at certain times
- Early difficulty coordinating suckling (some babies take longer than others to learn to suckle effectively)

Refusal of one breast only:

Sometimes a baby refuses one breast, but not the other. This is because the problem affects one side more than the other.

Has a change upset the baby?

Babies have strong feelings, and if they are upset they may refuse to breastfeed. They may not cry, but simply refuse to suckle.

This is commonest when a baby is aged 3–12 months. The baby suddenly refuses several breastfeeds. This behaviour is sometimes called a "nursing strike".

Possible causes:

- Separation from the mother, for example when she starts a job
- A new carer, or too many carers
- A change in the family routine – for example, moving house, visiting relatives
- Illness of his mother, or a breast infection
- The baby's mother menstruating
- A change in the mother's smell, for example, different soap or different food

Is it "apparent" and not "real" refusal?

Sometimes a baby behaves in a way that makes their mother think that they are refusing to breastfeed. However, the baby is not really refusing.

- When a newborn baby "roots" for the breast, they move their head from side to side as if they are saying "no". However, this is normal behaviour.
- Between 4 and 8 months of age, babies are easily distracted, for example when they hear a noise. They may suddenly stop suckling. It is a sign that they are alert.
- After the age of 1 year, a baby may wean themself. This is usually gradual.

Management of breast refusal

If a baby is refusing to breastfeed:

- Treat or remove the cause if possible.
- Help the mother and baby to enjoy breastfeeding again.

Treat or remove the cause if possible

Illness:

- Treat infections with appropriate antimicrobials and other therapy.
- Refer if necessary.
- If a baby is unable to suckle, they may need special care in hospital.
- Help the mother to express her breast milk to feed to the baby by cup or by tube, until the baby is able to breastfeed again.

Pain:

- For a bruise, help the mother to find a way to hold the baby without pressing on a painful place.
- For thrush, treat with nystatin; if the mother is HIV infected, use fluconazole.
- For teething, encourage the mother to be patient and to keep offering the baby her breast.
- For a blocked nose, explain how she can clear it; suggest short feeds, more often than usual for a few days.

Sedation:

- If the mother is on regular medication, try to find an alternative.

Breastfeeding technique:

- Discuss the reason for the difficulty with the mother. When her baby is willing to breastfeed again, you can help her more with her technique.

Changes that upset a baby:

- Discuss the need to reduce separation and changes if possible.
- Suggest that she stops using the new soap, perfume or food.

Apparent refusal:

- If it is rooting, explain that this is normal. She can hold her baby at her breast to explore her nipple.
- Help her to hold the baby closer, so that it is easier for them to attach.

If it is distraction:

- Suggest that she try to feed the baby somewhere more quiet for a while. The problem usually passes.

If it is self-weaning:

Suggest that she:

- makes sure that the child eats enough family food
- gives the baby plenty of extra attention in other ways
- continues to sleep with the baby, because night feeds may continue.

Help the mother and baby to enjoy breastfeeding again

This is difficult and can be hard work. You cannot force a baby to breastfeed.

The mother needs help to feel happy with her baby and to enjoy breastfeeding. They have to learn to enjoy close contact again. She needs you to build her confidence and to give her support.

Help the mother to do these things:

Keep her baby close to her all the time

- She should care for her baby herself as much of the time as possible.
- Ask grandmothers and other helpers to help in other ways, such as doing the housework and caring for older children.
- She should hold her baby often, and give plenty of skin-to-skin contact at times other than feeding times
- She should sleep with her baby.
- If the mother is employed, she should take leave from her employment – sick leave if necessary.
- It may help if you discuss the situation with the baby's father, grandparents and other helpful people.

Offer her breast whenever her baby is willing to suckle

- She should not hurry to breastfeed again, but offer the breast if her baby does show an interest.
- The baby may be more willing to suckle when they are sleepy or after a cup feed, than when they are very hungry. She can offer her breast in different positions.
- If she feels her ejection reflex working, she can offer her breast then.

Help her baby to breastfeed in these ways:

- Express a little milk into her baby's mouth.
- Position the baby well, so that it is easy for them to attach to the breast.
- She should avoid pressing the back of the baby's head, or shaking her breast.

Feed her baby by cup until they are breastfeeding again

- She can express her breast milk and feed it to her baby from a cup (or cup and spoon). If necessary, use artificial feeds and feed them by cup.
- She should avoid using bottles, teats and pacifiers (dummies) of any sort.

Notes

Session 17

Expressing breast milk 1

Objectives

After completing this session, participants will be able to:

- list the situations when expressing breast milk is useful
- explain how to stimulate the oxytocin reflex
- rub a mother's back to stimulate the oxytocin reflex
- demonstrate how to select and prepare a container for expressed breast milk
- describe how to store breast milk
- explain to a mother the steps of expressing breast milk by hand

Session outline . . . . . 45 minutes

Participants are all together for a demonstration by one trainer.

I. Introduce the session, present **Slide 17/1** . . . . . 3 minutes
II. Demonstrate how to stimulate the oxytocin reflex . . . . . 15 minutes
III. Demonstrate how to express breast milk by hand . . . . . 20 minutes
IV. Demonstrate breast pumps . . . . . 5 minutes
V. Summarize the session . . . . . 2 minutes

Preparation

- Refer to the Introduction for guidance on giving a demonstration.
- Study the notes for the session, so that you are clear about what to do.
- Make sure you have **Slide 17/1** ready. Alternatively, as there is only one slide in this session, you might prefer to read aloud the objectives on **Slide 17/1** without projecting them onto the screen.
- Obtain some examples of suitable containers to collect expressed breast milk, which would be available to ordinary mothers (for example, cups, jam jars).
- Collect samples of any breast pumps that are available in the area, from hospitals or from shops. (If none are available or used, do not give this demonstration.)
- Ask a participant to help you to demonstrate back massage to stimulate the oxytocin reflex. Explain what you want them to do.
- Have ready COUNSELLING CARD 6: HOW TO EXPRESS BREAST MILK AND CUP-FEED and COUNSELLING CARD 7: WHEN YOU ARE SEPARATED FROM YOUR BABY, and the *Guidance on the use of counselling cards*.

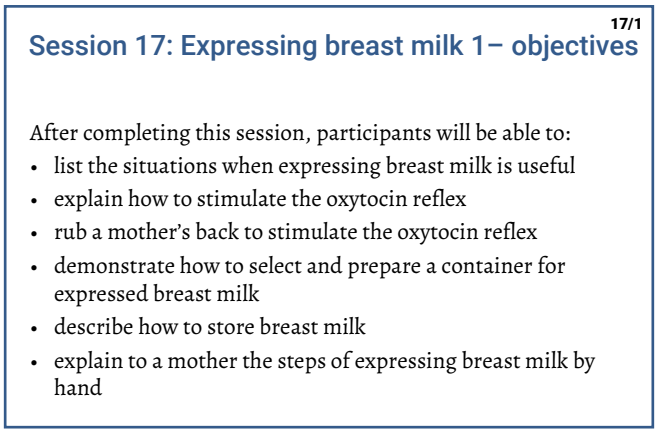
As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

I. Introduce the session — 5 minutes

► Show **Slide 17/1 – Session 17 – objectives** and read out the objectives:



► Make the following points:

- In this session, you will learn how to express breast milk effectively. Expressing breast milk is helpful in a number of situations. Difficulties can arise, but they are often due to poor technique.
- Many mothers are able to express plenty of breast milk using rather strange techniques. If a mother's technique works for her, let her continue to do it that way. But if a mother is having difficulty expressing enough milk, teach her a more effective technique.

► Discuss when it is useful to express breast milk.

- *Ask: In which situations is it useful for a mother to express her breast milk?*

► Write participants' ideas on a board. Try to develop a list with most of the ideas below.

► After a few minutes, if participants cannot think of any more, complete the list for them.

- Expressing milk is useful to:
  - leave breast milk for a baby when their mother goes out or goes to work
  - feed a low-birth-weight baby who cannot breastfeed
  - feed a sick baby who cannot suckle enough
  - keep up the supply of breast milk when a mother or baby is ill
  - prevent leaking when a mother is away from her baby
  - help a baby to attach to a full breast
  - help with breast health conditions, e.g. engorgement (see SESSIONS 19 and 28: BREAST CONDITIONS 1 and 2)
  - facilitate the transition to another method of feeding or to heat-treat breast milk (see MODULE 7: HIV AND INFANT FEEDING).
- So, there are many situations in which expressing breast milk is useful and important, to enable a mother to initiate or to continue breastfeeding.
- All mothers should learn how to express their milk, so that they know what to do if the need arises. It is important that all those who care for breastfeeding mothers should be able to teach mothers how to express their milk.
- Breast milk can be stored for about 8 hours at room temperature or up to 24 hours in a refrigerator.

II. Demonstrate how to stimulate the oxytocin reflex — 15 minutes

- Discuss why stimulating the oxytocin reflex is helpful:
  - *Ask: Why is it helpful to stimulate a mother's oxytocin reflex before she expresses milk?*
- Wait for a few replies and then continue.
- Encourage participants to recall what they learnt about how breastfeeding works. Give them a minute to think and make a few suggestions, then continue.
  - It is important that the oxytocin reflex works to make the milk flow from her breasts.
  - The oxytocin reflex may not work as well when a mother expresses as it does when a baby suckles. A mother needs to know how to help her oxytocin reflex, or she may find it difficult to express her milk.
  - *Ask: What ways can you think of to stimulate the oxytocin reflex?*
- Wait for a few replies and then continue.
- Ask participants to turn to page 104 of their *Participant's manual* and find the box HOW TO STIMULATE THE OXYTOCIN REFLEX.
- Ask participants to read through the box on their own, explaining anything that is not clear.

HOW TO STIMULATE THE OXYTOCIN REFLEX

- Help the mother **psychologically**:
  - Build her confidence.
  - Try to reduce any sources of pain or anxiety.
  - Help her to have good thoughts and feelings about the baby.
- Help the mother **practically**. Help or advise her to:
  - Sit quietly and privately or with a supportive friend.
    Some mothers can express easily in a group of other mothers who are also expressing for their babies.
  - Hold her baby with skin-to-skin contact if possible.
    She can hold her baby on her lap while she expresses. If this is not possible, she can look at the baby. If this is not possible, sometimes even looking at a photograph of her baby helps.
  - Warm her breasts.
    For example, she can apply a warm compress, or warm water, or have a warm shower. Warn her that she should test the temperature to avoid burning herself.
  - Stimulate her nipples.
    She can gently pull or roll her nipples with her fingers.
  - Massage or stroke her breasts lightly.
    Some women find that it helps if they stroke the breast gently with finger tips or with a comb.
    Some women find that it helps to gently roll their closed fist over the breast towards the nipple.
  - Ask a helper to rub her back.

- Demonstrate how to rub a mother's back; **Fig. 17.1** illustrates the technique.
- Ask a participant to help you. She should sit at the table resting her head on her arms, as relaxed as possible.
- She remains clothed, but explain that with a mother it is important for her breasts and her back to be naked.
- Make sure that the chair is far enough away from the table for her breasts to hang free. Explain what you will do, and ask her permission to do it.

- Rub both sides of her spine with your thumbs, making small circular movements, from her neck to her shoulder blades, and back again, for 2 or 3 minutes (see box inset in **Fig. 17.1**).
- Ask her how she feels, and whether it makes her feel relaxed.
- Ask participants to work in pairs and briefly practise the technique of rubbing a mother's back.

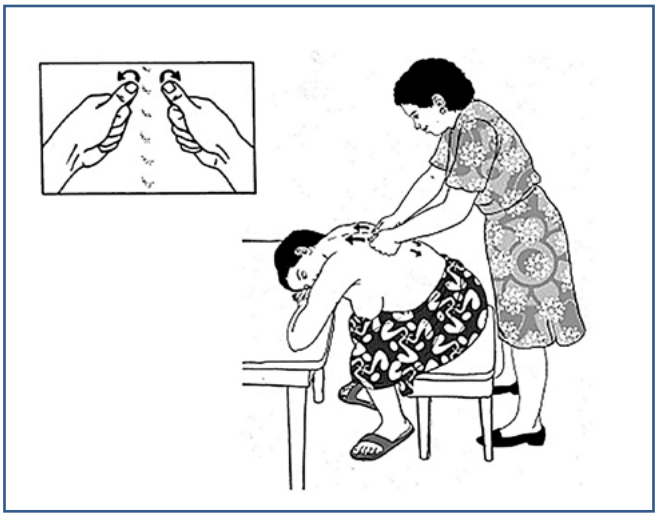


Fig. 17.1 A helper rubbing a mother's back to stimulate the oxytocin reflex

III. Demonstrate how to express breast milk by hand — 20 minutes

- Make these points:
  - Hand expression is the most useful way to express milk. It needs no appliance, so a woman can do it anywhere, at any time.
  - A woman should express her own breast milk. The breasts are easily hurt if another person tries.
  - If you are showing a woman how to express, show her on your own body as much as possible, while she copies you. If you need to touch her to show her exactly where to press her breast, be very gentle.
- Explain how to prepare a container for the expressed breast milk. (Do this demonstration quickly. Do not let it take a long time.)
- Show participants some of the containers to hold the expressed breast milk that you have collected. Go through the following points:

How to prepare a container for expressed breast milk

- Choose a cup, glass, jug or jar with a wide mouth.
- Wash the cup in soap and water (this can be done the day before).
- Pour boiling water into the cup, and leave it for a few minutes. Boiling water will kill most of the germs.
- When ready to express milk, pour the water out of the cup.

- Give the demonstration of how to express breast milk by hand.
- Demonstrate as much as possible on your own body. If you prefer not to use your own body, use a model breast or practise on the soft part of your arm or cheek. You can draw a nipple and areola on your arm.
- Follow the steps in the box How to express breast milk by hand, explaining what you do.

How to express breast milk by hand

Teach a mother to do this herself. Do not express her milk for her. Touch her only to show her what to do, and be gentle. Teach her to:

- Prepare a clean dry wide mouthed container for the expressed milk.
- Wash her hands thoroughly with soap and water every time before she expresses.
- She needs to wash her breasts only once a day. Frequent washing, especially with soap, dries the sensitive skin of the areola, increasing the risk of fissures.
- Sit or stand comfortably, and hold the container near her breast.
- Put her thumb on her breast **above** the nipple and areola, and her first finger or first two fingers on the breast **below** the nipple and areola, opposite the thumb. She supports the breast with her other fingers (see **Fig.33.2**).
- Press her thumb and first finger or first two fingers slightly inwards towards the chest wall. She should avoid pressing too far, or she may block the milk ducts.
- Press her breast behind the nipple and areola between her first finger or first two fingers and thumb. She should press on the larger ducts beneath the areola. Sometimes in a lactating breast, it is possible to feel the ducts. They are like pods, or peanuts. If she can feel them, she can press on them.
- Press and release, press and release. This should not hurt – if it hurts, the technique is wrong. At first no milk may come, but after pressing a few times, milk starts to drip out. It may flow in streams if the oxytocin reflex is active.
- Press the areola in the same way from the **sides**, to make sure that milk is expressed from all segments of the breast.
- Avoid rubbing or sliding her fingers along the skin. The movement of the fingers should be more like rolling.
- Avoid squeezing the nipple itself. Pressing or pulling the nipple cannot express the milk. It is the same as the baby sucking only the nipple.
- Express one breast for at least 3–5 minutes until the flow slows; then express the other side; and then repeat both sides. She can use either hand for either breast, and change when they tire.
- Alternate between breasts 5 or 6 times. Stop expressing when the milk no longer flows.
- Explain that to express breast milk adequately takes 20–30 minutes, especially in the first few days when only a little milk may be produced. It is important not to try to express in a shorter time.
- If she is expressing colostrum in the first one or two days, collect it in a 2 or 5 mL syringe as it comes from the nipple. A helper can do this. This avoids wasting the milk, which can happen with a small volume of milk in a large container.
- Some mothers find pushing slightly inwards towards the chest wall at the same time as compressing the breast helps to increase milk flow.

Avoid the following:

- Squeezing the nipple – this can block milk flow
- Sliding the fingers on the breast – friction can make the breasts sore

a. Place the first finger or first two fingers and thumb each side of the areola and press inwards towards the chest wall

b. Press behind the nipple and areola between your first finger or first two fingers and thumb

c. Press from the sides to empty all segments

Fig. 17.2 How to express breast milk by hand

- Tell participants that they can find the box HOW TO EXPRESS BREAST MILK BY HAND on page 105 of their *Participant's manual*, and the figures on page 106.
- Review together COUNSELLING CARD 6: HOW TO EXPRESS BREAST MILK AND CUP-FEED, and COUNSELLING CARD 7: WHEN YOU ARE SEPARATED FROM YOUR BABY. Refer participants to the sections in the *Guidance on the use of counselling cards* on KEY PRACTICES AND DISCUSSION POINTS for COUNSELLING CARDS 6 and 7 and remind them about use of the steps ASSESS, ANALYSE and ACT.
- Discuss how often to express milk:
  - *Ask: How often should a mother express her breast milk?*
- Wait for a few replies and then continue.
  - It depends on the reason for expressing the milk, but usually as often as the baby would breastfeed.
  - **To establish lactation, to feed a low-birth-weight or sick neonate**, she should start to express milk on the first day, as soon as possible after delivery. She may only express a few drops of colostrum at first, but it helps production of breast milk to begin, in the same way that a baby suckling soon after delivery helps production to begin.
  - She should express as much as she can, as often as her baby would breastfeed. This should be at least every 3 hours, including during the night. If she expresses only a few times, or if there are long intervals between expressions, she may not be able to produce enough milk.
  - **To keep up her milk supply to feed a sick baby**, she should express at least every 3 hours.
  - **To build up her milk supply, if it seems to be decreasing after a few weeks**, she should express very often for a few days (every 2 hours or even every hour), and at least every 3 hours during the night.

- **To leave milk for a baby while she is out at work**, she should express as much as possible before she goes to work, to leave for her baby. It is also very important to express while at work, to help keep up her supply.
- **To relieve symptoms, such as engorgement, or leaking at work**, she should express only as much as is necessary.

► Ask participants to practise the technique. Ask them to practise the rolling action of the fingers on a model breast or on their arms. Ask them to make sure that they avoid pinching. Ask them to practise on their own bodies privately later.

IV. Demonstrate breast pumps 5 minutes

► Make these points:

- If breasts are engorged and painful, it is sometimes difficult to express milk by hand.
- It can be helpful to express with a pump.
- A pump is easier to use when the breasts are full. It is not so easy to use when the breasts are soft.

► If breast pumps are available in your setting, you can demonstrate them here.

V. Summarize the session 2 minutes

► Ask participants whether they have any questions, and try to answer them.

► Make these points:

- Hand expression is the most useful way to express breast milk. It is less likely to carry infection than a pump, and is available to every woman at any time.
- It is important for women to learn to express their milk by hand, and not to think that a pump is necessary.
- To express milk effectively, it is helpful to stimulate the oxytocin reflex and to use a good technique.

► Explain that a summary of this session can be found on pages 103–106 of the *Participant's manual*.

Notes

Notes (contd)

Session 18

Cup-feeding

Objectives

After completing this session, participants will be able to:

- list the advantages of cup-feeding
- estimate the volume of milk to give to a baby according to weight
- demonstrate how to cup-feed safely

Session outline . . . . . 30 minutes

Participants are all together for a demonstration by one trainer.

I. Introduce the session, present **Slide 18/1** . . . . . 2 minutes
II. Discuss the advantages of cup-feeding . . . . . 5 minutes
III. Demonstrate how to feed a baby by cup . . . . . 10 minutes
IV. Discuss volumes of milk to give to a baby . . . . . 10 minutes
V. Summarize the session . . . . . 3 minutes

Preparation

- Refer to the Introduction for guidance on how to give a demonstration.
- Study the notes for the session so that you are clear what to do.
- Make sure you have **Slide 18/1** ready. Alternatively, as there is only one slide in this session, you might prefer to read aloud the objectives on **Slide 18/1** without projecting them onto the screen.
- For the demonstration, you will need a small cup, which holds approximately 60 mL of water, a cloth and a doll.
- You will need a flipchart to demonstrate the calculation.
- Have ready Counselling card 6: How to express breast milk and cup-feed, Counselling card 7: When you are separated from your baby, and the *Guidance on the use of counselling cards*.

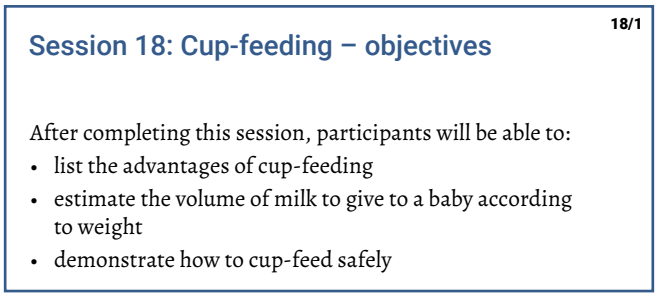
As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

I. Introduce the session — 2 minutes

- Show **Slide 18/1 – Session 18 – objectives** and read out the objectives :



II. Discuss the advantages of cup-feeding — 5 minutes

- Discuss why cup-feeding is safer than bottle feeding:
  - *Ask: Why are cups safer and better than bottles for feeding a baby?*
- Wait for a few replies and then continue. Make the points that have not been mentioned.
  - Cups are easy to clean with soap and water, if boiling is not possible.
  - Cups are less likely than bottles to be carried around for a long time, giving bacteria time to breed.
  - Cup-feeding is associated with less risk of diarrhoea, ear infections and tooth decay.
  - A cup cannot be left beside a baby, for the baby to feed themself. The person who feeds a baby by cup has to hold the baby and look at them, and give them some of the contact that they need.
  - A cup does not interfere with suckling at the breast.
  - A cup enables a baby to control their own intake, at their own pace.
  - The baby sits semi-upright to cup-feed, which reduces the risk of aspiration. **Milk must not be poured into the baby's mouth.**

III. Demonstrate how to feed a baby by cup — 10 minutes

- Give the demonstration of cup-feeding.
- Follow these steps:
  - Put some water into one of the small cups. Use approximately 60 mL of water, to demonstrate the typical volume of milk used for one feed for a young baby.
  - Prepare a doll, wrapping it with a cloth to hold its hands by its side, and to help to support its back. Put another small cloth on the doll's front, to protect its clothes from any spilled milk.
  - Hold the doll on your lap, closely, with it sitting upright or semi-upright. Explain that a baby should not lie down as if it were being bottle- or breastfed.
  - Hold the small cup or glass to the doll's lips. Tip it so that the water just reaches the lips. Point out that the edges of the cup touch the outer part of the baby's upper lip, and the cup rests lightly on their lower lip. This is normal when a person drinks.
  - Explain that at this point, a real baby becomes quite alert, and opens their mouth and eyes. The baby makes movements with the mouth and face, and starts to take the milk into their mouth with their tongue. Babies older than about 36 weeks' gestation try to suck.
  - Some milk may spill from the baby's mouth. You may want to put a cloth on the baby's front to protect their clothes. Spilling is more common with babies of more than about 36 weeks' gestation, and less common with smaller babies.
  - You should not pour the milk into a baby's mouth – just hold the cup to their lips.

- Explain that when a baby has had enough, they will close their mouth and will not take any more this feed. If the baby has not taken the calculated amount, they may take more next time, or may need feeds more often. Measure the baby's intake over 24 hours, not just at each feed.
- Demonstrate with a doll what happens when you try to feed a baby with a spoon. You need to hold the cup and the spoon, or you need to put the cup down and take milk from it. The procedure is more awkward.
- Tell participants that the technique is described in the box How to feed a baby by cup on page 110 of their *Participant's manual*. There is no need to read this box out to the participants.

How to feed a baby by cup

- Wash your hands.
- Wrap the baby in a cloth to hold their hands by their side, and to support their back.
- Hold the baby sitting upright or semi-upright on your lap.
- Put a cloth in front to protect the baby's clothes from spilled milk.
- Place the estimated amount of milk for one feed into the cup.
- Hold the small cup of milk to the baby's lips.
  - Tip the cup so that the milk just reaches the baby's lips.
  - The cup rests lightly on the baby's lower lip, and the edges of the cup touch the outer part of the baby's upper lip.
- The baby becomes alert, and opens their mouth and eyes.
  - A low-birth-weight baby starts to take the milk into their mouth with their tongue.
  - A full-term or older baby sucks the milk, spilling some of it.
- **Do not pour** the milk into the baby's mouth. Just hold the cup to their lips and let them take it themself (sipping or lapping).
- When the baby has had enough, they will close their mouth and will not take any more. If the baby has not taken the calculated amount, they may take more next time, or you may need to feed them more often.
- Measure the baby's intake over 24 hours – not just at each feed.

Ask participants to observe the cup-feeding in **Fig. 18.1**, to look at Counselling card 6: How to express breast milk and cup-feed and Counselling card 7: When you are separated from your baby and to refer to the sections in the *Guidance on the use of counselling cards* on Key practices and discussion points for those Counselling cards.

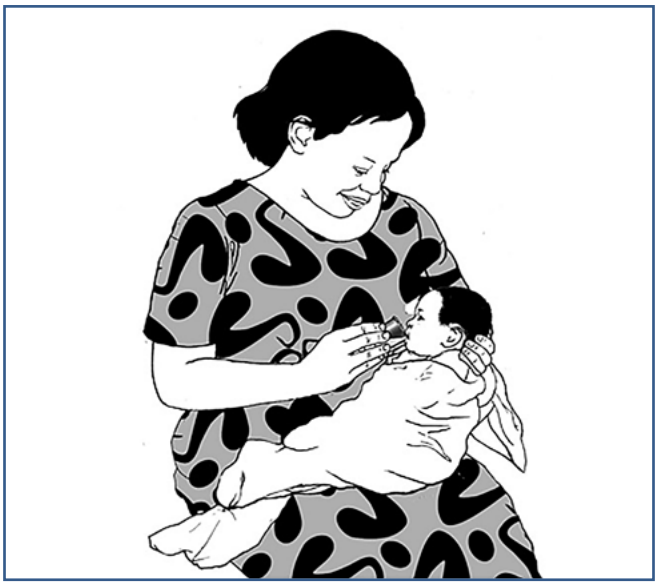


Fig. 18.1 Feeding a baby by cup

IV. Discuss the volumes of milk to give to a baby — 10 minutes

► **Make these points:**

- It is normal for the amount of milk that a baby takes at each feed to vary, whatever the method of feeding, including breastfeeding.
- Babies feeding by cup may take more or less than the calculated amount. If possible, offer a little extra, but let the baby decide when to stop.
- If a baby takes a very small feed, offer extra at the next feed, or give the next feed early, especially if the baby shows signs of hunger.
- Low-birth-weight babies need only very small volumes during the early days. If the mother can express even a small amount of colostrum, it is often all that her baby needs.
- Ask participants to turn to page 111 of their *Participant's manual*, to find the box AMOUNT OF MILK TO GIVE TO BABIES WHO CANNOT BREASTFEED. Ask the participants to read this box themselves before you go through the calculation that follows.

AMOUNT OF MILK TO GIVE TO BABIES WHO CANNOT BREASTFEED

What milk to give

- Choice 1: expressed breast milk (if possible from the baby's mother, or from a donor); this may be pasteurized or heat-treated according to local policy.
- Choice 2: formula milk made up according to the instructions and World Health Organization (WHO) guidelines

Amount of milk to give

Babies who weigh 2.5 kg or more

- 150 mL milk/kg body weight per day
- Divide the total into 8 feeds, and give 3-hourly

Babies who weigh less than 2.5 kg (low birth weight)

- Start with 60 mL/kg body weight per day
- Increase the total volume by 20 mL/kg per day, until the baby is taking a total of 180–200 mL/kg per day
- Divide the total into 8–12 feeds, to feed every 2–3 hours
- Continue until the baby weighs 1800 g or more, and is fully breastfeeding

Check the baby's 24-hour intake

The size of individual feeds may vary

► **Ask participants to turn to page 111 of their *Participant's manual*. Give the following example to explain how to calculate volumes. Use the flipchart to demonstrate how to calculate these volumes. Ask participants to fill in the correct answers in the spaces in their manuals.**

- Let us calculate the volume of milk, per feed, for a 2-week-old baby.
- Let us imagine that the baby weighs 3.8 kg.
- The volume of milk the baby needs in 24 hours is 150 mL/kg.
- *Ask: How much milk will this baby need in 24 hours?*

► **Wait for a few replies and then continue.**

- The baby will need 150 × 3.8 = 570 mL in 24 hours.
- If the baby feeds every 3 hours, they will take 8 feeds in 24 hours.
- *Ask: How much milk should the baby be offered each feed?*

- **Wait for a few replies and then continue.**
  - The baby should be offered 570 ÷ 8 = 71.25 mL. This could be rounded up to 75 mL, as this will be easier for the mother to measure, and some milk might spill during the cup-feed.
  - Many mothers do not have equipment for measuring volumes. You could explain to the mother how much milk the cup holds that she uses to feed the baby, and show her how much milk to offer each feed. For example, using the calculation above, if the mother has a cup that holds 150 mL, she should offer the baby approximately half a cup of milk per feed.

V. Summarize the session — 3 minutes

- **Ask participants whether they have any questions, and try to answer them.**
  - Cup-feeding may not be familiar to a mother. You will need to help her with the technique and give her support so she is confident to feed her baby at home.
  - Try and practise this technique when you have the opportunity. If you are able to cup-feed a baby yourself, then you will have more confidence when you teach a mother.
- **Explain that a summary of this session can be found on pages 109–112 of the *Participant's manual*.**

Notes

Notes (contd)

SESSION 19

Breast conditions 1

Objectives

After completing this session, participants will be able to recognize and manage these common breast conditions:

- flat and inverted nipples
- engorgement
- blocked duct and mastitis
- sore nipples and nipple fissure

Session outline . . . . . 45 minutes

Participants are all together for a demonstration by one trainer.

I. Introduce the session, present **Slide 19/1** . . . . . 3 minutes
II. Present **Slides 19/2** to **19/12** (DEMONSTRATION 19.A) . . . . . 40 minutes
III. Summarize the session . . . . . 2 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides and giving a demonstration.
- Study the **Slides 19/1** and **19/2** and the text that goes with them, so that you are able to present them. Be careful when you present the slides that you do not read out the title of the slide, as the participants are asked questions about what condition the slide shows.
- For DEMONSTRATION 19.A SYRINGE METHOD FOR TREATMENT OF INVERTED NIPPLES, prepare a 20 mL disposable syringe as shown in **Fig.19.2**. Take out the plunger and cut off the end of the barrel with the adaptor (you may find it helpful to use a hot knife to do this). Then put the plunger back into the barrel backwards.
- There is a lot of information in the **Further information** sections. Make sure that you have read this, as it may help you to answer participants' questions.

As you follow the text, remember:

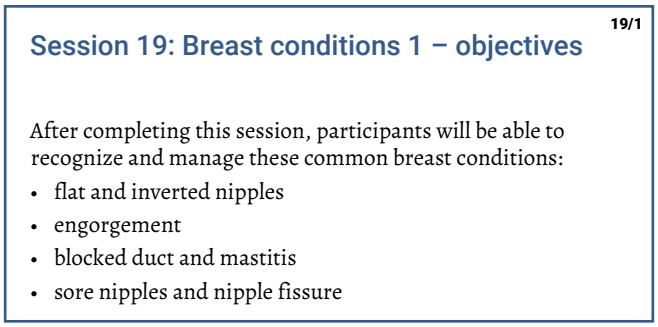
► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the session — 3 minutes

► Show **Slide 19/1 – Session 19 – objectives** and read out the objectives :

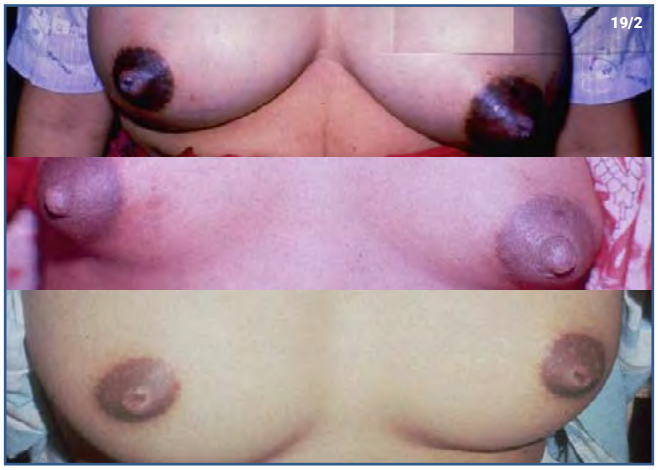


- ¤ Diagnosis and management of these breast conditions are important, both to relieve the mother and to enable breastfeeding to continue.
- ¤ Treatment differs for some breast conditions if the woman is living with HIV. We will discuss these during the session.

► **If you developed a list of reasons for stopping breastfeeding or starting other feeds early in SESSION 3: LOCAL INFANT AND YOUNG CHILD FEEDING SITUATION, refer back to that now. Remind participants if they identified any of these conditions as one of the common reasons.**

II. Present Slides 19/2 to 19/12 — 40 minutes

► Show **Slide 19/2 – Different breast shapes** and make the points that follow:



- ¤ Here are some breasts of different shapes and sizes. These breasts are all normal, and they can all produce plenty of milk for a baby – or two or even three babies (see **Fig. 19.1**).

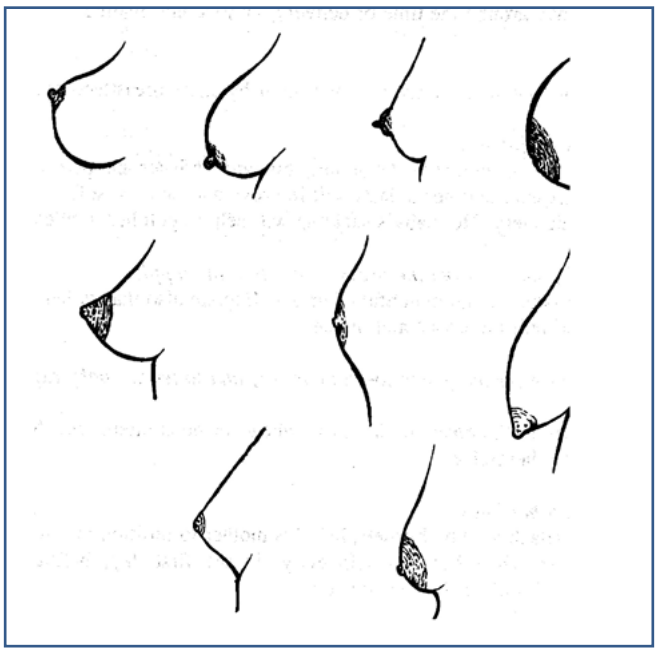


Fig. 19.1 There are many different shapes and sizes of breast; babies can breastfeed from almost all of them.

- Many mothers worry about the size of their breasts. Women with small breasts often worry that they cannot produce enough milk.
- *Ask: Think back to Session 12 when we looked at the anatomy of the breast. What is it that makes some breasts large and others small?*

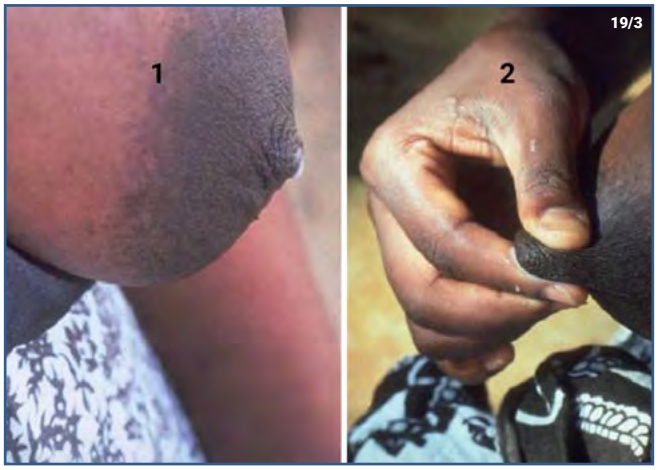
▶ Wait for a few replies and then continue.

- Differences in the sizes of breasts are mostly due to the amount of fat, and not the amount of tissue that produces milk. It is important to reassure women that they can produce enough milk, whatever the size of their breasts.
- The nipples and areolas are different shapes and sizes too.
- *Ask: Does the size or shape of the nipple affect breastfeeding?*

▶ Wait for a few replies and then continue.

- Sometimes the shape makes it difficult for a baby to get well attached to the breast. The mother may need extra help at first to make sure that her baby can suckle effectively.
- However, babies can breastfeed quite well from breasts of any size, with almost any shape of nipple.

▶ Show **Slide 19/3 – Flat nipple and protractility** and make the points that follow:

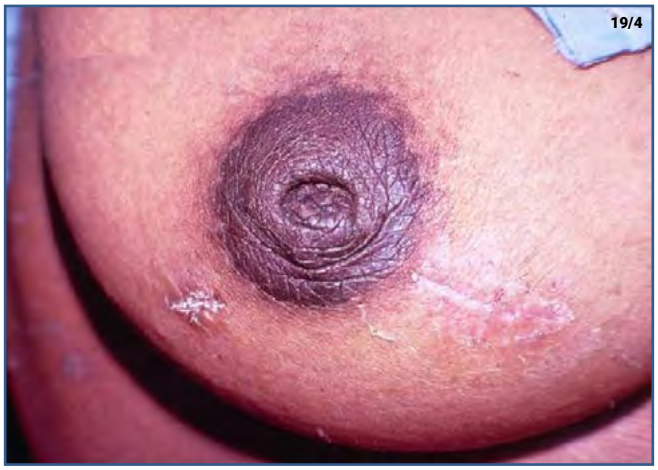


- *Ask: What do you think of the nipple in picture 1?*

▸ Wait for a few replies and then continue.

- The nipple looks flat.
- A doctor told this mother that her baby would not be able to suckle from it. She lost confidence that she could breastfeed successfully.
- However, remember from Session 12 that a baby does not suck from the nipple. The baby takes the nipple and the breast tissue underlying the areola into their mouth to form a "teat".
- In picture 2, the mother is testing her breast for protractility. She is finding out how easy it is to stretch out the tissues underlying the nipple. This nipple is quite protractile, and it should be easy for her baby to stretch it to form a "teat" in their mouth. The baby should be able to suckle from this breast with no difficulty.
- Nipple protractility is more important than the shape of a nipple.
- Protractility improves during pregnancy, and in the first week or so after a baby is born. So even if a woman's nipples look flat in early pregnancy, her baby may be able to suckle from the breast without difficulty.

▸ Show **Slide 19/4 – Inverted nipple** and make the points that follow:



- *Ask: What do you think of this nipple?*

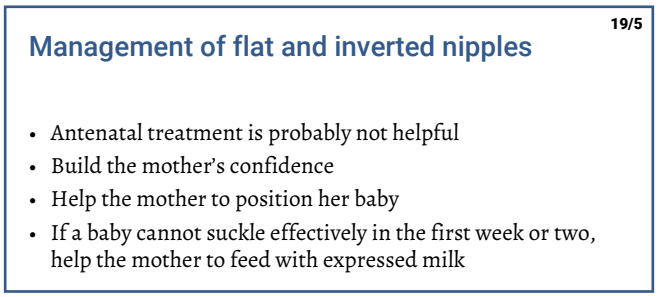
▸ Wait for a few replies and then continue.

- The nipple is inverted
- If this woman tests her breast for protractility, her nipple will go in instead of coming out.
- *Ask: What else do you notice about the breast?*

▸ Wait for a few replies and then continue.

- You can see a scar on her breast. This mother had a breast abscess. This was probably because her baby did not attach well to the breast and remove the milk effectively. With skilled help, she probably could have breastfed successfully.
- Fortunately, nipples as difficult as this are rare.

- Show **Slide 19/5 – Management of flat and inverted nipples** and make the points that follow:



- Antenatal treatment is probably not helpful, for example stretching the nipples or wearing nipple shells. Most nipples improve around the time of delivery, without any treatment. Help is most important soon after delivery when the baby starts breastfeeding.
- It is important to build the mother's confidence. Explain that, with patience and persistence, she can succeed. Explain that her breasts will become softer in the week or two after delivery, and that the baby suckles from the breast and not from the nipple. Encourage her to give plenty of skin-to-skin contact.
- If a baby does not attach well by themself, help the mother to position the baby so that they can attach better. Give her this help early, in the first day, before her breast milk "comes in" and her breasts are full. Sometimes, putting a baby to the breast in a different position makes it easier for them to attach, for example in the underarm position.
- If a baby cannot suckle effectively in the first week or two, help their mother to try to express her milk and feed it to her baby by cup. Expressing milk also helps to keep the breasts soft, so that it is easier for the baby to attach; it also helps to keep up the supply of milk. She should not use a bottle because that makes it more difficult for her baby to take her breast.
- Ask participants to turn to page 114 of their *Participant's manual* and find the box MANAGEMENT OF FLAT AND INVERTED NIPPLES. There is no need to read these points now. However, ask participants to look at this in their own time.

Management of flat and inverted nipples

- **Antenatal treatment**
  - Antenatal treatment is probably not helpful. For example, stretching the nipples or wearing nipple shells does not help.
  - Most nipples improve around the time of delivery without any treatment.
  - Help is most important soon after delivery, when the baby starts breastfeeding.
- **Build the mother's confidence**
  - Explain that it may be difficult at the beginning, but with patience and persistence she can succeed.
  - Explain that her breasts will improve and become softer in the week or two after delivery.
  - Explain that a baby suckles from the breast – not from the nipple. Her baby needs to take a large mouthful of breast.
  - Explain also that as her baby breastfeeds, they will stretch her nipple out.
  - Encourage her to give plenty of skin-to-skin contact, and to let her baby explore her breasts.
  - Let the baby try to attach to the breast on their own, whenever they are interested.
  - Some babies learn best by themselves.
- **Help the mother to position her baby**
  - If a baby does not attach well by themself, help the mother to position them so that they can attach better.
  - Give her this help early, in the first day, before her breast milk "comes in" and her breasts are full.
  - Sometimes, putting a baby to the breast in a different position makes it easier for them to attach. For example, some mothers find that the underarm position is helpful.
  - Sometimes, making the nipple stand out before a feed helps a baby to attach.
  - Stimulating her nipple may be all that a mother needs to do.
  - There is another method called the syringe method, which we will discuss in this session.
  - Sometimes, shaping the breast makes it easier for a baby to attach. To shape her breast, a mother supports it from underneath with her fingers, and presses the top of the breast gently with her thumb.
- **If a baby cannot suckle effectively in the first week or two, help the mother to feed with expressed milk**
  - The mother should express her milk and feed it to her baby with a cup.
  - Expressing milk helps to keep breasts soft, so that it is easier for the baby to attach to the breast; and it helps to keep up the supply of breast milk.
  - She should not use a bottle, because that makes it more difficult for her baby to take her breast.
  - Alternatively, she could express a little milk directly into her baby's mouth.
  - Some mothers find that this is helpful. The baby gets some milk straight away, so they are less frustrated. The baby may be more willing to try to suckle.
  - She should continue to give the baby skin-to-skin contact, and let them try to attach to her breast on their own.

► Demonstrate the syringe method for treating inverted nipples.

DEMONSTRATION 19.A SYRINGE METHOD FOR TREATMENT OF INVERTED NIPPLES

See **Fig.19.2**.

Explain that this method is for treating inverted nipples postnatally, and to help a baby to attach to the breast. It is not certain whether it is helpful antenatally.

- Show participants the 20 mL syringe that you have prepared, and explain how you cut off the adaptor end of the barrel.
- Put the plunger into the cut end of the barrel (that is, the reverse of its usual position).
- Use a model breast, and put the smooth end of the barrel over the nipple. Pull out the plunger to create suction on the nipple.
- Explain that, with a real breast, there is an airtight seal, and the nipple is drawn out into the syringe.
- Explain that the mother must use the syringe herself.
- Explain that you would teach her to:
  - put the smooth end of the syringe over her nipple, as you demonstrated
  - gently pull the plunger to maintain steady but gentle pressure
  - do this for 30 seconds to 1 minute, several times a day
  - push the plunger back to decrease the suction, if she feels pain. This prevents damaging the skin of the nipple and areola
  - push the plunger back, to reduce suction, when she removes the syringe from her breast
  - use the syringe to make her nipple stand out just before she puts her baby to the breast.

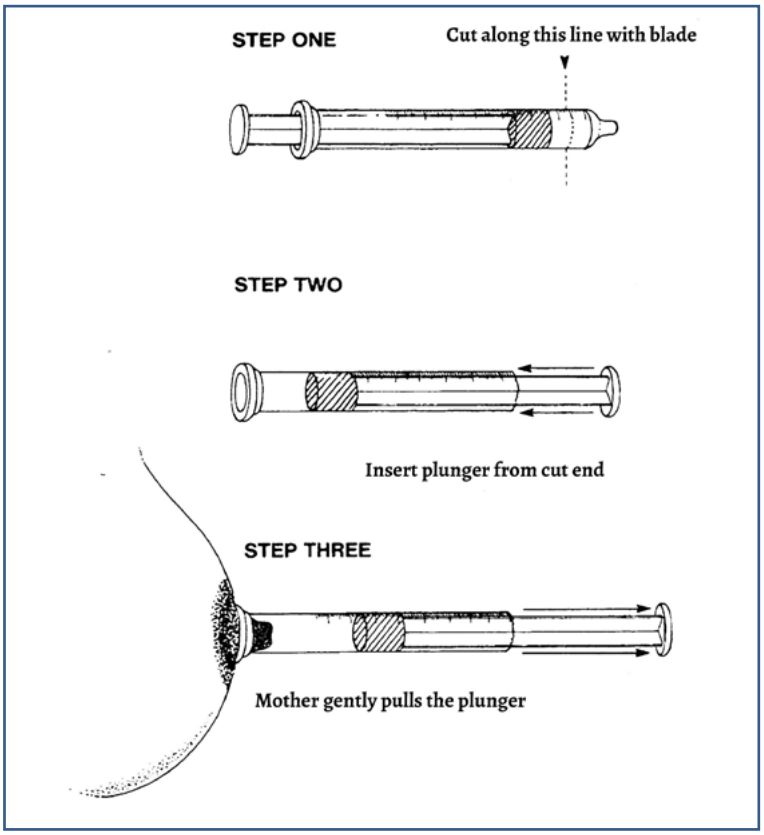
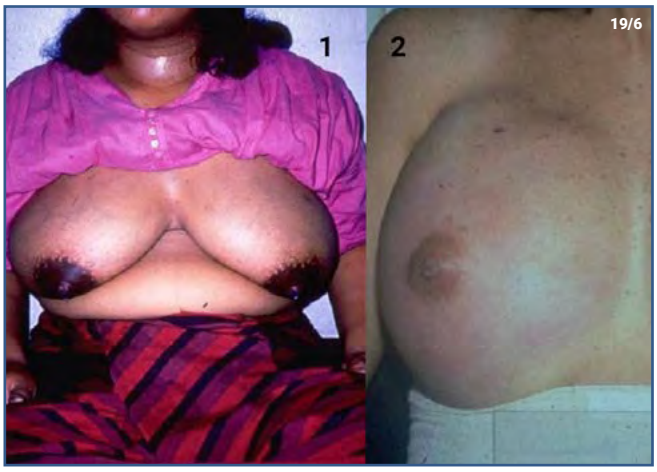


Fig. 19.2 Preparing and using a syringe for treatment of inverted nipples

▸ Show **Slide 19/6 – Full and engorged breasts** and make the points that follow:



- *Ask: What conditions are shown in picture 1 and picture 2?*

▸ Wait for a few replies and then continue.

- The woman in picture 1 has full breasts.
- This is a few days after delivery and her milk has "come in". Her breasts feel hot and heavy and hard.
- However, her milk is flowing well. You can see that milk is dripping from her breasts.
- This is normal fullness. Sometimes full breasts feel quite lumpy.
- The only treatment that she needs is for her baby to breastfeed frequently, to remove the milk.
- The heaviness, hardness or lumpiness decreases after a feed, and the breasts feel softer and more comfortable.
- In a few days, her breasts will adjust to the baby's needs, and they will feel less full.
- The woman in picture 2 has engorged breasts.
- Engorgement means that the breasts are overfull, partly with milk and partly with increased tissue fluid and blood, which interferes with the flow of milk so that it cannot get out easily.
- The breast in this picture looks shiny, because it is oedematous. Her breasts feel painful and her milk does not flow well.
- *Ask: What do you notice about the nipple?*

▸ Wait for a few replies and then continue.

- It is flat, because the skin is stretched tight.
- When a nipple is stretched tight and flat like this, it is difficult for a baby to attach to it, and to remove the milk.
- Sometimes when breasts are engorged, the skin looks red and the woman has a fever. This may make you think that she has mastitis. However, the fever usually settles in 24 hours.
- It is important to be clear about the difference between full and engorged breasts. Engorgement is not so easy to treat.

▸ Ask participants to turn to page 115 of their *Participant's manual* and find the box SUMMARY OF DIFFERENCES BETWEEN FULL AND ENGORGED BREASTS. Ask one participant to read out the points in the column entitled FULL BREASTS and another participant to read out the points in the column entitled ENGORGED BREASTS.

SUMMARY OF DIFFERENCES BETWEEN FULL AND ENGORGED BREASTS

Full breasts	Engorged breasts
Hot	Painful
Heavy	Oedematous
Hard	Tight, especially nipple
	Shiny
	May look red
Milk flowing	Milk NOT flowing (may drip)
No fever	May be fever for 24 hours

- *Ask: Can you think of any reasons why breasts may become engorged?*

► Wait for a few replies and then continue.

► Make the following points if they have not been mentioned by the participants:

- Delay in starting breastfeeding after birth
- Poor attachment to the breast so breast milk is not removed effectively
- Infrequent removal of milk, for example, if breastfeeding is not on demand
- Restricting the length of breast feeds
- Engorgement may be prevented by letting the baby feed as soon as possible after delivery; making sure that the baby is well positioned and attached to the breast; and encouraging unrestricted breastfeeding. Milk does not then build up in the breast.

► Ask participants to turn to page 116 of their *Participant's manual* and find the box TREATMENT OF BREAST ENGORGEMENT. Ask participants to take turns to read out the points.

TREATMENT OF BREAST ENGORGEMENT

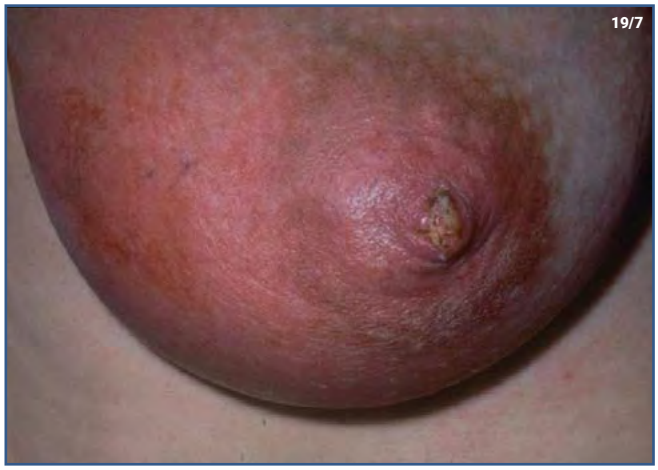
- Do not "rest" the breast. To treat engorgement, it is essential to remove milk. If milk is not removed, mastitis may develop, an abscess may form and production of breast milk decreases.
- If the baby is able to suckle, they should feed frequently. This is the best way to remove milk. Help the mother to position her baby, so that they attach well. Then the baby suckles effectively and does not damage the nipple.
- If the baby is not able to suckle, help the mother to express her milk. Sometimes it is only necessary to express a little milk to make the breast soft enough for the baby to suckle.
- Before feeding or expressing, stimulate the mother's oxytocin reflex. Some things that you can do to help her, or she can do are:
  - put a warm compress on her breasts
  - massage her back and neck
  - massage her breast lightly
  - stimulate her breast and nipple skin
  - help her to relax.
- Sometimes a warm shower or bath makes milk flow from the breasts, so that they become soft enough for the baby to suckle.
- After a feed, put a cold compress on her breasts. This will help to reduce oedema.
- Build the mother's confidence. Explain that she will soon be able to breastfeed comfortably again.

Engorgement in a woman living with HIV who is stopping breastfeeding

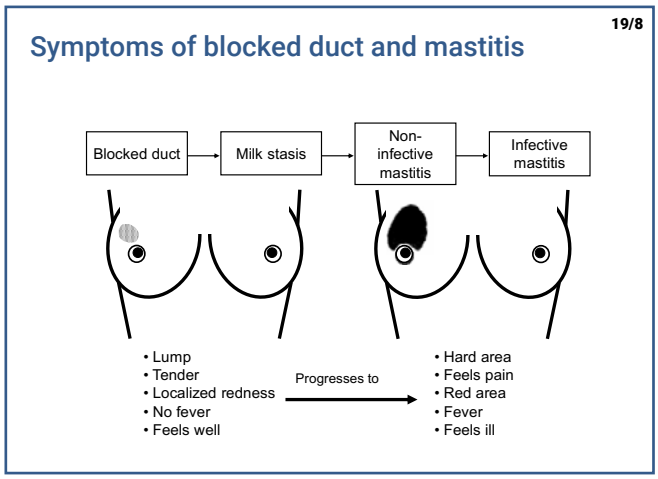
► **Make the following points:**

- We have just discussed the management of engorgement in a woman who wishes to continue breastfeeding.
- Engorgement may occur in a woman living with HIV who stops breastfeeding abruptly.
- When a mother who is living with HIV is trying to stop breastfeeding, she should only express enough milk to relieve the discomfort and not to increase the milk production.
- Milk may be expressed a few times per day when the breasts are overfull, to make the mother comfortable.
- You may have heard of pharmacological treatments to reduce the milk supply. These are not recommended. However, a simple analgesic, for example ibuprofen, may be used to reduce inflammation and help the discomfort while the mother's milk supply is decreasing. If ibuprofen is not available, then paracetamol may be used.

- Show **Slide 19/7 – Mastitis** and make the points that follow:

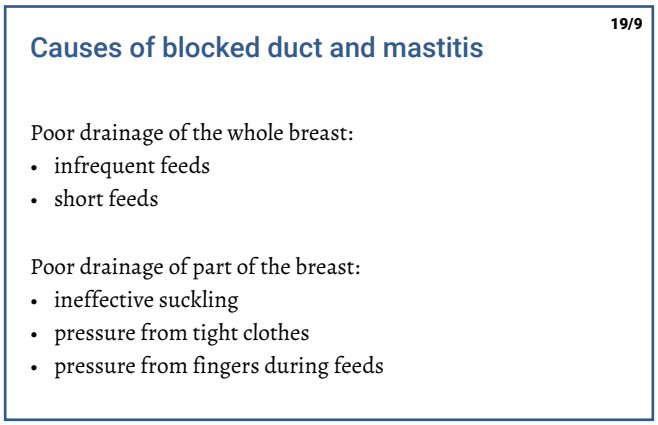


- A woman with mastitis has severe pain and fever and she feels ill. Part of the breast is swollen and hard, with redness of the overlying skin.
- Mastitis is sometimes confused with engorgement.
- However, engorgement affects the whole breast, and often both breasts. Mastitis affects part of the breast, and usually only one breast.
- Mastitis may develop in an engorged breast, or it may follow a condition called **blocked duct**.

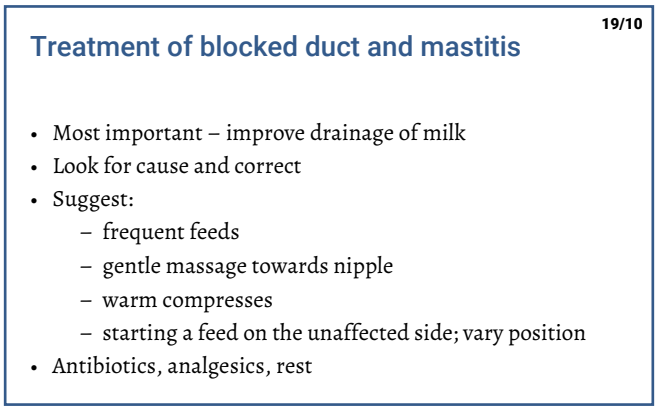


- This slide shows how mastitis develops from a blocked duct.
- A blocked duct occurs when the milk is not removed from part of a breast. Sometimes this is because the duct to that part of the breast is blocked by thickened milk.
- The symptoms are a lump that is tender, and often redness of the skin over the lump. The woman has no fever and feels well.
- When milk stays in part of a breast, because of a blocked duct, or because of engorgement, it is called **milk stasis**. If the milk is not removed, it can cause inflammation of the breast tissue, which is called **non-infective mastitis**.
- Sometimes a breast becomes infected with bacteria, and this is called **infective mastitis**.
- It is not possible to tell from the symptoms alone whether mastitis is non-infective or infective. If the symptoms are all severe, however, the woman is more likely to need treatment with antibiotics.

- Show **Slide 19/9 – Causes of blocked duct and mastitis** and make the points that follow:



- Poor drainage of the **whole breast** may be due to infrequent breastfeeds or ineffective suckling. Infrequent breastfeeds may occur when a mother is very busy, when a baby starts feeding less often, for example when starting to sleep through the night, or because of a changed feeding pattern for another reason, for example the mother returning to work. Ineffective suckling usually occurs when the baby is poorly attached to the breast.
- Poor drainage of **part of the breast** may be due to ineffective suckling, pressure from tight clothes, especially a bra worn at night, or pressure of the mother's fingers, which can block milk flow during a breastfeed.
- If a baby is poorly attached and positioned and is suckling at the breast, this may cause a nipple fissure, which provides a way for bacteria to enter the breast tissue and may lead to mastitis.



▶ Ask participants to turn to page 118 of their *Participant's manual* and look at the box TREATMENT OF BLOCKED DUCT AND MASTITIS. Read through it together.

TREATMENT OF BLOCKED DUCT AND MASTITIS

The most important part of treatment is to improve the drainage of milk from the affected part of the breast.

Look for a cause of poor drainage, and correct it:

- Look for poor attachment.
- Look for pressure from clothes, usually a tight bra.
- Notice what the mother does with her fingers as she breastfeeds. Does she hold the areola, and possibly block milk flow?

Whether or not you find a cause, advise the mother to do these things:

- **Breastfeed frequently** – the best way is to rest with her baby, so that she can respond to the baby and feed them whenever they are willing.
- **Gently massage the breast while her baby is suckling** – show her how to massage over the blocked area, and over the duct that leads from the blocked area, right down to the nipple. This helps to remove the block from the duct. She may notice that a plug of thick material comes out with her milk. (It is safe for the baby to swallow the plug.)
- **Apply warm compresses to her breast between feeds**

Sometimes it is helpful to do these things:

- **Start the feed on the unaffected breast:** this may help if pain seems to be preventing the oxytocin reflex. She should change to the affected breast after the reflex starts working.
- **Breastfeed the baby in different positions at different feeds** – this helps to remove milk from different parts of the breast more equally. Show the mother how to hold her baby in the underarm position, or how to lie down to feed them, instead of holding them across the front at every feed. However, do not make her breastfeed in a position that is uncomfortable for her.

Sometimes a mother is unwilling to feed her baby from the affected breast, especially if it is very painful. Sometimes a baby refuses to feed from an infected breast, possibly because the taste of the milk changes. In these situations, it is necessary to express the milk. If the milk stays in the breast, an abscess is more likely.

Usually, blocked duct or mastitis improves within a day when drainage to that part of the breast improves.

However, a mother needs additional treatment if there are any of the following:

- severe symptoms when you first see her
- a fissure, through which bacteria can enter
- no improvement after 24 hours of improved drainage.

Treat her, or refer her for antibiotics, analgesics (ibuprofen) and rest.

► Ask participants to turn to page 118 of their *Participant's manual* and look at the box ANTIBIOTIC TREATMENT FOR INFECTIVE MASTITIS. There is no need to read this out, but point out to participants that these are the recommended antibiotics and doses.

ANTIBIOTIC TREATMENT FOR INFECTIVE MASTITIS

The most common bacterium found in breast abscesses is *Staphylococcus aureus*. Therefore, it is necessary to treat breast infections with a penicillinase-resistant antibiotic such as either flucloxacillin or erythromycin.

Drug	Dose	Instructions
Flucloxacillin	250 mg orally 6-hourly for 7–10 days	Take dose at least 30 minutes before food
Erythromycin	250–500 mg orally 6-hourly for 7–10 days	Take dose 2 hours after food

Mastitis in a woman living with HIV

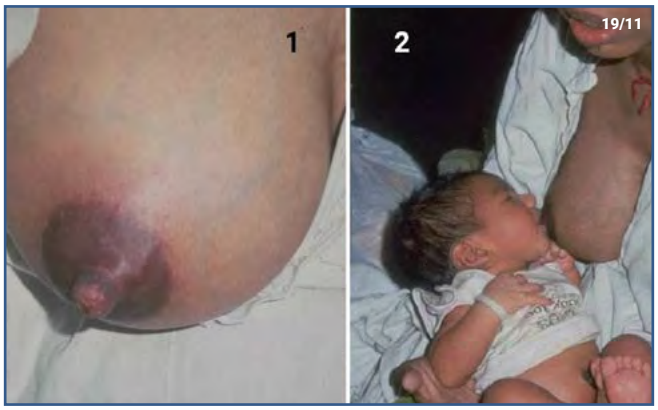
► Make the following points:

- In a woman who is HIV positive, mastitis or nipple fissure (especially if bleeding or oozing) may increase the risk of HIV transmission. Therefore, the recommendation to increase the frequency and duration of feeds in mastitis is not appropriate for these women.
- *Ask: If a woman who is HIV positive gets mastitis or a fissure, what should she do?*

► Wait for a few replies and then continue.

- If a woman living with HIV develops mastitis or a fissure, she should avoid breastfeeding from the affected side while the condition persists. It is the same if she develops an abscess.
- She must express milk from the affected breast, to ensure adequate removal of milk. This is essential to prevent the condition becoming worse, to help the breast recover, and to maintain milk production. The health worker should help her to ensure that she is able to express milk effectively.
- If only one breast is affected, the infant can feed from the unaffected side, feeding more often and for longer to increase milk production. Most infants get enough milk from one breast. The infant can feed from the affected breast again when it has recovered.
- If both breasts are affected, she will not be able to feed from either side. The mother will need to express her milk from both breasts. Breastfeeding can resume when the breasts have recovered.
- The health worker may need to discuss other feeding options for her to use meanwhile. The mother can feed the baby with her expressed breast milk; she may decide to heat-treat her expressed milk, or to give commercial formula. The infant should be fed by cup.
- Give antibiotics for 10–14 days to avoid relapse. Give pain relief and suggest rest, as for a woman who is not living with HIV.
- Sometimes a woman may decide to stop breastfeeding at this time, if she is able to give another form of milk safely. She should continue to express enough milk to allow her breasts to recover and to keep them healthy, until milk production ceases.

- Show **Slide 19/11 – Nipple fissure** and make the points that follow:



- Picture 1 shows a mother's breast, and picture 2 shows the same mother feeding her baby on the breast.
- *Ask: What do you notice about her breast?*

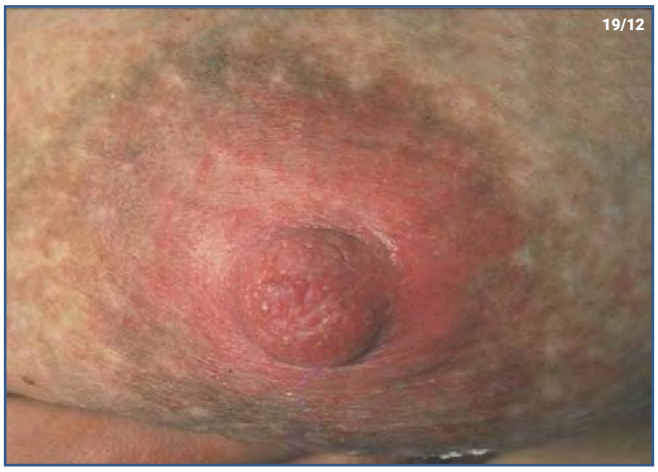
▶ Wait for a few replies and then continue.

- There is a fissure, or crack, around the base of the nipple. You may be able to see that the breast is also engorged.
- *Ask: What do you notice about the baby's position and attachment?*

▶ Wait for a few responses and then continue. Encourage participants to think systematically through THE FOUR KEY SIGNS OF GOOD POSITIONING and THE FOUR KEY SIGNS OF GOOD ATTACHMENT. Ask participants to turn to page 72 of their *Participant's manual* and find the JOB AID: BREASTFEED OBSERVATION.

- The baby is poorly positioned.
- His body is twisted away from his mother so his head and body are not in line.
- His body is not held close to his mother's.
- His body is unsupported.
- He is poorly attached.
- His mouth is closed.
- His lower lip is pointing forward.
- His chin is not touching the breast.
- There is more areola seen above baby's top lip than below the bottom lip.
- This poor attachment may have caused both the breast engorgement and the fissure.
- The most common cause of sore nipples is poor attachment.
- If a baby is poorly attached, they pull the nipple in and out as they suck, and rub the skin of the breast against their mouth. This is very painful for the mother.
- At first there is no fissure. The nipple may look normal, or it may look squashed with a line across the tip when the baby releases the breast. If the baby continues to suckle in this way, it damages the nipple skin and causes a fissure, as you see here.
- If a mother has sore nipples or a fissure:
  - Help her to improve her baby's position so that they are well attached.
  - Suggest to the mother not to wash her breasts more than once a day, and not to use soap or rub hard with a towel. Washing removes natural oils from the skin and makes soreness more likely.
  - Do not recommend medicated lotions and ointments, because these can irritate the skin and there is no evidence that they are helpful.
  - Suggest that after breastfeeding, she rubs a little expressed breast milk over the nipple and areola with her finger. This promotes healing.

► Show **Slide 19/12 – *Candida* infection** and make the points that follow:



- This mother has very sore, itchy nipples.
- *Ask: What do you see that might explain the soreness?*

► Wait for a few replies and then continue.

- There is a shiny red area of skin on the nipple and areola.
- This is a *Candida* infection, or thrush, which can make the skin sore and itchy. *Candida* infections often follow the use of antibiotics to treat mastitis or other infections.
- Some mothers describe a burning or stinging that continues after a feed. Sometimes the pain shoots deep into the breast. A mother may say that it feels as though needles are being driven into her breast.
- The skin may look red, shiny and flaky. The nipple and areola may lose some of their pigmentation. Sometimes the nipple looks normal.
- Suspect *Candida* if sore nipples persist, even when the baby's attachment is good. Check the baby for thrush. They may have white patches inside their cheeks or on their tongue, or may have a rash on their bottom.
- Treat both mother and baby with nystatin.
- Advise the mother to stop using pacifiers (dummies). Help her to stop using teats and nipple shields. If these are used, they should be boiled for 20 minutes daily and replaced weekly.
- In women who are living with HIV, it is particularly important to treat breast thrush and oral thrush in the infant promptly.

► Ask participants to turn to page 120 of their *Participant's manual* and find the box TREATMENT OF *CANDIDA* INFECTION OF THE BREAST. There is no need to read this out, but point out to participants that this is the recommended treatment.

TREATMENT OF *CANDIDA* INFECTION OF THE BREAST

- Use either nystatin cream or suspension
  - **Nystatin** cream 100 000 IU/g:
    - Apply to nipples 4 times daily after breastfeeds
    - Continue to apply for 7 days after lesions have healed
  - **Nystatin** suspension 100 000 IU/mL:
    - Apply 1 mL by dropper to the child's mouth 4 times daily after breastfeeds for 7 days, or as long as mother is being treated
- **Stop** using pacifiers, teats and nipple shields

III. Summarize the session 2 minutes

- Ask participants whether they have any questions, and try to answer them.
- Explain that a summary of this session can be found on pages 113–120 of the *Participant's manual*.

Further information

Breast shape

Breast shape and size is partly inherited. Breasts may be long in girls who have had no children, and small or flat in women who have breastfed several children.

Occasionally, a woman's breasts may fail to develop normally, so that they are unable to produce enough milk, but this is very rare.

Management of inverted nipples

Participants may have heard of different ways to treat inverted nipples, and they may wish to discuss the topic further – especially if they have known of a case that they found difficult to help. These notes may help you to answer questions. However, it is not necessary to give participants this information if they have not heard of these techniques.

Nipple shell

This is a glass or plastic hemisphere, with a hole in the base, to put over a nipple, under the clothes. The nipple is pressed through the hole, to make it stand out more. There is no evidence that these shells help, and they may cause oedema. However, if a mother is worried about inverted nipples, and she has heard of nipple shells and wants to try to use one, let her continue. It may make her feel that she is doing something, and it may help her to feel confident.

Hoffman's exercises

Some women have heard of exercises to stretch nipples. These exercises have not been shown to really help. They are unlikely to make much difference to severely inverted nipples. Nipple exercises can sometimes traumatize the breast, so do not recommend them. However, if a woman has heard about exercises and wishes to do them, let her continue.

Nipple shields

These are teats with a broad plastic or glass base to put over a nipple for a baby to suck through. Mothers sometimes use them if they have conditions such as inverted nipples, or sore nipples. Nipple shields are no longer recommended because they can cause problems and they do not remove the cause of the condition. Nipple shields can reduce the flow of milk; they can cause breast infections, including *Candida*; they can cause "nipple confusion", and may make it more difficult for a baby to learn to suckle directly from the breast. Some mothers find it difficult to stop using them. Nipple shields are not useful except in rare cases, for a short time and with careful supervision.

Engorgement

When breasts are engorged, the milk does not flow well, partly because of the pressure of fluid in the breast, and partly because the oxytocin reflex does not work well.

Non-infective mastitis

- The cause of non-infective mastitis is probably milk under pressure leaking back into the surrounding tissues.
- The tissues treat the milk as a "foreign" substance.
- Also, milk contains substances that can cause inflammation.
- The result is pain, swelling and fever, even when there is no bacterial infection.
- Trauma that damages breast tissue can also cause mastitis. This may also be because milk leaks back into the damaged tissues.

Breast abscess

Participants may wish to discuss breast abscess in more detail.

An abscess is when a collection of pus forms in part of the breast. The breast develops a painful swelling, which feels full of fluid. An abscess needs surgical incision and drainage. If possible, let the baby continue to feed from the breast. There is no

danger to the baby. However, if it is too painful, or if the mother is unwilling, show her how to express her milk, and let her baby start to feed from it again as soon as the pain is less – usually in 2–3 days. Meanwhile, continue to feed from the other breast. Good management of mastitis should prevent the formation of an abscess.

Treatment of nipple fissures

Ointments for nipple fissure

Sometimes a plain cream such as lanolin may help a fissured nipple to heal after the suckling position has been corrected. However, plain creams are often not available, and they are not usually necessary.

Clothes

In warm weather, a cotton bra may be better for fissured nipples than a nylon bra. However, cotton is not essential, and you should not recommend it to a mother who cannot afford it. If necessary, suggest that she leaves her bra off for a day or two.

Nipple shields

These are no longer recommended for the treatment of fissured nipples.

Notes

SESSION 20

Feeding low-birth-weight babies 1

Objectives

After completing this session, participants will be able to:

- describe feeding of low-birth-weight babies
- estimate the volume of milk to offer to a low-birth-weight baby

Session outline . . . . . 25 minutes

Participants are all together for a demonstration by one trainer.

I. Introduce the session, present **Slide 20/1** . . . . . 2 minutes
II. Discuss feeding of low birth-weight babies, present **Slide 20/2** . . . . . 20 minutes
III. Summarize the session . . . . . 3 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides.
- Study the **Slides 20/1** and **20/2** and the text that goes with them, so that you are able to present them.
- You need a flipchart and markers.
- You need to find out what percentage of babies in your area have low birth weight.
- Have ready COUNSELLING CARD 4: BREASTFEEDING POSITIONS, COUNSELLING CARD 23: FEEDING A LOW-BIRTH-WEIGHT BABY, and the *Guidance on the use of counselling cards*.
- Read the **Further information** sections, so that you are familiar with the ideas that they contain, so that you can answer participants' questions.

As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the session — 2 minutes

- Make this point:
  - In this session, we will discuss briefly the feeding recommendations for low-birth-weight infants.
- Show **Slide 20/1 – Session 20 – objectives** and read out the objectives :

> 20/1
>
> **Session 20: Feeding low-birth-weight babies 1 – objectives**
>
> After completing this session, participants will be able to:
> - describe feeding of low-birth-weight babies
> - estimate the volume of milk to offer to a low-birth-weight baby

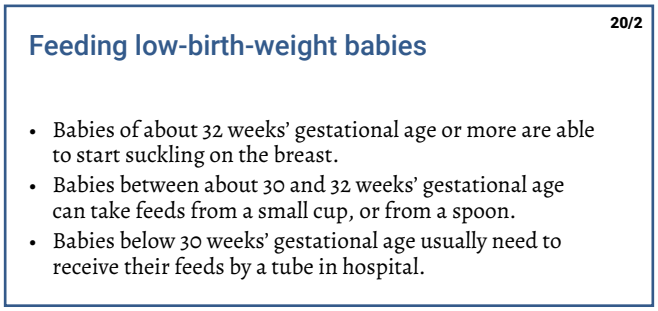
II. Discuss feeding of low-birth-weight babies — 20 minutes

- Ask participants to define the following terms:
  - Low birth weight
  - Preterm or premature
  - Small for gestational age.
- Record participants' responses on a flipchart. Correct any incorrect information.
  - *Ask: What does the term low birth weight mean?*
- Wait for a few replies and then continue
  - The term **low-birth-weight baby** includes any baby with a birth weight of less than 2500 g (up to and including 2499 g), regardless of gestational age. This includes babies who are **preterm**, that is, born before 37 weeks of gestation, or they may be born at term but **small for gestational age**.
  - In many countries, 15–20% of all babies are low birth weight.
  - *Ask: How many babies are low birth weight in this country?*
- Wait for a few replies and then continue.
  - In this country .....% of all babies are low birth weight.
  - *Ask: Why is it important for low-birth-weight babies to get breast milk?*
  - Low-birth-weight babies, whether they are term or preterm, are at particular risk of infection, and they need breast milk more than larger babies. Yet they are given artificial feeds more often than larger babies.
  - *Ask: Why is it sometimes difficult for low-birth-weight babies to breastfeed exclusively?*
- Wait for a few replies and then continue. (Participants may give answers such as: low-birth-weight babies are not able to suckle strongly at the breast; they need more of some nutrients than breast milk can provide; it can be difficult for mothers to express enough breast milk.)
  - Many low-birth-weight babies can breastfeed without difficulty. Babies born at term who are small for date usually suckle effectively. They are often very hungry and need to breastfeed more often than larger babies, so that their growth can catch up.
  - Babies who are born preterm may have difficulty suckling effectively at first. But they can be fed on breast milk by tube or cup, and helped to establish full breastfeeding later. Breastfeeding is easier for these babies than bottle feeding.
  - Mothers of low-birth-weight babies need skilled help to express their milk and to cup-feed.
  - *Ask: When should a mother with a low-birth-weight baby start to express her milk?*
- Wait for a few replies and then continue.

- It is important to start expressing on the first day, within 6 hours after delivery if possible. This helps to start the flow of breast milk, in the same way that suckling soon after delivery helps breast milk to "come in".
- If a mother can express just a few millilitres of colostrum, it is valuable for her baby.
- *Ask: At what age can low-birth-weight babies suckle from the breast?*

▶ Wait for a few replies and then continue by displaying the next slide.

▶ Show **Slide 20/2 – Feeding low-birth-weight babies** and make the points that follow:



- Babies of about 32 weeks' gestational age or more are able to start suckling on the breast.
- Babies between about 30 and 32 weeks' gestational age can take feeds from a small cup, or from a spoon.
- Babies below 30 weeks' gestational age usually need to receive their feeds by a tube in hospital.
- Let the mother put her baby to her breast as soon as they are well enough. The baby may only root for the nipple and lick it at first, or may suckle a little. Continue giving expressed breast milk by cup, to make sure the baby gets all that they need.
- When a low-birth-weight baby starts to suckle effectively, they may pause during feeds quite often and for quite long periods. For example, they may take 4–5 sucks and then pause for up to 4 or 5 minutes.
- It is important not to take the baby off the breast too quickly. Leave them on the breast so that they can suckle again when they are ready.
- The baby can continue for up to an hour if necessary. Offer a cup feed after the breastfeed.
- Make sure that the baby suckles in a good position. Good attachment may make effective suckling possible at an earlier stage

▶ Ask participants to pair up (groups of 2) and examine COUNSELLING CARD 4: BREASTFEEDING POSITIONS and COUNSELLING CARD 23: FEEDING A LOW-BIRTH-WEIGHT BABY, and the sections in the *Guidance on the use of counselling cards* on KEY PRACTICES AND DISCUSSION POINTS for those Counselling cards. Participants demonstrate to each other the positions that are suitable for a mother to hold her low-birth-weight baby.

▶ After the activity in pairs, bring all participants together. Ask one pair to present the results of their discussion and other participants to add any additional comment.

▶ Review together the best positions for a mother to hold her low-birth-weight baby at the breast.

- The best positions for a mother to hold her low-birth-weight baby at the breast are:
  - across her body, holding the baby with the arm on the opposite side to the breast
  - the underarm position.

▶ Ask participants to turn to page 82 of their *Participant's manual* and use the *Guidance on the use of counselling cards* to remind themselves of these positions. Continue with these points:

- Low-birth-weight babies need to be followed up regularly, to make sure that they are getting all the breast milk that they need.
- Low-birth-weight babies of mothers who are living with HIV and who are replacement feeding are at higher risk of complications and should also be followed up regularly to make sure they are growing. Encourage mothers to feed the replacement milk to their babies by cup.

► Ask participants to turn to page 122 of their *Participant's manual* and find the box AMOUNT OF MILK TO GIVE TO LOW-BIRTH-WEIGHT BABIES WHO CANNOT BREASTFEED. Ask participants to look at this in their own time.

AMOUNT OF MILK TO GIVE TO LOW-BIRTH-WEIGHT BABIES WHO CANNOT BREASTFEED

What milk to give

- Choice 1: expressed breast milk (if possible from the baby's mother, or from a donor); this may be pasteurized or heat-treated according to local policy
- Choice 2: formula milk made up according to the instructions and World Health Organization (WHO) guidelines

Amount of milk to give to babies who weigh less than 2.5 kg (low birth weight)

- Start with 60 mL/kg body weight per day
- Increase the total volume by 20 mL/kg per day, until the baby is taking a total of 180 mL/kg per day
- Divide the total into 8–12 feeds, to feed every 2–3 hours
- Continue until the baby weighs 1800 g or more, and is fully breastfeeding

Check the baby's 24-hour intake

The size of individual feeds may vary

III. Summarize the session 3 minutes

► Ask participants whether they have any questions, and try to answer them.

► Explain that a summary of this session can be found on pages 121–122 of the *Participant's manual*.

Further information

Low-birth-weight babies

Whenever possible, low-birth-weight babies should be under the care of a health worker with specialist training. However, this information may help you if specialist care is not easily available.

Time of first oral feed

If oral feeding is possible as soon as a baby is born, the first feed should be given within the first 2 hours, and every 2–3 hours thereafter, to prevent hypoglycaemia (low blood sugar).

Until the mother has put the baby to her breast and there is evidence the baby is receiving colostrum, give feeds of donated breast milk, if available. If breast milk is not available, give glucose water or formula milk. Glucose water is not necessary for well, term babies who are not at risk of hypoglycaemia.

Cup feeds

Cup feeds give a baby valuable experience of taking food by mouth, and the pleasure of taste. They stimulate the baby's digestion. Many babies show signs of wanting to take things into their mouths at this stage, yet they are not able to suckle effectively at the breast.

Weight as a guide to feeding method

Gestational age is a better guide to a baby's feeding ability than weight. However, it is not always possible to know gestational age. Many babies start to take milk from the breast when they weigh about 1300–1500 g. Many can breastfeed fully when they weigh about 1600–1800 g or less.

Development of coordinated suckling

Babies can already swallow and suck long before 32 weeks' gestation. From about 32 weeks, many babies can suckle from the breast, and some can breastfeed fully from this age, but they may have difficulty in coordinating suckling, swallowing and breathing. They need to pause during a breastfeed to breathe. They can suckle effectively for a short time, but they often cannot suckle long enough to take all the breast milk that they need. By about 36 weeks, most babies can coordinate suckling and breathing, and they can take all that they need by breastfeeding. However, a baby may feed well sometimes, but tire and feed poorly at other times. If a baby suckles poorly, offer a cup feed after the breastfeed. If they are hungry, they will take milk from the cup. If the baby has had enough, they will not take milk from the cup.

Skin-to-skin contact and kangaroo mother care

Skin-to-skin contact between a mother (or father) and baby has been found to help both bonding and breastfeeding, probably because it stimulates the secretion of prolactin and oxytocin.

If a baby is too sick to move, contact can be between the mother's hand and the baby's body. If a baby is well enough, let their mother hold them next to her body. Usually the best place is between her breasts, inside her clothes. This is called kangaroo mother care. It has the following advantages:

- the warmth of the mother's body keeps her baby warm; the baby does not get cold, and does not use up extra energy to keep warm; there is less need for incubators
- the baby's heart works better, and the baby breathes more regularly
- the baby cries less and sleeps better
- it is easier to establish breastfeeding.

Additional information on the subject can be found in the following references:

- WHO recommendations on interventions to improve preterm birth outcomes. Geneva: World Health Organization; 2015 (http://apps.who.int/iris/bitstream/10665/183037/1/9789241508988_eng.pdf).
- Guidelines on optimal feeding of low birth-weight infants in low- and middle-income countries. Geneva: World Health Organization; 2011 (http://www.who.int/maternal_child_adolescent/documents/9789241548366.pdf).

Notes

SESSION 21

Clinical practice session 1: Listening and learning – assessing a breastfeed

Objectives

After completing this session, participants will be able to:

- demonstrate appropriate LISTENING AND LEARNING SKILLS when counselling a mother on feeding her infant
- assess a breastfeed using the JOB AID: BREASTFEED OBSERVATION
- demonstrate appropriate use of COUNSELLING CARD 3: GOOD ATTACHMENT and COUNSELLING CARD 4: BREASTFEEDING POSITIONS

Session outline . . . . . 120 minutes

Participants are together as a class led by one trainer, to prepare for the session, and to discuss it afterwards.

Participants work in small groups of 3–4, each with one trainer, for the clinical practice session in a ward or clinic.

I. Prepare the participants . . . . . 20 minutes
II. Conduct the clinical practice . . . . . 95 minutes
III. Summarize the session . . . . . 5 minutes

Preparation

- If you are leading the session:
  - Make sure that you know where the clinical practice will be held and what times you are expected there. If you did not do so in a preparatory week, visit the wards or clinic where you will go. Introduce yourself to the staff members in charge, and make sure that they are prepared for the session (see *Director's guide*).
  - Study the instructions on the following pages, so that you can prepare the participants and conduct the clinical practice session.
  - Make sure that there are copies of the CLINICAL PRACTICE DISCUSSION CHECKLIST available for each trainer.
  - Make sure that there are two copies of the JOB AID: BREASTFEED OBSERVATION and one copy of the list of LISTENING AND LEARNING SKILLS CHECKLIST available for each participant and trainer.
  - Make sure that there are copies of COUNSELLING CARD 3: GOOD ATTACHMENT, COUNSELLING CARD 4: BREASTFEEDING POSITIONS, and the *Guidance on the use of counselling cards* for each participant and facilitator.
- If you are leading the small group:
  - Study the instructions on the following pages, so that you are clear about how to conduct the clinical practice.
  - Make sure that you have a copy of the CLINICAL PRACTICE DISCUSSION CHECKLIST, to help you to conduct discussions.
  - Make sure that the participants in your group each have two copies of the JOB AID: BREASTFEED OBSERVATION, and one copy of the LISTENING AND LEARNING SKILLS CHECKLIST. Have one or two spare copies with you.
  - Make sure participants take the following with them to the clinical practice session: COUNSELLING CARD 3: GOOD ATTACHMENT, COUNSELLING CARD 4: BREASTFEEDING POSITIONS, and the *Guidance on the use of counselling cards*.
- Find out where to take your group.

As you follow the text, remember:

- ▸ indicates an instruction to you, the trainer.
  - ¤ indicates what you say to participants.

I. Prepare the participants — 20 minutes

- ▸ One trainer leads a preparatory session with all participants and the other trainers together.
- ▸ If you have to travel to another facility for the clinical practice session, hold the preparatory session in the classroom before you leave. If necessary, this can take place on the evening or the morning before the clinical session.
- ▸ Explain the following to the participants:
  - ¤ You are going to practise the LISTENING AND LEARNING SKILLS that you learnt in Sessions 6 and 7, and assess a breastfeed, with mothers in the ward.
  - ¤ You may also help a mother to position and attach her baby to the breast; do not give any advice or help at this stage.
  - ¤ You will need to take with you two copies of the JOB AID: BREASTFEED OBSERVATION, one copy of the LISTENING AND LEARNING SKILLS CHECKLIST and pencil and paper to make notes.
  - ¤ You will also need to take with you copies of COUNSELLING CARD 3: GOOD ATTACHMENT, COUNSELLING CARD 4: BREASTFEEDING POSITIONS, and the *Guidance on the use of counselling cards*.
  - ¤ You do not need to take anything else – no books, manuals or handbags.
- ▸ Explain what to do in the ward:
  - ¤ Take it in turns to talk to a mother while your partner observes.
  - ¤ Introduce yourself to the mother and ask her permission to talk to her. Introduce the group and say they are interested in infant feeding. If the baby is feeding, ask the mother to continue as she is doing. If the baby is not feeding, ask the mother to give a feed in the normal way at any time that her baby seems ready.
  - ¤ Try to find a chair or a stool to sit on.
  - ¤ Practise as many of the LISTENING AND LEARNING SKILLS as possible. Try to get the mother to tell you about herself, her situation and her baby. You can talk about ordinary life, not only about breastfeeding.
  - ¤ Help the mother to position and attach her baby to her breast, if needed.
  - ¤ Use COUNSELLING CARD 3: GOOD ATTACHMENT or COUNSELLING CARD 4: BREASTFEEDING POSITIONS when helping a mother to attach and position her baby, as needed
  - ¤ The other participants should stand quietly in the background. Try to be as still and quiet as possible.
  - ¤ Make general observations of the mother and baby. Notice for example, does she look happy? Does she have formula milk or a feeding bottle with her?
  - ¤ Make general observations of the conversation between the mother and the participant-counsellor. Notice for example, who does most of the talking? Does the participant-counsellor ask open questions? Does the mother talk freely, and seem to enjoy it?
  - ¤ Make specific observations of the participant-counsellor's LISTENING AND LEARNING SKILLS.
  - ¤ Mark a tick on your LISTENING AND LEARNING SKILLS CHECKLIST when they use a skill, to help you to remember for the discussion. Notice whether they use helpful non-verbal communication.

- Notice whether the participant-counsellor makes a mistake, for example, if they use a judging word, or if they ask a lot of questions to which the mother says "yes" or "no".
- When a mother breastfeeds, observe the feed using the JOB AID: BREASTFEED OBSERVATION and put ticks in the boxes.
- Remember that you are not helping the mother at this point. If a mother needs help, your trainer will take the opportunity to demonstrate to you how to help the mother.
- When you have finished, thank the mother.

▸ Warn participants about MISTAKES TO AVOID.

MISTAKES TO AVOID

Do not say that you are interested in breastfeeding.

The mother's behaviour may change. She may not feel free to talk about formula feeding. You should say that you are interested in "infant feeding" or in "how babies feed".

Do not give a mother help or advice.

In Clinical practice session 1, if a mother seems to need help, you should inform your trainer, and a member of staff from the ward or clinic.

Be careful that the forms do not become a barrier.

The participant who talks to the mother should not make notes while she is talking. They may need to refer to the forms to remind themself what to do, but if they want to write, they should do so afterwards. The participants who are observing can make notes.

II. Conduct the clinical practice 95 minutes

These notes are for the trainers. Trainers should read them to ensure that they know what to do. There is no need to read these notes to the participants.

▸ Take your group to the ward or clinic.

▸ Introduce yourself and your group to the staff member in charge.

▸ Ask which mothers and babies it would be appropriate to talk to, and where they are.

▸ Try to find a mother and baby who are breastfeeding, or a mother who thinks that her baby may want to feed soon. If this is not possible, talk to any mother.

▸ Participants will work in pairs: one will talk with mother of an infant aged from 0 up to 6 months and assess a breastfeed, using LISTENING AND LEARNING SKILLS, while the other follows the discussion with the JOB AID: BREASTFEED OBSERVATION and LISTENING AND LEARNING SKILLS CHECKLIST, in order to give feedback later.

▸ Ask the participant-observer to fill out the JOB AID: BREASTFEED OBSERVATION and LISTENING AND LEARNING SKILLS CHECKLIST, and give feedback immediately after the interaction with mother and baby (away from the mother).

▸ Ask the participant-counsellor to share the Counselling cards with the mother.

▸ Pairs switch roles: the other participant will talk with mother of an infant aged from 0 up to 6 months and assess a breastfeed, while the participant who previously talked with the mother now follows the discussion with the JOB AID: BREASTFEED OBSERVATION and LISTENING AND LEARNING SKILLS CHECKLIST, in order to give feedback later. (Each pair talks to at least two mothers with infants aged from 0 up to 6 months.)

▸ Try to make sure that each participant talks to at least one mother.

▸ Each time the participants have finished a counselling session with a mother, take them into another room or a corner to discuss your observations.

- Take with you spare copies of the Job aid: Breastfeed observation, Listening and learning skills checklist and Clinical practice discussion checklist.
- Guide the participant who is practising: trainers/facilitators move from pair to pair to observe and provide any additional feedback.
  - Keep in the background, and try to let the participants work without too much interference.
  - You do not need to correct every mistake that a participant makes immediately. If possible, wait until the discussion afterwards. Then you can both praise what they did right and talk about anything they did not do right.
  - However, if the participant-counsellor is making a lot of mistakes, or not making any progress, or the participant-observer forgets to use the observation checklist, then you could help them. Try to help in a way that does not make them embarrassed in front of the mother and the group.
  - Also, if the participant-counsellor starts to help or advise the mother, remind them that they should not do that during this clinical practice session.
  - Additionally, if a mother and baby show something important that the participants may not have observed, you can quietly draw their attention to it.
  - You need to judge as participants work what will best help them to learn.
  - Use your Skills for building confidence and giving support to correct participants and to help them to develop confidence in their own clinical and counselling skills.
- Discuss the participant's performance:
  - Take the group away from the mother, and discuss what they observed.
  - Use the Clinical practice discussion checklist, to help you to lead the discussion. Try not to spend too long going through the clinical practice session with each participant. It is important that everyone has a chance to practise their skills. Use your counselling skills when giving feedback.
  - Ask the General questions, and then ask the specific questions about Listening and learning and about Assessing a breastfeed.
  - Ask the questions on building confidence and giving support in later clinical practice sessions.
  - Go through the Listening and learning skills checklist, and discuss how the participant practised them. First ask the participant themself to say how well they think they did. Then ask the other participants. Try to encourage the participants to use their counselling skills in the way they give feedback to other participants.
  - Go through the Job aid: Breastfeed observation, and discuss how many of the signs the group noticed. Ask them to decide whether the baby was well or poorly positioned and attached.
  - Go through Counselling card 3: Good attachment and Counselling card 4: Breastfeeding positions, and encourage participants to practise use of the cards with other participants and familiarize themselves with their use.
- Teach about mothers who need help:
  - If at any time, there is a mother who needs help, or who illustrates a particular situation, take the opportunity to teach about it.
  - Ask a participant who identifies a mother needing help to report it to you. Ask the staff of the ward or clinic whether they would like you to help the mother. If they agree, give the mother the necessary help, together with the participant.
  - Ask the staff to be present if possible, and make sure that they understand what you suggest to the mother, so that they can provide follow-up.
  - Explain and demonstrate the situation to the other participants. This may take you ahead of what has been covered so far in the course, but it is important not to miss a good learning opportunity.

- If possible, suggest that participants revisit the mothers whom they talked to, to follow them up the next day.

- Encourage participants to observe health-care practices:
  - Encourage participants, while they are in a ward or clinic, to notice:
    - whether babies room-in with their mothers
    - whether or not babies are given formula milk or glucose water
    - whether or not feeding bottles are used
    - the presence or absence of advertisements for baby milk
    - whether sick mothers and babies are admitted to hospital together
    - how low-birth-weight babies are fed
    - whether the child eats any food or drinks during the session
    - whether the child was given a bottle or soother/pacifier while waiting
    - what the interaction was like between the mother and the child
    - any posters or other information on feeding in the area.

- Explain that participants should not comment on their observations, or show any disapproval, while in the health facility. They should wait until the trainer invites them to comment privately, or in the classroom.

III. Summarize the session 5 minutes

- Ask participants whether they have any questions, and try to answer them.
- Explain that a summary of this session can be found on pages 125–128 of the *Participant's manual*.

CLINICAL PRACTICE DISCUSSION CHECKLIST

Practical skills are best developed by introducing and demonstrating the skills, observing participants as they practise the skills, and giving feedback to participants on how well they performed. Feedback should include praising participants for things done well, and giving gentle suggestions for how to overcome difficulties. Use the checklist below to help guide your feedback discussions.

Questions to ask after each participant completes their turn practising (either in the clinic or using counselling stories)

To the participant who practised:

- What did you do well?
- What difficulties did you have?
- What would you do differently in the future?

To the participants who observed:

- What did the participant do well?
- What difficulties did you observe?

LISTENING AND LEARNING SKILLS (give feedback on the use of these skills in all practical sessions)[1]

- Which LISTENING AND LEARNING SKILLS did you use?
- Was the mother willing to talk?
- Did the mother ask any questions? How did you respond?
- Did you empathize with the mother? Give an example.

SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT (give feedback on the use of these skills during clinical practice sessions after Session 10)[1]

- Which SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT were used? (check especially for praise and for two relevant suggestions)
- Which skills were most difficult to use?
- What was the mother's response to your suggestions?

KEY MESSAGES FOR COMPLEMENTARY FEEDING (give feedback on the use of these skills in Sessions 53 and 54 [Clinical practice sessions 5 and 6])[2]

- Which messages for complementary feeding did you use? (check especially for "only a few relevant messages")
- What was the mother's response to your suggestions?

General questions to ask at the end of each clinical practice session (in the clinic or using counselling stories)

- What special difficulties or situations helped you to learn?
- What was the most interesting thing that you learnt from this clinical practice session?

[1] See list of skills at the end of the session.
[2] See list of KEY MESSAGES FOR COMPLEMENTARY FEEDING on page xiv of the *Participant's manual* and page xvi of the *Trainer's guide*.

Job aid: Breastfeed observation

Mother's name: **Date:**

Baby's name: **Baby's age:**

Signs that breastfeeding is going well:	Signs of possible difficulty:
GENERAL	
Mother:	**Mother:**
☐ Mother looks healthy	☐ Mother looks ill or depressed
☐ Mother relaxed and comfortable	☐ Mother looks tense and uncomfortable
☐ Signs of bonding between mother and baby	☐ No mother/baby eye contact
Baby:	**Baby:**
☐ Baby looks healthy	☐ Baby looks sleepy or ill
☐ Baby calm and relaxed	☐ Baby is restless or crying
☐ Baby reaches or roots for breast if hungry	☐ Baby does not reach or root
BREASTS	
☐ Breasts look healthy	☐ Breasts look red, swollen, or sore
☐ No pain or discomfort	☐ Breast or nipple painful
☐ Breast well supported with fingers away from nipple	☐ Breasts held with fingers on areola
BABY'S POSITION	
☐ Baby's head and body in line	☐ Baby's neck and head twisted to feed
☐ Baby held close to mother's body	☐ Baby not held close
☐ Baby's whole body supported	☐ Baby supported by head and neck only
☐ Baby approaches breast, nose to nipple	☐ Baby approaches breast, lower lip/chin to nipple
BABY'S ATTACHMENT	
☐ Baby's mouth open wide	☐ Baby's mouth not open wide
☐ Lower lip turned outwards	☐ Lips pointing forward or turned in
☐ Baby's chin touches breast	☐ Baby's chin not touching breast
☐ More areola seen above baby's top lip	☐ More areola seen below bottom lip
SUCKLING	
☐ Slow, deep sucks with pauses	☐ Rapid shallow sucks
☐ Cheeks round when suckling	☐ Cheeks pulled in when suckling
☐ Baby releases breast when finished	☐ Mother takes baby off the breast
☐ Mother notices signs of oxytocin reflex	☐ No signs of oxytocin reflex noticed

LISTENING AND LEARNING SKILLS CHECKLIST

Name of counsellor:

Name of observer:

Date of visit:

(✓ for Yes and X for No)

Did the counsellor:

Use LISTENING AND LEARNING SKILLS:

- ☐ Keep the head level with mother/caregiver?
- ☐ Pay attention (eye contact)?
- ☐ Remove physical barriers (tables and notes)?
- ☐ Take time/allow the mother/caregiver time to talk?
- ☐ Use appropriate touch?
- ☐ Ask open questions?
- ☐ Use responses and gestures that showed interest?
- ☐ Reflect back what the mother/caregiver said?
- ☐ Empathize – showing that he or she understood how the mother/caregiver feels?
- ☐ Avoid using words that sound judging?

COUNSELLING SKILLS

LISTENING AND LEARNING SKILLS

1. Use helpful non-verbal communication
2. Ask open questions
3. Use responses and gestures that show interest
4. Reflect back what the mother/caregiver says
5. Empathize – show that you understand how the mother/caregiver feels
6. Avoid using words that sound judging

SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT

1. Accept what a mother/caregiver thinks and feels
2. Recognize and praise what a mother/caregiver and baby are doing right
3. Give practical help
4. Give a little, relevant information
5. Use simple language
6. Make one or two suggestions, not commands

Notes

Notes (contd)

SESSION 22

Clinical practice session 2: Building confidence and giving support – positioning a baby at the breast

Objectives

After completing this session, participants will be able to:

- demonstrate appropriate SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT when counselling a mother on feeding her infant
- demonstrate how to help a mother to position and attach her baby at the breast
- demonstrate appropriate use of COUNSELLING CARD 3: GOOD ATTACHMENT and COUNSELLING CARD 4: BREASTFEEDING POSITIONS

Session outline . . . . . 120 minutes

Participants are together as a class led by one trainer, to prepare for the session, and to discuss it afterwards.

Participants work in small groups of 3–4, each with one trainer, for the clinical practice session in a ward or clinic.

I. Prepare the participants . . . . . 20 minutes
II. Conduct the clinical practice . . . . . 95 minutes
III. Summarize the session . . . . . 5 minutes

Preparation

- Make sure that you know where the clinical practice will be held and what times you are expected there. Visit the wards or clinics if you have not done so before. Introduce yourself to the staff members in charge, and make sure that they are prepared for the session (see *Director's guide*).
- Study the instructions on the following pages, and ask all trainers who will lead groups to study the instructions also. You conduct this clinical practice in a similar way to CLINICAL PRACTICE SESSION 1: LISTENING AND LEARNING – ASSESSING A BREASTFEED but there are some differences. Make sure that you and the other trainers are clear about the differences.
- Make sure that there are two copies of the JOB AID: BREASTFEED OBSERVATION and one copy of the COUNSELLING SKILLS CHECKLIST available for each participant and additional copies for trainers.
- Make sure that there are copies of the CLINICAL PRACTICE DISCUSSION CHECKLIST for each trainer.
- Make sure participants take the following with them to the clinical practice session: COUNSELLING CARD 3: GOOD ATTACHMENT, COUNSELLING CARD 4: BREASTFEEDING POSITIONS, and the *Guidance on the use of counselling cards*.

As you follow the text, remember:

- ▶ indicates an instruction to you, the trainer.
- ¤ indicates what you say to participants.

I. Prepare the participants — 20 minutes

- One trainer leads a preparatory session with all participants and the other trainers together.
- If you have to travel to another facility for the clinical practice session, hold the preparatory session in the classroom before you leave. If necessary, this can take place on the evening or the morning before the clinical session.
- Explain the following to the participants:
  - You are going to practise the SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT that you learnt in Sessions 9 and 10, and helping a mother to position her baby.
  - You will also continue to practise assessing a breastfeed and using LISTENING AND LEARNING SKILLS.
  - It is important that you all practise helping a mother to position her baby at the breast, or to overcome any other difficulty. Often you will find that babies are sleepy. In this case, you could say to the mother something such as: "I see your baby seems to be sleepy now, but can we just go through the way to hold him when he is ready". Then go through THE FOUR KEY SIGNS OF GOOD POSITIONING with the mother. If you do this, quite a few babies will wake up and want another feed when their nose is opposite the nipple.
  - You will need to take with you two copies of the JOB AID: BREASTFEED OBSERVATION, one copy of the COUNSELLING SKILLS CHECKLIST and pencil and paper to make notes.
  - You will need to take with you the copies of COUNSELLING CARD 3: GOOD ATTACHMENT, COUNSELLING CARD 4: BREASTFEEDING POSITIONS, and the *Guidance on the use of counselling cards*.
  - When you are counselling the mother, you can share the Counselling cards with her, if needed.
  - You will work in groups of 3–4 with one trainer.
  - You do not need to take anything else – no books, manuals or handbags.
- Explain what to do in the ward:
  - Take it in turns to talk to a mother, assess a breastfeed and help her to position and attach her baby if she needs help.
  - Practise as many of the six SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT as possible. In particular, try to do these things:
    - praise two things that the mother and baby are doing right.
    - give the mother two pieces of relevant information that are useful to her now.
  - The other participants should stand quietly in the background.
  - Make **specific** observations of the participant-counsellor's counselling skills.
  - Mark a tick on your COUNSELLING SKILLS CHECKLIST when the participant-counsellor uses a skill, to help you remember for the discussion.
  - When a mother breastfeeds, observe the feed using the JOB AID: BREASTFEED OBSERVATION and put ticks in the boxes.
  - When you have finished, thank the mother.

II. Conduct the clinical practice 95 minutes

These notes are for the trainers. Trainers should read them to ensure that they know what to do. There is no need to read these notes to the participants.

- Take your group to the ward or clinic:
  - Conduct the session in the same way as CLINICAL PRACTICE SESSION 1.
  - This time, the participants may help a mother to position and attach her baby.
- Guide the participant who is practising:
  - Keep in the background, and try to let the participant work without too much interference.
  - You do not need to correct every mistake that a participant makes immediately. If possible, wait until the discussion afterwards. Then you can both praise what they did right and talk about anything they did not do right.
  - However, if the participant-counsellor is making a lot of mistakes, or not making any progress, then you should help them. Try to help in a way that does not make them embarrassed in front of the mother and the group.
  - If a participant has helped a mother to position her baby, but the mother is still having difficulties, then you should help the mother before your group leaves the mother.
  - Use your SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT to correct participants and to help them to develop confidence in their own clinical and counselling skills.
- Discuss the participants' performance:
  - Take the group away from the mother, and discuss what they observed.
  - Use the CLINICAL PRACTICE DISCUSSION CHECKLIST, to help you to lead the discussion. Try not to spend too long going through the clinical practice session with each participant. It is important that everyone has a chance to practise their skills. Use your counselling skills when giving feedback.
  - Go through the COUNSELLING SKILLS CHECKLIST, and discuss how the participant practised them. First ask the participant themself to say how well they think they did. Then ask the other participants. Try to encourage the participants to use their counselling skills in the way they give feedback to other participants.
  - Go through the JOB AID: BREASTFEED OBSERVATION, and discuss what the participants observed when assessing a breastfeed. Discuss how the participant helped a mother to position and attach her baby.

III. Summarize the session 5 minutes

- Ask participants whether they have any questions, and try to answer them.
- Explain that a summary of this session can be found on pages 131–133 of the *Participant's manual*.

CLINICAL PRACTICE DISCUSSION CHECKLIST

Practical skills are best developed by introducing and demonstrating the skills, observing participants as they practise the skills, and giving feedback to participants on how well they performed. Feedback should include praising participants for things done well, and giving gentle suggestions for how to overcome difficulties. Use the checklist below to help guide your feedback discussions.

Questions to ask after each participant completes their turn practising (either in the clinic or using counselling stories)

To the participant who practised:

- What did you do well?
- What difficulties did you have?
- What would you do differently in the future?

To the participants who observed:

- What did the participant do well?
- What difficulties did you observe?

LISTENING AND LEARNING SKILLS (give feedback on the use of these skills in all practical sessions)[1]

- Which LISTENING AND LEARNING SKILLS did you use?
- Was the mother willing to talk?
- Did the mother ask any questions? How did you respond?
- Did you empathize with the mother? Give an example.

SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT (give feedback on the use of these skills during clinical practice sessions after Session 10)[1]

- Which SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT were used? (check especially for praise and for two relevant suggestions)
- Which skills were most difficult to use?
- What was the mother's response to your suggestions?

KEY MESSAGES FOR COMPLEMENTARY FEEDING (give feedback on the use of these skills in Sessions 53 and 54 [Clinical practice sessions 5 and 6])[2]

- Which messages for complementary feeding did you use? (check especially for "only a few relevant messages")
- What was the mother's response to your suggestions?

General questions to ask at the end of each clinical practice session (in the clinic or using counselling stories)

- What special difficulties or situations helped you to learn?
- What was the most interesting thing that you learnt from this clinical practice session?

[1] See list of skills at the end of the session.
[2] See list of KEY MESSAGES FOR COMPLEMENTARY FEEDING on page xiv of the *Participant's manual* and page xvi of the *Trainer's guide*.

Job aid: Breastfeed observation

Mother's name: **Date:**

Baby's name: **Baby's age:**

Signs that breastfeeding is going well:	Signs of possible difficulty:
GENERAL	
Mother:	**Mother:**
☐ Mother looks healthy	☐ Mother looks ill or depressed
☐ Mother relaxed and comfortable	☐ Mother looks tense and uncomfortable
☐ Signs of bonding between mother and baby	☐ No mother/baby eye contact
Baby:	**Baby:**
☐ Baby looks healthy	☐ Baby looks sleepy or ill
☐ Baby calm and relaxed	☐ Baby is restless or crying
☐ Baby reaches or roots for breast if hungry	☐ Baby does not reach or root
BREASTS	
☐ Breasts look healthy	☐ Breasts look red, swollen, or sore
☐ No pain or discomfort	☐ Breast or nipple painful
☐ Breast well supported with fingers away from nipple	☐ Breasts held with fingers on areola
BABY'S POSITION	
☐ Baby's head and body in line	☐ Baby's neck and head twisted to feed
☐ Baby held close to mother's body	☐ Baby not held close
☐ Baby's whole body supported	☐ Baby supported by head and neck only
☐ Baby approaches breast, nose to nipple	☐ Baby approaches breast, lower lip/chin to nipple
BABY'S ATTACHMENT	
☐ Baby's mouth open wide	☐ Baby's mouth not open wide
☐ Lower lip turned outwards	☐ Lips pointing forward or turned in
☐ Baby's chin touches breast	☐ Baby's chin not touching breast
☐ More areola seen above baby's top lip	☐ More areola seen below bottom lip
SUCKLING	
☐ Slow, deep sucks with pauses	☐ Rapid shallow sucks
☐ Cheeks round when suckling	☐ Cheeks pulled in when suckling
☐ Baby releases breast when finished	☐ Mother takes baby off the breast
☐ Mother notices signs of oxytocin reflex	☐ No signs of oxytocin reflex noticed

COUNSELLING SKILLS CHECKLIST

Name of counsellor:

Name of observer:

Date of visit:

(✓ for Yes and X for No)

Did the counsellor:

Use LISTENING AND LEARNING SKILLS:

☐ Keep the head level with mother/parent/caregiver?

☐ Pay attention (eye contact)?

☐ Remove barriers (tables and notes)?

☐ Take time? Allow the mother/caregiver time to talk?

☐ Use appropriate touch?

☐ Ask open questions?

☐ Use responses and gestures that showed interest?

☐ Reflect back what the mother/caregiver said?

☐ Empathize – showing that he or she understood how the mother/caregiver feels?

☐ Avoid using words that sound judging?

Use SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT:

☐ Accept what the mother/caregiver thinks and feels?

☐ Recognize and praise what the mother/caregiver and baby are doing right?

☐ Give practical help?

☐ Give a little, relevant information?

☐ Use simple language?

☐ Make one or two suggestions, not commands?

Counselling skills

Listening and learning skills

1. Use helpful non-verbal communication
2. Ask open questions
3. Use responses and gestures that show interest
4. Reflect back what the mother/caregiver says
5. Empathize – show that you understand how the mother/caregiver feels
6. Avoid using words that sound judging

Skills for building confidence and giving support

1. Accept what a mother/caregiver thinks and feels
2. Recognize and praise what a mother/caregiver and baby are doing right
3. Give practical help
4. Give a little, relevant information
5. Use simple language
6. Make one or two suggestions, not commands

Notes

Notes (contd)

MODULE 4

Breastfeeding (advanced sessions)

SESSION 23

Why breastfeeding is important 2

Objectives

After completing this session, participants will be able to:

- state the advantages of exclusive breastfeeding for 6 months
- describe the main differences between breast milk, animal milk and infant formula milk
- list the advantages of continued breastfeeding with complementary feeding for up to 2 years or beyond
- list the risks of artificial feeding
- define the terms used to describe infant feeding

Session outline . . . . . 90 minutes

Participants are all together for a lecture presentation by one trainer.

I.	Introduce the session, present **Slide 23/1**	2 minutes
II.	Facilitate group work and plenary discussion	15 minutes
III.	Present **Slides 23/2** to **23/13**	25 minutes
IV.	Answer participants' questions	7 minutes
V.	Present **Slides 23/14** to **23/19**	15 minutes
VI.	Answer participants' questions	10 minutes
VII.	Present COUNSELLING CARDS 1 and 2	15 minutes
VIII.	Summarize the session	1 minute

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides and facilitating group discussion.
- Study the **Slides 23/1** to **23/19** and the text that goes with them, so that you are able to present them.
- Set three flipcharts out round the room, with the titles IMPORTANCE OF BREASTFEEDING TO INFANT, IMPORTANCE OF BREASTFEEDING TO MOTHER and RISKS OF NOT BREASTFEEDING.
- Have ready COUNSELLING CARD 1: DURING THE FIRST 6 MONTHS, YOUR BABY NEEDS ONLY BREAST MILK; COUNSELLING CARD 2: THE IMPORTANCE OF EXCLUSIVE BREASTFEEDING DURING THE FIRST 6 MONTHS, and the *Guidance on the use of counselling cards*.
- Read the *Guidance on the use of counselling cards*, so you are familiar with the methodology to introduce the Counselling cards to participants.
- Read the **Further information** sections, so that you are familiar with the ideas that they contain, so that you can answer participants' questions.

As you follow the text, remember:

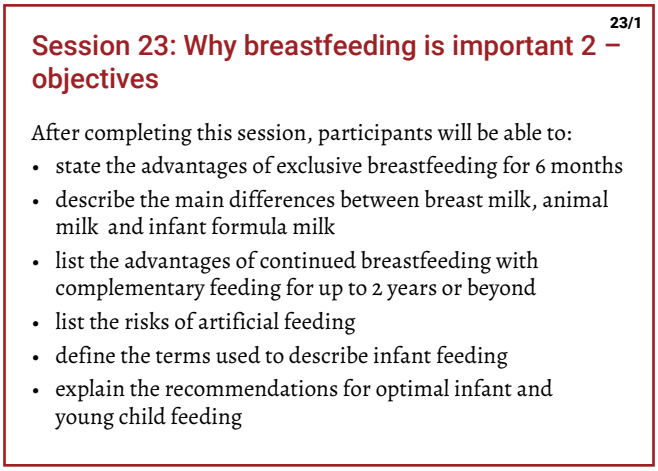
► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the session — 2 minutes

- **Make these points:**
  - The World Health Organization (WHO) and United Nations Children's Fund (UNICEF) recommend that infants should be exclusively breastfed for the first 6 months of life, starting within 1 hour after birth, and to continue breastfeeding up to 2 years of age or beyond.
  - You need to understand why breastfeeding is important, so you can help to support mothers who may have doubts about the value of breast milk.
  - Breastfeeding is the normal, healthy way to feed a baby. It is the best, but it is not something extra: it is what a baby needs. A child who is artificially fed, for example on infant formula milk or cow's or other animal milk, is at a disadvantage.
  - You need to know the differences between breast milk, animal milks and infant formula milk, and the risks of artificial feeding.
  - You will find notes for this session on pages 137–149 in your *Participant's manual*.
- **Show Slide 23/1 – Session 23 – objectives and read out the objectives:**



- **Make the following points:**
  - We will review the rationale for the breastfeeding recommendations, with emphasis on exclusive breastfeeding for the first 6 months of life.
  - To do that, you will have workgroup discussions, followed by plenary discussion and a presentation to share up-to-date evidence on breastfeeding.

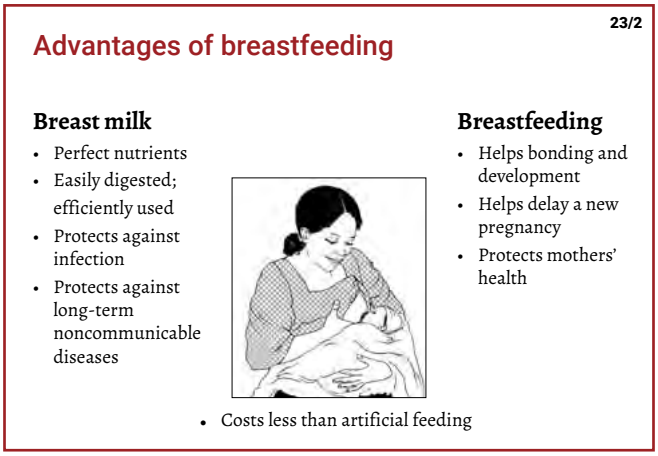
II. Facilitate group work and plenary discussion — 15 minutes

- **Divide participants into three groups. Each group will be with one trainer/facilitator.**
- **Make the following points:**
  - Now you will work in groups
  - You will find three flipcharts set throughout the room (*let them know where the flipcharts are*).
  - One flipchart has the title IMPORTANCE OF BREASTFEEDING TO INFANT, the second IMPORTANCE OF BREASTFEEDING TO MOTHER and the last RISKS OF NOT BREASTFEEDING.
  - Each group will have about 3 minutes at each flipchart, to write as many points as you can think of; you should not repeat what is already listed.
  - Groups will rotate to the next flipchart and repeat the exercise until the three groups have written something on each of the three flipcharts.
  - At the end of the exercise, you will get back to your places so we continue with the plenary session.

- Ask a representative of group 1 to present the list of the first flipchart (IMPORTANCE OF BREASTFEEDING TO INFANT) and ask the other groups to contribute or make clarifications they consider necessary.
- Then ask a representative of group 2 to present the list of the second flipchart (IMPORTANCE OF BREASTFEEDING TO MOTHER) and ask the other groups to contribute or make clarifications they consider necessary.

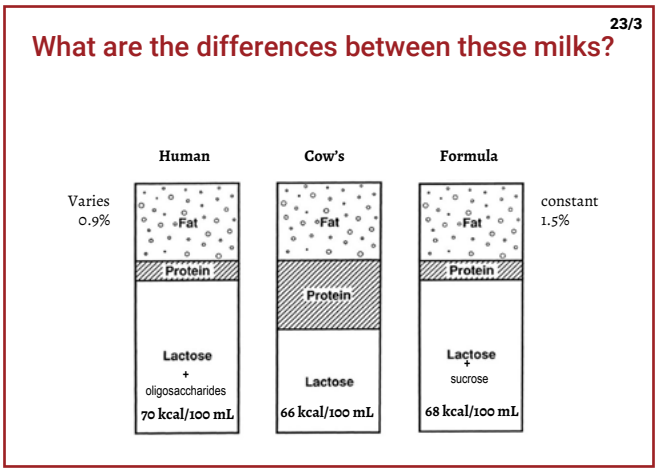
III. Present **Slides 23/2** to **23/13** 25 minutes

- Show **Slide 23/2 – Advantages of breastfeeding** and make the points that follow, consider the participants' contributions and avoid repetitions:



- This diagram summarizes the main advantages of breastfeeding.
- It is useful to think of the advantages of both breast milk (listed on the left) and the process of breastfeeding (listed on the right) (*refer to what the participants mentioned*).
- Breastfeeding includes more than just feeding a baby on breast milk. It is important for the whole family, emotionally and economically, and it protects a mother's health in several ways.
- The value of a baby having breast milk is that:
  - it contains exactly the nutrients that a baby needs
  - it is easily digested and efficiently used by the baby's body
  - it protects a baby against infection, which is particularly important for neonates
  - it provides long-term health benefits, such as a reduced risk of obesity, allergy, hypertension and diabetes.
- All other milks are different, and not as good for a human baby.
- The importance of breastfeeding is that:
  - it helps a mother and baby to bond – that is, to develop a close, loving relationship
  - it helps a baby's development
  - it can help to delay a new pregnancy.
- Breastfeeding helps to protect the mother's health in several ways:
  - it helps the uterus to return to its previous size. This helps to reduce bleeding, and may help to prevent anaemia
  - it reduces her risk of breast and ovarian cancer, and type 2 diabetes.
- The other advantages of breastfeeding are that:
  - it costs less than artificial feeding, including fewer costs for health care
  - it produces no waste materials, so it is better for the environment.
- In the next few slides, we will look at some of these advantages in more detail.

► Show **Slide 23/3 – What are the differences between these milks?** and make the points that follow:



- First, look at this chart and compare the nutrients in breast milk with the nutrients in cow's milk and infant formula milk.
- All the milks contain fat, which provides about half of the energy that a young human or a young animal needs; they contain protein, for growth; and they contain the special milk sugar lactose, which also provides energy.
- In some communities, other animal milks are used, such as goat's milk. There are differences between milks from different animals, but in general what we say here applies to all of them.
- *Ask: What is the difference between the amount of protein in human milk and the amount in cow's milk?*

► Wait for a few replies and then continue.

- Cow's milk contains more protein than human milk.
- Protein is an important nutrient, and you might think that more protein must be better. However, cows and other animals grow more quickly than humans, so they need milk with a higher concentration of protein. It is difficult for a baby's immature kidneys to excrete the extra waste from the protein in animal milks.
- *Ask: What is the difference between the amount of protein in infant formula milk and in the other milks?*

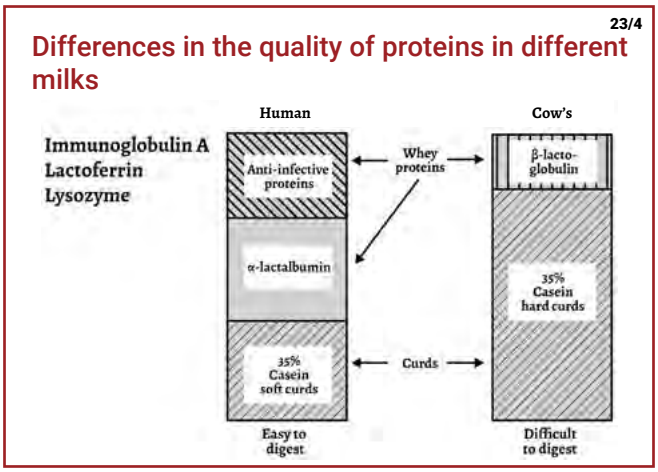
► Wait for a few replies and then continue.

- Infant formula milk has less protein than cow's milk, but it is a little more than in human milk.
- Infant formula milk may be made from animal milk, or from soybean and vegetable oils. The quantity of protein in the formula milk is adjusted, so that it is nearer to that in human milk.
- But the quality is very different, and is far from perfect for babies, as you will see in the next slide.
- *Ask: What is the difference between the amount of lactose in human and cow's milk?*

► Wait for a few replies and then continue.

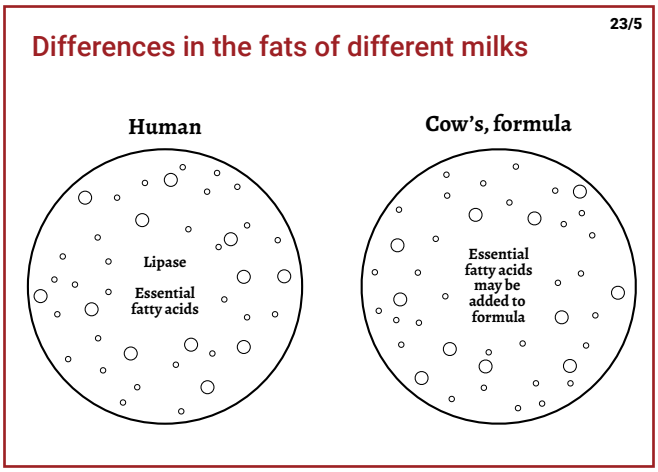
- To make formula milk more like human milk, sugars have to be added. Sometimes other sugars such as sucrose are added instead of lactose. Sucrose is less suitable for a baby and can cause dental caries in the child.
- Breast milk also contains oligosaccharides, which are short chains of sugar molecules. They have important anti-infective properties.

► (Show **Slide 23/4 – Differences in the quality of proteins in different milks** and make the points that follow:



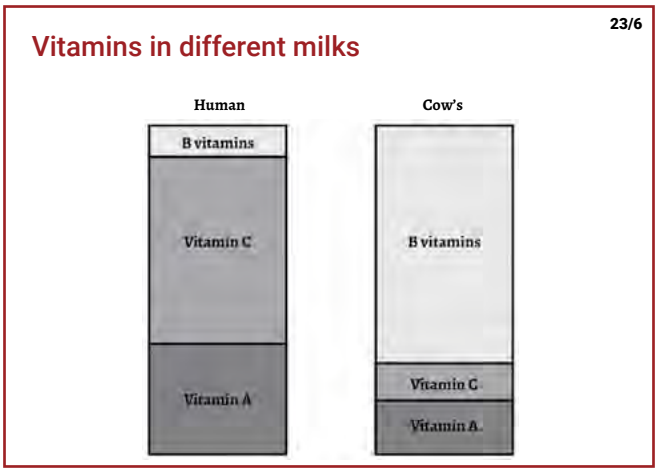
- The protein in different milks varies in quality, as well as in quantity. While the quantity of protein in cow's milk can be modified to make formula milk, the quality of proteins cannot be changed.
- This slide shows that much of the protein in cow's milk is casein, which forms thick, indigestible curds in a baby's stomach. Human milk contains a different kind of casein. It forms softer curds that are easier to digest, and there is less of it.
- The soluble or whey proteins are also different. Human milk contains mainly alpha-lactalbumin, and cow's milk contains beta-lactoglobulin. In human milk, much of the whey protein consists of anti-infective proteins, such as immunoglobulin A, or IgA, and lactoferrin, which help to protect a baby against infection. Cow's milk and formula milk do not contain the anti-infective proteins that protect babies.
- Babies fed artificially on cow's milk or formula milk may develop intolerance to the proteins in the milk, such as beta-lactoglobulin. They may develop diarrhoea, abdominal pain, rashes and other symptoms when they have feeds that contain the different kinds of protein. Diarrhoea may become persistent, which can contribute to malnutrition.
- Artificially fed babies are also more likely than breastfed babies to develop allergies, which may cause eczema, and possibly asthma.
- A baby may develop intolerance or allergy after only a few artificial feeds given in the first few days of life.

► Show **Slide 23/5 – Differences in the fats of different milks** and make the points that follow:



- The amount of fat in cow's milk and human milk is similar, but there are important differences in the quality of the fat in the different milks.
- Human milk contains essential fatty acids that are not present in cow's milk. These essential fatty acids are needed for a baby's growing brain and eyes, and for healthy blood vessels. Essential fatty acids are sometimes added to formula milk, but it is not certain whether the baby's body uses them in the same way as those in breast milk.
- Human milk also contains an enzyme lipase, which helps to digest fat. This enzyme is not present in cow's milk or formula milk.
- So the fat in breast milk is more completely digested and more efficiently used by a baby's body than the fat in cow's milk or formula milk.
- The faeces of an artificially fed baby are thicker and more solid than those of a breastfed baby. This is partly because an artificially fed baby's faeces contain more unused fat and other food.

▸ Show **Slide 23/6 – Vitamins in different milks** and make the points that follow:

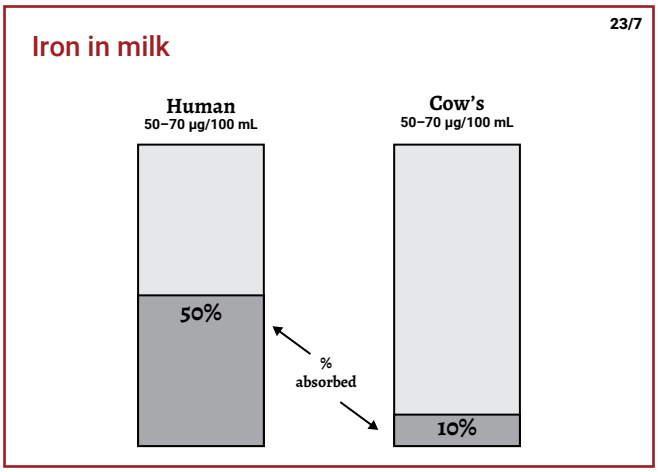


- This slide compares the amounts of vitamins in human and cow's milk.
- It shows that human milk contains more of some important vitamins than cow's milk.
- Breast milk contains plenty of vitamins A and C, if the mother has enough in her food. Breast milk can supply much of the vitamin A that a child needs in the second year of life.
- Cow's milk contains plenty of the B vitamins but it does not contain as much vitamin A and vitamin C as human milk.
- Infant formula milk has enough vitamins added to it to cover a baby's needs.
- *Ask: What can you do if you are worried about a woman's diet, and you think that there may not be enough vitamins for her baby in her breast milk?*

▸ Wait for a few replies and then continue.

- Give extra vitamins to the mother.

▸ Show **Slide 23/7 – Iron in milk** and make the points that follow:

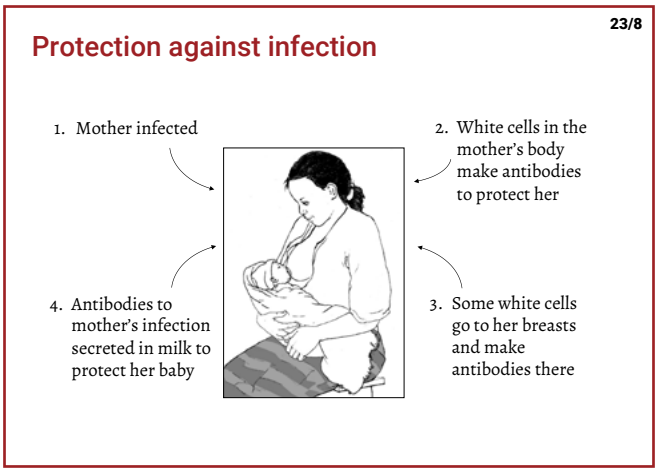


- Iron is important to prevent anaemia. Different milks contain very small amounts of iron (50–70 µg/100 mL, i.e. 0.5–0.7 mg/L). But there is an important difference.
- *Ask: What does this chart show you about the absorption of iron from different milks?*

▸ Wait for a few replies and then continue.

- Only about 10% of the iron in cow's milk is absorbed, but about 25–50% of the iron from breast milk is absorbed.
- Babies fed cow's milk may not get enough iron, and they often develop anaemia. Exclusively breastfed babies do get enough iron, and they are protected against iron-deficiency anaemia until at least 6 months of age, and often longer.

▶ Show **Slide 23/8 – Protection against infection** and make the points that follow:



- Breast milk is not just a food for babies. It is a living fluid, which protects a baby against infections.
- For the first year or so of life, a baby's immune system is not fully developed, and cannot fight infections as well as an older child's or adult's. So a baby needs to be protected by their mother.
- Breast milk contains white blood cells, and a number of anti-infective factors, which help to protect a baby against infection.
- Breast milk also contains antibodies against infections that the mother has had in the past, and to the bacteria in her environment. This protection is particularly important immediately after a baby is born, and through the neonatal period.
- This diagram shows the special way in which breast milk is able to protect a baby against new infections that the mother has, or that are in the family's environment now.
- When a mother develops an infection (1), white cells in her body become active, and make antibodies against the infection to protect her (2).
- Some of these white cells go to her breasts and make antibodies (3), which are secreted in her breast milk to protect her baby (4).
- So a baby should not be separated from their mother when she has an infection, because her breast milk protects the baby against the infection.
- Artificial feeds are inactive. They contain no living white cells or antibodies, and few other anti-infective factors, so they provide much less protection against infection. The main immunoglobulin in breast milk is IgA – often called "secretory" immunoglobulin A. It is secreted within the breast into the milk, in response to the mother's infections. This is different from other immunoglobulins (such as IgG), which are found mainly in the blood.
- Breast milk also contains many other anti-infective factors.

► Show **Slide 23/9 – Summary of differences between milks** and make the points that follow:

23/9

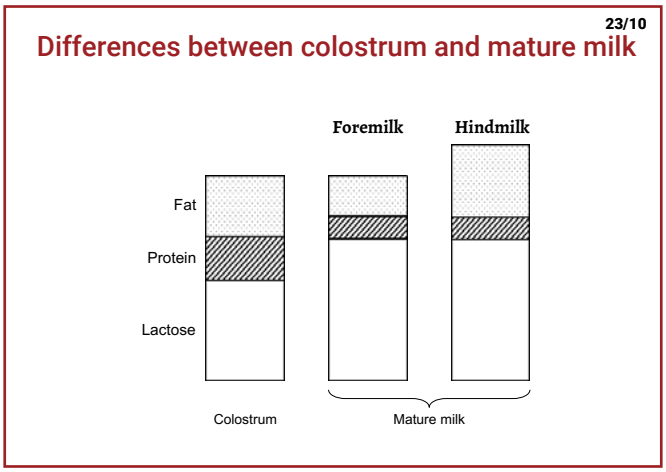
Summary of differences between milks

Component	Human milk	Cow's milk	Formula milk
Protein	Right amount Easy to digest	Too much Difficult to digest	Quantity reduced Quality as cow's
Fats	EFAs present Lipase to digest	No EFAs No lipase	Some EFA added No lipase
Carbohydrate	Lactose – plenty Oligosaccharides (anti-infective)	Lactose – less Oligosaccharides not suitable	Lactose + sucrose Lacks oligosaccharides
Vitamins and minerals	Adequate if mother has enough	Low vitamin A and C and iron	Vitamins/minerals added usually enough
Anti-infective factors	IgA, lactoferrin, lysozyme, cells	**None**	**None**
Growth factors	Present	**None**	**None**

EFA: essential fatty acid; IgA: immunoglobulin A.

- This slide shows a table that summarizes the differences between human milk, cow's milk and infant formula milk.
- You can see that each of the components is present in human milk in the right quantity, and with optimal quality.
- In cow's milk and other animal milks, some components are present in unsuitable amounts or they are absent, as well as being of inappropriate quality.
- In infant formula milk, the quantities of some components are adjusted so that they are more suitable than animal milks, but the quality remains inappropriate. It is impossible to add anti-infective or growth factors (you will learn more about growth factors with **Slide 23/12**).
- Different kinds of infant formula milk vary, but in general they are similar in these respects.

▸ Show **Slide 23/10 – Differences between colostrum and mature milk** and make the points that follow:

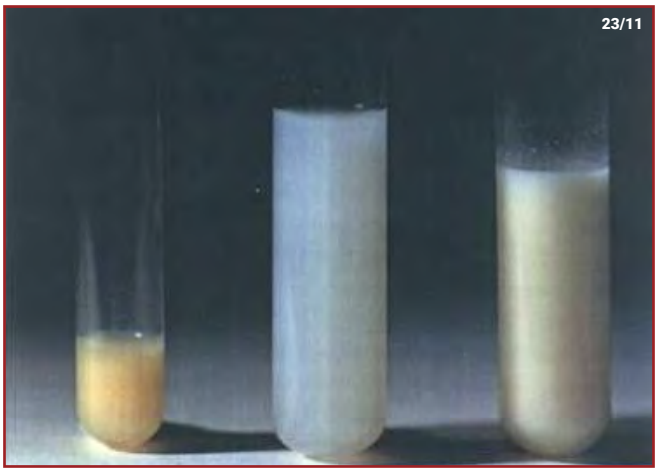


- The composition of breast milk is not always the same. It varies according to the age of the baby, and from the beginning to the end of a feed. It also varies between feeds, and may be different at different times of the day. This chart shows some of the main variations.
- *Ask: What differences do you notice between the different types of breast milk?*

▸ Wait for a few replies and then continue.

- Colostrum is the special breast milk that women produce in the first few days after delivery. Some women produce colostrum before delivery. There is a small amount, and it is thick, and yellowish or clear in colour. It contains more protein than later milk (*point to the area on the graph*). Much of this extra protein is immunoglobulin.
- After 2–3 days, the breasts start to secrete milk in larger amounts, and the breasts feel full, hard and heavy. This is called the milk "coming in". At first, the milk is called transitional, and after 2 weeks it is called mature milk.
- Breast milk also changes from the beginning to the end of a feed. The milk that comes first is called foremilk. The milk that comes later is called hindmilk.
- Hindmilk contains more fat than foremilk. The baby gets more energy towards the end of a feed.

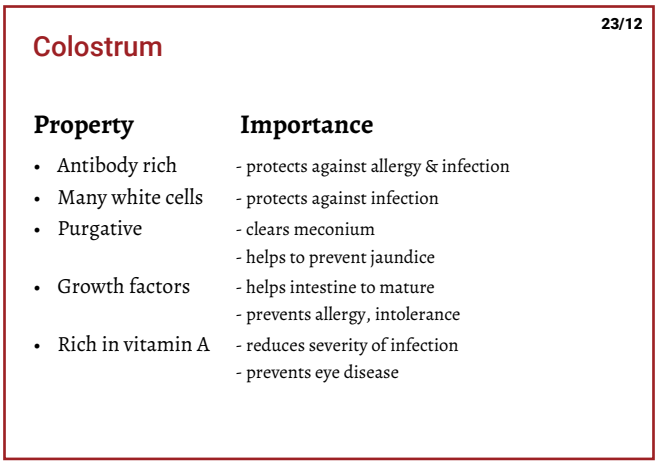
► Show **Slide 23/11 – The appearances of colostrum, foremilk and hindmilk** and make the points that follow:



- This photograph shows how the appearance of colostrum, foremilk and hindmilk differs.
- *Ask: What is the milk on the left?*
- It is colostrum. It is yellow, and there is a small quantity.
- *Ask: What is the milk in the centre?*
- It is foremilk. This is the milk that comes at the beginning of a feed. It looks quite watery, and there is a larger amount.
- *Ask: What is the milk on the right?*
- It is hindmilk. This is the milk that comes at the end of the feed and it looks whiter and more creamy than foremilk.
- Foremilk is produced in larger amounts than hindmilk, and it provides plenty of protein, lactose and other nutrients, and a lot of water. Because babies get large amounts of foremilk, they get all the water that they need from it, even in a hot climate. Babies do not need other drinks of water before they are 6 months old. If they satisfy their thirst on water supplements, they take less breast milk, and get less energy, protein and other nutrients.
- Hindmilk is the whiter milk that is produced later in a feed, it is produced in smaller amounts, but the fat that it contains provides much of the energy of a breastfeed. Because of this, it is important not to take a baby off a breast too quickly. The baby should be allowed to continue until they have had all that they want, and release the breast themself, so that the baby gets plenty of fat-rich hindmilk.
- Mothers sometimes worry that their milk is "too thin". This is because they notice the foremilk. Ask them to look at the milk that comes at the end of a feed. Explain that it is important for the baby to have both foremilk and hindmilk to get a complete "meal", and all the water, energy and nutrients that they need. Milk is never "too thin".
- *Ask: Why is colostrum so important?*

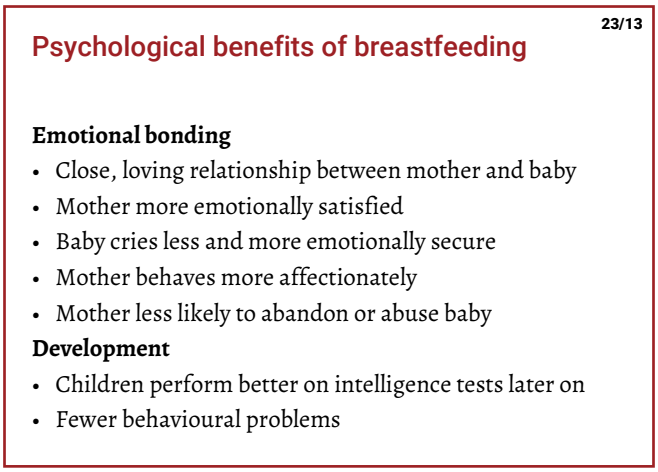
► Wait for a few answers and continue with **Slide 23/12**.

▶ Show **Slide 23/12 – Colostrum** and make the points that follow:



- This chart shows the special properties of colostrum, and why it is important.
- Colostrum contains more antibodies and other anti-infective proteins than mature milk. This is part of the reason why colostrum contains more protein than mature milk.
- It contains more white blood cells than mature milk.
- These anti-infective proteins and white cells provide a neonate's first immunization against the microorganisms that surround them when they are born. Colostrum helps to prevent the bacterial infections that can cause sepsis and death. Babies who start to breastfeed immediately after delivery, and who are not given any other feeds at this time, are less likely to die than neonates for whom the first feed is delayed, or who are given other feeds.
- Colostrum has a mild purgative effect, which helps to clear the baby's gut of meconium (the first dark stools). This clears bilirubin from the gut, and helps to prevent jaundice from becoming severe.
- Colostrum contains many growth factors that help a baby's immature intestine to develop after birth. This helps to prevent the baby from developing allergies and intolerance to other foods.
- Colostrum is richer in some vitamins than mature milk, especially vitamin A, which helps to reduce the severity of any infections the baby might have.
- So it is very important for babies to have colostrum for their first few feeds. Colostrum is ready in the breasts when a baby is born. It is all that most babies need before the transitional milk comes in.
- Babies should not be given any drinks or foods at this time. Artificial feeds given before a baby has colostrum are likely to cause allergy and infection.

► Show **Slide 23/13 – Psychological benefits of breastfeeding** and make the points that follow:



- Breastfeeding has important psychological benefits for both mothers and babies.
- Breastfeeding helps a mother and baby to form a close, loving relationship, which makes mothers feel deeply satisfied emotionally. Close contact from immediately after delivery helps this relationship to develop. This process is called bonding.
- Babies cry less, and they may develop more quickly, if they stay close to their mothers and are put to the breast from immediately after delivery.
- Mothers who breastfeed respond to their babies in a more affectionate way. They complain less about the baby's need for attention and feeding at night. They are less likely to abandon or abuse their babies.
- Some studies suggest that breastfeeding may help a child to develop intellectually.
- Low-birth-weight babies fed breast milk in the first weeks of life perform better on intelligence tests in later childhood than children who are artificially fed.
- Newer studies also show that children who were breastfed have fewer behavioural problems.
- If mothers are not breastfeeding, for a medical reason, it is important to help them to bond with their babies in other ways apart from breastfeeding.

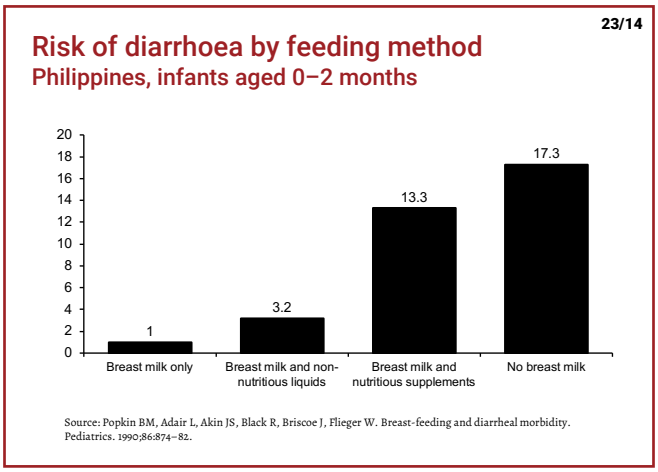
IV. Answer participants' questions — 7 minutes

► Ask participants whether they have any questions on the information in **Slides 23/2** to **23/13**, and try to answer them.

► If they have questions about topics that will be covered in later sessions, give a brief answer, and explain that the topic will be discussed more fully later.

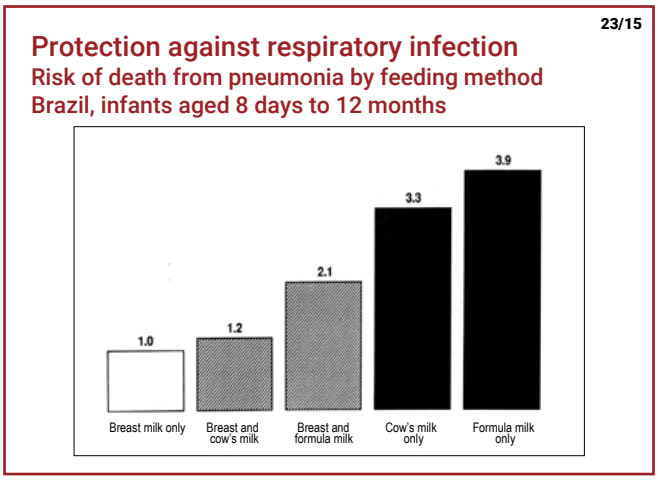
V. Present **Slides 23/14** to **23/19** 15 minutes

- **Make this introductory point:**
  - The next few slides will explain the present recommendations for infant feeding, and the reasons for them. They will also introduce the terms that are used to describe infant feeding practices.
- **Show Slide 23/14 – Risk of diarrhoea by feeding method and make the points that follow:**



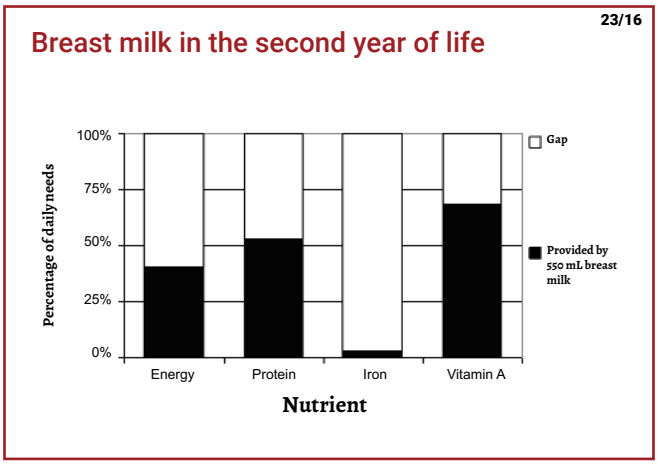
  - This chart shows how breastfeeding protects a baby against diarrhoea.
  - It chart shows the main findings of a study from the Philippines comparing how often babies fed in different ways get diarrhoea.
  - The bar on the left is for babies who were exclusively breastfed. The bar is small, because very few babies who are exclusively breastfed get diarrhoea.
  - The bar on the right is for artificially fed babies, who received no breast milk. This column is 17 times taller, because these babies were 17 times more likely to get diarrhoea than babies fed only on breast milk.
  - Some of the babies were given breast milk and other feeds or fluids, here called "nutritious supplements". This is partial breastfeeding. These babies were more likely to have diarrhoea than exclusively breastfed babies, but less likely than babies who received no breast milk at all (*point to the two bars in the middle of the chart*).
  - Some babies were breastfed, and also given non-nutritious liquids such as tea. They were predominantly breastfed. These babies were more likely to have diarrhoea than exclusively breastfed babies, but less likely than partially breastfed or artificially fed babies.
  - Artificially fed babies get diarrhoea more often, partly because artificial feeds lack anti-infective factors, and partly because artificial feeds are often contaminated with harmful bacteria. Breast milk is not contaminated.

► Show **Slide 23/15 – Protection against respiratory infection** and make the points that follow:



- Breastfeeding also protects against respiratory illness. Mortality from pneumonia is increased in babies who are not exclusively breastfed.
- This chart shows some of the findings from a study in Brazil, of babies aged 8 days to 12 months. It compares how many babies fed in different ways died from pneumonia. In this study, artificially fed babies were 3–4 times more likely to die from pneumonia than were exclusively breastfed babies. Partially breastfed babies came somewhere in between.
- Other studies have shown that breastfeeding also protects babies against other infections, for example ear infections, meningitis and urinary tract infections.

► Show **Slide 23/16 – Breast milk in the second year of life** and make the points that follow:



- For the first 6 months of life, exclusive breastfeeding can provide all the nutrients and water that a normal full-term baby needs.
- From the age of 6 months, breast milk is no longer sufficient by itself. From 6 months, all babies should receive other foods, known as complementary foods, in addition to breast milk. Complementary foods should be given by cup or cup and spoon.
- The amount of food required to cover the gap increases as the child gets older, and as the intake of breast milk decreases.
- The energy needed in addition to breast milk is about 200 kcal per day for infants aged 6–8 months, 300 kcal per day for infants aged 9–11 months, and 550 kcal per day for children aged 12–23 months.
- However, breast milk continues to be an important source of energy and high-quality nutrients beyond 6 months of age.
- This chart shows how much of a child's daily energy and nutrient needs can be supplied by breast milk during the second year of life.
- *Ask: How much of the protein that a child needs in the second year can breast milk provide? How much of the energy that a child needs in the second year can breast milk provide?*

► Wait for a few replies and then continue.

- It can provide up to 40% of the energy needs of a young child in the second year of life and half of the protein a child needs.
- *Ask: How much of the vitamin A that a child needs can breast milk provide?*

► Wait for a few replies and then continue.

- Breast milk can provide about 75% of the vitamin A that a child needs, provided the mother is not deficient in vitamin A herself.
- The different nutrients mentioned above may not be easily available from the family diet. Continuing to breastfeed during the second year can help to prevent malnutrition, especially among children who are most at risk.

▸ Show **Slide 23/17 – Risks of artificial feeding** and make the points that follow:

23/17

Risks of artificial feeding

- Interferes with bonding
- More diarrhoea and persistent diarrhoea
- More frequent respiratory infections
- Malnutrition; vitamin A deficiency
- More allergy and milk intolerance
- Increased risk of some chronic diseases
- Obesity
- Lower scores on intelligence tests
- Mother may become pregnant sooner
- Increased risk of anaemia, ovarian cancer and breast cancer in the mother

- This slide summarizes the risks of artificial feeding.
- Artificial feeding may interfere with bonding. The mother and baby may not develop such a close, loving relationship.
- An artificially fed baby is more likely to become ill with diarrhoea or respiratory or other infections. The diarrhoea may become persistent.
- The baby may get too little milk and become malnourished because they receive too few feeds or because the feeds are too dilute. The baby is more likely to suffer from vitamin A deficiency.
- An artificially fed baby is more likely to die from infections than a breastfed baby, particularly in the first month of life.
- The baby is more likely to develop allergic conditions, such as eczema and possibly asthma.
- The baby may become intolerant of animal milk, so that the milk causes diarrhoea, rashes and other symptoms.
- The risk of some chronic diseases in the child, such as diabetes, is increased.
- The baby may get too much artificial milk, and become obese.
- The baby may not develop so well mentally, and may score lower on intelligence tests.
- A mother who does not breastfeed may become pregnant sooner. She is more likely to become anaemic after childbirth, and later to develop cancer of the ovary or the breast, and type 2 diabetes.
- So, artificial feeding may be harmful for children and their mothers.

▸ Show **Slide 23/18 – Terms for infant feeding** and make the points that follow:

23/18

Terms for infant feeding

▸ Ask participants to turn to page 148 of their *Participant's manual*, and to find the list TERMS FOR INFANT FEEDING.

▸ Ask participants in turn to read out from the list the definition of each term after you mention it.

Terms for infant feeding

- This slide illustrates the main terms to describe different ways of feeding infants.
- Baby 1 is **exclusively breastfed** (*a participant reads the definition*).
- Baby 2 is **predominantly breastfed**. He is breastfeeding, but there is also a small cup on the table with some water in it (*a participant reads the definition*).
- Both Baby 1 and Baby 2 are **fully breastfed** (*a participant reads the definition*).
- Baby 3 is **bottle fed** (*a participant reads the definition*).
- Baby 3 is also **artificially fed** (*a participant reads the definition*).
- The terms "bottle fed" and "artificially fed" are both necessary, because a baby may be fed breast milk from a bottle, or receive artificial feeds without a bottle, for example from a cup.
- Baby 4 is breastfeeding, but his mother also has a bottle of an artificial feed for him. He is **partially breastfed**, or **mixed fed** (*a participant reads the definition*).
- Baby 5 is more than 6 months old, and his mother is giving him some food in a bowl, in addition to breastfeeding him. This is introduction of complementary foods (*a participant reads the definition*).

Exclusive breastfeeding

Exclusive breastfeeding means giving a baby no other food or drink, not even water, in addition to breastfeeding (except medicines and vitamin or mineral drops; expressed breast milk is also permitted).

Predominant breastfeeding

Predominant breastfeeding means breastfeeding a baby, but also giving small amounts of water or water-based drinks – such as tea.

Full breastfeeding

Full breastfeeding means breastfeeding either exclusively or predominantly.

Bottle feeding

Bottle feeding means feeding a baby from a bottle, whatever is in the bottle, including expressed breast milk.

Artificial feeding

Artificial feeding means feeding a baby on infant formula milk, animal milk, or other drinks or foods such as dilute cereals, and not breastfeeding at all.

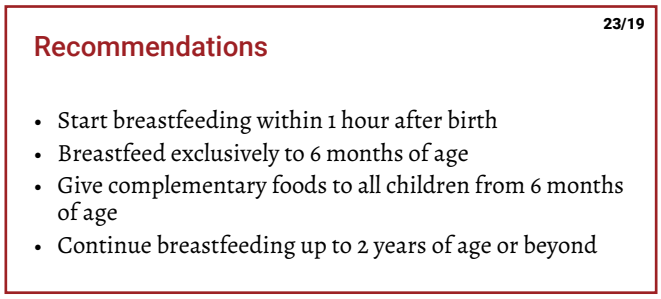
Partial breastfeeding, or mixed feeding

Partial breastfeeding or mixed feeding means giving a baby some breastfeeds and some artificial feeds, either milk or cereal, or other food.

Introduction of complementary foods

This means giving the baby solid, semi-solid or soft foods starting at 6 months of age.

- Show **Slide 23/19 – Recommendations** and make the points that follow:



  - This slide summarizes the current recommendations for feeding infants and young children. We call this "optimal infant and young child feeding".
  - Babies should have immediate skin-to-skin contact with their mothers, so that they can start to breastfeed within 1 hour after birth. They should not have any food or drink before they start to breastfeed, or before the mature milk "comes in".
  - Babies should be exclusively breastfed for the first 6 months of life.
  - All children older than 6 months should receive complementary foods.
  - Children should continue to breastfeed with complementary feeding up to 2 years of age or beyond.
- Explain that participants can find a box with these recommendations on page 149 of their *Participant's manual*.

VI. Answer participants' questions — 10 minutes

- Ask participants whether they have any questions on the information in **Slides 23/14** to **23/19** and the material that you have presented, and try to answer them.
- If they have questions about topics that will be covered in later sessions, give a brief answer, and explain that you will discuss the topic more fully later.

VII. Present Counselling cards 1 and 2 — 15 minutes

- Tell participants that they will review Counselling card 1: During the first 6 months, your baby needs only breast milk) and Counselling card 2: The importance of exclusive breastfeeding during the first 6 months.
- Model the use of Counselling card 1 to the entire group of participants – applying the steps: Assess, Analyse and Act.
- Write on a flipchart the word Assess and ask the following questions to the group:
  - *What do you see in this card?*
  - *What does each image represent?*
  - *What recommended practice(s) is shown?*
- Write on a flipchart the word Analyse and ask the following questions to the group:
  - *What do you think about this card?*
  - *Is there anything you disagree with – or think would not possible? Please explain.*
  - *What are the advantages of adopting the recommended practice(s)?*

- Write on a flipchart the word ACT and ask the following questions to the group:
  - *If mothers/caregivers in this community were in the same situation, would they be willing to try the recommended practice(s)? Why? Why not?*
  - *If YOU were the mother/caregiver, would YOU be willing to try the new practice(s)?*
  - *What difficulties might you experience?*
  - *How would you be able to overcome them?*
- Distribute and discuss HOW TO USE A COUNSELLING CARD from the *Guidance on the use of counselling cards*.
- Ask participants to form pairs; one participant from each pair will act as "counsellor" and demonstrate the use of COUNSELLING CARD 1 to the other participant "mother", applying the steps: ASSESS, ANALYSE and ACT.
- After 10 minutes, ask pairs to switch their roles and the "counsellor" will demonstrate the use of COUNSELLING CARD 2 to the other participant "mother", applying the steps: OBSERVE, THINK and TRY.
- Refer participants to the sections in the *Guidance on the use of counselling cards* on KEY PRACTICES AND DISCUSSION POINTS FOR COUNSELLING CARDS 1 and 2, and POSITIVE COUNSELLING SKILLS.

VIII. Summarize the session — 1 minute

- Ask participants whether they have any further questions, and try to answer them.
- Explain that a summary of this session can be found on pages 137–149 of the *Participant's manual.*

Further information

Sugar

The sugar lactose is the main carbohydrate in milk. None of the milks contain the carbohydrate starch. Starch is a very important nutrient for older children and adults – it is the main nutrient in staple foods, and in many complementary foods. But young babies cannot digest starch easily, so it is not appropriate to give them starchy foods in the first few months of life. Breast milk contains more lactose than other milks.

Protein

There is some casein in human milk, but less than in cow's milk, and it forms soft curds that are easier to digest.

The whey proteins in animal and human milks are different. Human milk contains alpha-lactalbumin and cow's milk contains beta-lactoglobulin.

In addition, the proteins in animal milks and formula milk contain a different balance of amino acids from breast milk, which may not be ideal for a baby. Animal milk and formula milk may lack the amino acid cystine, and formula milk may lack taurine, which neonates need especially for brain growth. Taurine is now sometimes added to formula milks.

The anti-infective proteins in human milk include lactoferrin (which binds iron, and prevents the growth of bacteria which need iron) and lysozyme (which kills bacteria), as well as antibodies (immunoglobulin, mostly IgA).

Other important anti-infective factors include the bifidus factor (which promotes the growth of *Lactobacillus bifidus*. *L. bacillus* inhibits the growth of harmful bacteria, and gives breastfed babies' stools their yoghurty smell). Breast milk also contains antiviral and antiparasitic factors.

Babies who develop intolerance to animal proteins may develop diarrhoea that becomes persistent. Babies who are fed animal milks or formula milk are also more likely than breastfed babies to develop allergies, which may cause eczema. A baby may develop intolerance or allergy after only a few artificial feeds given in the first few days of life.

Vitamins

The amounts of vitamins are different in breast milk and animal milks. Cow's milk has plenty of the B vitamins, but does not contain as much vitamin A and vitamin C as human milk. Breast milk contains plenty of vitamin A, if the mother has enough in her diet. Breast milk can supply much of the vitamin A that a child needs, even in the second year of life.

Vitamin A supplements for post-partum mothers

Do not give a mother high-dose capsules of vitamin A (over 10 000 units daily) for more than 4–6 weeks after she has given birth. After 6 weeks, there is a slight possibility that she could be pregnant, and if a high dose of vitamin A is given in early pregnancy, it could damage the fetus. High-dose vitamin A supplementation for post-partum mothers is no longer recommended by WHO nor provided in all countries.

B vitamins in different milks

For some B vitamins, the amount in human milk is the same as or more than in cow's milk, but for most of them the amount in cow's milk is 2–3 times higher than in breast milk. These high levels are more than a baby needs. Goat's milk lacks the B vitamin folic acid (vitamin B_{12}), and this can cause anaemia.

Vitamin C

Health workers often recommend giving babies fruit juice from a very early age, to provide vitamin C. This may be necessary for artificially fed babies, but it is not necessary for breastfed babies.

Iron

Different milks contain similar very small amounts of iron. However, only about 10% of the iron in cow's milk is absorbed, but about 50% of the iron from breast milk is absorbed. Babies fed on cow's milk may not get enough iron, and they often become anaemic.

Some brands of formula milk have iron added. This added iron is not well absorbed, so a large amount has to be added to ensure that a baby gets enough iron to protect against anaemia.

Added iron may make it easier for some kinds of bacteria to grow, which may increase the chances of some kinds of infection, for example, meningitis and septicaemia.

Foremilk and hindmilk

There is no sudden change from "fore" to "hind"milk. The fat content increases gradually from the beginning to the end of a feed.

Protection against infection

The main immunoglobulin in breast milk is IgA – often called "secretory" immunoglobulin A. It is secreted within the breast into the milk, in response to the mother's infections.

This is different from other immunoglobulins (such IgG), which are carried in the blood.

Intolerance and allergies to milk proteins

Colostrum and breast milk contain many hormones and growth factors. The function of all of them is not certain. However, epidermal growth factor, which is present in both, has been shown to stimulate growth and maturation of the intestinal villi. Undigested cow's milk proteins can pass through the immature infant gut into the blood, and may cause intolerance and allergy to milk protein. Epidermal growth factor helps to prevent the absorption of large molecules by stimulating rapid development of the gut. This "seals" the baby's intestine, so that it is more difficult for proteins to be absorbed without being digested.

Antibodies probably help to prevent allergies by coating the intestinal mucosa, and preventing the absorption of larger molecules.

Vitamin A from breast milk in the second year of life

There are different estimates of how much of a child's vitamin A requirements can be provided by breastfeeding in the second year, ranging from 38% to 75%. The amount depends on the mother's vitamin A status, and the volume of breast milk consumed. However, what we do know is that breastfeeding in the second year provides useful protection to the child against vitamin A deficiency.

Vitamin C from breast milk in the second year of life

Breast milk can provide almost all of the vitamin C that a child needs, provided the mother herself is not deficient.

Colostrum and breast milk contain many hormones and growth factors. The function of all of them is not certain. However, epidermal growth factor, which is present in both, has been shown to stimulate growth and maturation of the intestinal villi. Undigested cow's milk proteins can pass through the immature infant gut into the blood, and may cause intolerance and allergy to milk protein. Epidermal growth factor helps to prevent the absorption of large molecules by stimulating rapid development of the gut. This "seals" the baby's intestine, so that it is more difficult for proteins to be absorbed without being digested. Antibodies probably help to prevent allergies by coating the intestinal mucosa, and preventing the absorption of larger molecules. Bacteria also can pass through the immature gut into the tissues more easily than they can pass through the mature gut.

The *Lancet* series on Breastfeeding (2016)[1]

The *Lancet* Breastfeeding series shows why breastfeeding is one of the highest-impact interventions, providing benefits for children, women, and society. Breastfeeding reduces infant morbidity and mortality and is associated with increased intelligence quotient (IQ) score, improved school achievement, and higher adult earnings – all essential for reducing poverty. It also contributes to equity by giving all children a nutritional head start for success in life. For many people living in poverty, malnutrition remains a prime contributor to stunted development, and this Lancet series documents how breastfeeding can make a lasting difference. This series suggests that, alongside other factors, breastfeeding could have an important role in addressing inequality, by providing equal opportunity to all children to grow and contribute to national economies, and countries such as Bangladesh and Brazil show that it is possible to increase breastfeeding rates with comprehensive strategies. The evidence on breastfeeding leaves no doubt that it is a smart and cost-effective investment in a more prosperous future.

[1] Lancet series: Breastfeeding. Lancet. 2016;387:404–504.

Special issue of *Acta Paediatria*: Impact of breastfeeding on maternal and child health (2015)[1]

The papers presented here clearly demonstrate that breastfeeding protects against a spectrum of adverse health outcomes, over and above these traditional perspectives. In one of the papers, the authors document substantially higher rates of mortality among infants who were never breastfed, compared to those who were exclusively breastfed in the first 6 months of life and receiving continued breastfeeding beyond. Otitis media occurs nearly twice as frequently among those who are not exclusively breastfed in the first 6 months. The papers in this supplement demonstrate that many of the benefits of breastfeeding are experienced well beyond the period that breastfeeding is stopped. Children who were breastfed have a lower risk of obesity, higher IQs, reduced malocclusion and less asthma. Breastfeeding mothers likewise benefit from having breastfed, with lower rates of breast cancer, ovarian cancer, type 2 diabetes and postpartum depression. These multiple benefits of breastfeeding demonstrate the contribution and relevance of breastfeeding as a global public health issue, for low- and high-income populations alike. The mechanisms by which breastfeeding affect health are extremely varied; for example, many of the maternal benefits of breastfeeding are probably related to the hormonal effects of producing milk over a long period. For some outcomes in the child, the composition of the milk itself is probably important. Long-chain polyunsaturated fatty acids may be important for intellectual development; ghrelin and leptin in the milk may be important for appetite regulation; pathogen-specific antibodies may be important for protection against otitis media; and nonspecific immune factors may be important for asthma. On the other hand, the feeding of breast milk from a bottle or cup, rather than feeding directly from the breast, may be more important for outcomes such as malocclusion or obesity. Even when most of the infant's diet comes from breastfeeding, small amounts of breast-milk substitutes can substantially alter the intestinal flora, with health outcomes yet to be fully elucidated. Breastfeeding practices are responsive to interventions delivered in health systems, communities and homes. The largest effects are achieved when interventions are delivered in combination.

Notes

[1] Special issue: Impact of breastfeeding on maternal and child health. Acta Paed. 2015;104(Suppl. 467):1–134.

Notes (contd)

Notes (contd)

SESSION 24

How breastfeeding works 2

Objectives

After completing this session, participants will be able to describe:

- the relevant anatomy of the breast
- the physiology of the lactation hormones
- the physiology of breast-milk production and flow
- the suckling action of the baby when well attached and poorly attached
- the causes and effects of poor attachment
- reflexes in the baby related to breastfeeding

Session outline . . . . . 75 minutes

Participants are all together for a lecture presentation by one trainer.

I. Introduce the session, present **Slide 24/1** . . . . . 2 minutes
II. Present **Slides 24/2** to **24/13** and COUNSELLING CARD 3 . . . . . 70 minutes
III. Summarize the session . . . . . 3 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides.
- Study the **Slides 24/1** to **24/13** and the text that goes with them, so that you are able to present them.
- Have ready COUNSELLING CARD 3: GOOD ATTACHMENT, and the *Guidance on the use of counselling cards*
- Read the *Guidance on the use of counselling cards*, so you are familiar with the methodology to introduce the Counselling cards to participants.
- Read the **Further information** sections, so that you are familiar with the ideas that they contain, so that you can answer participants' questions.

As you follow the text, remember:

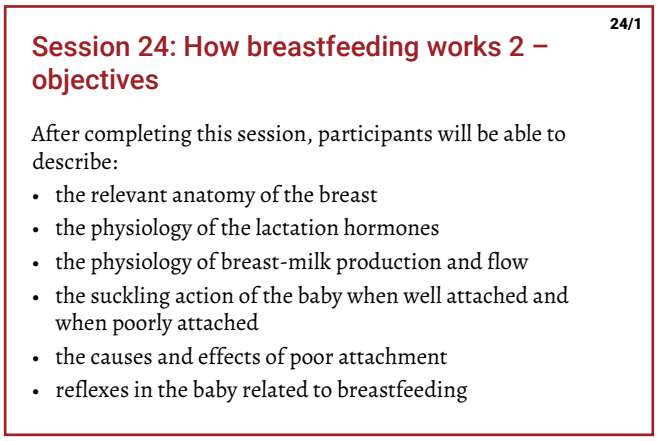
► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the session — 2 minutes

► Show **Slide 24/1 – Session 24 – objectives** and read out the objectives:



► Make these points:

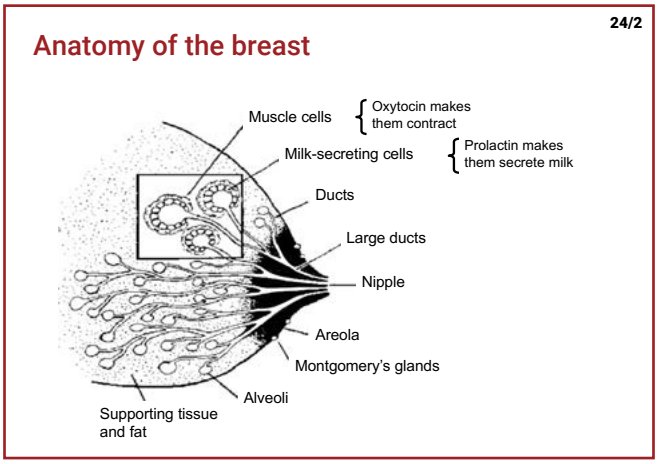
- In order to help mothers, you need to understand how breastfeeding works.
- In this session, we will review the anatomy and physiology of breastfeeding.
- You cannot learn a specific way of counselling for every situation, or every difficulty. But if you understand how breastfeeding works, you can work out what is happening, and help each mother to decide what is best for her.

II. Present **Slides 24/2 to 24/13** and COUNSELLING CARD 3 — 70 minutes

- **Ask participants to form four working groups, in which each group draws and labels:**
  - The breast as it looks on the outside.
  - The breast as it looks from the inside.

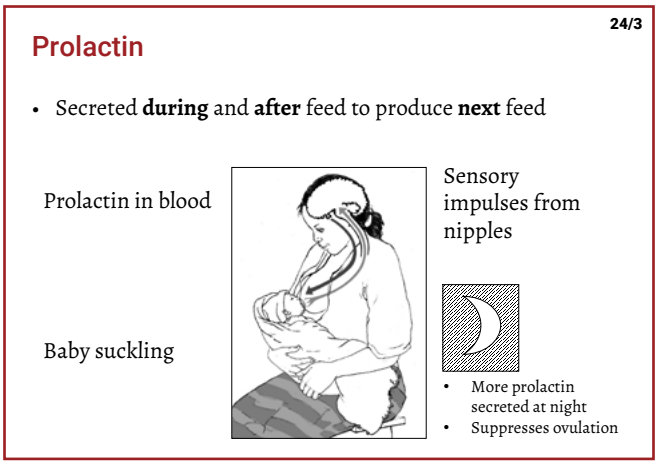
In the large group,

- **Ask one group to explain the outside drawing and others to comment.**
- **Ask another group to explain the inside drawing and others to comment.**
- **Show Slide 24/2 – Anatomy of the breast and compare drawings with the slide, noting similarities and correcting misinformation:**



- **Make the points that follow, as appropriate and to complement what was discussed in the large group.**
  - This diagram shows the anatomy of the breast.
  - First, look at the nipple, and the dark skin called the areola that surrounds it. In the areola are small glands called Montgomery's glands, which secrete an oily fluid to keep the skin healthy (clean and lubricated) (*point to the relevant parts of the diagram on the slide as you explain them*).
  - Inside the breast are the alveoli, which are very small sacs made of milk-secreting cells. There are millions of alveoli – the diagram shows only a few. The box shows three of the alveoli enlarged. A hormone called prolactin makes these cells produce milk.
  - Around the alveoli are muscle cells, which contract and squeeze out the milk. A hormone called oxytocin makes the muscle cells contract.
  - Small tubes, or ducts, carry milk from the alveoli to the outside. Between feeds, milk is stored in the alveoli and small ducts. The ducts join to form 7–10 larger ducts that pass through the nipple.
  - The larger ducts beneath the areola dilate during feeding and hold the breast milk temporarily during the feed.
  - The secretory alveoli and ducts are surrounded by supporting tissue and fat.
  - *Ask: Some mothers think their breasts are too small to produce enough milk. What is the difference between large breasts and small breasts?*
- **Wait for a few replies and then continue.**
  - It is the fat and other tissue that give the breast its shape, and that make most of the difference between large and small breasts.
  - Small breasts and large breasts both contain about the same amount of gland tissue, so they can both make plenty of milk.
- **Ask one of the working groups to explain how milk is produced; ask the other groups to add additional points.**

Show **Slide 24/3 – Prolactin** and make the points that follow:

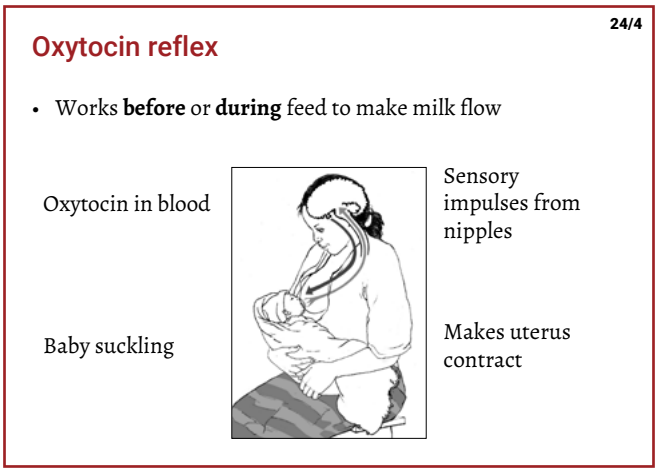


- This diagram explains about the hormone prolactin.
- The hormone prolactin is important to initiate, or start, milk production after delivery, and to sustain, or continue, milk production.
- The prolactin level is high in pregnancy, but it cannot make the cells secrete milk at that time, because the hormone progesterone blocks it. After delivery, progesterone decreases, and prolactin can start working. This makes milk production increase after delivery; 2–3 days postpartum, a mother notices that her breasts feel full, and we say that the milk has "come in". Remember from the previous session that before the milk "comes in", breasts produce milk called colostrum; the amount is small but it is all that the baby needs soon after delivery.
- When a baby suckles at the breast, sensory impulses go from the nipple to the brain. In response, the pituitary gland at the base of the brain secretes prolactin.
- Prolactin goes in the blood to the breast, and makes the milk-secreting cells produce milk.
- Most of the prolactin is in the blood about 30 minutes after the feed – so it makes the breast produce milk for the next feed. For this feed, the baby takes the milk that is already in the breast, stored in the alveoli and smaller ducts.
- *Ask: What does this suggest about how to increase a mother's milk supply?*

▶ **Wait for a few replies and then continue.**

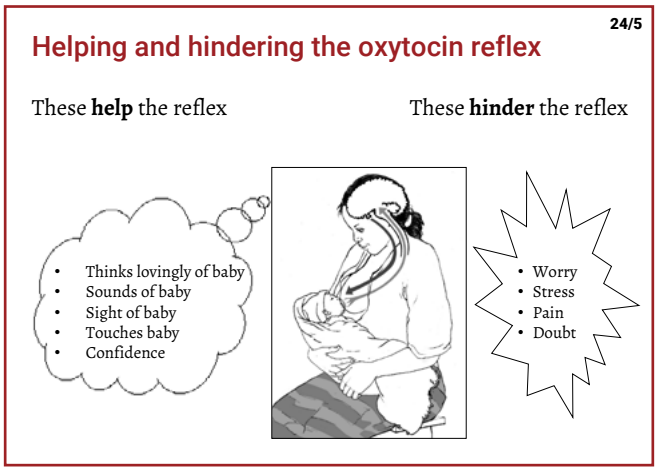
- It tells us that if her baby suckles more, her breasts will make more milk. So, suckling makes more milk.
- If a baby does not suckle enough, the prolactin level falls, and the breasts make less milk. This is most important in the first month or two after delivery, when milk production is adjusting to the baby's needs.
- If a mother has two babies, and they both suckle, her breasts make milk for two. If a baby stops suckling, the breasts soon stop making milk.
- Sometimes people suggest that, to make a mother produce more milk, we should give her more to eat, more to drink, more rest or medicines. It is important for a mother to eat and drink enough, but these things do not help her to produce milk if her baby does not suckle.
- Some special things to remember about prolactin are:
  - More prolactin is produced at night, when the mother is relaxed, so breastfeeding at night is especially helpful for keeping up the milk supply.
  - Prolactin makes a mother feel relaxed, and sometimes sleepy, so she usually rests well even if she breastfeeds at night.
  - Hormones related to prolactin suppress ovulation, so breastfeeding can help to delay a new pregnancy. Breastfeeding at night is important for this.

▶ Show **Slide 24/4 – Oxytocin reflex** and make the points that follow:



- This slide explains about the hormone oxytocin.
- When a baby suckles, sensory impulses go from the nipple to the brain. In response, the pituitary gland at the base of the brain secretes the hormone oxytocin.
- Oxytocin goes in the blood to the breast, and makes the muscle cells around the alveoli contract.
- This makes the milk that has collected in the alveoli flow along the ducts to the larger ducts beneath the areola. Here the milk is stored temporarily during the feed. This is the oxytocin reflex, the milk-ejection reflex or the "let-down" reflex.
- As the reflex works, the larger ducts beneath the areola fill with milk and increase in size. Sometimes the milk flows to the outside. Oxytocin is necessary to enable the baby to get the milk.
- Oxytocin is produced more quickly than prolactin. It makes the milk in the breast flow for **this** feed. Oxytocin can start working before a baby suckles, when a mother learns to expect a feed.
- If the oxytocin reflex does not work well, the baby may have difficulty in getting the milk. It may seem as if the breasts have stopped producing milk. However, the breasts are producing milk, but it is not flowing out.
- Another important point about oxytocin is that it makes a mother's uterus contract after delivery. This helps to reduce bleeding, but it sometimes causes uterine pain and a rush of blood during a feed for the first few days. The pains can be quite strong.
- Oxytocin is sometimes called "the love hormone" because it makes a mother feel loving towards her baby, and calm. This effect of oxytocin is important for bonding with the baby, and behaving in a motherly way. Mothers who bottle feed their babies may not have the same feelings.

- Show **Slide 24/5 – Helping and hindering the oxytocin reflex** and make the points that follow:



- This diagram shows how the oxytocin reflex is easily affected by a mother's thoughts and feelings.
- Good feelings, for example feeling pleased with her baby, or thinking lovingly of them, and feeling confident that her milk is the best for the baby, can help the oxytocin reflex to work and her milk to flow. Sensations such as touching or seeing her baby, or hearing the baby cry, can also help the reflex.
- But bad feelings, such as pain, or worry, or doubt that she has enough milk, can hinder the reflex and stop her milk from flowing.
- Acute stress, as in times of emergency, can also hinder the reflex. It may seem as if the breasts have stopped producing milk. However, the breasts are producing milk, but it is not flowing out, and it is difficult for the baby to get it. Fortunately, this effect is usually temporary, and can be overcome.
- The mother needs support and comfort to help her feel calmer. If the baby continues to suckle, her milk will flow again.
- *Ask: Why is it important to understand the oxytocin reflex in the way we care for mothers after delivery?*

► Wait for a few replies and then continue.

- **Key point:** A mother needs to have her baby near her all the time, so that she can see, touch and respond to them. This helps her body to prepare for a breastfeed, and it helps her breast milk to flow. If a mother is separated from her baby between feeds, her oxytocin reflex may not work so easily.
- **Key point:** You need to remember a mother's feelings whenever you talk to her. Try to make her feel good and build her confidence, to help her breast milk to flow well. Try not to say anything that may make her doubt her breast milk supply.
- Mothers are often aware of their oxytocin reflex. There are several signs of an active reflex that they, or you, may notice.

► Ask participants to turn to page 154 of their *Participant's manual*, and find the box SIGNS AND SENSATIONS OF AN ACTIVE OXYTOCIN REFLEX.

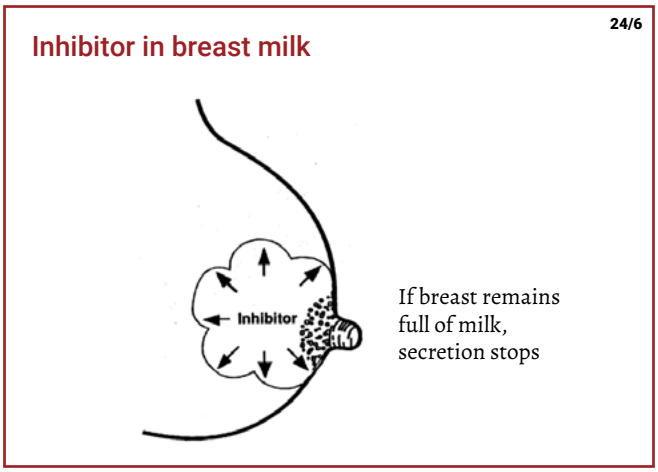
► Ask participants to take it in turns to read out the signs.

SIGNS AND SENSATIONS OF AN ACTIVE OXYTOCIN REFLEX

A mother may notice:

- A squeezing or tingling sensation in her breasts just before she feeds her baby, or during a feed
- Milk flowing from her breasts when she thinks of her baby, or hears him crying
- Milk dripping from her other breast, when her baby is suckling
- Milk flowing from her breasts in fine streams, if her baby comes off the breast during a feed
- Pain from uterine contractions, sometimes with a rush of blood, during feeds in the first week
- Slow deep sucks and swallowing by the baby, which show that breast milk is flowing into the baby's mouth

▸ Show **Slide 24/6 – Inhibitor in breast milk** and make the points that follow:



- Production of breast milk is also controlled within the breast itself.
- You may wonder why sometimes one breast stops making milk, while the other breast continues to make milk – although oxytocin and prolactin go equally to both breasts. This diagram shows why.
- There is a substance in breast milk that can reduce or inhibit production of milk.
- If a lot of milk is left in a breast, the inhibitor stops the cells from secreting any more. This helps to protect the breast from the harmful effects of being too full. This is obviously necessary if a baby dies or stops breastfeeding for some other reason.
- If breast milk is removed, by suckling or expression, the inhibitor is also removed. Then the breast makes more milk.
- This helps you to understand why:
  - If a baby stops suckling from one breast, that breast stops making milk.
  - If a baby suckles more from one breast, that breast makes more milk and becomes larger than the other.
- It also helps you to understand why:
  - For a breast to continue making milk, the milk must be removed.
  - If a baby cannot suckle from one or both breasts, the breast milk must be removed by expression to enable production to continue. This is an important point that we will discuss later in the course when we talk about expressing breast milk.
- This local control of breast-milk production is especially important after the first few weeks, when the level of prolactin decreases.
- *Ask: From what you have learnt so far, can you suggest what controls the production of milk?*

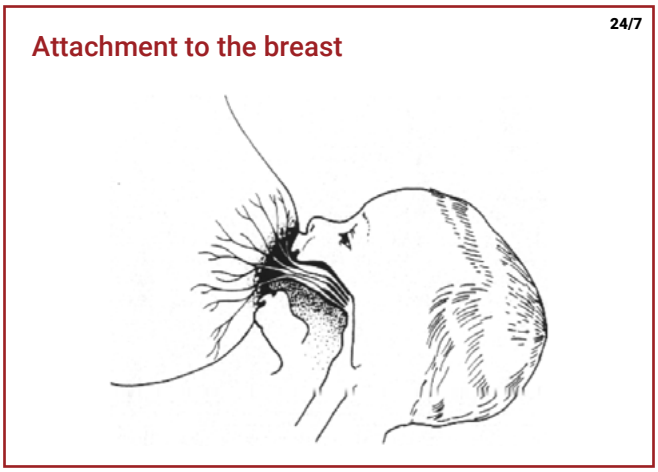
▸ Wait for a few responses and then continue.

- The baby's suckling makes the breasts produce milk.

▸ Make these points:

- **Key point:** For a mother to produce enough milk, her baby must suckle often and remove the milk. Her breasts will respond and produce as much milk as the baby takes.
- To remove the milk efficiently, it is necessary for the baby to suckle in the right way.
- If a baby cannot suckle, then the mother can remove her milk by expression. This also helps to keep up her milk production.

► Show **Slide 24/7 – Attachment to the breast** and make the points that follow:

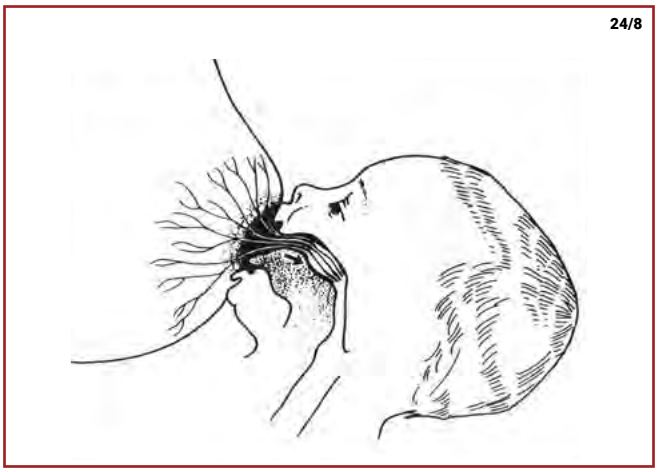


- This diagram shows how a baby takes the breast into his mouth to suckle.
- *Ask: What do you see?*

► Ask one participant to come to the screen to show how the baby takes the breast into their mouth.

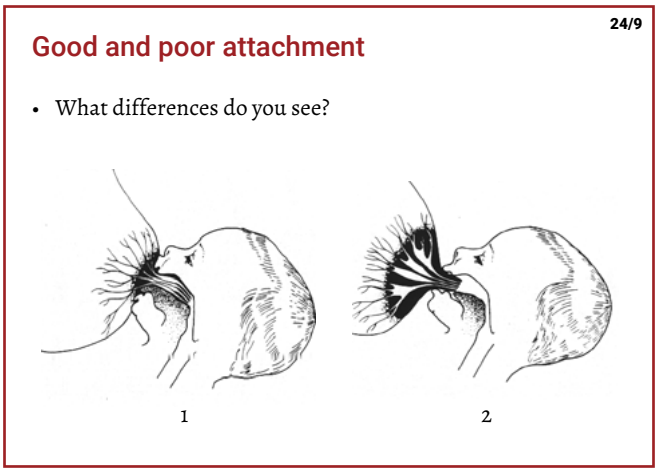
- Notice these points:
  - The baby has taken much of the areola and the underlying tissues into his mouth.
  - The larger ducts are included in these underlying tissues.
  - The baby has stretched the breast tissue out to form a long "teat".
  - The nipple forms only about one third of the "teat".
  - The baby is suckling from the breast, not the nipple.
- Notice the position of the baby's tongue:
  - The baby's tongue is forward, over the lower gums, and beneath the larger ducts.
  - The tongue is cupped round the "teat" of breast tissue. You cannot see that in this drawing, though you may see it when you observe a baby.
  - The tongue presses milk out of the larger ducts into the baby's mouth.
- If a baby takes the breast into their mouth in this way, we say that the baby is well attached to the breast. The baby can remove breast milk easily and we say that the baby is suckling effectively.
- When a baby suckles effectively, their mouth and tongue do not rub the skin of the breast and nipple.

▸ Show **Slide 24/8 – Attachment to the breast** and make the points that follow:



- This is the same baby as in **Slide 24/7**, and you can see what happens to the baby's tongue when he suckles.
- The arrow shows a wave going along the baby's tongue from the front to the back. The wave presses the "teat" of breast tissue against the baby's hard palate. This presses milk out of the larger ducts into the baby's mouth, from where he swallows it.
- So a baby does not simply suck milk out of a breast, like drinking through a straw.
- Instead:
  - The baby uses suction to stretch out the breast tissue to form a teat, and to hold the breast tissue in their mouth.
  - The oxytocin reflex makes breast milk flow and fill the ducts beneath the areola.
  - The action of the baby's tongue presses the milk from the ducts into their mouth.
- When a baby is well attached, they remove breast milk easily, and it is called effective suckling. You can often see and hear a baby swallowing the milk when suckling effectively.
- It is also helpful to understand that when a baby suckles in this way, the baby's mouth and tongue do not rub the skin of the breast and nipple.

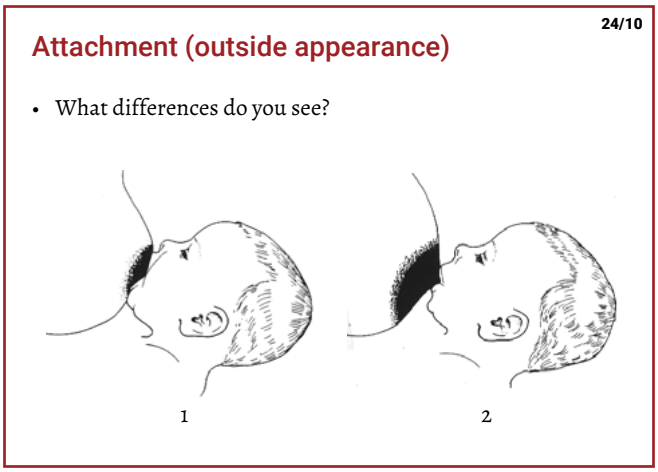
- Show **Slide 24/9 – Good and poor attachment** and make the points that follow:



  - Here you see two pictures. Picture 1 is the same baby as in **Slide 24/7**. He is well attached to the breast. Picture 2 shows a baby suckling in a different way.
  - *Ask: In what way is picture 2 different from picture 1?*

- Wait for a few replies and then continue.
- Make sure that the points below are clear.
- If participants notice signs that are described with **Slide 24/10**, accept their observations, but do not repeat or emphasize them yet.
  - The most important differences to see in picture 2 are:
    - Only the nipple is in the baby's mouth, not the underlying breast tissue.
    - The larger ducts are outside the baby's mouth, where his tongue cannot reach them.
    - The baby's tongue is back inside his mouth, and not pressing on the larger ducts.
  - The baby in picture 2 is poorly attached. He is "nipple sucking" and cannot suckle effectively.

▸ Show **Slide 24/10 – Attachment (outside appearance)** and make the points that follow:



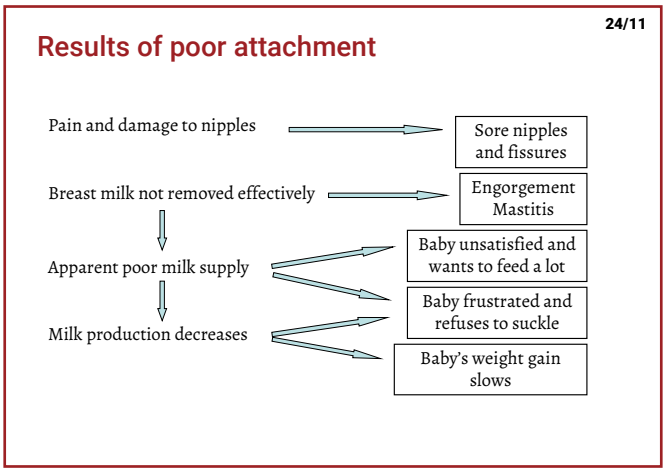
- This picture shows the same two babies from the outside.
- *Ask: What differences do you see between pictures 1 and 2?*

▸ Wait for a few replies and then continue.

- In picture 1, you can see more of the areola above the baby's top lip and less below his bottom lip. This shows that he is reaching with his tongue under the larger ducts to press out the milk. In picture 2, you can see the same amount of areola above his top lip and below his bottom lip, which shows that he is not reaching the larger ducts.
- In picture 1, his mouth is wide open. In picture 2, his mouth is not wide open and points forward.
- In picture 1, his lower lip is turned outwards. In picture 2, his lower lip is not turned outwards.
- In picture 1, the baby's chin touches the breast. In picture 2, his chin does not touch the breast.
- These are some of the signs that you can see from the outside that tell you that a baby is well attached to the breast.
- **Key point:** Seeing a lot of areola is not a reliable sign of poor attachment. Some mothers have a very large areola, and you can see a lot even if the baby is well attached. It is more reliable to compare how much areola you see above the baby's top lip and below their bottom lip.
- THE FOUR KEY SIGNS OF GOOD ATTACHMENT are:
  1. The baby's mouth is wide open.
  2. The baby's lower lip is turned outwards.
  3. The baby's chin is touching the mother's breast.
  4. More areola is seen above the baby's top lip than below the bottom lip.
- There are other differences that you can see when you look at a real baby, which you will learn about in the next sessions.
- Take out the COUNSELLING CARD 3: GOOD ATTACHMENT and look at the figure. How could you use the card to explain attachment to the mother?
- Wait for a few replies and then remind them of the steps ASSESS, ANALYSE and ACT and using them when counselling a mother. Ask them to look at the sections in the *Guidance on the use of counselling cards* on KEY PRACTICES AND DISCUSSION POINTS FOR COUNSELLING CARD 3 and on POSITIVE COUNSELLING SKILLS.
- *Ask: What do you think might be the results of poor attachment?*

▸ Wait for a few responses before showing the next slide.

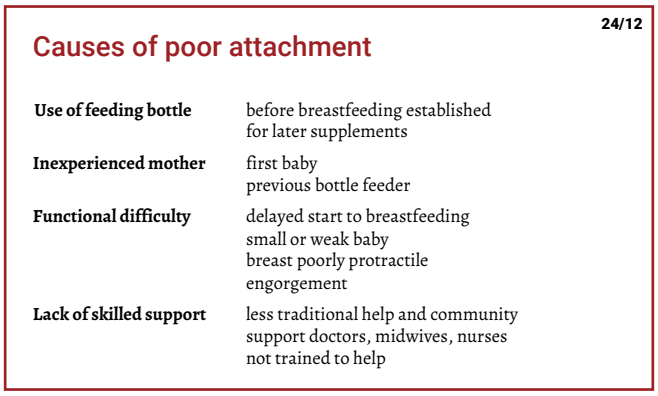
▶ Show **Slide 24/11 – Results of poor attachment** and make the points that follow:



- This diagram summarizes what may happen when a baby is poorly attached to the breast.
- The baby may cause pain and damage to the nipple.
- If a baby is poorly attached, and "nipple sucks", it is painful for the mother. Poor attachment is the most important cause of sore nipples.
- As the baby sucks hard to try to get milk, they pull the nipple in and out. This makes the nipple skin rub against the baby's mouth. If a baby continues to suck in this way, it can damage the nipple skin and cause cracks (also known as fissures).
- Suction pressure on the tip of the nipple can cause a fissure across the tip. Rubbing the skin at the base of the nipple can cause a fissure around the base.
- The baby does not remove breast milk effectively.
- If a baby is poorly attached, they do not remove breast milk effectively. The way that the baby suckles is called ineffective suckling. These can be the results:
  - The breasts may become engorged.
  - The baby may be unsatisfied, because the breast milk comes slowly.
  - The baby may cry a lot, and want to feed often, or for a very long time at each feed.
  - The baby may not get enough breast milk.
  - The baby may be so frustrated that they refuse to feed altogether.
  - The baby may fail to gain weight, so poor attachment can be a cause of slow growth.
  - If the oxytocin reflex works well, the baby may get enough breast milk at least for a few weeks, by feeding very often. But it can exhaust the mother.
  - The breasts may make less milk, because the milk is not removed.
- So poor attachment can make it **seem** as though a mother is not producing enough milk. In other words, she has an apparent poor milk supply. Then, if the situation continues, her breasts may really make less milk. In either situation, the result may be poor weight gain in her baby and breastfeeding failure.
- To prevent this happening, all mothers need skilled help to position and attach their babies.
- Also, babies should not be given feeding bottles. If a baby feeds from a bottle before breastfeeding is established, they may have difficulty suckling effectively. Even babies who start bottle feeds after a few weeks may also begin to suckle ineffectively.
- *Ask: What do you think are the reasons why a baby may be poorly attached?*

▶ Wait for a few replies and then show the next slide.

▸ Show **Slide 24/12 – Causes of poor attachment**:



▸ Discuss with participants the causes of poor attachment that they thought of and those that they did not think of.

- This slide summarizes the common causes of poor attachment to the breast.

▸ Use of a feeding bottle

- If a baby feeds from a bottle before breastfeeding is established, they may have difficulty suckling effectively from the breast. Some babies who start bottle feeds after a few weeks may also begin to suckle ineffectively. Skilled help is needed to overcome the problem. Sucking on a pacifier in the first few weeks may also interfere with breastfeeding.

▸ Inexperienced mother

- If a mother has not had a baby before, or if she bottle fed or had difficulties breastfeeding previous babies, she may have difficulty getting her baby well attached to her breast. Sometimes mothers are in a hurry or lack patience to wait for the baby to attach well.

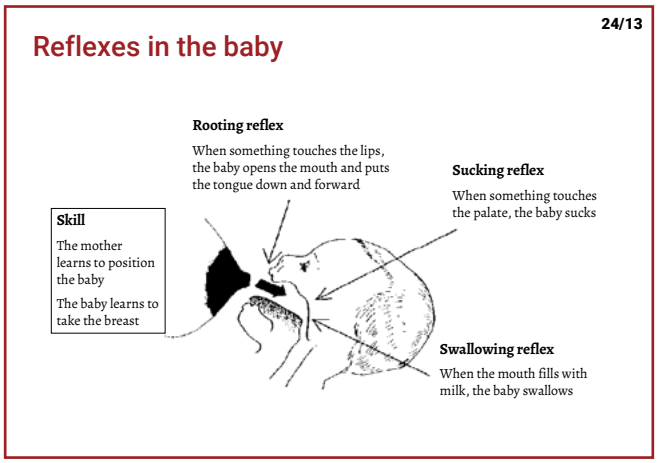
▸ Functional difficulty

- Some situations can make it more difficult for a baby to attach well to the breast.
- For example:
  - if there has been a delay in starting to breastfeed, for example, if the mother and baby were separated after birth, and did not have skin-to-skin contact in the first hour after birth
  - if a baby is very small or weak
  - if a mother's nipples and the underlying tissue are poorly protractile (difficult to stretch out to form a "teat" (see SESSIONS 19 and 28: BREAST CONDITIONS 1 and 2)
  - if her breasts are engorged.
- Mothers and babies can breastfeed in all these situations, but they may need extra skilled help to succeed.

▸ Lack of skilled support

- A very important cause of poor attachment is lack of skilled help and support.
- Some women are isolated, and lack support from the community. They may lack help from experienced women such as their own mothers, or from traditional birth attendants, who often are very skilled at helping with breastfeeding.
- Women in "bottle-feeding" cultures may be unfamiliar with how a breastfeeding mother holds and feeds her baby. They may never have seen a baby breastfeeding.
- Health workers who look after mothers and babies, for example doctors, nurses and midwives, may not have been trained to support mothers to breastfeed. Those who are trained may not have enough time to give as much help as mothers need.

- Show **Slide 24/13 – Reflexes in the baby** and make the points that follow:



- Earlier slides showed reflexes in a mother, but it is also useful to know about the reflexes in a baby. A reflex happens automatically, in response to a certain stimulus.
- There are three main reflexes concerned directly with suckling – the rooting reflex, the sucking reflex and the swallowing reflex.
- When something touches a baby's lips or cheek, the baby opens their mouth and may turn the head to find it. The baby puts the tongue down and forward. This is the "rooting" reflex. It should normally be the breast that the baby is "rooting" for.
- When something touches a baby's palate, they start to suck it. This is the sucking reflex.
- When the baby's mouth fills with milk, they swallow. This is the swallowing reflex.
- All these reflexes happen automatically without the baby having to learn to do them.
- Babies are born with many other reflexes, including putting their hands to their mouths and "massaging" the mother's breast with their hands. A baby also makes stepping and crawling movements when put on the mother's abdomen or chest, which help the baby to get to the breast to suckle. (See in SESSIONS 79 and 80: HEALTH-CARE PRACTICES 1 and 2 how a baby crawls to the breast after delivery.)
- A mother also has an instinct to hold her baby at the breast. If she holds them close to the breast and facing it, this stimulates the reflexes in the baby, which help the baby to attach well to the breast.
- With many mothers and babies, this happens easily and naturally. Most healthy term infants can attach themselves to the breast instinctively. The mother and baby must be kept together in a comfortable, supportive environment that helps the reflexes. Mothers need to learn how to avoid uncomfortable positions and ways of holding the baby that inhibit the reflexes.
- Health workers need not interfere if things are going well. But they should be aware of those mothers who do need help; for example, if they are in any of the situations mentioned in **Slide 24/11**, or if they are in an uncomfortable position that hinders the process. Also, some babies need more help than others to learn to attach and suckle effectively.
- Notice in the drawing that the baby is not coming straight towards the breast. He is coming up to it from below the nipple. A baby should, in fact, approach the breast with the nose opposite the nipple. This helps the baby to attach well because:
  - The nipple is aiming towards the baby's palate, so it can stimulate the sucking reflex.
  - The baby's lower lip is aiming well below the nipple, so the baby can get their tongue under the larger ducts.

III. Summarize the session 3 minutes

- Ask participants whether they have any questions, and try to answer them.
- Explain that a summary of this session can be found on pages 151–162 of the *Participant's manual*.

Further information

Prolactin and milk volume

Prolactin is most important for regulating milk production in the first month or two after delivery, while the volume of milk being produced is adjusting to the baby's needs. After this time, prolactin levels decrease, and other factors become more important. A baseline prolactin level continues to be necessary to enable lactation to continue, and the level increases during feeds. However, the relationship between the prolactin level and the volume of milk produced is not close. The onset of milk production is dependent on the high levels of prolactin following pregnancy, and on the fall in estrogen and progesterone levels. It is not dependent on the infant suckling. The continuation of milk production does depend on the infant suckling.

Suckling and ovulation

Prolactin itself does not suppress ovulation. Suckling suppresses production of gonadotrophin-releasing hormone, or GnRH, which is needed for release of the hormones that stimulate ovulation.

Attachment

The amount of areola that you see outside a baby's mouth may help you to compare the attachment of the same baby before and after you correct it. However, the first time that you see a baby, it is not a reliable sign. A mother may have a very small areola, which all goes inside the baby's mouth easily, or a very large areola, so that you can always see a lot outside.

Effective suckling

The point about frequent suckling being a result of ineffective suckling may seem to contradict the idea that "more suckling makes more milk". More suckling makes more milk if a baby is well attached, suckling effectively and allowed to finish a feed, so that they remove the milk. In this case, if the baby suckles more often, the breasts will make more milk.

A baby who is suckling effectively may not want to feed very often, though the interval between feeds may be irregular. If a baby wants to feed more often than about every 1–1½ hours, it is likely that they are either not well attached, or are having very short feeds, so that they are not removing much milk. Increased frequency of suckling will not make more milk for the baby, until the other conditions are corrected. See also Session 34: Not enough milk.

Sucking/suckling

The term "**suckling**" is usually used when referring to a baby feeding from the breast. The term "**sucking**" is used when referring to a baby feeding from a bottle. However, note that the reflex referred to on page 312 (page 162 in the *Participant's manual*) is known as the "**sucking reflex**", as it refers to anything that touches the baby's palate.

Notes

SESSION 25

Assessing a breastfeed 2

Objectives

After completing this session, participants will be able to:

- explain the contents and arrangement of the JOB AID: BREASTFEED OBSERVATION
- describe how to assess a breastfeed using the JOB AID: BREASTFEED OBSERVATION
- describe how to recognize a mother who needs help

Session outline . . . . . 60 minutes

Participants are all together for a lecture presentation by one trainer.

I. Introduce the session, present **Slide 25/1** . . . . . 5 minutes
II. Demonstrate and explain how to assess a breastfeed (DEMONSTRATION 25.A) . . . . . 40 minutes
III. Answer participants' questions . . . . . 5 minutes
IV. Explain the JOB AID: BREASTFEED OBSERVATION . . . . . 10 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides and giving a demonstration.
- For **Section II**, points 1 and 2
  - Ask two participants to help you with the DEMONSTRATION 25.A.
  - Give them a copy of the scenarios for mothers A and B for them to act.
  - Explain what you want them to do, and help them to practise.
  - Make sure that they have dolls for the demonstration (see page 12 for instructions on HOW TO MAKE A MODEL DOLL), and that you have pillows and a blanket and somewhere for the "mother" to lie down, e.g. a bed or a table.
  - If you feel on the first day of the course that participants cannot do this, ask other trainers to help instead.
- Points 4–6
  - Make sure that you have a model breast available (see page 12 for instructions on HOW TO MAKE A MODEL BREAST).
- Make sure you have **Slide 25/1** ready; for point 6, have **Slide 24/10** ready to show again if necessary.
- Have ready COUNSELLING CARD 3: GOOD ATTACHMENT, and the *Guidance on the use of counselling cards*.
- Read the **Further information** sections, so that you are familiar with the ideas that they contain, so that you can answer participants' questions.

As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the session — 5 minutes

► Show **Slide 25/1 – Session 25 – objectives** and read out the objectives:

25/1

Session 25: Assessing a breastfeed 2 – objectives

After completing this session, participants will be able to:

- explain the contents and arrangement of the JOB AID: BREASTFEED OBSERVATION
- describe how to assess a breastfeed using the JOB AID: BREASTFEED OBSERVATION
- describe how to recognize a mother who needs help

► Make these points:

- Assessing a breastfeed helps you to decide whether a mother needs help or not, and how to help her.
- You can learn a lot about how well or badly breastfeeding is going by observing, before you ask questions.
- This is just as important a part of clinical practice as other kinds of examination, such as looking for signs of dehydration, or counting how fast a child is breathing.
- There are some things you can observe when a baby is not breastfeeding. Other things you can only observe if a baby is breastfeeding.

► Ask participants to turn to page 165 of their *Participant's manual* and find the list of points HOW TO ASSESS A BREASTFEED.

► Ask them to read out the points in turn.

II. Demonstrate and explain how to assess a breastfeed — 40 minutes

► Ask them to keep the list in front of them and to refer to it as you explain the points.

HOW TO ASSESS A BREASTFEED

1. Look at the mother herself
2. Look at how the mother holds her baby
3. Look at the baby's condition
4. Observe how the baby responds to the breast
5. Observe how the mother holds her breast for the baby
6. Observe the baby's attachment and suckling
7. Notice how the breastfeed finishes
8. Observe the condition of the mother's breasts

► Demonstrate and discuss each point in turn.

► Ask two participants to hold dolls to play the role of mothers and babies in the following demonstration. Let them choose names for themselves and their babies.

DEMONSTRATION 25.A ASSESSING A BREASTFEED

Mother A	Mother B
Sits comfortably and relaxed	Uncomfortable and tense
Happy and pleased with the baby	Sad and not interested in the baby
Looks at the baby, talks to her	Looks away from the baby, does not talk to her
Fondles and touches the baby lovingly	Does not touch the baby lovingly
Holds the baby close, facing her breast	Holds the baby loosely, turned away, neck twisted
Supports the baby's whole body	Supports only the baby's head and shoulders
Holds the baby calmly and securely and looks confident	Holds the baby nervously, not looking confident
	May shake or prod the baby to make her suckle

- **Ask the other participants to observe the "mothers" and "babies".**
- **Ask them to notice the differences between the mothers, and to think about how this might affect breastfeeding.**
- **Ask the following questions. Give participants a few minutes to make some suggestions. Help them to think of the points listed after the questions. Indicate which points the "mothers" are acting, and which they cannot act.**

Point 1. Look at the mother herself

- *Ask: What do you see that tells you how mother A and mother B are feeling? How may this affect breastfeeding?*
- You can see that:

Mother A	Mother B
Sits comfortably and relaxed	Is uncomfortable and tense
Is happy and pleased with the baby	Is sad and not interested in the baby

- Being happy and comfortable (mother A) helps breastfeeding.
- Being miserable and uncomfortable (mother B) makes breastfeeding difficult.

- You can see that:

Mother A	Mother B
Looks at the baby, talks to her	Looks away from the baby, does not talk to her
Fondles and touches the baby lovingly	Does not touch the baby lovingly

- Touching and talking to her baby (mother A) are signs of bonding.
- Not looking at, touching or talking to her baby (mother B) are signs that she may not have bonded well.
- Bonding with the baby means that breastfeeding is more likely to go well.
- *Ask: What may you notice about a mother's general appearance that tells you about her life situation?*
- You may notice:
  - Her age, general health, nutrition and socioeconomic status.
  - This may tell you whether it is easy or difficult to care for and breastfeed her baby. (Clothes may be misleading if women dress up to go to a health centre.)

- *Ask: What other things may you notice that can be important for breastfeeding?*
- There may be other family members present, such as the father or grandmother. You may be able to observe how they relate to the mother and baby.
- The mother or other family member may be carrying a feeding bottle in their bag.
- The mother may wear tight clothes that make it difficult to breastfeed.

Point 2. Look at how the mother holds her baby

- *Ask: What do you notice about how mothers A and B hold their babies? How do these ways of holding a baby affect breastfeeding?*

Mother A	Mother B
Her baby's body and neck are **straight**	Her baby's head and neck are twisted or bent
The baby is **facing** her breast	The baby's body is turned away
She holds the baby **close**	She holds the baby loosely

- You may notice that:
  - It is easier for baby A to suckle effectively, and more difficult for baby B.

Mother A	Mother B
Supports the baby's whole body	Supports only the baby's head and shoulders

- Supporting a young baby's whole body makes it easier to attach to the breast.
- Supporting only the head and shoulders makes it more difficult.
- (Supporting the whole body is less important after the first few months.)
- **Key point:** These four signs – the baby is **straight, close, supported** and **facing the breast** summarize THE FOUR KEY SIGNS OF GOOD POSITIONING. We will discuss them more in SESSION 27: POSITIONING A BABY AT THE BREAST.

Mother A	Mother B
Holds the baby calmly, securely and looks confident	Holds the baby nervously, not looking confident May shake or poke the baby to make her suckle

- Mother B's nervousness may upset her baby and interfere with suckling and flow of breast milk.
- It is easier for mother A's baby to get enough milk.

► **Ask the two "mothers" to stay while participants think about the next two points.**

Point 3. Look at the baby's condition

- *Ask: What might you notice about the baby's condition?*
- You may notice that the baby looks:
  - average size or very small or large
  - generally healthy and hydrated
  - well nourished or poorly nourished
  - alert, asleep or unconscious
  - obviously abnormal (for example with cleft lip).

- You may notice signs of conditions that can interfere with breastfeeding:
  - blocked nose
  - difficult breathing
  - thrush
  - jaundice
  - dehydration
  - tongue tie
  - a cleft lip or palate.

Point 4. Observe how the baby responds to the breast

- **Explain that you want participants to recall how they have observed babies responding at the breast.**
- **Use a doll and either a model breast or your own body to imitate the different ways in which a baby may respond at the breast and demonstrate the responses while you ask the questions.**
- **Or ask another trainer to demonstrate while you talk.**
  (It is only possible to demonstrate the responses partially, but it helps participants to understand the points you are making.)
  - *Ask: What do the following signs show?*
  - You may see a baby respond in these ways:
    1. A young infant may "root" or search for the breast. The baby turns the head from side to side, opens the mouth, puts the tongue down and forward, and reaches for the breast.
       Answer: This shows that the baby is hungry and wants a feed.
    2. An older baby may turn and reach for the breast with their hand.
       Answer: This shows that the baby wants to breastfeed.
    3. A baby may cry or pull back or turn away from their mother.
       Answer: This response shows that a baby does not want to breastfeed, and that there is a problem with breastfeeding.
    4. A baby may be restless and slip off the breast or refuse to feed.
       Answer: This may mean that the baby is not well attached and is not getting the breast milk.
    5. A baby may be calm during a feed, and relaxed and contented after a feed.
       Answer: These are signs that the baby is getting enough breast milk.
- **Thank the participants who played the two mothers. They can return to the class.**

Point 5. Observe how the mother holds her breast for the baby

- **Explain that you want participants to recall how they have seen mothers holding their breasts.**
- **Give them a model breast and ask them to show you what they have seen.**
- **Then, demonstrate the points with a model breast, or ask another trainer to do so while you ask the questions.**
  - *Ask: How may a mother hold her breast during a feed? How does this affect a baby suckling and getting breast milk?*
  - You may notice that:
  - She holds her breast very close to the areola.
    - Her fingers may get in the way of the baby suckling, so it is more difficult to take enough of the breast into the baby's mouth.
    - The pressure of her fingers may block the milk ducts.

- She holds her breast with the "scissor" hold.
  - The "scissor" hold is when the mother holds the nipple and areola between her index finger above and middle finger below.
  - If her fingers are close to the nipple, they may get in the way of the baby suckling, and block the milk ducts.
- She may try to pinch up her nipple to push it into her baby's mouth.
  - She may lean forward to do this.
  - This is not an effective way of getting a baby to attach, and pinching the nipple makes it the wrong shape for a baby and may block the milk ducts.
  - If she leans forward, she may get back pain.
- She may hold her breast back from her baby's nose with her finger.
  - This is not necessary, and may pull the nipple out of the baby's mouth.
- *Ask: How can a mother hold her breast to make it easier for her baby to suckle?*
- She can put her whole hand flat against her chest wall beneath the breast, supporting the breast with her forefinger.
- She can use her thumb above the breast a long way back from the nipple, to shape her breast. This is sometimes called the "C-hold".
- Some mothers do not need to hold the breast at all, especially when the breasts are not too large. It is not necessary to correct the breast hold if the baby is well attached and suckling effectively, provided the mothers fingers are not too close to the nipple.

Point 6: Observe the baby's attachment and suckling

- Remind participants that this was explained in SESSION 24: HOW BREASTFEEDING WORKS 2.
- Show **Slide 24/10** of that session again, or ask participants to look at the figure in their *Participant's manual*.
  - *Ask: Which signs of good attachment can you see (**Slide 24/10**, figure 1)?*
  - The baby's mouth is wide open.
  - The baby's lower lip is turned outwards.
  - The baby's chin is touching the mother's breast.
  - More areola is seen above the baby's top lip than below the bottom lip.
  - *Ask: Which signs of poor attachment can you see (**Slide 24/10**, figure 2)?*
  - The baby's mouth is not wide open
  - The baby's lips point forward or the lower lip is turned in.
  - The baby's chin is not touching the mother's breast.
  - More areola is seen below the baby's bottom lip than above the top lip, or the same amount can be seen above and below.
- Review COUNSELLING CARD 3: GOOD ATTACHMENT and The four signs of good attachment: Ask participant "mothers" to point to themselves and name in sequence: (1) the baby's mouth is wide open; (2) the baby's lower lip is turned outwards; (3) the baby's chin is touching the mother's breast; and (4) more of the darker skin (areola) is seen above the baby's top lip than below the bottom lip.
  - *Ask: How can you tell if the baby is suckling effectively?*

- **Ask participants what they learned about effective suckling from SESSION 24: HOW BREASTFEEDING WORKS 2.**
- **Give the following demonstrations as you explain:**
  To demonstrate effective suckling
  Suck on your fist, with your mouth open wide, your tongue forward, and your lower lip curled back. Give slow deep sucks, about 1 per second.
- ***To demonstrate ineffective suckling:***
  Suck on your thumb, with your mouth almost closed, your lips pointing forward, and letting your cheeks pull in. Give quick, small sucks.
  - These are signs of **effective** suckling:
    - The baby takes slow deep sucks.
    - Then the baby pauses and waits for the ducts to fill up again.
    - Then the baby takes a few quick sucks to start the milk flow.
    - As the milk flows, the sucks become deeper and slower again.
    - You may see or hear swallowing.
    - The baby's cheeks are round.
  - Signs of effective suckling show that the baby is getting plenty of breast milk.
  - These are signs of **ineffective** suckling:
    - The baby takes quick shallow sucks all the time.
    - The baby may make smacking sounds as they suck.
    - The baby's cheeks may be tense or pulled in as they suck.
  - Signs of ineffective suckling show that the baby is not getting much breast milk.

Point 7. Notice how the breastfeed finishes

- *Ask: What might you observe at the end of a breastfeed?*
- You may see the baby ending the feed themself.
  - The baby releases the breast themself, and looks satisfied and sleepy.
  - These are signs that the baby has taken enough milk from that breast.
  - The baby may or may not want to suckle from the other side too.
- You may see the mother ending the feed before the baby has finished.
  - A mother sometimes takes her baby off her breast as soon as they pause, because she thinks the baby has finished, or because she wants to make sure that the baby suckles from the other side as well, or because she wants to do something else.
  - A baby who is taken off the breast before they have finished may not get enough hindmilk. The baby may want to feed again soon.
- You may notice how long the breastfeed continued.
- *Ask: How long should a breastfeed continue?*
- The exact length of time is not important.
- Feeds normally vary very much in length, from a few minutes to half an hour.
- If breastfeeds are very long (more than about half an hour) or very short (less than about 4 minutes), it may mean that there is a difficulty, perhaps with attachment.
- However, in the first few days, or with a low-birth-weight baby, breastfeeds may be very long with many pauses, and this is normal.

► **Ask participants if they have any questions about the issues just discussed, and try to answer them. Ask whether they have met mothers with concerns about how long a breastfeed should last, or whether to take the baby off the breast.**

Point 8. Observe the condition of the mother's breasts

- *Ask: What would you look for when you observe the mother's breasts?*
- Notice the size and shape of her breasts and nipples:
  - A mother may worry that her breasts are too large or too small, or that her nipple may be flat or too large and difficult for a baby to suckle from.
  - She may lack confidence in her ability to breastfeed.
  - You need to be ready to reassure her that there should be no difficulty, or to help her if there might be a difficulty (see SESSIONS 19 and 28: BREAST CONDITIONS 1 and 2).
- Look and ask for signs of an active oxytocin reflex:
  - Milk dripping or spraying out of a mother's breasts.
  - This shows that she has an active oxytocin reflex.
  - If milk does not flow out, however, it does not mean that her reflex is not active.
  - Uterine pains during breastfeeds for the first few days.
  - These are called afterpains. They are another sign of an active oxytocin reflex.
- Look also for these signs:
  - Breasts that are full before and soft after a feed, showing that the baby is removing breast milk.
  - Breasts that are very full or engorged all the time, showing that the baby may not be removing breast milk effectively.
  - Healthy-looking skin of the nipples and breast.
  - Red skin or fissures, which show that there is a problem.
  - A nipple that looks squashed or with a line across the tip or down the side as the baby releases the breast. This is a sign of poor attachment (see SESSIONS 19 and 28: BREAST CONDITIONS 1 and 2).
- **Key point:** Always ask the mother how the breastfeed feels to her:
  - If it is comfortable and pain free, her baby is probably well attached.
  - If it is uncomfortable or painful, the baby is probably not well attached.

III. Answer participants' questions — 5 minutes

► **Ask participants whether they have any questions about assessing a breastfeed, and try to answer them.**

IV. Explain the Job aid: Breastfeed observation — 10 minutes

- **Ask participants to turn to page 170 of their *Participant's manual*, where they will find the Job aid: Breastfeed observation.**
- **Introduce the form:**
  - This is called the Job aid: Breastfeed observation. It summarizes the key points for assessing a breastfeed. You will use this form to practise observing breastfeeds with mothers and babies.
- **Ask participants to read through the form, and to ask whether there are any signs that they are not yet clear about (allow 5 minutes).**
- **Explain the form: ask participants to study the form as you make these points:**
  - The signs are in six groups: general signs of the mother, and of the baby; condition of the breasts; the baby's position; the baby's attachment; and suckling. There are three signs each for mother and baby, and four signs in each of the other groups.
  - Try to remember the groups, as it will help you to remember the signs with each group. Then, later on, when you have had more practice, you will not need to use the form all the time.
  - Notice that the signs on the left all show that breastfeeding is going well. The signs on the right indicate a possible difficulty.
  - Beside each sign is a box to mark with a tick if you have seen the sign in the mother and baby that you are observing.
- **Explain how to use the form:**
  - As you observe a breastfeed, mark a tick in the box for each sign that you observe. If you do not observe a sign, you should make no mark.
- **Explain how to interpret the form:**
  - If all ticks are on the left-hand side of the form, breastfeeding is probably going well.
  - If there are some ticks on the right-hand side, then breastfeeding may not be going well. This mother may have a difficulty, and she may need your help.

Job aid: Breastfeed observation

Mother's name: **Date:**

Baby's name: **Baby's age:**

Signs that breastfeeding is going well:	Signs of possible difficulty:
GENERAL	
Mother:	**Mother:**
☐ Mother looks healthy	☐ Mother looks ill or depressed
☐ Mother relaxed and comfortable	☐ Mother looks tense and uncomfortable
☐ Signs of bonding between mother and baby	☐ No mother/baby eye contact
Baby:	**Baby:**
☐ Baby looks healthy	☐ Baby looks sleepy or ill
☐ Baby calm and relaxed	☐ Baby is restless or crying
☐ Baby reaches or roots for breast if hungry	☐ Baby does not reach or root
BREASTS	
☐ Breasts look healthy	☐ Breasts look red, swollen, or sore
☐ No pain or discomfort	☐ Breast or nipple painful
☐ Breast well supported with fingers away from nipple	☐ Breasts held with fingers on areola
BABY'S POSITION	
☐ Baby's head and body in line	☐ Baby's neck and head twisted to feed
☐ Baby held close to mother's body	☐ Baby not held close
☐ Baby's whole body supported	☐ Baby supported by head and neck only
☐ Baby approaches breast, nose to nipple	☐ Baby approaches breast, lower lip/chin to nipple
BABY'S ATTACHMENT	
☐ Baby's mouth open wide	☐ Baby's mouth not open wide
☐ Lower lip turned outwards	☐ Lips pointing forward or turned in
☐ Baby's chin touches breast	☐ Baby's chin not touching breast
☐ More areola seen above baby's top lip	☐ More areola seen below bottom lip
SUCKLING	
☐ Slow, deep sucks with pauses	☐ Rapid shallow sucks
☐ Cheeks round when suckling	☐ Cheeks pulled in when suckling
☐ Baby releases breast when finished	☐ Mother takes baby off the breast
☐ Mother notices signs of oxytocin reflex	☐ No signs of oxytocin reflex noticed

Further information

"Gulping" as a baby swallows

Gulps are very loud swallowing sounds, when a lot of fluid is being swallowed at once. This is a sign that a baby is getting a lot of milk. It sometimes means that the mother has an oversupply, and her baby is getting too much milk too fast. Oversupply is sometimes the cause of breastfeeding difficulties (see SESSION 35: CRYING).

These points may help you to answer questions about the JOB AID: BREASTFEED OBSERVATION that arise later, as participants practise using it in clinical practice sessions.

- The negative signs, such as "no signs of milk ejection", and "cannot see tongue", do not necessarily mean that there is a difficulty. However, the opposite positive signs are always helpful.
- If a mother says that breastfeeding is going well, but you see signs that indicate a possible difficulty, you must decide what to do.

In the days soon after delivery, while the mother is still learning, offer to help her. Even if she is not aware of any difficulty now, you may prevent one occurring later.

If breastfeeding seems to be well established, you probably do not want to intervene immediately. It is usually more helpful to see her again soon, and follow the baby's growth, to make sure that breastfeeding continues to go well. Intervene only if a difficulty arises.

Notes

Notes (contd)

SESSION 26

Observing a breastfeed

Objectives

After completing this session, participants will be able to:

- recognize THE FOUR KEY SIGNS OF GOOD ATTACHMENT
- recognize good and poor positioning of the baby according to THE FOUR KEY SIGNS OF GOOD ATTACHMENT
- assess a breastfeed using the JOB AID: BREASTFEED OBSERVATION
- recognize a mother who needs help, using the JOB AID: BREASTFEED OBSERVATION

Session outline . . . . . 60 minutes

Participants are all together for a lecture presentation and exercise led by one trainer.

All trainers help to give individual feedback on the exercise.

I. Introduce the session, present **Slide 26/1** . . . . . 4 minutes
II. Present **Slides 26/2** to **26/12**. . . . . 35 minutes
III. Practise using the JOB AID: BREASTFEED OBSERVATION (EXERCISE 26.A, **Slides 26/13** to **26/16**) . . . . . 20 minutes
IV. Summarize the session . . . . . 1 minute

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides.
- Study the **Slides 26/1** to **26/16** and the text that goes with them, so that you are familiar with what each slide shows and the particular points to teach from them.
- At the beginning of the session, ask participants to arrange their seats so that they are sitting in a half circle near to the screen, without tables or other obstruction in front of them. They need to be able to go to the screen to point out appearances on the slides.
- Put a seat for yourself to sit with the participants, so that you do not stand up in front to lecture.
- Have ready COUNSELLING CARD 3: GOOD ATTACHMENT, and the *Guidance on the use of counselling cards*.
- Read the **Further information** sections, so that you are familiar with the ideas that they contain, so that you can answer participants' questions.

As you follow the text, remember:

► **indicates an instruction to you, the trainer.**

¤ indicates what you say to participants.

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the session — 4 minutes

- Show **Slide 25/1 – Session 25 – objectives** and read out the objectives:

> 26/1
>
> **Session 26: Observing a breastfeed – objectives**
>
> After completing this session, participants will be able to:
> - recognize THE FOUR KEY SIGNS OF GOOD ATTACHMENT
> - recognize good and poor positioning of the baby according to THE FOUR KEY SIGNS OF GOOD POSITIONING
> - assess a breastfeed using the JOB AID: BREASTFEED OBSERVATION
> - recognize a mother who needs help, using the JOB AID: BREASTFEED OBSERVATION

- Make these points:
  - You will now see a series of slides of babies breastfeeding.
  - You will practise recognizing the signs of good or poor attachment and positioning shown in the slides, and you will practise using the JOB AID: BREASTFEED OBSERVATION.
  - You will not be able to see all of the signs in the slides. For example, you cannot see signs with movement in slides, and you may not be able to see the position of a baby's body clearly, but you can see how they are attached.
  - Observe the signs that are clear, and do not worry about signs that you cannot see. However, when you see real mothers and babies, you should look for all the signs.

II. Show and discuss slides 26/2 to 26/12 — 35 minutes

- Ask participants to keep their *Participant's manual* closed during this part of the session.
- Explain what to do:
  - As you look at each slide:
    - Decide which signs of good or poor attachment you see.
    - Decide whether you think the baby's attachment is good or poor.
    - Notice whether there are any signs of good or poor positioning shown.
  - Look at the JOB AID: BREASTFEED OBSERVATION. Remember that there are FOUR KEY SIGNS OF GOOD ATTACHMENT:
    1. The baby's mouth is wide open.
    2. The baby's lower lip is turned outwards.
    3. The baby's chin is touching the mother's breast.
    4. More areola is seen above the baby's top lip than below the bottom lip.
  - **Key point:** To say that a baby is well attached, all four of the signs must be good. But if any ONE of the signs is NOT good, then the baby is poorly attached.
  - You may also see that the baby's cheeks are rounded or pulled in.
  - Rounded cheeks are a sign of effective suckling.
  - If the cheeks are pulled in, it is a sign of ineffective suckling.
  - You cannot see the other "suckling" signs in a still photograph.
  - You may see some signs of the "baby's position".
- Ask a different participant to come forward for each of the **Slides 26/2** to **26/12**.
- As you show each slide:

- *Ask: What do you think of this baby's attachment (and positioning, if signs are visible)?*

- **Give the participant at the screen a few moments to study the picture, and to describe and point to the signs that they see. Then ask other participants to describe the signs that they see.**
- **Then point out any signs that they have missed. Try not to repeat signs that they have already mentioned.**
- **After the participant has described the signs, ask them to decide about the baby's attachment. Do not let the participant decide about the attachment until they have described the signs.**
  - *Ask: Is the baby well attached or poorly attached?*
- **The text below lists the signs that each slide illustrates particularly well, and that can help the observer to make a decision. Try to encourage participants to go through THE FOUR KEY POINTS OF GOOD ATTACHMENT FIRST (see COUNSELLING CARD 3: GOOD ATTACHMENT) and then to list points from the other sections of the JOB AID: BREASTFEED OBSERVATION. This will help them to think more systematically as they assess a breastfeed.**
- **Participants may describe more signs than are given in the text. There are other signs in the slides, but most of them are not very helpful. Accept participants' observations, or gently correct them if they are incorrect.**
- **With some slides, there are extra questions about some point of interest in the slide. Let participants try to observe and think of the significance of the observation.**
- **Show Slide 26/2**

  - Signs that you can see clearly are:
    - The baby's mouth is quite wide open.
    - The baby's lower lip is turned outwards.
    - The baby's chin is almost touching the breast.
    - There is more areola above the baby's top lip than below the bottom lip.
  - These signs show that the baby is well attached to the breast.
  - In addition, the baby is close to the breast and facing it and has round cheeks.
  - These signs show that the baby is well attached and positioned at the breast.
- **Additional points for Slide 26/2:**
  - *Ask: How is the mother holding her breast? Does this affect the baby breastfeeding?*
  - She is not holding her breast at all, and she is not holding her breast back from the baby's nose.
  - The baby is breathing quite well without the mother holding her breast back with her finger.

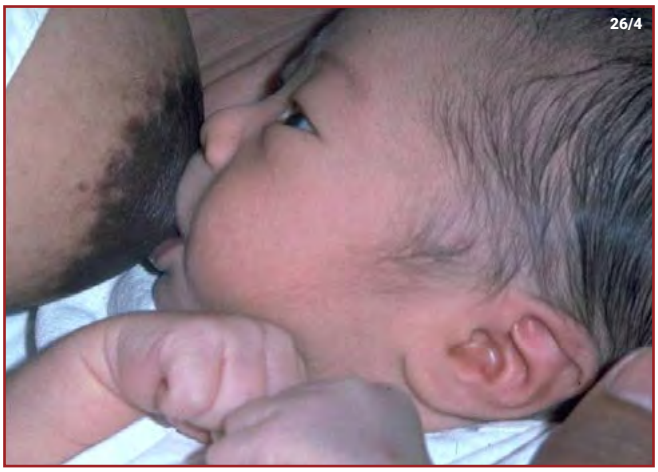
▶ Show **Slide 26/3**

- Signs that you can see clearly are:
  - The baby's mouth is pointing forward.
  - The lower lip is partly turned outwards.
  - The baby's chin is not touching the breast.
  - It is difficult to see the areola clearly.
- This baby is poorly attached.
- In addition, the baby's cheeks are pulled in when suckling.

▶ Additional point for **Slide 26/3**:

- *Ask: How is the mother holding her breast?*
- The mother is holding her breast with the "scissor" hold, which sometimes interferes with suckling. But this mother's fingers are not near the nipple.

▶ Show **Slide 26/4**



- Signs that you can see clearly are:
  - The baby's mouth is not wide open, the lips are pointing forward.
  - The baby's lower lip is turned outwards.
  - The baby's chin is not touching the breast.
  - There is as much or more areola below the baby's mouth as above it.
- Other signs:
  - The baby's cheeks are round.
  - The baby is not close to the breast.
  - The position of the baby's hands shows that the body is twisted away, and not facing the mother.
- This baby is poorly attached and poorly positioned.
- The baby looks as though he is feeding from a bottle.

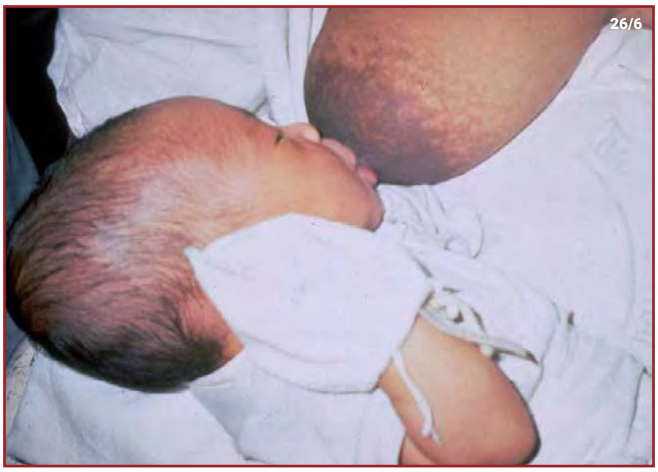
▸ Show **Slide 26/5**

- Signs that you can see clearly are:
  - The baby's chin is touching the breast.
  - There is a little areola above the baby's top lip.
  - As the baby is very close to the breast, it makes it difficult to see many other signs.
- It is difficult to see the baby's mouth, but the little crease (fold) in his chin suggests that his mouth is wide open.
- You cannot see the baby's lower lip
- This baby is well attached.
- The baby's cheek is round and not pulled in (though it is somewhat flattened against the mother's breast)
- The position of the baby's hand shows that he is facing the mother and not twisted.
- The baby is well attached and well positioned.

▸ Additional points for **Slide 26/5**:

- This is the same baby as in slide 26/4 after the health worker has helped the mother to position the baby better. In a better position, a baby can attach more easily.
- *Ask: What do you notice about the shape of the mother's breast?*
- The breast looks rounded. In **Slide 26/4**, where you saw the same baby, he was not well attached and the breast looks more stretched out.

▸ Show **Slide 26/6**

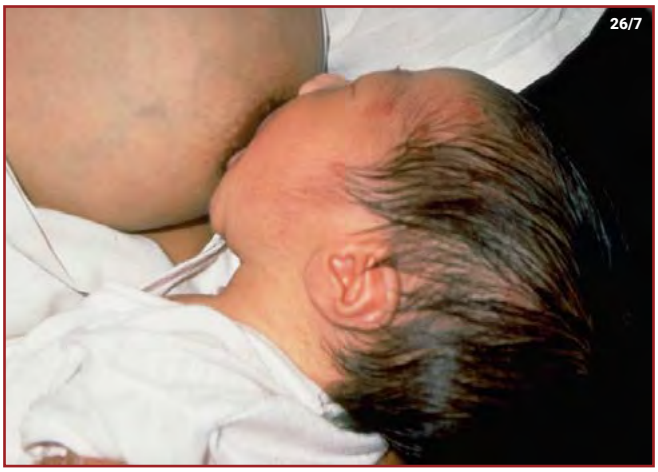


- Signs that you can see clearly are:
  - The baby's mouth is not wide open.
  - The lower lip is pointing forwards, not fully outwards.
  - The baby's chin is not touching the mother's breast.
  - There is as much areola below the baby's bottom lip as above the top lip.
- This baby is poorly attached to the breast.
- The baby's cheek is slightly pulled in.
- The baby's body is not close to the mother's.

▸ Additional point for **Slide 26/6**:

- *Ask: What do you notice about the mother's areola?*
- This mother's areola is very large, so it is unlikely that you would see a lot of it even if her baby was well attached. However, you should see more above the baby's top lip than below the bottom lip.

▸ Show **Slide 26/7**



- Signs that you can see clearly are:
  - The baby's mouth is wide open.
  - The baby's lower lip is turned outwards.
  - The baby's chin is close to the breast.
  - There is more areola above the baby's mouth than below it.
- Other signs:
  - The baby's cheek is round.
  - The baby's body is turned slightly away from the mother and her neck is slightly twisted, but this is not very clear.
- This baby is well attached, but her body position is not very good.

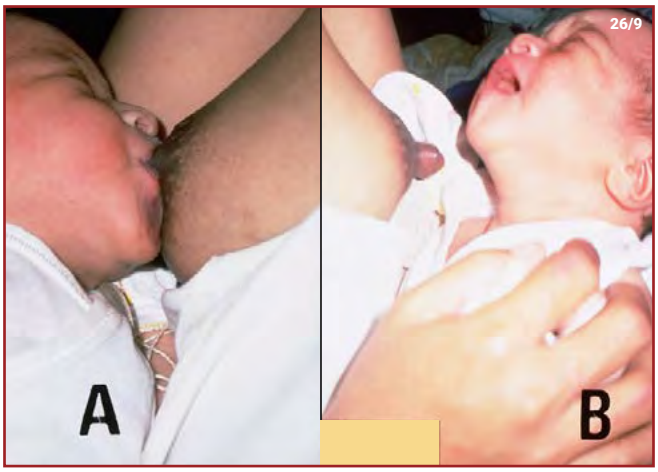
▸ Additional point for **Slide 26/7**:

- *Ask: What do you notice about this mother's areola?*
- It is much smaller than the areola of the mother in Slide 26/6, so you do not see much of it either above or below the baby's mouth.

▶ Show **Slide 26/8**

- Signs that you can see clearly are:
  - The baby's mouth is quite wide open.
  - The baby's lower lip is turned in and not outwards.
  - The baby's chin is touching the breast.
  - There is more areola above the baby's top lip than below the bottom lip.
- Other signs:
  - The baby's cheek is round.
  - The baby is facing the breast.
- This baby is not well attached.
- The baby's lower lip is turned in, so he is not well attached, even if the other three signs are good.
- In addition, the baby's head and body are straight and he is facing the breast.

▶ Show **Slide 26/9**



- Picture A shows a baby suckling, and picture B shows the same baby a few seconds later. The baby has stopped suckling.
- *Ask: What signs do you see in pictures A and B that explain what has happened in picture B?*
- Signs of attachment in picture A:
  - The baby's mouth is not wide open, it is quite closed.
  - The baby's lower lip is not turning outwards.
  - The baby's chin is close to the breast.
  - There may be more areola above the baby's mouth than below it.
- Other signs:
  - The baby's cheek is pulled in.
  - It is difficult to see the baby's body position.
- Signs that you can see in picture B:
  - The baby is pulling away from the mother's breast.
  - The baby is crying with frustration.
  - The mother's nipple is quite large and long.
- Picture A shows that this baby was poorly attached to the breast, and was not getting the milk effectively, so she pulled away in frustration, as shown in Picture B.

▶ Additional point for **Slide 26/9**:

- *Ask: Why do you think the baby may have been poorly attached?*
- Possibly because of the mother's long nipple. This can result in a baby not taking enough breast into the mouth. The mother and baby need help to prevent problems (see Sessions 19 and 28: Breast conditions 1 and 2).

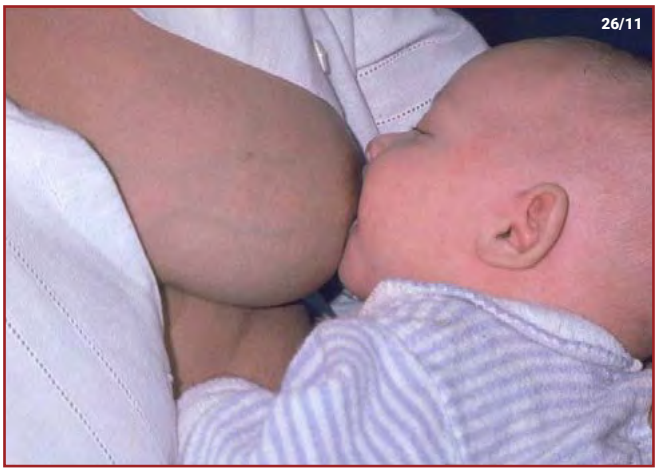
▸ Show **Slide 26/10**

- Signs of attachment:
  - The baby's mouth is not wide open.
  - The baby's lower lip is not turned outwards.
  - The baby's chin is touching the breast.
  - There is more areola below the baby's mouth than above it.
- Other signs:
  - The baby's cheeks look round.
  - The baby is close to the breast, and facing it.
- This baby is not well attached.

▸ Additional point for **Slide 26/10**:

- This baby was not satisfied, and wanted to feed often, because he was not getting breast milk effectively. The mother has rather large breasts, and she may have put the baby straight onto the breast instead of from below. The baby did not approach the breast with his nose opposite the nipple (see **Slide 26/10**. This can make it more difficult for a baby to attach well (see SESSIONS 14 and 27: POSITIONING A BABY AT THE BREAST 1 and 2).

▶ Show **Slide 26/11**

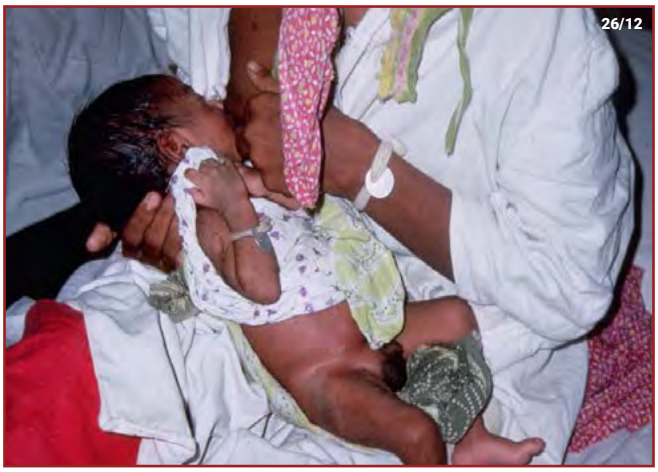


- Signs of attachment:
  - The baby's mouth is wide open.
  - The baby's lower lip is turned outwards (though it is difficult to see).
  - The baby's chin is touching the breast.
  - There is more areola above the baby's mouth than below it.
- Other signs:
  - The baby's cheek is round (there is a dimple, but the cheek is not pulled in).
  - The baby is close to the breast and facing it.
- This baby is well attached and positioned.

▶ Additional point for **Slide 26/11**:

- *Ask: What do you notice about how the baby's mother is holding her breast, and where the baby's nose is?*
- She is not holding her breast, but the baby's nose is well away from the breast. When a baby is in a good position, there is usually plenty of room to breathe.

▶ Show **Slide 26/12**



- Signs of attachment:
  - These are difficult to see, because the picture is not taken closely enough.
  - However, the baby's mother is holding her breast very close to the nipple, so it is likely that the baby is poorly attached.
- Other signs:
  - The position of the baby's hands show that his body is turned away from the mother's, and is not close to her.
  - The baby's neck is twisted.
  - The baby's mother is supporting only the head and not the whole body.
  - The baby is only a few days old, so it would help if she supported the whole body.
  - The mother has no back support. She is leaning forward over the baby, and may be tense and uncomfortable.
- This baby is poorly positioned, and the mother is not comfortable, which makes holding the baby more difficult.

▶ **Conclude with these points:**

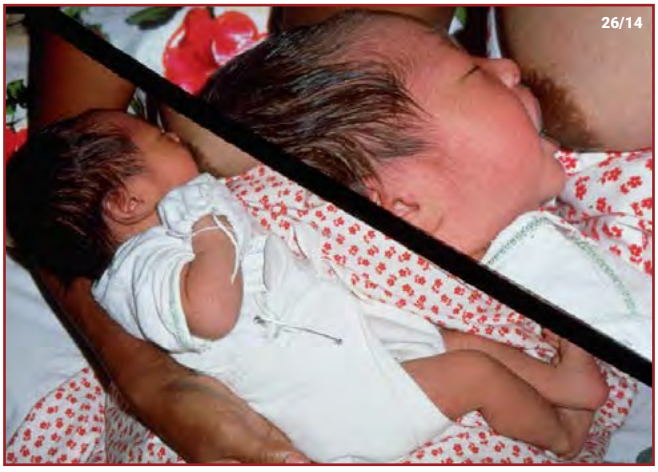
- Observing a breastfeed is an important way to learn about how a baby is feeding, and to decide how to help a mother.
- The JOB AID: BREASTFEED OBSERVATION summarizes the main points to notice, with four essential points relating to the BREASTS, BABY'S POSITION, BABY'S ATTACHMENT and SUCKLING. This makes them easier to remember.
- If even one of THE FOUR KEY SIGNS OF GOOD ATTACHMENT is poor, then the baby is probably poorly attached, and it is worth offering to help his mother.
- Always ask how breastfeeding feels to the mother. If she has discomfort or pain in her breasts, then her baby may not be well attached, even if the signs look good. If she is comfortable, then the baby is likely to be well attached.
- Remember that in a live baby, you will also be looking at the baby's suckling. If a baby takes slow deep sucks, sometimes pausing, they are suckling effectively and are probably well attached.
- Always ask about the baby's general health and their growth and behaviour. If the baby is satisfied, and growing well, they are probably suckling effectively.

III. Practise using the JOB AID: BREASTFEED OBSERVATION — 20 minutes

EXERCISE 26.A USING THE JOB AID: BREASTFEED OBSERVATION

- **Explain what to do:**
  - With **Slides 26/13** to **26/16**, you will use your observations to practise filling in the JOB AID: BREASTFEED OBSERVATION.
  - There are four copies of the form for this exercise in the *Participant's manual* on pages 186–189. Fill in one form for each slide.
  - If you see a sign, make a tick mark in the box next to the sign. If you do not see a sign, leave the box empty.
  - If you see something that you think is important, but there is not a box for it, you can make a note at the bottom of the form.
  - Concentrate on the sections on the baby's position and attachment. However, when you see mothers and babies in the practical sessions, you should fill in all sections of the form. Remember, you may not see all the signs with every baby.
- **Ask all the trainers to help. They should circulate and make sure that participants understand what to do. They should give individual feedback on participants' observations of the slides.**
- **Show Slides 26/13 to 26/16.**
- **Show each slide for about 4 minutes. If there is shortage of time, omit Slides 26/14 and 26/15. Finish on Slide 26/16, to emphasize all the signs of good attachment and positioning.**
- **In the *Trainer's guide*, on pages 342–345, for each of the Slides 26/13 to 26/16, the JOB AID: BREASTFEED OBSERVATION is copied. They have been marked with ticks for the signs that participants should see in these slides. Boxes have only been ticked if the signs are clear. Remember, it is difficult in slides to see all the signs. Use these answers to give individual feedback.**
- **Show Slide 26/13**

- **Show Slide 26/14**



▶ Show **Slide 26/15**

▶ Show **Slide 26/16**

JOB AID: BREASTFEED OBSERVATION – SLIDE 26/13

Mother's name: **Date:**

Baby's name: **Baby's age:**

Signs that breastfeeding is going well:	Signs of possible difficulty:
GENERAL	
Mother:	**Mother:**
☑ Mother looks healthy	☐ Mother looks ill or depressed
☐ Mother relaxed and comfortable	☑ Mother looks tense and uncomfortable
☐ Signs of bonding between mother and baby	☐ No mother/baby eye contact
Baby:	**Baby:**
☐ Baby looks healthy	☐ Baby looks sleepy or ill
☐ Baby calm and relaxed	☐ Baby is restless or crying
☐ Baby reaches or roots for breast if hungry	☐ Baby does not reach or root
BREASTS	
☑ Breasts look healthy	☐ Breasts look red, swollen, or sore
☐ No pain or discomfort	☐ Breast or nipple painful
☐ Breast well supported with fingers away from nipple	☑ Breasts held with fingers on areola
BABY'S POSITION	
☐ Baby's head and body in line	☑ Baby's neck and head twisted to feed
☐ Baby held close to mother's body	☑ Baby not held close
☐ Baby's whole body supported	☑ Baby supported by head and neck only
☐ Baby approaches breast, nose to nipple	☐ Baby approaches breast, lower lip/chin to nipple
BABY'S ATTACHMENT	
☐ Baby's mouth open wide	☑ Baby's mouth not open wide
☐ Lower lip turned outwards	☑ Lips pointing forward or turned in
☐ Baby's chin touches breast	☑ Baby's chin not touching breast
☐ More areola seen above baby's top lip	☑ More areola seen below bottom lip
SUCKLING	
☐ Slow, deep sucks with pauses	☐ Rapid shallow sucks
☐ Cheeks round when suckling	☑ Cheeks pulled in when suckling
☐ Baby releases breast when finished	☐ Mother takes baby off the breast
☐ Mother notices signs of oxytocin reflex	☐ No signs of oxytocin reflex noticed

- **Conclusions**
  - Most of the ticks are on the right side, under SIGNS OF POSSIBLE DIFFICULTY.
  - So the baby in **Slide 26/13** is poorly positioned and poorly attached.
- **Participants may also notice that the mother's fingers are over the lower part of the areola, making it difficult for the baby to attach well.**

JOB AID: BREASTFEED OBSERVATION – SLIDE 26/14

Mother's name: **Date:**

Baby's name: **Baby's age:**

Signs that breastfeeding is going well:	Signs of possible difficulty:
GENERAL	
Mother:	**Mother:**
☐ Mother looks healthy	☐ Mother looks ill or depressed
☐ Mother relaxed and comfortable	☐ Mother looks tense and uncomfortable
☐ Signs of bonding between mother and baby	☐ No mother/baby eye contact
Baby:	**Baby:**
☑ Baby looks healthy	☐ Baby looks sleepy or ill
☑ Baby calm and relaxed	☐ Baby is restless or crying
☐ Baby reaches or roots for breast if hungry	☐ Baby does not reach or root
BREASTS	
☑ Breasts look healthy	☐ Breasts look red, swollen, or sore
☐ No pain or discomfort	☐ Breast or nipple painful
☐ Breast well supported with fingers away from nipple	☐ Breasts held with fingers on areola
BABY'S POSITION	
☐ Baby's head and body in line	☐ Baby's neck and head twisted to feed
☐ Baby held close to mother's body	☑ Baby not held close
☐ Baby's whole body supported	☑ Baby supported by head and neck only
☐ Baby approaches breast, nose to nipple	☐ Baby approaches breast, lower lip/chin to nipple
BABY'S ATTACHMENT	
☐ Baby's mouth open wide	☑ Baby's mouth not open wide
☐ Lower lip turned outwards	☑ Lips pointing forward or turned in
☐ Baby's chin touches breast	☑ Baby's chin not touching breast
☐ More areola seen above baby's top lip	☑ More areola seen below bottom lip
SUCKLING	
☐ Slow, deep sucks with pauses	☐ Rapid shallow sucks
☑ Cheeks round when suckling	☐ Cheeks pulled in when suckling
☐ Baby releases breast when finished	☐ Mother takes baby off the breast
☐ Mother notices signs of oxytocin reflex	☐ No signs of oxytocin reflex noticed

▸ Conclusions

- Most of the ticks are on the right side, under SIGNS OF POSSIBLE DIFFICULTY.
- So the baby in **Slide 26/14** is poorly positioned and poorly attached.

Job aid: Breastfeed observation – Slide 26/15

Mother's name: **Date:**

Baby's name: **Baby's age:**

Signs that breastfeeding is going well:	Signs of possible difficulty:
GENERAL	
Mother:	**Mother:**
☑ Mother looks healthy	☐ Mother looks ill or depressed
☑ Mother relaxed and comfortable	☐ Mother looks tense and uncomfortable
☐ Signs of bonding between mother and baby	☐ No mother/baby eye contact
Baby:	**Baby:**
☑ Baby looks healthy	☐ Baby looks sleepy or ill
☐ Baby calm and relaxed	☐ Baby is restless or crying
☐ Baby reaches or roots for breast if hungry	☐ Baby does not reach or root
BREASTS	
☑ Breasts look healthy	☐ Breasts look red, swollen, or sore
☐ No pain or discomfort	☐ Breast or nipple painful
☐ Breast well supported with fingers away from nipple	☐ Breasts held with fingers on areola
BABY'S POSITION	
☑ Baby's head and body in line	☐ Baby's neck and head twisted to feed
☑ Baby held close to mother's body	☐ Baby not held close
☑ Baby's whole body supported	☐ Baby supported by head and neck only
☐ Baby approaches breast, nose to nipple	☐ Baby approaches breast, lower lip/chin to nipple
BABY'S ATTACHMENT	
☐ Baby's mouth open wide	☐ Baby's mouth not open wide
☐ Lower lip turned outwards	☐ Lips pointing forward or turned in
☐ Baby's chin touches breast	☐ Baby's chin not touching breast
☐ More areola seen above baby's top lip	☐ More areola seen below bottom lip
SUCKLING	
☐ Slow, deep sucks with pauses	☐ Rapid shallow sucks
☑ Cheeks round when suckling	☐ Cheeks pulled in when suckling
☐ Baby releases breast when finished	☐ Mother takes baby off the breast
☐ Mother notices signs of oxytocin reflex	☐ No signs of oxytocin reflex noticed

▸ Conclusions

- The baby in **Slide 26/15** is the same baby as in **Slide 26/14**, after a health worker has helped the mother to reposition her baby.
- Most of the ticks are on the left side, under Signs that breastfeeding is going well.
- So the baby is now better positioned. He is probably well attached, though he is so close to the breast that it is difficult to see his mouth.

JOB AID: BREASTFEED OBSERVATION – SLIDE 26/16

Mother's name: **Date:**

Baby's name: **Baby's age:**

Signs that breastfeeding is going well:	Signs of possible difficulty:
GENERAL	
Mother:	**Mother:**
☑ Mother looks healthy	☐ Mother looks ill or depressed
☐ Mother relaxed and comfortable	☐ Mother looks tense and uncomfortable
☐ Signs of bonding between mother and baby	☐ No mother/baby eye contact
Baby:	**Baby:**
☑ Baby looks healthy	☐ Baby looks sleepy or ill
☑ Baby calm and relaxed	☐ Baby is restless or crying
☐ Baby reaches or roots for breast if hungry	☐ Baby does not reach or root
BREASTS	
☑ Breasts look healthy	☐ Breasts look red, swollen, or sore
☐ No pain or discomfort	☐ Breast or nipple painful
☐ Breast well supported with fingers away from nipple	☐ Breasts held with fingers on areola
BABY'S POSITION	
☑ Baby's head and body in line	☐ Baby's neck and head twisted to feed
☑ Baby held close to mother's body	☐ Baby not held close
☐ Baby's whole body supported	☐ Baby supported by head and neck only
☐ Baby approaches breast, nose to nipple	☐ Baby approaches breast, lower lip/chin to nipple
BABY'S ATTACHMENT	
☑ Baby's mouth open wide	☐ Baby's mouth not open wide
☐ Lower lip turned outwards	☐ Lips pointing forward or turned in
☑ Baby's chin touches breast	☐ Baby's chin not touching breast
☑ More areola seen above baby's top lip	☐ More areola seen below bottom lip
SUCKLING	
☐ Slow, deep sucks with pauses	☐ Rapid shallow sucks
☑ Cheeks round when suckling	☐ Cheeks pulled in when suckling
☐ Baby releases breast when finished	☐ Mother takes baby off the breast
☐ Mother notices signs of oxytocin reflex	☐ No signs of oxytocin reflex noticed

▸ Conclusions

- Most of the ticks are on the left side, under SIGNS THAT BREASTFEEDING IS GOING WELL.
- So the baby in **Slide 26/16** is well positioned and almost certainly well attached. It is difficult to see the baby's mouth, because she is so close to the mother's breast.

IV. Summarize the session 1 minute

- Ask participants whether they have any questions, and try to answer them.
- Explain that a summary of this session can be found on pages 173–189 of the *Participant's manual*.

Further information

If a mother says that breastfeeding is going well, but you see signs that indicate a possible difficulty, you must decide what to do.

In the days soon after delivery, while the mother is still learning, you may want to offer to help her. Even if she is not aware of any difficulty now, you may prevent one occurring later.

If breastfeeding seems to be well established, you probably do not want to intervene immediately. It is usually more helpful to see her again soon, and follow the baby's growth, to make sure that breastfeeding continues to go well. Intervene only if a difficulty arises.

Notes

Notes (contd)

Notes (contd)

SESSION 27

Positioning a baby at the breast 2

Objectives

After completing this session, participants will be able to:

- explain THE FOUR KEY SIGNS OF GOOD POSITIONING
- explain the different positions for a mother to breastfeed
- explain different ways to hold a baby
- describe how a mother should support her breast for feeding
- explain the common mistakes of positioning a baby
- help a mother to hold and position her baby at the breast, by demonstrating with a doll.

Session outline . . . . . 90 minutes

Participants are all together for a demonstration led by one trainer. One participant helps with the demonstrations. For the practical session on positioning using dolls, participants are in groups of 3–4, with one trainer per group.

All trainers help to give individual feedback on the exercise.

I. Introduce the session, present **Slide 27/1** . . . . . 3 minutes
II. Demonstrate helping a mother to position her baby (DEMONSTRATIONS 27.A–27.E) . . . . . 50 minutes
III. CLASSROOM PRACTICAL: POSITIONING A BABY USING DOLLS (small groups) . . . . . 35 minutes
IV. Summarize the session . . . . . 2 minutes

Preparation

- Refer to the Introduction for guidance on giving a demonstration.
- The demonstrations in this session need a lot of practice if they are to be effective. One trainer leads the session. Another trainer helps with the demonstration of helping a mother who is sitting and lying.
- The day before the demonstration:
  - Ask a participant to help you with the demonstration.
  - Explain that you want her to play a mother who needs help to position her baby. Ask her to decide on a name for herself and her "baby". She can use her real name if she likes.
  - Explain what you want to happen as follows:

1. You will demonstrate how to help a mother who is sitting.
   - She will sit holding the doll in the common way, with the doll across the front.
   - You will greet her and ask how breastfeeding is going, and she will say that it is painful and that she has sore nipples.
   - You will ask her to "breastfeed" the doll, while you observe.
   - She will hold it in a poor position: loosely, supporting only its head, with its body away from hers, so that she has to lean forward to get her breast to its mouth. She will pretend that breastfeeding is painful. You will then help her to sit more comfortably and to improve the doll's position.
   - You will then help her to sit more comfortably and to improve the doll's position.
   - When the position is better, she should say "Oh! That feels better", and look happier. She can rub the other breast, to show that now she is feeling the ejection reflex.

2. You will demonstrate other ways to hold a baby with the mother sitting – the underarm position, and using the opposite hand, reclining, sitting on the floor (when appropriate), and any other positions that are used in the local community.
3. You will demonstrate how to help a mother who is lying down.
   - She will lie down, propped on her arm, with the doll far from her body, loosely held on the bed.
   - Practise giving the demonstration with the participant, so that you know how to follow the steps.
   - Decide the "comfortable" position that you will help her to lie in.
   - Ask her to wear clothes such as a long skirt or trousers, so that she feels comfortable lying down for this demonstration.
   - Find a cloth to cover the table, and a cloth to cover the "mother's" legs. Find some pillows if these are appropriate in this community.

- Early on the day of the demonstration:
  - Arrange chairs, a footstool and a bed, or a table that can be used for a bed, to demonstrate breastfeeding lying down.
  - You will need a doll and a model breast for the demonstration of common mistakes in positioning.
  - Make sure you have **Slide 27/1** ready. Alternatively, as there is only one slide in this session, you might prefer to read aloud the objectives on **Slide 27/1** without projecting them onto the screen.
  - Have ready COUNSELLING CARD 3: GOOD ATTACHMENT, COUNSELLING CARD 4: BREASTFEEDING POSITIONS, and the *Guidance on the use of counselling cards*.

As you follow the text, remember:

- ▶ indicates an instruction to you, the trainer.
- ¤ indicates what you say to participants.

I. Introduce the session 3 minutes

▸ Show **Slide 27/1 – Session 27 – objectives** and read out the objectives:

27/1

Session 27: Positioning a baby at the breast 2 – objectives

After completing this session, participants will be able to:

- explain THE FOUR KEY SIGNS OF GOOD POSITIONING
- explain the different positions for a mother to breastfeed
- explain different ways to hold a baby
- describe how a mother should support her breast for feeding
- explain the common mistakes of positioning a baby
- help a mother to hold and position her baby at the breast, by demonstrating with a doll

▸ Ask participants to turn to page 198 of their *Participant's manual*, where the technique HOW TO HELP A MOTHER TO POSITION HER BABY is described.

▸ Explain what the session will be about:

- In this session, we will review how to help a mother to position her baby at the breast, so that her baby can attach well and suckle effectively.
- The techniques are described in your *Participant's manual*, for you to read again later.
- There are three main kinds of mother whom you may need to help:
  - New mothers, who are breastfeeding for the first time
  - Mothers who have some difficulty with breastfeeding, or who use a poor technique
  - Mothers who artificially fed a previous baby but now want to breastfeed.
- We will be using the four key points from the section on BABY'S POSITION on the JOB AID: BREASTFEED OBSERVATION.
- There are several steps to follow when helping a mother to position her baby at the breast.

▸ Make these points:

- Always observe a mother breastfeeding before you help her.
- Take time to see what she does, so that you can understand her situation clearly. Do not rush to make her do something different. Notice other things that may affect breastfeeding, such as her clothing, or the presence of men looking at her.
- Give a mother help if she had difficulty.
- All mothers who have difficulties definitely need help. However, some mothers may not have a difficulty at present, but they use a poor technique that can lead to difficulties. Help these mothers, especially in the first 2 months before breastfeeding is fully established. However, some mothers with babies older than about 2 months breastfeed satisfactorily in positions that would make difficulties for younger babies. There is no point trying to change an older baby's position if the baby is getting breast milk effectively and growing well, and the mother is comfortable
- Let the mother do as much as possible herself.
- Be careful not to "take over" from her. Explain what you want her to do. If possible, demonstrate on your own body to show her what you mean.
- Make sure that the mother understands what you do, so that she can do it herself.
- Your aim is to help her to position her own baby. It does not help if you can get the baby to attach effectively, if the mother cannot.

II. Demonstrate helping a mother to position her baby — 50 minutes

- Give the four demonstrations described below.
- Ask participants to turn to page 198 of their *Participant's manual* and find the box How to help a mother to position her baby. They should follow the steps in the form as you demonstrate.
- As you follow each step:
- Demonstrate how to talk to a mother:
  - Be gentle. Explain what you do, so that she understands, and talk in a way that builds her confidence.
  - Although participants may not yet have done Session 8: Building confidence and giving support, it is important for trainers to demonstrate good technique from the beginning.
- Explain to participants what you are doing:
  - Sometimes you need to step out of your role of helping the mother, to make sure that participants understand what you are demonstrating.
  - Let the mother do as much as possible herself. Be careful not to "take over" from her. Explain what you want her to do. If possible, demonstrate on your own body, to show her what you mean.
  - Make sure that she understands what you do, so that she can do it herself. Your aim is to help her to position her own baby. It does not help if you can get a baby to suckle, if the mother cannot.

Demonstration 27.A Demonstrate how to help a mother who is sitting

- Demonstrate how to help a mother to position her baby, going through the points in the box How to help a mother to position her baby on page 361 of the *Trainer's guide*. Ask the participant who is helping you to sit on the chair or bed that you have arranged.
  As you have practised:
- She should hold the doll across her body in the common way, but in a poor position, loosely, supporting only its head, with the baby's body away from hers, so that she has to lean forward to get her breast into the baby's mouth.
  - You will ask her how breastfeeding is going, and she should say that it is painful when the baby suckles.
- Follow these steps, as in the form How to help a mother to position her baby:
- **Greet the mother and ask how breastfeeding is going**
  When you have greeted the "mother", introduced yourself and asked how breastfeeding is going, the "mother" should respond by saying that breastfeeding is painful.
- **Assess a breastfeed**
  Ask whether you may see how (child's name) breastfeeds, and ask the "mother" to put him to her breast in the usual way. She holds him loosely, away from her body, with his neck twisted, as you practised. Observe her breastfeeding for a few minutes.
- **Explain what might help and ask whether she would like you to show her**
  Say something encouraging such as: "He really wants your breast milk, doesn't he?"
  Then say: "Breastfeeding might be less painful if (child's name) took a larger mouthful of breast when he suckles. Would you like me to show you how?" If she agrees, you can start to help her.
- **Make sure that she is comfortable and relaxed**
  Make sure the "mother" is sitting in a comfortable and relaxed position – as you decided when you practised this demonstration beforehand.

- Sit down yourself in a **comfortable, convenient position**
  - You cannot help a mother satisfactorily if you are in an awkward or uncomfortable position yourself or if you are bending over her.
- Demonstrate the following points to the participants using a doll, a high chair, a low chair and a stool. Make sure the following points are clear:
  - A low seat is usually best, if possible one that supports the "mother's" back.
  - If the seat is rather high, find a stool for her to put her feet onto. However, be careful not to make her knees so high that her baby is too high for her breast.
  - If she is sitting on the floor, make sure that her back is supported.
  - If she supports her baby on her knee, help her to hold the baby high enough so that she does not lean forward to put the baby onto her breast.
- **Explain how to hold her baby, and show her if necessary**
  Demonstrate how to help the mother to position her baby, making sure that THE FOUR KEY SIGNS OF GOOD POSITIONING are clear to the mother and to the participants.

  When you have finished helping the "mother" to position her baby, make these points to the participants, using a doll to demonstrate:
  - These four key points are the same as the points that you learnt to observe in the JOB AID: BREASTFEED OBSERVATION.
  - **For point 1 – Baby's head and body in line:** a baby cannot suckle or swallow easily if the head is twisted or bent.
  - **For point 2 – Baby held close to mother's body:** a baby cannot attach well to the breast if they are far away from it. The baby's whole body should almost face their mother's body. The baby should be turned away just enough to be able to look at her face. This is the best position for the baby to take the breast, because most nipples point down slightly. If the baby faces the mother completely, they may fall off the breast.
  - **For point 3 – Baby's whole body supported:** the whole body should be supported, with the mother's arm along the baby's back. This is particularly important for neonates and young babies. For older babies, support of the upper part of the body is usually enough. A mother needs to be careful about using the hand of the same arm, which supports her baby's back, to hold their bottom. Holding the baby's bottom may result in her pulling them too far out to the side, so that their head is in the crook (bend) of her arm. The baby then has to bend their head forward to reach the nipple, which makes it difficult for them to suckle.
  - **For point 4 – Baby approaches breast, nose to nipple:** we will talk about this a little later when we discuss how to help a baby to attach to the breast.
  - Try not to touch the mother or baby if possible. But if you need to touch them to show the mother what to do put your hand over her hand or arm, so that you hold the baby through her.
  - This is the easiest position for the baby to take the breast, because most nipples point slightly downwards and outwards. So the baby faces the breast with the nose approaching the nipple. If the baby faces the mother's body completely flat, it is more difficult to take the breast.
  - After you have reviewed the four points of positioning, review the steps 1, 2, 3 and 4, using either the right or left hand and arm to show them: (1) slap the hand on the opposite forearm (demonstrating where the baby's head lies); (2) slap the palm and whole arm against the stomach (demonstrating that the baby is close to the mother and turns towards the mother); (3) slap the arm on the opposite palm (demonstrating that the mother supports the buttocks, not holds); and (4) swing the hand and arm behind the waist (demonstrating that the baby's hand and arm should be behind the mother).

- **Show her how to support her breast**
  Demonstrate how to help the mother to support her breast.
  When you have finished helping the "mother" to support her breast, make these points to the participants, demonstrating on your own body or on a model breast:
  - It is important to show a mother how to support her breast with her hand to offer it to her baby.
  - She should place her fingers flat on her chest wall under her breast, so that her first finger forms a support at the base of the breast (see **Fig. 27.1**).
  - She can use her thumb to press the top of her breast slightly. This can improve the shape of the breast so that it is easier for her baby to attach well.
  - She should not hold her breast too near to the nipple.
  - Holding the breast too near the nipple makes it difficult for a baby to attach and suckle effectively. The "scissor" hold can block milk flow (see **Fig 27.2**).
  - If a mother has large and low breasts, support may make attachment easier. If she has small and high breasts, she may not need to support them.

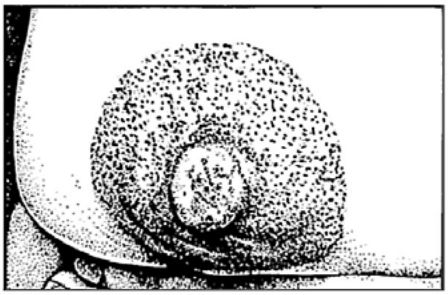


Fig. 27.1 Supporting the breast with fingers against the chest wall

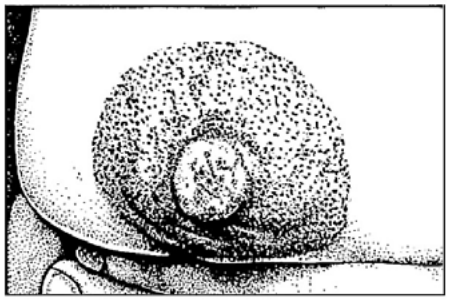


Fig. 27.2 Holding the breast close to the nipple and pinching

- **Demonstrate to participants these ways of holding a breast, and explain that they make it difficult for a baby to attach:**
  - holding the breast with the fingers and thumb close to the areola
  - pinching up the nipple or areola between your thumb and fingers, and trying to push the nipple into a baby's mouth
  - holding the breast in the "scissor" hold – index finger above and middle finger below the nipple.
- **Explain or show her how to help the baby to attach**
  Demonstrate how to help the "mother" to attach her baby.
  When you have finished helping the "mother" to attach her baby, make these points to the participants, using a doll and your own body or a model breast:
  - Explain that she first holds the baby with their nose opposite her nipple, so that they approach the breast from underneath the nipple.
  - Explain how she should touch her baby's lips with her nipple, so that the baby opens the mouth, puts out the tongue, and reaches up.
  - Explain that she should wait until her baby's mouth is opening wide, before she moves the baby onto her breast. The baby's mouth needs to be wide open to take a large mouthful of breast.
  - It is important to use the baby's reflexes, so that they open their mouth wide to take the breast themself. You cannot force a baby to suckle, and the mother should not try to open her baby's mouth by pulling the chin down.
  - Explain or show her how to quickly move her baby to her breast, when they are opening their mouth wide.
  - She should keep her back straight and bring her baby to her breast. She should not move herself or her breast to her baby.

- As she brings the baby to her breast, she should aim her baby's lower lip below her nipple, with the nose opposite the nipple, so that the nipple aims towards the baby's palate, the tongue goes under the areola, and the chin will touch her breast.
- Hold the baby at the back of the shoulders – not the back of the head. Be careful not to push the baby's head forward.
- Try not to touch the mother or baby if possible. But if you need to touch them to show the mother what to do, ask her permission and then:
  - Put your hand over her hand or arm, and explain that you will be touching the baby through her.
  - Hold the baby at the back of their shoulders – not the back of the head. Be careful not to push the baby's head forward.

▶ **Notice how she responds and ask her how her baby's sucking feels**
Ask the "mother" how she feels. She should say something such as, "Oh, much better thank you." Then explain to the participants:

- Notice how the mother responds.
- Ask the mother how suckling feels.
- If suckling is comfortable for the mother, and she looks happy, her baby is probably well attached.

▶ **Look for signs of good attachment. If the attachment is not good, try again.**
Make these points to the participants:

- Look for all the signs of good attachment (which you cannot see with a doll). If the attachment is not good, try again.
- It often takes several tries to get a baby well attached. You may need to work with the mother again at a later time, or the next day, until breastfeeding is going well.
- Make sure that the mother understands about her baby taking enough breast into their mouth to get the milk.
- If she is having difficulty in one position, try to help her to find a different position that is more comfortable for her. For example, in one of the positions described below.
- Unfortunately, sometimes a mother goes back to her old position for holding the baby. Make sure that she knows what to do, and leave her to practise. Her position may improve, especially if the baby learns how to attach well and get the milk.
- Use COUNSELLING CARD 3: GOOD ATTACHMENT to review with the "mother" the signs of good attachment.

DEMONSTRATION 27.B OTHER WAYS FOR A MOTHER WHO IS SITTING TO POSITION HER BABY

- Ask participants to turn to page 194 of their *Participant's manual* to look at other ways that mothers can position their babies.
- Demonstrate the positions shown in **Figs. 27.3** and **27.4** using a doll.

Fig. 27.3 A mother holding her baby in the underarm position

Useful for:
- twins
- blocked duct
- difficulty attaching the baby
- very small or low-birth-weight babies

Fig 27.4 A mother holding her baby with the arm opposite the breast

Useful for:
- very small or low-birth-weight babies
- sick babies
- blocked duct

Give these demonstrations in the same way as DEMONSTRATION 27A, using a doll.

- Follow these steps:
- Show the "mother" how to hold her baby in the underarm position (see **Fig. 27.3**).
  - Exactly the same four key points are important for positioning.
  - She may need to support the baby with pillows at her side.
- Explain to participants:
  - The baby's head rests in the mother's hand, but she does not push it at the breast.
  - The underarm position is useful:
    - for twins
    - if she is having difficulty attaching her baby across the front
    - to treat a blocked duct (see SESSIONS 19 and 28: BREAST CONDITIONS 1 and 2)
    - for very small or low-birth-weight babies
    - if the mother prefers it.
- Show the "mother" how to hold her baby with the arm opposite to the breast (**Fig. 27.4**).
  - Exactly the same four key points are important for positioning.
  - If she needs to support her breast, she can use the hand on the same side as the breast.

- **Explain to participants:**
  - The mother's forearm supports the baby's body.
  - Her hand supports the baby's head, at the level of the ears or lower. She does not push at the back of the baby's head.
  - This way of holding a baby is useful:
    - for very small or low-birth-weight babies
    - for sick or disabled babies
    - if the mother prefers it.

DEMONSTRATION 27.C DEMONSTRATE HOW TO HELP A MOTHER WHO IS LYING DOWN

- **Ask the participant who is helping to lie in the way that you practised. The "mother" should lie down propped on one elbow, with the doll far from her body, loosely held on the bed.**
- **Demonstrate helping the "mother" to lie down in a comfortable, relaxed position. Explain that the same steps are followed in the box HOW TO HELP A MOTHER TO POSITION HER BABY.**
- **During or after the demonstration, make these points clear to participants:**
  - To be relaxed, the mother needs to lie down on her side in a position in which she can sleep. Being propped on one elbow is not relaxing for most mothers.
  - If she has pillows, a pillow under her head and another under her chest may help.
  - Exactly the same four key points on positioning are important for a mother who is lying down.
  - The baby's body should be straight, close to the mother, supported and facing the breast.
  - She can support her baby with her lower arm. She can support her breast if necessary with her upper arm.
  - If she does not support her breast, she can hold her baby with her upper arm.
  - It may be helpful to put a pillow or a roll of cloth at the baby's back to keep the baby in position.
  - A common reason for difficulty attaching when lying down, is that the baby is too "high" near the mother's shoulders, and the baby's head has to bend forward to reach the breast.
  - Breastfeeding lying down (see **Fig. 27.5**) is useful:
    - when a mother wants to sleep, so that she can breastfeed without getting up
    - soon after a caesarian section, when lying on her back or side may help her to breastfeed her baby more comfortably.

Fig. 27.5 A mother breastfeeding her baby lying down

Demonstration 27.D How to help a mother to use a reclining position

- Follow these steps.
- Help the mother into a reclining position, leaning back, supported by pillows. She needs to lean back far enough for the baby to be fully supported on her reclining body, but she should not be completely flat. The baby can be naked and lie prone on her naked chest, for skin-to-skin contact. This is very useful if a baby has difficulty attaching at the breast, or if the baby is restless and crying. The position often calms the baby, and they find their own way to the breast, in the same way as a neonate. The reclining position is sometimes called "biological nurturing".
- Make these points:
  - There are many other positions in which a mother can breastfeed. In any position, the important thing is for the baby to take enough of the breast into their mouth so that they can suckle effectively.
- Demonstrate these positions for breastfeeding:
  - With the mother standing up.
  - If the baby has difficulty attaching to the breast, it sometimes helps if the mother lies on her front, propped on her elbows, with the baby underneath her.
  - If she has very large nipples, it may help to lean over the baby and offer the nipple from that position.
  - If she has an oversupply of milk (and the baby gets too much milk too fast), lying on her back with the baby on top of her sometimes helps (see Session 30: Refusal to breastfeed).

Demonstration 27.E Some common mistakes made by mothers and health workers

- **Make this point:**
  - Remember from the session on assessing a breastfeed that there are some ways in which a mother holds a baby that can make it difficult for the baby to attach to her breast and suckle effectively.
- **Give these demonstrations holding a doll and a model breast. As you give each demonstration ask participants what you are doing wrong:**
  - **Too high (for example, sitting with your knees very high).**
  - **Too low (for example, with the baby unsupported, so you have to lean forward).**
  - **Too far to the side (with the baby's head in the "crook" of the arm). A baby may be too far to the side because the mother holds her baby's bottom in her hand on the same side as the breast, which has the effect of pulling the baby to that side.**
- **Explain to participants:**
  - If a mother holds her baby too high, or too low, or too far to the side, the baby's mouth is not opposite her nipple. It will be difficult for the baby to take the breast into their mouth.
  - When a mother supports her baby's body, she should not grip the baby's bottom, because this pulls the baby's head too far out to the side. She should have her hand along the baby's back, so that their head rests on her forearm, not in the crook of the arm.
- **Show these ways of holding a breast and ask participants what you are doing wrong:**
  - **With the fingers and thumb close to the areola (see Fig. 27.2).**
  - **Pinching up the nipple or areola between the thumb and fingers, and trying to push the nipple into the baby's mouth.**
  - **The "scissor" hold (index finger above and middle finger below the nipple).**
- **Explain to participants:**
  - Holding the breast in these ways makes it difficult for a baby to attach and suckle effectively. The "scissor" hold can block milk flow.
- **Demonstrate holding the breast back from the baby's nose with a finger, and ask participants to recognize what you are doing wrong.**
- **Explain to participants:**
  - This is not necessary, and can pull the nipple out of the baby's mouth. A baby can breathe quite well without the breast being held back.
  - **Key point:** If you think that the baby's nose is too close to the breast, ask the mother to pull the baby's bottom in closer to her body.
  - **Key point:** One reason why a baby's nose may be very close to the breast is if the baby's body is too far out to the side, so that the baby has to bend their head forward to reach the nipple. Help the mother to reposition the baby so that their head is on her forearm. The baby will bend the head back and bring the chin closer to the breast.
- **Make this point:**
  - There are some common mistakes that health workers make when they help mothers.

- **Give the demonstration:**
- **Ask a participant to help you again. She should hold a doll in the same way as for the first demonstration. She should also hold a model breast in place as if the doll is trying to suckle.**
- **Take hold of the model breast in one hand and the doll in the other and push them together.**
- **Explain to participants:**
  - This shows what some health workers do. They try to put the baby onto the breast, instead of helping the mother to put the baby on herself. Sometimes they press on the back of the baby's head to force the baby to take the breast.
  - If you position and attach the baby for the mother, she does not learn how to position her baby herself, and she does not gain confidence.
- **Hold the doll at the back of his head, and demonstrate trying to push him onto the breast.**
- **Explain to participants:**
  - If you put pressure on the back of a baby's head, the baby may react by pushing the head back. The natural reaction of a health worker is then to push the baby onto the breast more strongly. The baby may fight back, and this may cause the baby to refuse to breastfeed.
- **Ask participants whether they have any questions, and try to answer them.**
- **Review positions using COUNSELLING CARD 4: BREASTFEEDING POSITIONS. Refer participants to the section in the *Guidance on the use of counselling cards* on KEY PRACTICES AND DISCUSSION POINTS for COUNSELLING CARD 4.**

III. CLASSROOM PRACTICAL: POSITIONING A BABY USING DOLLS — 35 minutes

- **Divide the participants into their small groups of 3–4 participants with one trainer. Each group will need one doll. The participants should take it in turns to be the "counsellor", the "mother" and "observers". The "mother" should pretend to be having difficulties positioning her baby. Encourage the participants to practise all the skills they have learnt so far. Encourage them to follow the steps on page 198 of their *Participant's manual* in the box HOW TO HELP A MOTHER TO POSITION HER BABY. These steps can be found on page 361 of the *Trainer's guide*.**
- **Explain to participants what to do:**
  - You will now work in pairs to practise helping a mother to position her baby. One of you plays the mother, and one plays the health worker. Other participants in the group observe.
  - If you are the mother:
    - Sit and hold the doll in the common way, across your front. Hold it in a poor position.
    - When the health worker asks you how breastfeeding is going, say that it is painful, and your nipples are sore, or think of another difficulty.
  - If you are the health worker:
    - Follow all the steps in the box HOW TO HELP A MOTHER TO POSITION HER BABY.
    - Use a doll to demonstrate to the mother what you want her to do.
    - Use the SKILLS FOR LISTENING AND LEARNING to talk to the mother.
  - If you are observing:
    - Follow the steps in the box, and afterwards comment on the practice. Praise what the pair did well, remind them about steps that were left out, and discuss any weak points.
- **Make sure that each participant has a turn to play the part of the health worker helping a mother to position her baby.**
- **Let participants practise helping mothers in all the different positions, particularly lying down, and with different stories.**

IV. Summarize the session — 2 minutes

- Ask participants whether they have any questions, and try to answer them.
- Explain that a summary of this session can be found on pages 191–198 of the *Participant's manual*.

How to help a mother to position her baby

- Greet the mother and ask how breastfeeding is going.
- Assess a breastfeed.
- Explain what might help, and ask whether she would like you to show her.
- Make sure that she is comfortable and relaxed.
- Sit down yourself in a comfortable, convenient position.
- Explain how to hold her baby, and show her if necessary.
  The **four key points** are:
  - Baby's head and body in line
  - Baby held close to mother's body
  - Baby's whole body supported
  - Baby approaches breast, nose to nipple
- Show her how to support her breast:
  - With her fingers against her chest wall below her breast
  - With her first finger supporting the breast
  - With her thumb above
  - Her fingers should not be too near the nipple
- Explain or show her how to help the baby to attach:
  - Touch her baby's lips with her nipple
  - Wait until her baby's mouth is opening wide
  - Move her baby quickly onto her breast, aiming the lower lip below the nipple
- Notice how she responds and ask her how her baby's suckling feels.
- Look for signs of good attachment. If the attachment is not good, try again.

The four key signs of good positioning

1. The baby's head and body are in line.
2. The baby is held close to the mother's body.
3. The baby's whole body is supported.
4. The baby approaches the breast, nose to nipple.

The four key signs of good attachment

1. The baby's mouth is wide open.
2. The baby's lower lip is turned outwards.
3. The baby's chin is touching the mother's breast.
4. More areola is seen above the baby's top lip than below the bottom lip.

Notes

SESSION 28

Breast conditions 2

Objectives

After completing this session, participants will be able to recognize and describe how to manage these common breast conditions:

- flat and inverted nipples
- engorgement
- blocked duct and mastitis
- sore nipples and nipple fissure

Session outline . . . . . 90 minutes

Participants are all together for a lecture presentation and demonstration by one trainer. Alternatively, two trainers may present half the slides each, or the session can be divided into two parts.

All trainers help to give individual feedback on the exercise.

I. Introduce the session, present **Slide 28/1** . . . . . 5 minutes
II. Present **Slides 28/2** to **28/26** (DEMONSTRATION 28.A) . . . . . 80 minutes
III. Summarize the session . . . . . 5 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides and giving a demonstration.
- Study the **Slides 28/1** to **28/26** and the text that goes with them, so that you are able to present them. Be careful when you present the slides that you do not read out the title of the slide, as the participants are asked questions about what condition the slide shows.
- There is a lot of information in the **Further information** sections. Make sure that you have read this, so that you are familiar with the ideas that they contain, so that you can answer participants' questions.
- For DEMONSTRATION 28.A, prepare a 20 mL disposable syringe as shown in **Fig. 28.5**. Take out the plunger and cut off the end of the barrel with the adaptor (you may find it helpful to use a hot knife to do this). Then put the plunger back into the barrel backwards.

As you follow the text, remember:

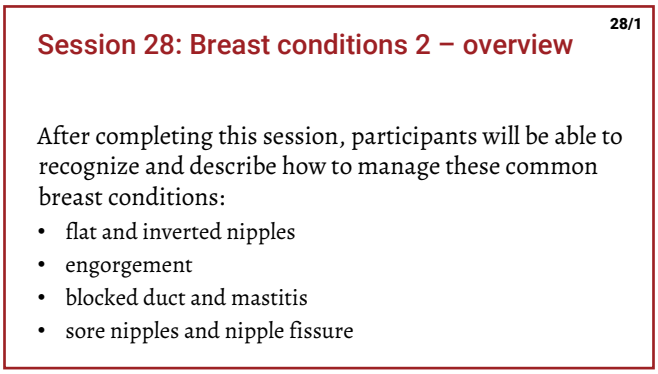
► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the session — 5 minutes

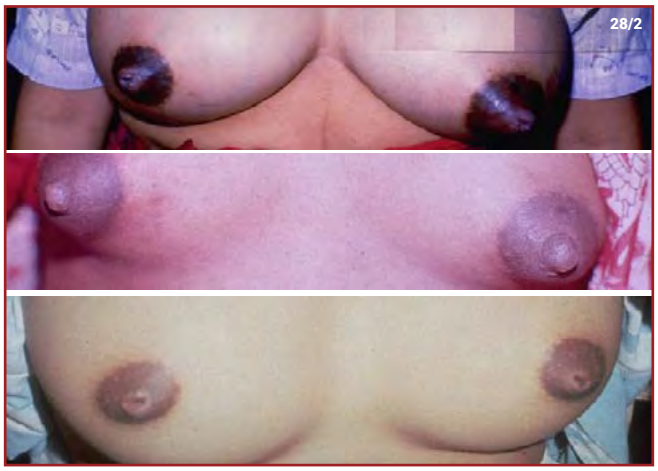
► Show **Slide 28/1 – Breast conditions – objectives** and read out the objectives:



- There are several common breast conditions that sometimes cause difficulties with breastfeeding:
  - Flat or inverted nipples, and long or big nipples
  - Engorgement
  - Blocked duct and mastitis
  - Sore nipples and nipple fissure
- Diagnosis and management of these breast conditions are important, both to relieve the mother and to enable breastfeeding to continue.
- Treatment differs for some breast conditions if the woman is living with HIV. We will discuss these during the session.
- If you developed a list of reasons for stopping breastfeeding or starting other feeds early in SESSION 3: LOCAL INFANT AND YOUNG CHILD FEEDING SITUATION, refer back to that now. Remind participants if they identified any of these conditions as one of the common reasons.

II. Present **Slides 28/2 to 28/26** 80 minutes

▸ Show **Slide 28/2 – Different breast shapes** and make the points that follow:



- Here are some breasts of different shapes and sizes. These breasts are all normal, and they can all produce plenty of milk for a baby – or two or even three babies.
- Many mothers worry about the size of their breasts. Women with small breasts often worry that they cannot produce enough milk.
- *Ask: Think back to Session 24 when we looked at the anatomy of the breast. What is it that makes some breasts large and others small?*

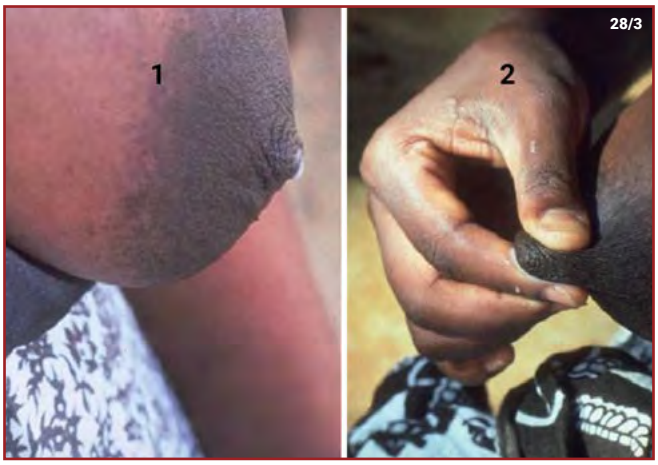
▸ Wait for a few replies and then continue.

- Differences in the sizes of breasts are mostly due to the amount of fat, and not the amount of tissue that produces milk. It is important to reassure women that they can produce enough milk, whatever the size of their breasts.
- The nipples and areolas are different shapes and sizes too.
- *Ask: Does the size or shape of the nipple affect breastfeeding?*

▸ Wait for a few replies and then continue.

- Sometimes the shape makes it difficult for a baby to get well attached to the breast. The mother may need extra help at first to make sure that her baby can suckle effectively.
- However, babies can breastfeed quite well from breasts of any size, with almost any shape of nipple.
- Remember also that a baby can attach poorly whatever the shape of their mother's nipple – for example if they have been given bottle feeds, or if there is no one to help their mother to improve her technique.

► Show **Slide 28/3 – Flat nipple and protractility** and make the points that follow:

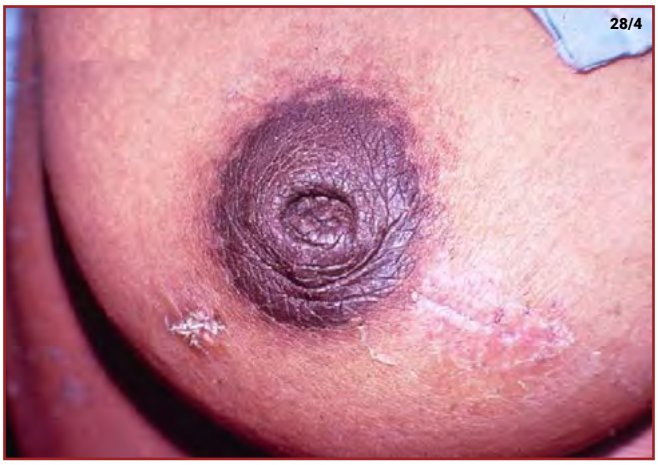


- *Ask: What do you think of the nipple in picture 1?*

► Wait for a few replies and then continue.

- The nipple looks flat. It does not stand out much.
- A doctor told this mother that her baby would not be able to suckle from it. She lost confidence that she could breastfeed successfully.
- However, remember from Session 24 that a baby does not suck from the nipple. The baby takes the nipple and the breast tissue underlying the areola into their mouth to form a "teat". The nipple only forms about one third of the "teat" of breast tissue in the baby's mouth.
- In picture 2, the mother is testing her breast for protractility. She is finding out how easy it is to stretch out the tissues underlying the nipple. This nipple is quite protractile, and it should be easy for her baby to stretch it to form a "teat" in their mouth. The baby should be able to suckle from this breast with no difficulty.
- **Key point:** Nipple protractility is more important than the shape of a nipple.
- Protractility improves during pregnancy, and in the first week or so after a baby is born. So even if a woman's nipples look flat in early pregnancy, her baby may be able to suckle from the breast without difficulty.

▸ Show **Slide 28/4 – Inverted nipples** and make the points that follow:



- *Ask: What do you think of this nipple?*

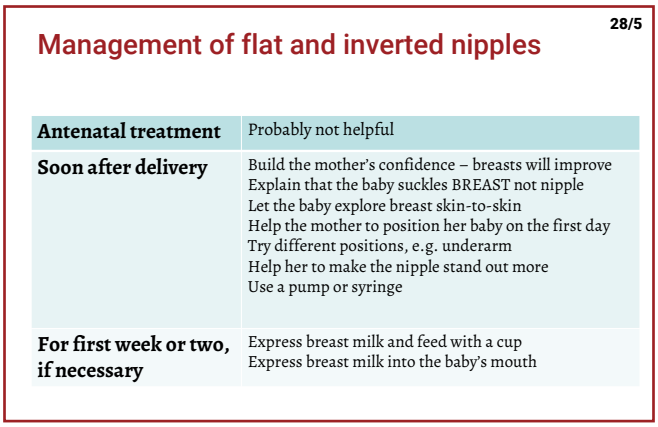
▸ Wait for a few replies and then continue.

- The nipple is inverted.
- If this woman tests her breast for protractility, her nipple will go in instead of coming out.
- *Ask: What else do you notice about the breast?*

▸ Wait for a few replies and then continue.

- You can see a scar on her breast. This mother had a breast abscess. This was probably because her baby did not attach well to the breast and remove the milk effectively. With skilled help, she probably could have breastfed successfully.
- Fortunately, nipples as difficult as this are rare.

▸ Show **Slide 28/5 – Management of flat nipples** and make the points that follow:



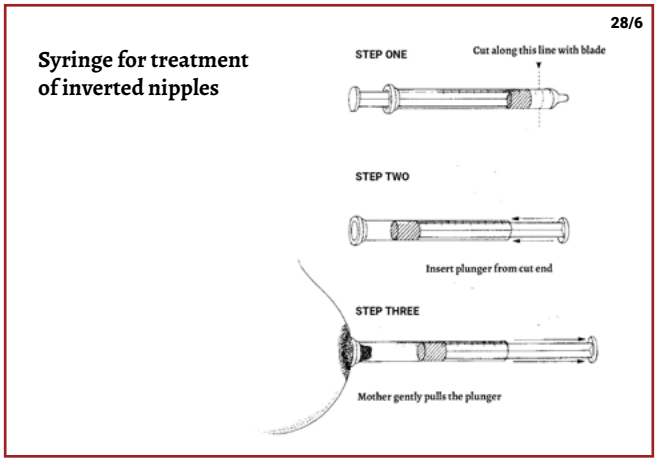
- **Antenatal treatment is probably not helpful**. For example, stretching the nipples or wearing nipples shells does not help. Most nipples improve around the time of delivery without any treatment.
- However, if a woman is worried that her nipples may be flat or inverted, examine them and assess their protractility. It is helpful to explain about them and to build her confidence that she will be able to breastfeed.
- Help is most important soon after delivery when the baby starts breastfeeding.
- It is important to **build the mother's confidence**. Explain that it may be difficult at the beginning, but with patience and persistence, she can succeed. Explain that her breasts will become softer in the week or two after delivery.
- **Explain that a baby suckles from the breast – not from the nipple**. Her baby needs to take a large mouthful of breast. Explain also that, as her baby breastfeeds, they will stretch her breast and nipple out.
- **Encourage her to give plenty of skin-to-skin contact, and let her baby explore her breasts**. Let the baby try to attach to the breast on their own, whenever they are interested. Some babies learn best by themselves. Show her how to lean back in the reclining position to give the baby skin-to-skin contact. Some babies can attach more easily in this position.
- **Help her to position her baby so that they can attach better**. If a baby does not attach well by themself, help the mother to position the baby so that they can attach better. Give her this help early, in the first day, before her breast milk "comes in" and her breasts are full.
- **Help her to try different positions to hold her baby**. Sometimes putting a baby to the breast in a different position makes it easier for them to attach; for example, some mothers find that the underarm position is helpful. Sometimes it helps if the mother leans over the baby so that her breast fall towards her baby's mouth.
- **Help her to make her nipple stand out more before a feed**. Sometimes making the nipple stand out before a feed helps a baby to attach. Stimulating her nipple may be all that a mother needs to do. Or she can use a hand breast pump, or a syringe, to pull her nipple out.
- Sometimes **shaping the breast** makes it easier for a baby to attach. To shape her breast, a mother supports it from underneath with her fingers, and presses the top of the breast gently with her thumb. She should be careful not to hold her breast too near the nipple. If it is acceptable to both partners, the woman's husband can suck on her nipples a few times to stretch them.
- If a baby cannot suckle effectively in the first week or two, help their mother to **try to express her milk and feed it to her baby by cup**. Expressing milk also helps to keep the breasts soft, so that it is easier for the baby to attach; it also helps to keep up the supply of milk. She should not use a bottle because that makes it more difficult for her baby to take her breast.
- Some mothers find it helpful to **express a little milk directly into the baby's mouth**. The baby gets some milk straight away, so they are less frustrated. The baby may be more willing to try to suckle.
- The mother should continue to give the baby skin-to-skin contact, and let them explore her breasts and try to attach on their own.

▸ Demonstrate the syringe method for treating inverted nipples.

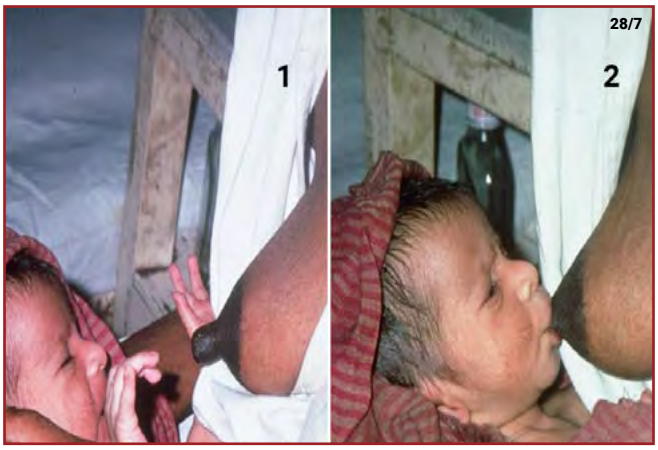
DEMONSTRATION 28.A SYRINGE METHOD FOR TREATMENT OF INVERTED NIPPLES

- Show **Slide 28/6** and leave it on the screen while you give the demonstration. Let participants know that the method is also included in Fig. 28.1 in their *Participant's manual*.
- Explain that this method is for treating inverted nipples postnatally, and to help a baby to attach to the breast. It is not certain whether it is helpful antenatally.
- Show participants the 20 mL syringe that you have prepared, and explain how you cut off the adaptor end of the barrel.
- Put the plunger into the cut end of the barrel (that is, the reverse of its usual position).
- Use a model breast, and put the smooth end of the barrel over the nipple. Pull out the plunger to create suction on the nipple.
- Explain that, with a real breast, there is an airtight seal, and the nipple is drawn out into the syringe.
- Explain that the mother must use the syringe herself.
- Explain that you would teach her to:
  - put the smooth end of the syringe over her nipple, as you demonstrated
  - gently pull the plunger to maintain steady but gentle pressure
  - do this for 30 seconds to 1 minute, several times a day
  - push the plunger back to decrease the suction, if she feels pain. This prevents damaging the skin of the nipple and areola
  - push the plunger back, to reduce suction, when she removes the syringe from her breast
  - use the syringe to make her nipple stand out just before she puts her baby to the breast.

- Demonstrate how the syringe creates suction, by trying it on the front of your forearms. Usually, the syringe will stick there for a few minutes.
- Pass the prepared syringe around among the participants and let them try it out on their own forearms.



▸ Show **Slide 28/7 – Long nipples** and make the points that follow:



- *Ask: What do you think of the nipple in picture 1?*

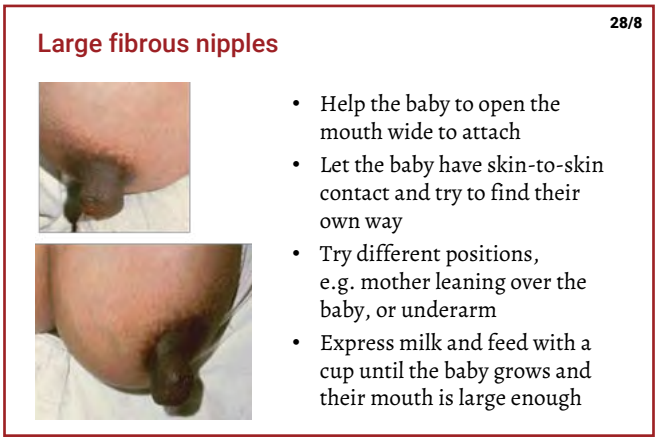
▸ Wait for a few replies and then continue.

- The nipple is long.
- *Ask: What do you think of the baby's attachment in picture 2?*

▸ Wait for a few replies and then continue.

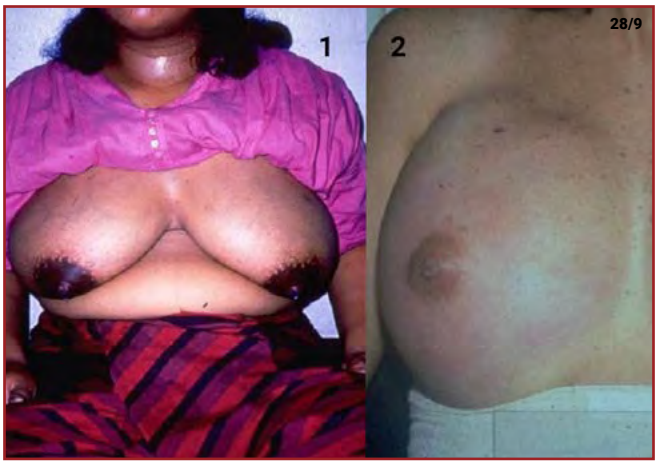
- The baby is poorly attached. Their chin is far from the breasts, the baby's mouth is closed, and the breast looks pulled out.
- You might think that long nipples are an advantage, and that they are easy for a baby to suckle from. But this slide shows that long nipples too can cause difficulties. A baby is likely to suck only the nipple, and they may not take the breast with the large ducts into their mouth.
- It is important to be ready to help this mother with her breastfeeding technique. Help her to get her baby to take more breast into their mouth – not just the nipple.

▸ Show **Slide 28/8 – Large fibrous nipples** and make the points that follow:



- Some nipples are very large, such as the ones shown here. It may be difficult for a baby to get this sort of nipple into their mouth.
- However, if the mother holds her baby in a good position, and touches their mouth so that they open it, the baby may open wide enough to attach to the breast. The mother needs extra help and patience to do this.
- Show her how to lean over her baby, on a bed or table, so that her breast falls towards the baby's mouth; this may make it easier for the baby.
- Suggest that she gives the baby plenty of skin-to-skin contact and lets them try to find their own way to the breast.
- Teach her how to express her milk and feed her baby with a cup until they have grown and their mouth is big enough to suckle more easily.

▸ Show **Slide 28/9 – Full and engorged breasts** and make the points that follow:



- *Ask: What do you notice about the woman's breasts in picture 1?*

▸ Wait for a few replies and then continue.

- They look large, and you can see that milk is dripping out of them. It has made stains on her skirt. Her breasts are full.
- This is a few days after delivery, and her milk has "come in" and her breasts have filled with milk. Her breasts feel hot and heavy and hard.
- However, her milk is flowing well.
- This is normal fullness. Sometimes full breasts feel quite lumpy.
- The only treatment that she needs is for her baby to breastfeed frequently, to remove the milk.
- The heaviness, hardness or lumpiness decreases after a feed, and the breasts feel softer and more comfortable.
- In a few days, her breasts will adjust to the baby's needs, and they will feel less full.
- *Ask: What do you notice about the breast in picture 2?*

▸ Wait for a few replies and then continue.

- This breast is engorged.
- Engorgement means that the breasts are overfull and swollen, partly with milk, and partly with increased tissue fluid and blood, which interferes with the flow of milk, so that it cannot get out easily.
- The breast in this picture looks shiny, because it is oedematous. Her breasts feel painful and her milk does not flow well.
- *Ask: What do you notice about the nipple in picture 2?*

▸ Wait for a few replies and then continue.

- It is flat, because the skin is stretched tight.
- When a nipple is stretched tight and flat like this, it is difficult for a baby to attach to it, and to remove the milk.
- Sometimes when breasts are engorged, the skin looks red and the woman has a fever. This may make you think that she has mastitis. However, the fever usually settles in 24 hours.

▸ Show **Slide 28/10 – Differences between full and engorged breasts** and make the points that follow:

28/10

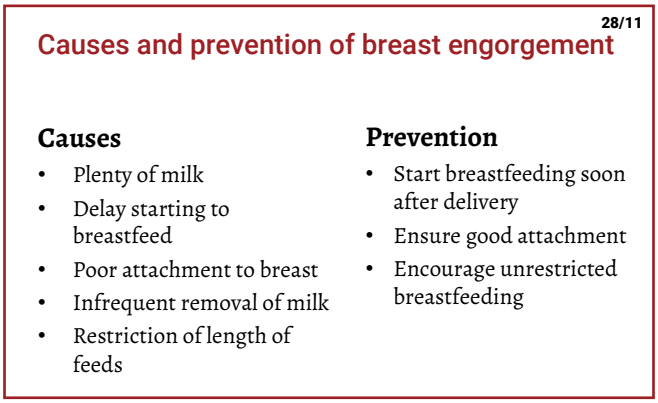
Differences between full and engorged breasts

Full breasts	Engorged breasts
Hot	Painful
Heavy	Oedematous
Hard	Tight, especially nipple
	Shiny
	Faint diffuse redness
Milk flowing	Milk not flowing (may drip)
No fever	May be fever for 24 hours

- Refer participants to the table SUMMARY OF DIFFERENCES BETWEEN FULL AND ENGORGED BREASTS on page 206 of their *Participant's manual*.
- Ask participants to have their manuals closed for the next few slides.
- It is important to be clear about the difference between full and engorged breasts. Engorgement is not so easy to treat.
- This slide summarizes the differences.
- Ask one participant to read from the slide the signs of FULL BREASTS, and then ask another participant to read the signs of ENGORGED BREASTS.
- *Ask: Can you think of any reasons why breasts may become engorged?*

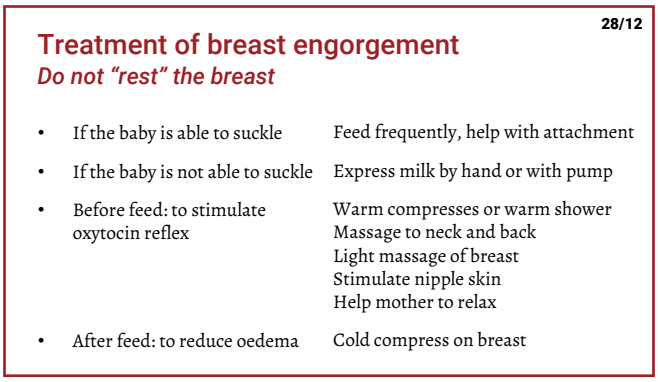
▸ Wait for a few replies and then continue.

▶ Show **Slide 28/11 – Causes and prevention of breast engorgement** and make the points that follow, if they have not been mentioned by the participants:



- Causes of engorgement are:
  - Plenty of milk
  - Delay in starting breastfeeding after birth
  - Poor attachment to the breast so breast milk is not removed effectively
  - Infrequent removal of milk, for example, if breastfeeding is not on demand
  - Restricting the length of breast feeds.
- The slide also shows that three most important ways to prevent engorgement are:
  - Letting the baby feed as soon as possible after delivery
  - Making sure that the baby is well positioned and attached to the breast
  - Encouraging unrestricted breastfeeding.
- You can see that prevention is closely related to the causes of engorgement. A baby should suckle effectively from soon after delivery, without restrictions on the length or frequency of feeds. Then the milk pressure does not build up in the breasts. Engorgement is less likely to occur.

▸ Show **Slide 28/12 – Treatment of breast engorgement** and make the points that follow:

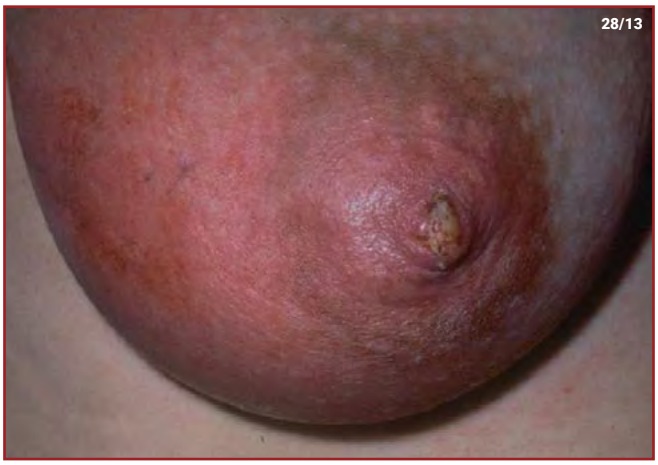


- This slide summarizes the treatment of breast engorgement.
- To treat engorgement, it is essential to remove milk. If milk is not removed, mastitis may develop, an abscess may form and production of breast milk decreases.
- So, do not advise a mother to "rest" her breast.
- **If the baby is able to suckle, they should feed frequently**. This is the best way to remove milk. Help the mother to position her baby, so that they attach well. Then the baby suckles effectively, and does not damage the nipple.
- **If the baby is not able to suckle, help the mother to express her milk=**. She may be able to express by hand or she may need to use a breast pump, or a warm bottle (see SESSIONS 17 and 33: EXPRESSING BREAST MILK 1 and 2. Sometimes it is only necessary to express a little milk to make the breast soft enough for the baby to suckle. Pressing around the areola can help to soften the tissues beneath, which makes expressing easier.
- **Before feeding or expressing, stimulate the mother's oxytocin reflex**. Some things that you can do to help her, or that she can do are:
  - put a warm compress on her breasts, or take a warm shower
  - massage her back and neck
  - massage her breast lightly
  - stimulate her breast and nipple skin
  - help her to relax.
- Sometimes a warm shower or bath makes milk flow from the breasts so that they become soft enough for the baby to suckle.
- **After a feed, put a cold compress on her breasts**. This will help to reduce oedema.
- **Build the mother's confidence**. Explain that she will soon be able to breastfeed comfortably again.

Engorgement in a woman living with HIV who is stopping breastfeeding

- **Make the following points:**
  - We have just discussed the management of engorgement in a woman who wishes to continue breastfeeding.
  - Engorgement may occur in a woman living with HIV who stops breastfeeding abruptly.
  - When a mother who is living with HIV is trying to stop breastfeeding, she should only express enough milk to relieve the discomfort and not to increase the milk production.
  - Milk may be expressed a few times per day when the breasts are overfull, to make the mother comfortable.
  - You may have heard of pharmacological treatments to reduce the milk supply. These are not recommended. However, a simple analgesic, for example ibuprofen, may be used to reduce inflammation and help the discomfort while the mother's milk supply is decreasing. If ibuprofen is not available, then paracetamol may be used.

- **Show Slide 28/13 – Mastitis and make the points that follow:**

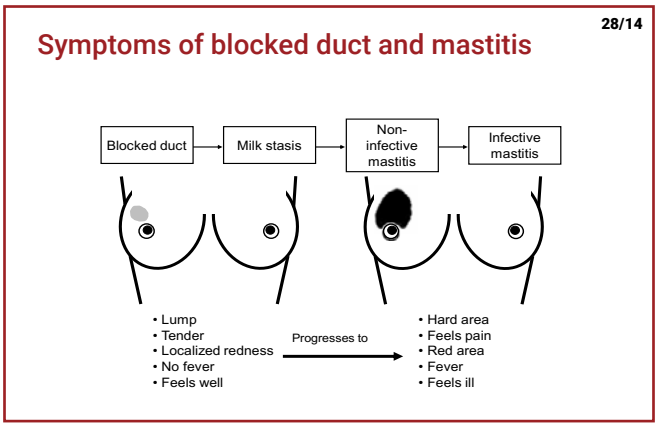


  - *Ask: What do you notice about this breast?*

- **Wait for a few replies and then continue.**
  - Part of the breast looks red and swollen. There is a fissure on the tip of the nipple.
  - *Ask: What condition is this?*

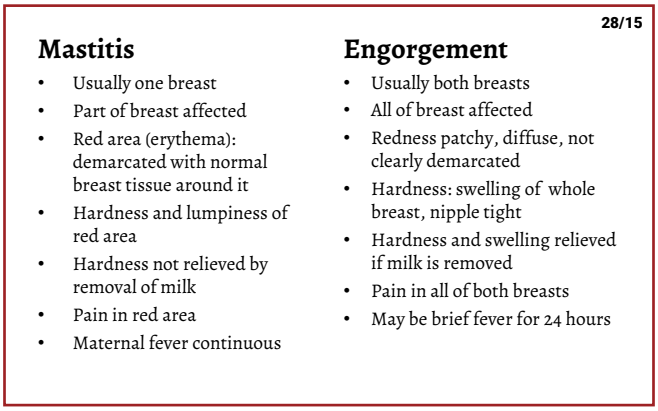
- **Wait for a few replies and then continue.**
  - This is mastitis.
  - The woman has severe pain and a fever, and she feels ill. Part of the breast is swollen and hard, with redness of the overlying skin. The other part of the breast looks normal.
  - Mastitis is sometimes confused with engorgement.
  - However, engorgement affects the whole breast, and often both breasts. Mastitis affects part of the breast, and usually only one breast.
  - Mastitis may develop in an engorged breast, or it may follow a condition called blocked duct.

► Show **Slide 28/14 – Symptoms of blocked duct and mastitis** and make the points that follow:



- This slide shows how mastitis develops from a blocked duct.
- A blocked duct occurs when the milk is not removed from part of a breast. Sometimes this is because the duct to that part of the breast is blocked by thickened milk.
- The symptoms are a lump that is tender, and often redness of the skin over the lump. The woman has no fever and feels well.
- When milk stays in part of a breast, because of a blocked duct, or because of engorgement, it is called milk stasis. If the milk is not removed, it can cause inflammation of the breast tissue, which is called non-infective mastitis.
- Sometimes a breast becomes infected with bacteria, and this is called infective mastitis.
- It is not possible to tell from the symptoms alone whether mastitis is non-infective or infective. If the symptoms are all severe, however, the woman is more likely to need treatment with antibiotics.

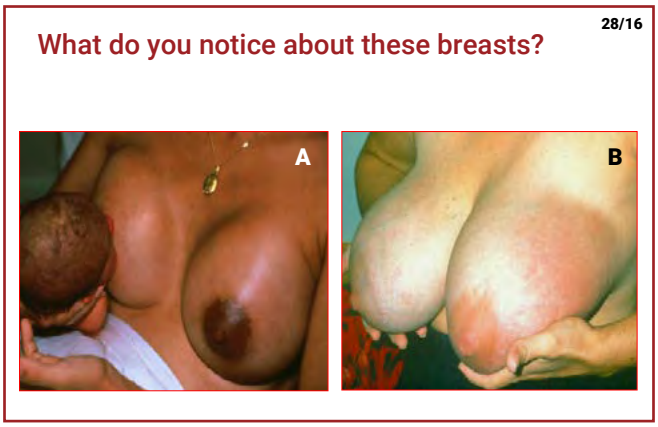
¤ Show **Slide 28/15 – Differences between mastitis and engorgement** and make the points that follow:



¤ Mastitis is sometimes confused with engorgement. There are important differences that can help you to decide which it is:

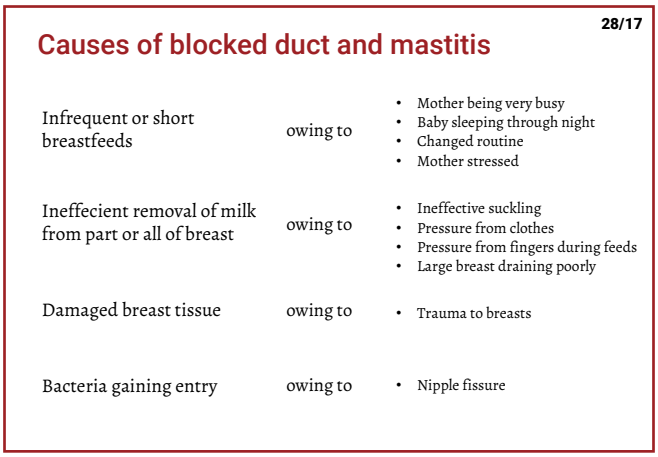
- Mastitis usually affects only one breast, though sometimes it can affect both. Engorgement usually affects both breasts.
- Mastitis affects part of the breast, and engorgement affects the whole breast.
- With mastitis, there is usually a clearly demarcated (or marked) area of bright redness of the skin, surrounded by normal breast tissue. With engorgement, there may also be some redness, but it is diffuse and patchy and not clearly demarcated.
- With mastitis, the red area is hard and may be lumpy, but the rest of the breast is soft, and the nipple is unaffected. With engorgement, the whole breast is swollen, and the nipple may be pulled tight and flattened.
- With mastitis, removal of the milk does not relieve the hardness, but with engorgement, there is usually some relief immediately.
- With mastitis, there is severe pain, mostly in the red area. With engorgement, the pain is less severe, but through the whole breast.
- With mastitis, the woman has a continuous fever. With engorgement, there may be fever; if there is, it is usually for only 24 hours.

- Show **Slide 28/16 – Comparing engorgement and mastitis** and make the points that follow:



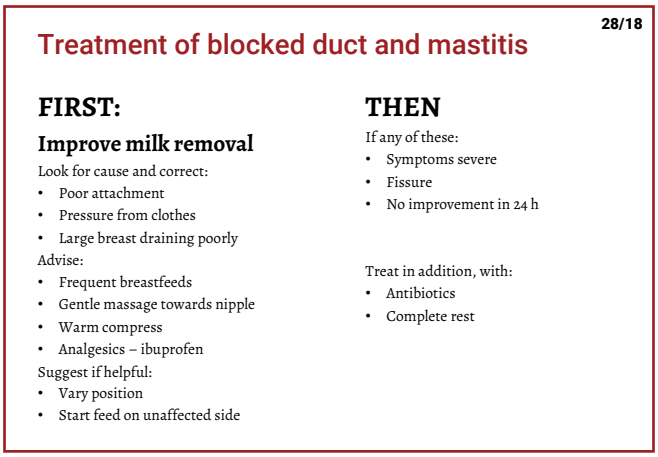
  - *Ask: What is the difference between the breasts of these two women?*
- Wait for a few responses and then continue.
- Participants may say straight away "engorgement" or "mastitis. Do not tell them whether they are correct or not, but ask them to look at the list of signs or engorgement and mastitis from the previous slide, and to check for the signs that they can see. Some signs such as pain and fever cannot be seen in a photograph.
- Ask participants to compare the breasts, to say what condition each woman has, and to explain why they have come to that conclusion.
  - With woman A:
    - Both breasts are affected.
    - The whole of both breasts is swollen, with a "shelf" at the edge of the swelling.
    - There is no clearly demarcated redness.
  - With woman B:
    - Only the left breast is affected.
    - Part of the breast is bright red.
    - The red area is clearly demarcated, and the skin around it looks normal.
  - Woman A has engorgement; woman B has mastitis of the left breast.
  - You may notice that there are pressure lines on the breast of woman B, behind the red area near her chest. This suggest that the women's clothes are too tight and are pressing on the breast. This may be a cause of the mastitis.

▶ Show **Slide 28/17 – Causes of blocked duct and mastitis** and make the points that follow:



- This slide summarizes the causes of blocked duct and mastitis. The main cause is not removing the milk adequately from all or part of a breast.
- Failure to remove the milk may be due to infrequent or short breastfeeds, or inefficient removal of milk from part or all of the breast.
- **Infrequent breastfeeds** may occur when a mother is very busy; when a baby starts feeding less often, for example when they start to sleep through the night, or feed irregularly; or because of a changed feeding pattern for another reason, for example, the mother returning to work or going on a journey; or if the mother is stressed or overworked.
- **Inefficient removal of milk** from part or all the breast usually occurs when the baby is poorly attached to the breast, so the baby may remove milk from only part of the breast; it can also occur if there is pressure from tight clothes, especially a bra worn at night, or from lying on the breast, which can block one of the ducts, or pressure of the mother's fingers, which can block milk flow during a breastfeed; it can also occur if the lower part of a large breast drains poorly because of the way in which the breast hangs.
- **Damaged breast tissue**, for example caused by trauma, sometimes causes mastitis, for example, a sudden blow, or an accidental kick by an older child.
- Remember that if a baby is poorly attached and positioned and is suckling at the breast, this may cause a nipple fissure, which provides a way for **bacteria to enter the breast tissue** and may lead to mastitis.

▶ Show **Slide 28/18 – Treatment of blocked duct and mastitis** and make the points that follow:



- This slide summarizes the treatment of blocked duct and mastitis.
- **Key point:** The most important part of treatment is to improve the drainage of milk from the affected part of the breast.
- Look for a cause of poor drainage and correct it. Look for poor attachment or pressure from clothes (particularly a tight bra) and notice what the mother does with her fingers as she breastfeeds. Does she hold the areola and possibly block milk flow? Notice whether she has large, pendulous breasts, and whether the blocked duct is in the lower part of her breast.
- Suggest that she lifts the breast more while she feeds the baby, to help the lower part of the breast to drain better.
- Whether or not you find a cause, there are several suggestions to offer to the mother.
- **Breastfeed frequently**. The best way is for the mother to rest with her baby, so that she can respond to the baby and feed them whenever they are willing.
- **Gently massage the breast while the baby is suckling**. Show her how to massage over the blocked area right down to the nipple. This helps to remove the block from the duct. She may notice that a plug of thick material comes out with her milk. This is safe for the baby to swallow.
- **Apply warm compresses to the breast between feeds**.
- **Treat symptoms of pain and fever**. Give an analgesic, preferably ibuprofen, which decreases inflammation. An alternative is paracetamol.
- Sometimes it is helpful to start the feed on the unaffected breast. This may help if pain seems to be preventing the oxytocin reflex. Change to the affected breast after the reflex starts working.
- **Try feeding the baby in different positions at different feeds**. This helps to remove milk from different parts of the breast more equally. Show the mother how to hold her baby in the underarm position, or how to lie down to feed them, instead of holding them across the front at every feed. However, do not make her breastfeed in a position that is uncomfortable for her.
- Sometimes a mother is unwilling to feed her baby from the affected breast, especially if it is very painful. Sometimes a baby refuses to feed from an infected breast, possibly because the taste of the milk changes, and becomes more salty. In these situations, it is necessary to express the milk. If the milk stays in the breast, an abscess is more likely to develop.
- Usually blocked duct or mastitis improves within a day or two, when drainage to that part of the breast improves.
- However, a mother needs additional treatment if there are any of the following: severe symptoms when you first see her, or a fissure through which bacteria may enter, or no improvement after 24 hours of improved drainage.
- Treat her, or refer her for treatment with antibiotics:
  - It can be difficult to find an antibiotic that is readily available and effective; many commonly used antibiotics, such as ampicillin, are not usually effective.
  - Flucloxacillin and erythromycin are usually effective but may not be available.

▸ **Ask participants to turn to page 213 of their *Participant's manual* and look at the box ANTIBIOTIC TREATMENT FOR INFECTIVE MASTITIS, which lists some of the antibiotics that are recommended. However, there is little research on their effectiveness.**

- ¤ Explain to the mother that is very important that she completes the course of antibiotics, even if she feels better in a day or two. If she stops the treatment before is complete, the mastitis is likely to recur.
- ¤ In addition to antibiotics:
  - She needs complete rest.
  - Advise her to take sick leave, if she is employed, or to get help at home with her duties. Talk to her family, if possible, about sharing her work.
  - If she is stressed and overworked, encourage her to try to take more rest.
  - Resting with her baby is a good way to increase the frequency of breastfeeds, to improve drainage.
  - Explain that she should continue with frequent breastfeeds, massage and warm compresses. If she is not eating well, encourage her to take adequate food and fluids. Remember that the most important part of treatment is removal of milk from the breast.

ANTIBIOTIC TREATMENT FOR INFECTIVE MASTITIS

The most common bacterium found in breast abscesses is *Staphylococcus aureus*. Therefore, it is necessary to treat breast infections with a penicillinase-resistant antibiotic such as either flucloxacillin or erythromycin.

Drug	Dose	Instructions
Flucloxacillin	250 mg orally 6-hourly for 7–10 days	Take dose at least 30 minutes before food
Erythromycin	250–500 mg orally 6-hourly for 7–10 days	Take dose 2 hours after food
Alternatives if these are not available		
Amoxicillin/clavulanate (Augmentin)	875 mg orally Twice daily for 7–10 days	
Cefalexin	250–500 mg orally 6-hourly for 7–10 days	
Clindamycin	300 mg orally 6-hourly for 7–10 days	
Dicloxacillin	500 mg 6-hourly for 7–10 days	
Cloxacillin	250–500 mg 6-hourly for 7–10 days	

Mastitis in a woman living with HIV

- **Make the following points:**
  - In a woman who is HIV positive, mastitis or nipple fissure (especially if bleeding or oozing) may increase the risk of HIV transmission. Therefore, the recommendation to increase the frequency and duration of feeds in mastitis is not appropriate for these women.
  - *Ask: If a woman who is HIV positive gets mastitis or a fissure, what should she do?*
- **Wait for a few replies and then continue.**
  - If a woman living with HIV develops mastitis or a fissure, she should avoid breastfeeding from the affected side while the condition persists. It is the same if she develops an abscess.
  - She must express milk from the affected breast, to ensure adequate removal of milk. This is essential to prevent the condition becoming worse, to help the breast recover, and to maintain milk production. The health worker should help her to ensure that she is able to express milk effectively.
  - If only one breast is affected, the infant can feed from the unaffected side, feeding more often and for longer to increase milk production. Most infants get enough milk from one breast. The infant can feed from the affected breast again when it has recovered.
  - If both breasts are affected, she will not be able to feed from either side. The mother will need to express her milk from both breasts. Breastfeeding can resume when the breasts have recovered.
  - The health worker may need to discuss other feeding options for her to use meanwhile. The mother can feed the baby with her expressed breast milk; she may decide to heat-treat her expressed milk, or to give commercial formula milk. The infant should be fed by cup.
  - Give antibiotics for 10–14 days to avoid relapse. Give pain relief and suggest rest, as for a woman who is not living with HIV.
  - Sometimes a woman may decide to stop breastfeeding at this time, if she is able to give another form of milk safely. She should continue to express enough milk to allow her breasts to recover and to keep them healthy, until milk production ceases.

- Show **Slide 28/19 – Nipple fissure** and make the points that follow:

- Picture 1 shows a mother's breast, and picture 2 shows the same mother feeding her baby on the breast.
- *Ask: What do you notice about her breast?*

▶ Wait for a few replies and then continue.

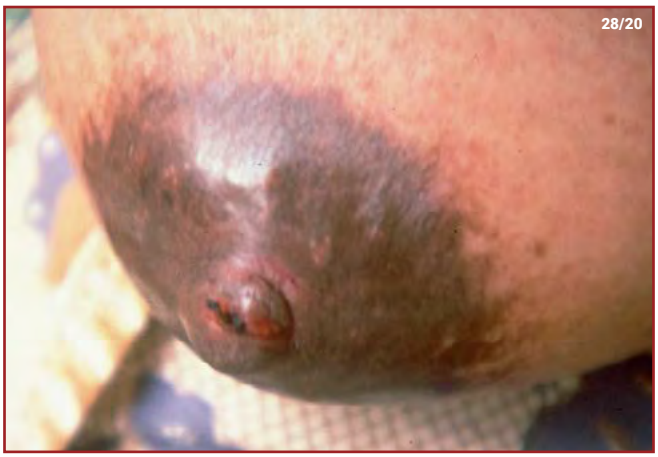
- There is a fissure, or crack, around the base of the nipple. You may be able to see that the breast looks swollen and shiny, showing that it is also engorged.
- *Ask: What do you notice about the baby's position and attachment?*

▶ Wait for a few responses and then continue. Encourage participants to think systematically through THE FOUR KEY POINTS OF GOOD POSITIONING and THE FOUR KEY POINTS OF GOOD ATTACHMENT. Ask participants to turn to page 170 of their *Participant's manual* and find the JOB AID: BREASTFEED OBSERVATION.

- The baby is poorly positioned.
- His body is twisted away from his mother so his head and body are not in line.
- His body is not held close to his mother's.
- His body is unsupported.
- He is poorly attached.
- His mouth is closed.
- His lower lip is pointing forward.
- His chin is not touching the breast.
- There is more areola seen above baby's top lip than below the bottom lip.
- This poor attachment may have caused both the breast engorgement and the fissure.
- The most common cause of sore nipples is poor attachment.
- If a baby is poorly attached, they pull the nipple in and out as they suck, and rub the skin of the breast against their mouth. This is very painful for their mother.
- At first there is no fissure. The nipple may look normal; or it may look squashed with a line across the tip when the baby releases the breast. If the baby continues to suckle in this way, it damages the nipple skin and causes a fissure, as you see here.
- If a mother has sore nipples or a fissure:
  - Suggest to the mother not to wash her breasts more than once a day, and not to use soap or rub hard with a towel. Washing removes natural oils from the skin and makes soreness more likely.
  - Do not recommend medicated lotions and ointments, because these can irritate the skin, and there is no evidence that they are helpful.

- Suggest that after breastfeeding, she rubs a little expressed breast milk over the nipple and areola with her finger. This promotes healing.
- Help her to improve her baby's position, so that they are well attached.
- Often, as soon as the baby is well attached, the pain is less. The baby can then continue breastfeeding normally – there is no need to rest the breast to allow the nipples to heal. They will heal rapidly when they are not being damaged any more.
- When the mother understands what she needs to do, leave her to practise attaching the baby for a few feeds. Then come back and observe her breastfeeding again and see whether she needs more help. If a baby has been poorly attached for a number of feeds, it can take a while to get it right.

► Show **Slide 28/20 – Breast engorgement and nipple fissure** and make the points that follow:



¤ *Ask: What do you notice about this breast?*

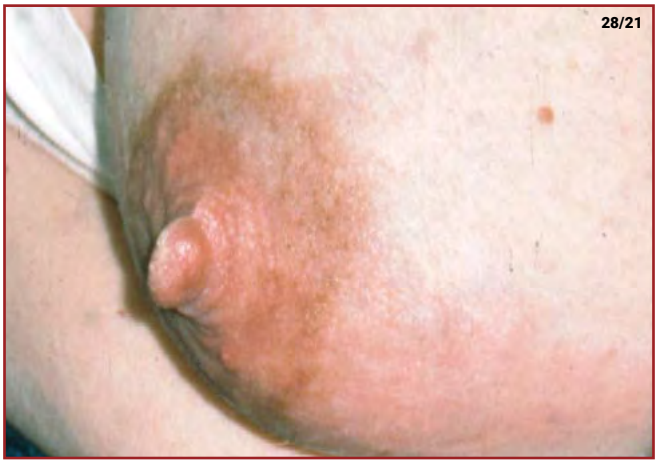
► Wait for a few replies and then continue.

¤ There is a fissure across the tip of the nipple. You can also see that the breast skin is tight and shiny. It is oedematous. This breast is also engorged.

¤ This mother waited to put her baby to her breast until her milk had "come in" and her breasts felt full – at about 3 days. The skin was so tight that her nipples were flat and her breast was poorly protractile. Her baby could suck only on the nipple, which damaged the nipple skin.

¤ This shows some of the reasons why it is important to breastfeed within an hour after delivery. It is easier for a baby to attach well at this time, when the breasts are still soft, so there is less chance of nipple damage. Also, breastfeeding early helps to prevent the milk pressure from building up, so it helps to prevent engorgement.

- Show **Slide 28/21 – Pressure line on the nipple** and make the points that follow:



- *Ask: What do you notice about this breast?*

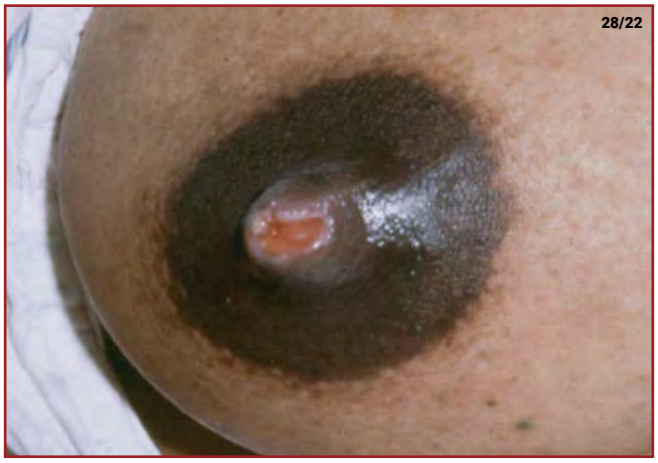
▶ **Wait for a few replies and then continue.**

- There is a ridged line across the tip of the nipple. This is because of pressure, which has squashed the nipple. It is a sign of poor attachment.
- There is a red area on the breast skin below the nipple. The mother also had mastitis. She had a fever and felt unwell.
- You may see a line like this as a baby releases the breast. It stays for a few seconds, and then the nipple returns to its usual shape. The mother may not feel pain at this stage, but if the baby continues to suckle in this way, then the line will become a painful fissure.
- *Ask: What may be the connection between the line on the nipple and the mastitis?*

▶ **Wait for a few replies and then continue.**

- Both resulted from poor attachment.
- A midwife helped her to improve the attachment. The mastitis cleared after a few days, and there were no more lines on the nipple.

- Show **Slide 28/22 – Ulcerated nipple** and make the points that follow:



- *Ask: What do you notice about this breast?*

▶ **Wait for a few replies and then continue.**

- There is an open fissure across the tip of the nipple. It is really an ulcer.
- This kind of damage results when a baby continues to suckle with poor attachment for a long time. This mother was determined to feed her baby in the best way, so she neglected herself and continued breastfeeding even though she was in severe pain.
- Explain that the baby's suckling has damaged her nipple because the baby is not taking the breast into his mouth properly. Explain that if the baby is well attached, suckling will become less painful, they will stop damaging the nipple, and the ulcer will be able to heal.
- Show her how to attach her baby well and encourage her to continue breastfeeding if she possibly can. Encourage her to continue feeding on the other breast if is not affected.
- If the pain is severe and she cannot breastfeed immediately, then it is important to remove the milk another way, to avoid engorgement and mastitis. Show her how to express her milk and feed it to the baby with a cup for a few days.
- *Ask: Would you apply ointment or a dressing to cover this nipple?*

▶ **Wait for a few replies and then continue.**

- A simple fissure usually heals by the edges joining together. But with open fissures and ulcers, the edges cannot come together, and they need to heal from the base of the wound. New skin cells need to grow over the surface. They do this best if the surface is wet. If the wound is dry, a hard scab forms, which delays healing. It is like having a cracked lip: if you let it dry, and then you smile and stretch the lip, you easily open the crack again. If you put a dry dressing over the ulcer, the exudate may stick to the dressing, so that the ulcer opens again when you take the dressing off.
- There are many ointments that are sometimes recommended for sore nipples. Medicated ointments can cause sensitivities and allergies, and is better not to use them.
- The most useful method is called moist wound healing, which is explained in the next slide.

▸ Show **Slide 28/23 – Moist wound healing for ulcerated nipples** and make the points that follow:

28/23

Moist wound healing for ulcerated nipples

Open fissure or ulcer:

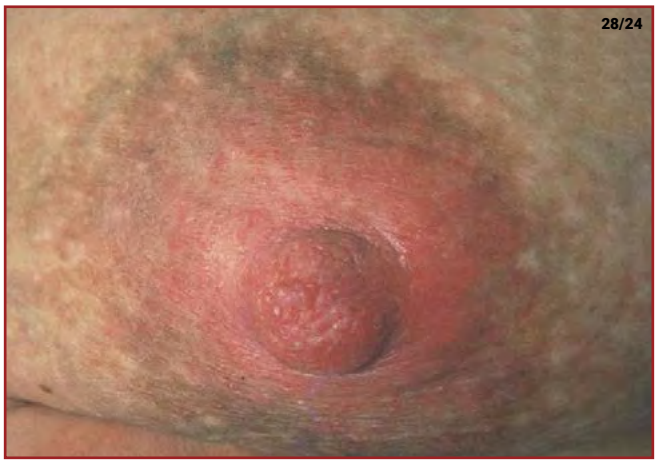
- The wound needs to heal from the base up
- New cells need to grow over a moist (wet) surface
- If the wound is dry, it delays healing

Management:

- Apply white soft paraffin or purified lanolin between feeds
- Cover with a clean breast pad, piece of gauze or cloth
- If the wound is inflamed, or exudes pus, the mother may need antibiotics

- To keep the wound moist, cover it with white soft paraffin, or purified lanolin. Then cover it with a clean dressing – a breast pad, or a piece of gauze or clean cloth. The mother's clothes may keep the dressing in place, or if necessary use zinc oxide tape.
- If the wound becomes inflamed, or if there is a lot of pus, then it may be infected and the woman may need antibiotics, as for mastitis.

▸ Show **Slide 28/24 – *Candida* infection** and make the points that follow:



- This mother has very sore, itchy nipples.
- *Ask: What do you see that might explain the soreness?*

▸ Wait for a few replies and then continue.

- There is a shiny red area of skin on the nipple and areola.
- This is a *Candida* infection, or thrush, which can make the skin sore and itchy. *Candida* infections often follow the use of antibiotics to treat mastitis or other infections.
- Some mothers describe burning or stinging and sometimes the pain shoots deep into the breast. A mother may say that it feels as though needles are being driven into her breast.
- The pain continues after the end of a feed, and may be worse between feeds than during them. This is different from soreness due to poor attachment, which is mostly during feeds.
- The skin may look red, shiny and flaky. The nipple and areola may lose some of their pigmentation. Sometimes the nipple looks normal.
- Suspect *Candida* if sore nipples persist even when the baby's attachment is good. Check the baby for thrush. They may have white patches inside their cheeks or on their tongue, or they may have a rash on their bottom.
- Treat both mother and baby with nystatin. If treatment is not effective, consider using fluconazole, which is given orally.

- Advise the mother to stop using pacifiers (dummies). Help her to stop using teats, and nipple shields. If these are used, they should be boiled for 20 minutes daily and replaced weekly.
- In women who are living with HIV, it is particularly important to treat breast thrush and oral thrush in the infant promptly.

► Ask participants to turn to page 217 of their *Participant's manual* and find the box TREATMENT OF *CANDIDA* INFECTION OF THE BREAST.

TREATMENT OF *CANDIDA* INFECTION OF THE BREAST

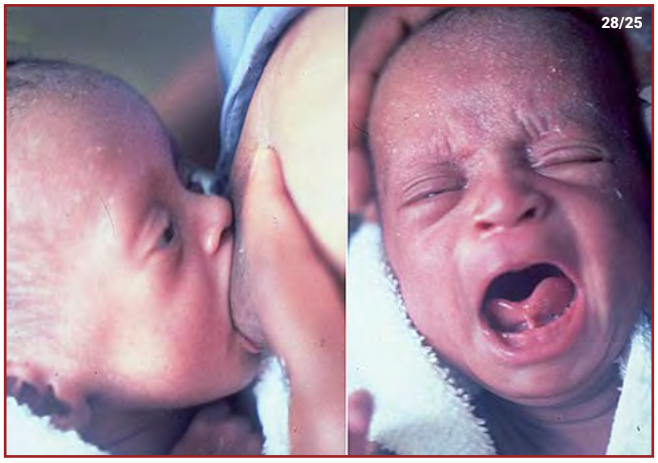
- **Gentian violet paint**
  - To baby's mouth: 0.25%, apply daily or alternate days for 5 days, or until 3 days after the lesions have healed
  - To mother's nipples: 0.5% apply daily for 5 days
- **Nystatin** cream 100 000 IU/g:
  - Apply to nipples 4 times daily after breastfeeds
  - Continue to apply for 7 days after lesions have healed
- **Nystatin** suspension 100 000 IU/mL:
  - Apply 1 mL by dropper to child's mouth 4 times daily after breastfeeds for 7 days, or as long as mother is being treated

OR

- For mother: **fluconazole** 150–300 mg orally once, followed by 50–100 mg twice daily for 2–3 weeks
- For infant, oral *Candida*: **fluconazole** 6 mg/kg orally once, followed by 3 mg/kg per day for 14 days

Stop using pacifiers, teats and nipple shields

► Show **Slide 28/25 – Short frenulum or "tongue tie"** and make the points that follow:



- *Ask: What do you notice about this baby's mouth?*

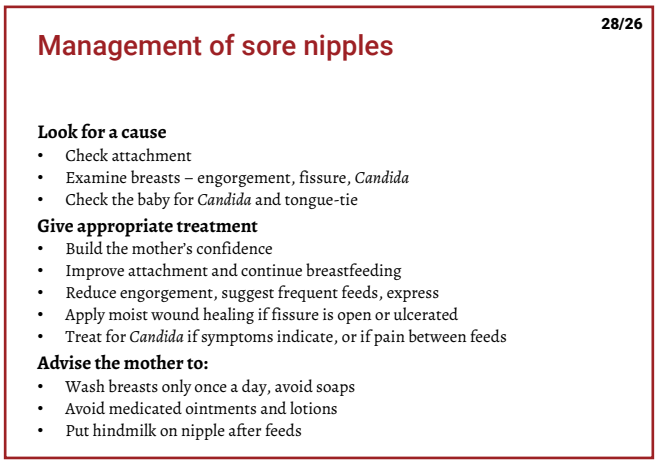
► Wait for a few replies and then continue.

- This is not a breast condition, but it can sometimes be a cause of sore nipples.
- Many mothers worry that their babies have "tongue-tie". In most cases, the baby's tongue is normal, but a little short. Many babies with tongue-tie can breastfeed without any difficulty. Sometimes however, a baby cannot get their tongue far enough over their lower gum to reach the large ducts beneath the areola, so they have difficulty attaching and suckling effectively. The baby may not get enough breast milk, and they may make the nipples sore.
- *Ask: What do you think of this baby's attachment?*

► Wait for a few replies and then continue.

- The baby's chin is not close to the breast, so it is not very good.
- It may be possible to improve the baby's attachment, but even then, they may have difficulty suckling effectively.
- If a baby has difficulty with breastfeeding, and you or their mother think that a short frenulum may be the cause, try to get the baby to take more of the breast into their mouth. In some cases, that is all that is necessary. However, if the tongue-tie is severe, or if the difficulties continue, you may need to refer the baby to a doctor to consider cutting the frenulum surgically.

▶ Show **Slide 28/26 – Management of sore nipples** and make the points that follow:



- This slide summarizes the management of sore nipples.
- First look for a cause.
- Observe the baby breastfeeding, and check for signs of poor attachment.
- Examine the mother's breasts.
- Look for signs of *Candida* infection; look for engorgement; look for fissures.
- Look in the baby's mouth for signs of *Candida* and for tongue tie; and at the baby's bottom for *Candida* rash.
- Then give appropriate treatment.
- Build the mother's confidence.
- Explain that the soreness is temporary, and that soon breastfeeding will be completely comfortable.
- Help her to improve her baby's attachment. Often this is all that is necessary. She can continue breastfeeding, and need not rest her breast.
- Help her to reduce engorgement if necessary. She should breastfeed frequently, or express her breast milk.
- Consider treatment for *Candida* if pain is deep in the breast, if it continues between feeds, if it persists after attachment is corrected, or if there is itchiness.
- Then advise the mother:
  - Not to wash her breasts more than once a day, and not to use soap or rub hard with a towel.
  - Breasts do not need to be washed before or after feeds – normal washing, as for the rest of the body, is all that is necessary. Washing removes natural oils from the skin and makes soreness more likely.
  - Not to use medicated lotions and ointments, because these can irritate the skin, and there is no evidence that they are helpful.
  - Suggest that, after breastfeeding, she applies a little expressed breast milk over the nipple and areola with her finger. This promotes healing.

III. Summarize the session 5 minutes

- Ask participants whether they have any questions, and try to answer them.
- Explain that a summary of this session can be found on pages 201–218 of the *Participant's manual*.

Further information

Breast shape

Breast shape and size is partly inherited. Breasts may be long in girls who have had no children, and small or flat in women who have breastfed several children.

Occasionally, a woman's breasts may fail to develop normally, so that they are unable to produce enough milk, but this is very rare.

Management of inverted nipples

Participants may have heard of different ways to treat inverted nipples, and they may wish to discuss the topic further – especially if they have known of a case that they found difficult to help. These notes may help you to answer questions. However, it is not necessary to give participants this information if they have not heard of these techniques.

Nipple shell

This is a glass or plastic hemisphere, with a hole in the base, to put over a nipple, under the clothes. The nipple is pressed through the hole, to make it stand out more. There is no evidence that these shells help, and they may cause oedema. However, if a mother is worried about inverted nipples, and she has heard of nipple shells and wants to try to use one, let her continue. It may make her feel that she is doing something, and it may help her to feel confident.

Hoffman's exercises

Some women have heard of exercises to stretch nipples. These exercises have not been shown to really help. They are unlikely to make much difference to severely inverted nipples. Nipple exercises can sometimes traumatize the breast, so do not recommend them. However, if a woman has heard about exercises and wishes to do them, let her continue.

Nipple shields

These are teats with a broad plastic or glass base to put over a nipple for a baby to suck through. Mothers sometimes use them if they have conditions such as inverted nipples, or sore nipples. Nipple shields are no longer recommended because they can cause problems and they do not remove the cause of the condition. Nipple shields can reduce the flow of milk; they can cause breast infections, including *Candida*; they can cause "nipple confusion", and may make it more difficult for a baby to learn to suckle directly from the breast. Some mothers find it difficult to stop using them. Nipple shields are not useful except in rare cases, for a short time and with careful supervision.

Engorgement

When breasts are engorged, the milk does not flow well, partly because of the pressure of fluid in the breast, and partly because the oxytocin reflex does not work well.

Non-infective mastitis

- The cause of non-infective mastitis is probably milk under pressure leaking back into the surrounding tissues.
- The tissues treat the milk as a "foreign" substance.
- Also, milk contains substances that can cause inflammation.
- The result is pain, swelling and fever, even when there is no bacterial infection.
- Trauma that damages breast tissue can also cause mastitis. This may also be because milk leaks back into the damaged tissues.

Breast abscess

Participants may wish to discuss breast abscess in more detail.

An abscess is when a collection of pus forms in part of the breast. The breast develops a painful swelling, which feels full of fluid. An abscess needs surgical incision and drainage. If possible, let the baby continue to feed from the breast. There is no danger to the baby. However, if it is too painful, or if the mother is unwilling, show her how to express her milk, and let her baby start to feed from it again as soon as the pain is less – usually in 2–3 days. Meanwhile, she should continue to feed from the other breast. Good management of mastitis should prevent the formation of an abscess.

Treatment of nipple fissures

Ointments for nipple fissure

Sometimes a plain cream such as lanolin may help a fissured nipple to heal after the suckling position has been corrected. However, plain creams are often not available, and they are not usually necessary.

Clothes

In warm weather, a cotton bra may be better for fissured nipples than a nylon bra. However, cotton is not essential, and you should not recommend it to a mother who cannot afford it. If necessary, suggest that she leaves her bra off for a day or two.

Nipple shields

These are no longer recommended for the treatment of fissured nipples.

Notes

Notes (contd)

SESSION 29

Breast conditions: exercise

Participants will now practise what they learnt about in Session 28.

Session outline . . . . . 60 minutes

Participants work in groups of 8–10 with two trainers.

All trainers help to give individual feedback on the exercise.

I. Introduce the session . . . . . 5 minutes
II. Facilitate the written exercise . . . . . 55 minutes

Preparation

- Refer to the Introduction for guidance on facilitating group work and written exercises.
- Study the notes for the session, so that you are clear about what to do.
- Make sure that Answer sheets are available to give to participants at the end of the session.

As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

I. Introduce the session — 5 minutes

- Ask participants to turn to pages 221–227 of their *Participant's manual* and find the exercise for this session.
- Explain what they will do:
  - You will now practise what you learnt about in Session 28.
  - The exercise contains short stories about mothers with various breast conditions, followed by some questions.
  - You should answer the questions using the information from Session 28.
  - You can look back at the notes for Session 28 in your manual if you wish.
  - Read the instructions **How to do the exercise** and the **Example** of what to do
  - Then write your answers in the section that says **To answer**.
  - If possible, use pencil, so that it is easier to correct the answers.
  - When you are ready, discuss your answers with a trainer. Trainers will give feedback individually as you do the exercise and will give you Answer sheets at the end of the session.

II. Facilitate the written exercise — 55 minutes

How to do the exercise:

- Read the stories and write your answers to the questions in pencil in the space after each story.
- When you have finished, discuss your answers with the trainer.

Example:

Mrs A says that both her breasts are swollen and painful. She put her baby to her breast for the first time on the third day, when her milk "came in". This is the sixth day. Her baby is suckling, but now it is rather painful, so she does not let him suck for very long. Her milk is not dripping out as fast as it did before.

What is the diagnosis?

(Engorged breasts)

What may have caused the condition?

(Delay starting to breastfeed)

How can you help Mrs A?

(Help her to express her milk, and help her to position her baby at her breast, so that he can attach better.)

To answer:

Mrs B's baby was born yesterday. She tried to feed her soon after delivery, but she did not suckle very well. She says that her nipples are inverted, and she cannot breastfeed. You examine her breasts, and notice that her nipples look flat. You ask Mrs B to use her fingers and to stretch her nipple and areola out. She is able to stretches the nipple out a short way, showing that the nipple and areola are protractile.

What could you say to accept Mrs B's idea about her nipples?

(Something such as:
I see or *You are worried about your nipples?*)

How could you build her confidence?

(Praise the protractility of her breasts.
Give her relevant information. For example, explain how, if her baby suckles from the breast not the nipple, she stretches the nipple out. She can get the milk if she takes a big mouthful of breast.)

What practical help could you give Mrs Betty?

(Offer to help her to get her baby to take more of her breast into her mouth, that is, to improve her attachment.)

Mrs C has had a painful swelling in her left breast for 3 days. The skin of a large part of the breast looks red, and it is hard and extremely tender. Mrs C has a fever and feels too ill to go to work today. She is a teacher in the local primary school. Her baby sleeps with her and breastfeeds at night. By day, she expresses milk to leave for him. She has no difficulty in expressing her milk. But she is very busy, and it is difficult for her to find time to express milk, or to breastfeed her baby during the day.

What is the diagnosis?

(Mastitis. It is not possible to say if it is infective or non-infective.)

Why do you think that Mrs C has this condition?

(She is very busy, and she feeds and expresses in a hurry. There is a long time between feeds during the day.)

How would you treat Mrs C?

(Suggest that she takes sick leave for a few days, and breastfeeds her baby more often. Help her to get a sick-leave certificate so that she can do this. Ask her about family members and friends who could help her with some of her tasks at home.

- She should rest as much as possible, in bed if she can.
- Give her analgesics (ibuprofen) for a few days.
- If the mastitis is not better by tomorrow, give her antibiotics.)

What could you suggest to prevent the same problem occurring again?

(Discuss the reasons why the condition has occurred.
Help her to think of ways to breastfeed her baby more, and to take more time to express her milk, especially during the day.)

Mrs D complains of nipple pain when her 6-week-old baby is suckling. You examine her breasts while her baby is asleep, and can see no fissures. When the baby wakes, you watch her feeding. Her body is twisted away from her mother's. Her chin is away from the breast, and her mouth is not wide open. She takes rapid, shallow sucks. As she releases the breast, you notice that the nipple looks squashed.

What is the cause of Mrs Dora's nipple pain?

(Her baby is poorly attached to her breast.)

What could you say to build Mrs Dora's confidence?

(Possibilities include:
Praise her for breastfeeding exclusively;
Give relevant information, in a positive way, using simple language:
If you hold your baby closer so that she can take more of the breast into her mouth, breastfeeding should soon be more comfortable.)

What practical help could you give her?

(Offer to help her to improve her baby's position and attachment.)

Mrs E says that her right breast has been painful since yesterday, and she can feel a lump in it, which is tender. She has no fever and feels well. She has started to wear an old bra which is tight, because she wants to prevent her breasts from sagging. Her baby is 10 weeks old and now sometimes sleeps for 6–7 hours at night without feeding. You watch him suckling. Mrs E holds him close, and his chin is touching her breast. His mouth is wide open and he takes slow, deep sucks.

What could you say to empathize with Mrs Ellen's worries about her figure?
(You are worried that breastfeeding may change your figure?)

What is the diagnosis?
(Blocked duct)

What may be the cause?
(Tight clothes, and a long interval between feeds at night.
The baby's attachment to the breast is good.)

What three suggestions would you give Mrs Ellen?
(1. Breastfeed her baby more often for a day or two.
2. Massage the lump gently while her baby is feeding.
3. Try to find a larger bra, which supports her breasts without blocking the ducts.)

Mrs F's baby is 3 months old. She says that her nipples are sore. They have been sore on and off since an attack of mastitis several weeks ago. The mastitis cleared up after a course of antibiotics. This new pain feels like needles going deep into her breast when her baby suckles. The pain continues between feeds, and her nipples are sometimes itchy.

You watch her baby breastfeeding. You can see areola above her mouth but not below. The baby's mouth is wide open, her lower lip is turned back, and her chin is close to the breast. The baby takes some slow deep sucks and you see her swallow.

What might be the cause of Mrs Flora's sore nipples?
(*Candida* infection. Her baby is well attached to her breast.)

What treatment would you give to her and her baby?
(Give gentian violet or nystatin for her nipples.
Check and treat her baby's mouth and bottom for *Candida*.)

How would you build Mrs Flora's confidence?
(Possibilities include:
Praise the way in which her baby is suckling.
Give relevant information: explain the reason for the sore nipples, and explain that breastfeeding should be comfortable again after the treatment.)

Mrs G says that her breasts are painful. Her baby is 5 days old. Both Mrs Graces' breasts are swollen, and the skin looks shiny. The nipples are stretched flat and there is a fissure across the tip of her right nipple. You watch her breastfeeding. Her baby is restless and makes smacking sounds as he tries to suckle. After a few sucks, he pulls away and cries.

What can you say to empathize with Mrs Grace?
(You are very uncomfortable, aren't you?)

What is the cause of Mrs Grace's difficulties?
(Her breasts are engorged, her nipples are stretched tight and her baby cannot attach well, and her right nipple is damaged.)

What practical help can you give Mrs Grace?
(Help her to express some of her milk, by hand or pump, to make the breasts softer. Then help her to attach her baby to her breast better.
Suggest that she breastfeeds her as often as she is willing, so that the baby removes more of the milk. She may need to express again until the engorgement has cleared.)

- **Give participants the Answer sheets for Session 29.**
- **If some participants are having difficulties with the exercises, or have not finished them, arrange to help them later.**

Notes

Notes (contd)

SESSION 30

Refusal to breastfeed

Objectives

After completing this session, participants will be able to:

- list the causes of refusal to breastfeed
- decide why a baby is refusing to breastfeed
- describe the management of refusal to breastfeed

Session outline . . . . . 60 minutes

Participants work in groups of 8–10 with two trainers.

All trainers help to give individual feedback on the exercise.

I.	Introduce the session, present **Slide 30/1**	3 minutes
II.	Discuss causes of refusal to breastfeed	15 minutes
III.	Read and discuss MANAGEMENT OF REFUSAL TO BREASTFEED	15 minutes
IV.	Facilitate the written exercise (EXERCISE 30.A)	25 minutes
V.	Summarize the session	2 minutes

Preparation

- Refer to the Introduction for guidance on facilitating group work.
- Study the notes for the session, so that you are clear about what to do.
- Make sure that there are two flipcharts or boards available. If not, put flipchart sheets on the wall where participants can see them.
- Make sure that you have **Slide 30/1** ready. Alternatively, as there is only one slide in this session, you might prefer to read aloud the objectives on **Slide 30/1** without projecting them onto the screen.
- Read the **Further information** sections, so that you are familiar with the ideas that they contain, so that you can answer participants' questions.

As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the session — 3 minutes

- Show **Slide 30/1 – Session 30 – objectives** and read out the objectives:

> 30/1
>
> **Session 30: Refusal to breastfeed – objectives**
>
> After completing this session, participants will be able to:
> - list the causes of refusal to breastfeed
> - decide why a baby is refusing to breastfeed
> - describe the management of refusal to breastfeed

- Ask participants to keep their *Participant's manual* closed until asked to refer to it.
- Make these introductory points:
  - This session is about the problem of a baby refusing to breastfeed, or being unwilling to suckle.
  - *Ask: Have you heard of babies who refused to breastfeed?*
- Let participants relate their experience for 2–3 minutes. Thank them, and then continue with these points:
  - In some communities, refusal is a common reason for stopping breastfeeding. However, it need not lead to complete cessation of breastfeeding, and can often be overcome.
  - Refusal can cause great distress to the baby's mother. She may feel rejected and frustrated by the experience.
  - You need to know how to decide why a baby is refusing, and how to help the mother and baby enjoy breastfeeding again.
- If you developed a list of reasons for stopping breastfeeding or starting other feeds early in SESSION 3: LOCAL INFANT AND YOUNG CHILD FEEDING SITUATION, refer back to that now. Remind participants if they identified refusal to breastfeed as one of the common reasons.

II. Discuss causes of refusal to breastfeed — 15 minutes

- Write the heading WHY BABIES REFUSE TO BREASTFEED on a flipchart or board.
- Ask participants to suggest why a baby may refuse to breastfeed.
- Write their suggestions on the board under the heading.
- Make the following list on another board or flipchart
  - BABY ILL, IN PAIN OR SEDATED
  - DIFFICULTY WITH BREASTFEEDING
  - CHANGE THAT UPSETS THE BABY
  - APPARENT, NOT REAL, REFUSAL
- Explain that most causes of breast refusal fall into one or other of these groups.
- Discuss the four groups of causes.
- Use the notes presented next: WHY A BABY MAY REFUSE TO BREASTFEED.
- Discuss which group each of the participants' suggestions belong to.
- Add to the participants' list reasons that they did not think of. Try not to repeat what they have already suggested.

Why a baby may refuse to breastfeed

Is the baby ill, in pain, or sedated?

- These are common reasons in the first few days. The baby may have refused to breastfeed since birth. However, they may also be the reason in older babies.

Illness

- The baby is ill because of a difficult delivery (e.g. brain damage) or infection.
- The baby may not attach and suckle at all.
- The baby may attach to the breast, but less than before.
- The baby is weak, owing to malnutrition.

Pain

- The baby has a painful place, such as a bruise on their head from vacuum extraction.
- The baby cries and fights as their mother breastfeeds them, and she presses the painful place.

Sedation

- A baby may be sleepy because of:
  - drugs that the mother was given during labour
  - drugs that she is taking for psychiatric treatment or epilepsy.

Is there a difficulty with breastfeeding?

- These are common reasons in the first month or two of a baby's life.
- Sometimes breastfeeding has become unpleasant for a baby, and they pull away from the breast in frustration.

Possible causes

- Separation of the mother and baby after delivery.
- Feeding from a bottle, or sucking on a pacifier (dummy).
- Poor attachment, so that the baby does not get much milk.
- Poor technique of the mother or helper positioning and attaching the baby, such as pressure on the back of the baby's head, which makes the baby resist.
- Delay in the milk "coming in", or engorgement, so the baby does not get much milk.
- Oversupply, so that too much milk comes too fast. The baby may suckle for a minute, and then come off the breast choking or crying, with milk spraying out.
- Blocked nose. The baby starts suckling, but then has to stop to breathe.
- Sore mouth (Candida infection [thrush]; in an older baby, teething), the baby may suckle a few times, and then stop and cry; or may refuse altogether.

Refusal of one breast only

- Sometimes a baby refuses one breast, but not the other. This is because the problem affects one side more than the other. For example, the baby has more difficulty attaching to one side.

Has a change upset the baby?

- Babies have strong feelings, and if they are upset they may refuse to breastfeed. They may not cry, but simply refuse to suckle.
- This is most common when a baby is aged 3–12 months. They suddenly refuse several breastfeeds. This behaviour is sometimes called a "nursing strike".

Possible causes

- Separation from the mother, for example when she starts a job outside home.
- A new carer, or too many carers.
- A change in the family routine – for example, moving house, visiting relatives.
- Illness of the mother, or mastitis, which makes milk salty.
- The mother menstruating.
- A change in the mother's smell, for example, different soap, perfume or different food.

Is it "apparent" and not "real" refusal?

Sometimes a baby behaves in a way that makes their mother think that they are refusing to breastfeed. However, the baby is not really refusing.

- When a newborn baby "roots" (or searches) for the breast, they move their head from side to side as if they are saying "no". However, this is normal rooting behaviour.
- Between 4 and 8 months of age, babies are easily distracted, for example when they hear a noise. They may suddenly stop suckling. It is a sign that they are alert.
- After the age of 1 year, a baby may decide to stop breastfeeding by themself. This is usually gradual.

▶ **Ask participants to find the box CAUSES OF REFUSAL TO BREASTFEED on page 231 of their *Participant's manual*. Read the titles of the sections, and point out that they are the same four groups of causes. Point out that they also have the notes on why a baby may refuse to breastfeed on pages 229–230 in their manuals.**

CAUSES OF REFUSAL TO BREASTFEED

Illness, pain, discomfort or sedation (especially in the first week)	• Difficult delivery (e.g. brain damage) • Infection • Pain from bruise (vacuum, forceps) • Sedation (drugs given to mother) • Blocked nose • Sore mouth (thrush, teething)
Difficulty with breastfeeding technique (especially in the first month)	• Separation from mother after delivery • Use of bottles and pacifiers while breastfeeding • Not getting much milk (e.g. poor attachment) • Pressure on back of head when positioning • Delay "coming in", engorgement • Mother shaking her breast • Restricting the length of feeds • Difficulty coordinating suckle
Change that upsets the baby (especially aged 3–12 months)	• Separation from mother (e.g. if mother returns to work) • New carer or too many carers • Change in the family routine • Mother ill • Mother has breast problem (e.g. mastitis) • Mother menstruating • Change in smell of mother
Apparent refusal	• Neonate – rooting • Age 4–8 months – distraction • Above 1 year – self-weaning

III. Read and discuss Management of refusal to breastfeed — 15 minutes

- Ask participants to read the section Management of refusal to breastfeed on pages 232–233 of their *Participant's manual*.
- Ask participants to read the section out loud, and to take turns each reading one section.

Management of refusal to breastfeed

- If a baby is refusing to breastfeed:
  - Treat or remove the cause if possible.
  - Help the mother and baby to enjoy breastfeeding again.

Treat or remove the cause if possible

Illness

- If a baby is unable to attach and suckle, they may need special care in hospital.
- Treat infections with appropriate antimicrobials and other therapy. Refer if necessary.
- Help the mother to express her breastmilk to feed to the baby by cup or by tube, until the baby is able to breastfeed again (see Sessions 17 and 33: Expressing breast milk 1 and 2).

Pain

- Help the mother to find a way to hold the baby without pressing on a painful place.

Sedation

- If the mother is on regular medication, try to find an alternative.
- For analgesics during labour, give the mother extra support while the drugs clear.

Breastfeeding difficulty

- Discuss the reason for the difficulty with the mother, and teach her to express her milk.
- When her baby is willing to breastfeed again, help her more with her technique, and help her to build up her milk supply (see Session 34: Not enough milk).

Oversupply

- Suggest that she expresses her milk before she offers the baby the breast. She can slow the flow of milk by holding her breast with the "scissor" hold, or she can breastfeed lying on her back. She should let the baby suckle from only one breast at each feed (see **Further information** at the end of this session and Session 35: Crying).

Thrush

- Treat with gentian violet or nystatin (see Sessions 19 and 28: Breast conditions 1 and 2).

Teething

- Encourage the mother to be patient and to keep offering the baby her breast.

Blocked nose

- Explain how to clear it. Suggest short feeds, more often than usual for a few days.

Changes that upset the baby

- Discuss the need to reduce separation and changes if possible.
- Suggest that she stops using the new soap, perfume or food.

Apparent refusal

- If it is rooting:
  - Explain that this is normal. She can hold her baby at her breast to explore her nipple.
  - Help her to hold the baby closer, so that it is easier for them to attach.
- If it is distraction:
  - Suggest that she tries to feed the baby somewhere more quiet for a while. The problem usually passes.
- If it is self-weaning:
  Suggest that she:
  - makes sure that the child eats enough family food
  - gives the baby plenty of extra attention in other ways
  - continues to sleep with the baby because night feeds may continue
  - expresses her breast milk and feeds it to the baby by cup.
- This is valuable at least up to the age of 2 years.

Help the mother and baby to enjoy breastfeeding again.

- This is difficult and can be hard work. You cannot force a baby to breastfeed.
- The mother needs help to feel happy with her baby and to enjoy breastfeeding. They have to learn to enjoy close contact again. She needs you to build her confidence, and to give her support.
- Help the mother to do these things:
  - Keep her baby close to her all the time.
    - She should care for her baby herself as much of the time as possible.
    - Ask grandmothers and other helpers to help in other ways, such as doing the housework, and caring for older children.
    - She should hold her baby often, and give plenty of skin-to-skin contact at times other than feeding times. She should sleep with the baby.
    - If the mother is employed, she should take leave from her employment – sick leave if necessary.
    - It may help if you discuss the situation with the baby's father, grandparents and other helpful people.
  - Offer her breast whenever her baby is willing to suckle.
    - She should not hurry to breastfeed again, but offer the breast if her baby does show an interest.
    - The baby may be more willing to suckle when sleepy or after a cup feed, than when they are very hungry. She can offer her breast in different positions.
    - If she feels her ejection reflex working, she can offer her breast then.
  - Help her baby to breastfeed in these ways:
    - Express a little milk into her baby's mouth.
    - Position the baby well, so that it is easy for them to attach to the breast.
    - Show her how to hold and feed her baby in the reclining position: she leans well back, so that the baby is supported on her chest. She can do this skin-to-skin, so the baby crawls to her breast (see Sessions 14 and 17: Positioning a baby at the breast 1 and 2).
    - She should avoid pressing the back of the baby's head, or shaking her breast.

- Feed her baby by cup until they are breastfeeding again.
  - She can express her breast milk and feed it to her baby by cup (or cup and spoon).
  - Express as often as the baby would feed (3-hourly), to keep up her supply of breast milk supply, and to keep her breasts healthy.
  - If necessary, use artificial feeds, and feed them by cup.
  - She should avoid using bottles, teats and pacifiers (dummies) of any sort.

▶ **Tell participants that they can find a summary of this information in the box HELPING A MOTHER AND BABY TO BREASTFEED AGAIN on page 234 of their *Participant's manual*.**

▶ **Give them 2 minutes to read the box through, to remind them of the main points in the preceding section.**

HELPING A MOTHER AND BABY TO BREASTFEED AGAIN

Help the mother to do these things:

- Keep her baby close – no other carers
  - Give plenty of skin-to-skin contact at all times, not just at feeding times
  - Sleep with her baby
  - Ask other people to help in other ways.
  - Take leave from employment
- Offer her breast whenever her baby is willing to suckle
  - When her baby is sleepy, or after a cup feed
  - In different positions
  - When she feels her ejection reflex working
- Help her baby to take the breast
  - Express breast milk into the baby's mouth
  - Position the baby so that they can attach easily to the breast – try different positions
  - Show her how to feed the baby in the reclining position skin-to-skin
  - Avoid pressing the back of the baby's head or shaking her breast.
- Feed her baby by cup
  - Express her breast milk to keep the supply and keep her breasts healthy
  - Give her own expressed breast milk if possible; if necessary, give artificial feeds
  - Avoid using bottles, teats, pacifiers

IV. Facilitate the written exercise — 25 minutes

- Ask participants to turn to page 234 of their *Participant's manual*, and to find EXERCISE 30.A
- Explain what the exercise is about.
  - This exercise contains short stories about babies who are refusing to breastfeed.
  - Answer the questions after the stories, using information from this session, and from SESSION 5: LISTENING AND LEARNING and SESSION 8: BUILDING CONFIDENCE AND GIVING SUPPORT. You can look at the notes in your manuals from these sessions if you wish.
- Explain what to do:
  - Read the instructions **How to do the exercise**.
  - Then answer the questions **To answer** in the same way as for previous exercises.

EXERCISE 30.A BREAST REFUSAL

How to do the exercise:

- Read the stories and write your answers to the questions in pencil in the space after each story.
- When you have finished, discuss your answers with the trainer.

To answer:

Mrs H had her baby 3 days ago. She says that she has been trying by herself to put her baby to her breast for 2 days, but he could not attach well, and now he is refusing. She will have to bottle feed.

A nurse has now come to help Mrs H to attach the baby. The nurse puts the baby to face Mrs H's breast. The nurse then holds Mrs H's breast with one hand, and the back of the baby's head with her other hand. The nurse then tries to push the baby onto the breast. The baby pushes his head back and cries.

Why does Mrs H's baby refuse to breastfeed?

(The baby had difficulty attaching, and Mrs H did not receive help at first.
Now a nurse has come to help her, but the nurse's technique is not good.
She is pushing on the back of the baby's head, which makes the baby want to fight back.)

What could you say to praise the mother and the nurse?

(The mother: *It is good that you are still trying to breastfeed.*
The nurse: *It is good that you are trying to help Mrs Haley to attach her baby.*)

What would you suggest that the nurse does differently?

(Suggest that a different technique might help:

- Try to guide the mother to position and attach her baby by herself, without touching.
- Show her what to do using a doll, if you have one, or a rolled up towel.
- Explain that she should support the baby by his shoulders and back, and not by pressing on his head.
- If you need to help her to position the baby, put your hand over her hand to guide her – do not hold the baby yourself.

See SESSIONS 14 and 27: POSITIONING A BABY AT THE BREAST 1 and 2.)

What three things could you suggest that Mrs H does?

(Do not try to make the baby take the breast any more now.
Let him enjoy skin-to-skin contact, and explore the breast with his mouth, until he is willing to try to suckle.
Teach her to express her breast milk to feed him by cup until he suckles.)

Mrs J has a baby who is 1 month old. The baby was born in hospital, and was given three bottle feeds before she started to breastfeed. When Mrs J went home, her baby wanted to breastfeed often, and she seemed unsatisfied. Mrs J thought that she did not have enough milk. She continued to give bottle feeds, in addition to breastfeeding, and hoped that her supply of breast milk would increase. Now her baby is refusing to breastfeed. When Mrs J tries to breastfeed, the baby cries and turns away. Mrs J wants very much to breastfeed, and she feels rejected by her baby.

What could you say to empathize with Mrs J?
(*You are upset that she seems not to want your breast milk.*)

Why is Mrs J's baby refusing to breastfeed?
(She started having bottle feeds before breastfeeding was established, and did not learn to attach properly.)

What two pieces of relevant information might be helpful to Mrs J?
(Explain why the baby is refusing: Your baby is having difficulty getting your breast milk, so she is frustrated. She has learnt to get milk from a bottle.
Reassure her that she can overcome it: *She still wants you, and she can learn to enjoy breastfeeding again.*)

What four things would you offer to help Mrs J to do, so that she and her baby can enjoy breastfeeding again?

(1. Stop using the bottle – feed her by cup.
2. Keep her baby close, with skin-to-skin contact, and offer her breast whenever she is willing.
3. Express her milk, and feed it to her baby by cup.
4. Learn how to position her baby so that, when she is ready, she can attach well.)

Mrs K says that her 3-month-old baby is refusing to breastfeed. He was born in hospital and roomed-in from the beginning. He breastfed without any difficulty. Mrs K returned to work 2 weeks ago. Her baby has 2–3 bottle feeds while she is at work. For the last week, he has refused to breastfeed when she comes home in the evening. She thinks that her breast milk is not good, because she works hard and feels hot all day.

What could you say to accept Mrs K's ideas about her milk?
(*O dear.* Or: *You think that getting hot harms your milk?*)

What might be the cause of her baby's refusal to breastfeed?
(He is separated from his mother for a large part of the day. Also, he has bottle feeds while she is away.)

What praise and relevant information could you give to build Mrs K's confidence?
(Praise her for breastfeeding up till now, and for her baby's good health.
Relevant information: breast refusal is quite common when a baby's routine changes, and can be overcome.)

What could you suggest that she does to breastfeed again?
(Suggest that, if possible, she takes sick leave, and cares for the baby herself, with plenty of skin-to-skin contact, offering him her breast when he is willing.
She should express her milk to feed him with.
She can give other feeds from a cup and not a bottle, so that her baby wants to suckle when she is with him.
If she cannot take sick leave, she can try to do the same thing over a weekend, and whenever she is at home. Ask the person who cares for the baby to use a cup not a bottle to feed him.)

V. Summarize the session — 2 minutes

- Ask participants whether they have any questions, and try to answer them.
- Explain that a summary of this session can be found on pages 229–237 of the *Participant's manual*.

Further information

Babies sometimes refuse to suckle because of gastro-oesophageal reflux. Reflux is when milk from the stomach passes back into the oesophagus, which can be painful for the baby. The baby may regurgitate milk (small vomits). Reflux is also a cause of colicky crying. It is more common in babies who have been tube fed. It may help if the mother feeds the baby in an upright position, so that the milk does not flow back so easily. Symptoms improve as the baby grows. (See Session 35: Crying.)

Oversupply of milk

This is the usual cause of too much milk coming too fast. It may be partly because a woman is producing a large quantity of milk, and partly because the oxytocin reflex is very active.

A mother may feel that her breasts are very full, that the milk seems to pour out when her baby feeds, and when the ejection reflex starts, and that the baby seems to choke when they suckle.

The baby may pull away from the breast and cry. This may happen several times during a feed, if the baby persists. Or the baby may refuse to try again.

Oversupply often occurs in the first month after delivery, before the supply of breast milk has adjusted to the baby's needs. Oversupply may also result from a baby suckling and stimulating the breast more than is necessary to get the milk that they need. This can happen if a mother tries to make her baby feed from both breasts at each feed, when the baby does not need to, particularly if she moves the baby quickly from one side to the other. Oversupply may also result from poor attachment. If a baby suckles ineffectively, they may breastfeed frequently, or for a long time, and stimulate the breast so that it produces more milk than the baby needs.

One of the effects of oversupply can be that a baby gets mostly foremilk and less fat-rich hindmilk. The baby takes extra foremilk to try to get enough energy to satisfy their hunger.

The baby gets too much lactose in their gut, and this can cause colic, loose stools with a lot of gas, and sometimes green stools (see also Session 35: Crying).

To help the milk supply to adjust to the baby's needs, suggest that the mother feeds the baby on only one breast at each feed. Let the baby continue at that breast until they finish by themself. The baby will get more hindmilk if they stay on the breast longer. She can offer the other breast at the next feed.

She can use one breast only for all feeds during a certain block of time – 4, 6 or 8 hours, depending on how severe the problem is. Then for the next block of time, use the other breast only. By leaving the milk in the unsuckled breast, the inhibitor will act and reduce milk secretion from the breast.

Sometimes a mother finds it helpful also to:

- express some milk before a feed
- lie on her back to breastfeed (if milk flows upwards, it is slower)
- hold her breast with the "scissor" hold to slow the flow (see Sessions 14 and 27: Positioning a baby at the breast 1 and 2).

However, these techniques do not reduce milk secretion.

Notes

SESSION 31

Taking a feeding history – 0 up to 6 months 2

Objectives

After completing this session, participants will be able to:

- describe how to take a feeding history of an infant aged 0 up to 6 months
- describe the content and arrangement of the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS
- demonstrate appropriate use of the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS

Session outline . . . . . 60 minutes

Participants work in groups of eight, with two trainers.

All trainers help to give individual feedback on the exercise.

I. Introduce the session, present **Slide 31/1**. . . . . 5 minutes
II. Explain how to take a feeding history . . . . . 15 minutes
III. Explain the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS. . . . . 15 minutes
IV. Demonstrate how to use the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS (DEMONSTRATION 31.A, **Slides 31/2** and **31/3**) . . . . . 20 minutes
V. Summarize the session . . . . . 5 minutes

Preparation

- Refer to the Introduction for guidance on facilitating group work and written exercises.
- Study the notes for the session, so that you are clear about what to do.

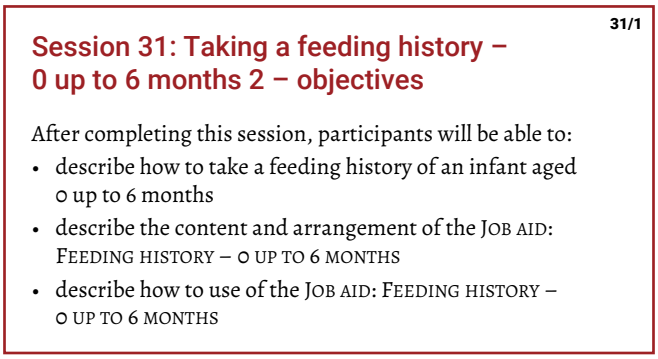
As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

I. Introduce the session — 5 minutes

▶ **Show Slide 31/1 – Session 31 – objectives and read out the objectives:**



▶ **Explain why it is necessary to take a history:**

- In this session, we will learn how to take a feeding history of a child aged 0 up to 6 months. The baby may be breastfeeding or receiving another form of milk, and may or may not be receiving complementary feeds.
- The JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS will help you to remember the main questions to ask for any infant.
- As you become more experienced, your counselling skills will help you to learn more about different situations.
- *Ask: What things may you only be able to learn if you ASK the mother?*

▶ **Wait for a few replies and then continue.**

- Among other things, we can learn when the baby was born, what happened at the time of delivery, what else she feeds her baby.

▶ **Explain these points about taking a history:**

- Taking a history means finding out about a mother and baby in a systematic way. First, we will look at the technique of HOW TO TAKE A FEEDING HISTORY – 0 UP TO 6 MONTHS.
- Then you will learn to use a special form, the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS, to help you to remember what to find out about.

II. Explain how to take a feeding history — 15 minutes

- Ask participants to turn to page 239 of their *Participant's manual* and find the box HOW TO TAKE A FEEDING HISTORY – 0 UP TO 6 MONTHS.
- Ask participants to take turns to read out the points.
- Discuss each point to make sure that it is clear.

HOW TO TAKE A FEEDING HISTORY – 0 UP TO 6 MONTHS

- Greet the woman in a kind and friendly way.
- Use the mother's name and the baby's name (if appropriate).
- Ask her to tell you about herself and her baby in her own way, starting with the things that she feels are important.
- Look at the child's growth chart. It may tell you some important facts and save you asking some questions.
- Ask the questions that will tell you the most important facts.
  The JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS is a guide to the facts that you may need to learn about.
  Decide what you need to know from each of the six sections.
- Be careful not to sound critical.
- Use SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT.
- Try not to repeat your questions.
  If you need to repeat a question, first say: "Can I make sure that I have understood clearly?" and then, for example, "You said that (name) had both diarrhoea and pneumonia last month?"
- Take time to learn about more difficult, sensitive things.
  For example:
  - What does the baby's father say? Her mother? Her mother-in-law?
  - Is the mother happy about having the baby now? About the baby's sex?

Some mothers tell you these things spontaneously. Others tell you when you empathize, and show that you understand how they feel. Others take longer. If a mother does not talk easily, wait, and ask again later, or on another day, perhaps somewhere more private.

III. Explain the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS 15 minutes

- **Ask participants to look at the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS, on page 241 of their *Participant's manual*. Notice that the Job aid has six sections. Ask participants to make themselves familiar with the form.**
- **Make these points:**
  - The Job aid lists the main things that you need to find out about to help a mother and baby.
  - It has six sections. Try to memorize the headings:
    - Feeding
    - Health
    - Pregnancy, birth and early feeds (where applicable)
    - Mother's condition and family planning
    - Previous infant feeding experience
    - Family and social situation
  - When you know the headings, you will find it easier to remember the different points in each section.
  - Often, questions about points in the first two sections give you the answer to a problem. Sometimes, you need to find out more about the mother, her pregnancy and delivery, her previous babies, or the family's situation, before you can understand her difficulties.
  - **Key point:** Start with the first two sections. They are the most important. Then continue through the other sections until you are clear about the situation. When you are clear, you need not continue to ask about all the other details. However, it is a good idea to go quickly through each section, in case there is something relevant.
- **Make these points about using the JOB AID:**
  - Remember that the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS is not a questionnaire. When you first use it, go through all the points. As you gain experience, you will find it easier to choose which points you need to ask about. You may need to follow up some of the points with more detailed questions.
  - When you are talking to a mother, the facts may not all come out in the same order as on the Job aid. If at any time, a mother wants to tell you about something that is important to her, let her tell you that first. Ask about the other things afterwards. Try to remember the things that she has told you about already.
  - Remember to use your counselling skills when you are taking a history from a mother. Try to ask questions in an open way, although you may also have to ask some closed questions if you need specific information.
  - Remember to use other counselling skills, such as reflecting back, empathy and praise, in between questions, so that the mother is encouraged to talk more and to feel confident.

Job aid: Feeding history – 0 up to 6 months

Mother's name: **Date:**

Baby's name: **Baby's age:**

Particular concerns about feeding of child:

FEEDING

- Milk (breast milk, formula, cow's milk, other)
- Frequency of milk feeds
- Length of breastfeeds/quantity of other milks
- Night feeds
- Other foods in addition to milk (when started, what, frequency)
- Other fluids in addition to milk (when started, what, frequency)
- Use of bottles and how cleaned
- Feeding difficulties (breastfeeding/other feeding)

HEALTH

- Growth chart (birth weight, weight now; length at birth, length now)
- Urine frequency per day (6 times or more)
- Stools (frequency, consistency)
- Illnesses

PREGNANCY, BIRTH AND EARLY FEEDS (where applicable)

- Antenatal care
- Feeding discussed at antenatal care
- Delivery experience
- Rooming-in
- Prelacteal feeds
- Postnatal help with feeding

MOTHER'S CONDITION AND FAMILY PLANNING

- Age
- Health – including nutrition and medications
- Breast health
- Family planning

PREVIOUS INFANT FEEDING EXPERIENCE

- Number of previous babies
- How many breastfed and for how long
- If breastfed – exclusive or mixed fed
- Other feeding experiences

FAMILY AND SOCIAL SITUATION

- Work situation
- Economic situation
- Family's attitude to infant feeding practices

IV. Demonstrate how to use the Job aid: Feeding history – 0 up to 6 months 20 minutes

- **Explain that you will demonstrate how to use the Job aid: Feeding history – 0 up to 6 months. Ask the participants whom you have prepared to read the words of the health worker and the mother. Pass Lucy's growth charts around the participants during the demonstration and display Slides 31/2 and 31/3 if you are using those as the charts.**
  - Ask participants to follow the Job aid: Feeding history – 0 up to 6 months on page 241 of their *Participant's manual* as you give the demonstration.
  - Make sure that they have a copy of the Listening and learning skills to look at as they follow the demonstration. Ask them to listen for counselling skills, for example if the counsellor asks open questions, reflects back, shows empathy, accepts and praises.
  - They can make notes in the *Participant's manual* if it helps them to remember.

Demonstration 31.A Taking a feeding history – 0 up to 6 months

Health worker: *Good morning, I am Nurse Jane. May I ask your name, and your baby's name?*
Mother: *Good morning, nurse; I am Mrs Green and this is my daughter Lucy.*

Health worker: *She is lovely – how old is she?*
Mother: *She is 5 months now.*

Health worker: *Yes – and she is taking an interest in what is going on, isn't she? Tell me, what milk have you been giving her?*
Mother: *Well, I started off breastfeeding her, but she is so hungry and I never seemed to have enough milk, so I had to give her bottle feeds as well.*

Health worker: *Oh dear, it can be very worrying when a child is always hungry. You decided to start bottle feeds? What are you giving her?*
Mother: *Well, I put some milk in the bottle and then mix in a spoonful or two of cereal.*

Health worker: *When did she start these feeds?*
Mother: *Oh, when she was about 2 months old.*

Health worker: *About 2 months. How many bottles do you give her each day?*
Mother: *Oh, usually two – I mix up one in the morning and one in the evening, and then she just sucks it when she wants to – each bottle lasts quite a long time.*

Health worker: *So she just takes the bottle little by little? What kind of milk do you use?*
Mother: *Yes – well, if I have formula, I use some of that; or else I just use cow's milk and mix in some water, or sweetened milk, because they are cheaper. She likes the sweet milk!*

Health worker: *Formula is very expensive isn't it? Tell me more about the breastfeeding. How often is she doing that now?*
Mother: *Oh, she breastfeeds when she wants to – quite often in the night, and about 4 or 5 times in the day – I don't count. She likes it for comfort.*

Health worker: *She breastfeeds at night?*
Mother: *Yes, she sleeps with me.*

Health worker: *Oh, that makes it easier, doesn't it? Did you have any other difficulties with breastfeeding, apart from worrying about not having enough?*
Mother: *No, it wasn't difficult at all.*

Health worker: *Do you give her anything else yet? Any other foods or drinks?*
Mother: *No – I won't give her food for a long time yet. She is quite happy with the bottle feeds.*

Health worker: *Can you tell me how you clean the bottles?*
Mother: *I just rinse them out with hot water. If I have soap I use that, but otherwise just water.*

Health worker: *OK. Now can you tell me about how Lucy is. Has she got a growth chart? Can I see it? [mother hands over growth chart] Thank you, now let me see.... She was 3.5 kg and 51 cm when she was born, she was 5.5 kg and 59 cm when she was 2 months old, and now she is 6.0 kg and 66 cm. You can see that she gained weight fast for the first 2 months, but it is a bit slower since then. Can you tell me whether Lucy has had any illnesses?*

Mother: *Well, she had diarrhoea twice last month, but she seemed to get better. Her stools are normal now.*

Health worker: *Can I ask about the earlier days – how was your pregnancy and delivery?*

Mother: *They were normal.*

Health worker: *What did they tell you about feeding her when you were pregnant, and soon after she was born? Did anyone show you what to do?*

Mother: *Nothing – they told me to breastfeed her, but that was all. The nurses were so busy, and I came home after one day.*

Health worker: *They just told you to breastfeed?*

Mother: *Yes – but I didn't have any milk in my breasts even then, so I gave her some glucose water until the milk started.*

Health worker: *It is confusing isn't it when your breasts feel soft after delivery? You need help then, don't you?*

Mother: *Yes.*

Health worker: *Can I ask about you? How old are you?*

Mother: *Sure – I am 22.*

Health worker: *And how is your health?*

Mother: *I am fine.*

Health worker: *How are your breasts?*

Mother: *I have had no trouble with my breasts.*

Health worker: *May I ask whether you are thinking about another pregnancy at any time? Have you thought about family planning?*

Mother: *No – I haven't thought about it – I thought that you can't get pregnant when you are breastfeeding.*

Health worker: *Well, it is possible if you are also giving other feeds. We will talk about it more later if you like. Is Lucy your first baby?*

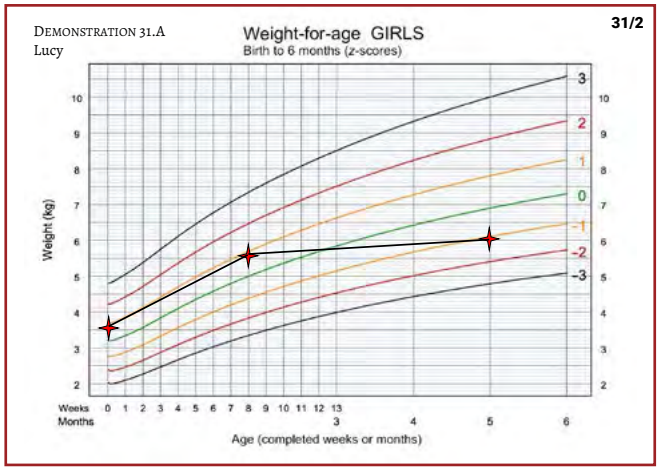
Mother: *Yes. And I do not want another one just yet.*

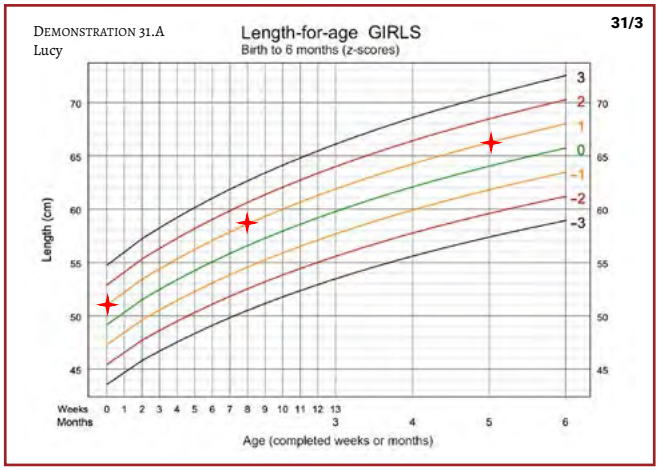
Health worker: *Tell me about how things are at home – are you going out to work?*

Mother: *No – I am a housewife now. I may try to find a job later when Lucy is older.*

Health worker: *Who else do you have at home to help you?*

Mother: *Lucy's father is with me. He has a job as a driver and he is very fond of Lucy, but he thinks she should not breastfeed at night – he thinks she breastfeeds too much and he wants her to sleep in another bed. But I am not sure . . . He says that too much breastfeeding is what gives her diarrhoea.*





- **Discuss the demonstration. Ask the group to think about the technique of taking a feeding history. Participants may look at the demonstration on pages 242–243 of their *Participant's manual*, to help them to answer the following questions:**
  - Did Nurse Jane use LISTENING AND LEARNING SKILLS to obtain information – can you give some examples? (Encourage participants to give specific examples of open questions and reflection)
  - What examples of empathy did you hear the health worker use? (Examples of empathy included: *Oh dear, it can be very worrying when a child is always hungry* and *It is confusing isn't it when your breasts feel soft after delivery*.)
  - Did Nurse Jane ask some questions from all six sections of the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS?
  - Did she leave out any important questions?
  - Did asking questions from each section of the form help her to understand the difficulties?
  - What were the feeding difficulties in this situation? (These included: perceived milk insufficiency at 2 months, leading to introduction of bottle feeds; giving cereal in the bottles; use of non-modified cow's milk and sweetened milk if the formula runs out; inappropriate cleaning of the feeding bottles; two episodes of diarrhoea; poor growth since 2 months; no help with early breastfeeds; early introduction of glucose water; attitude of Lucy's father).

V. Summarize the session — 5 minutes

- **Ask participants to find the box SUMMARY: HOW TO TAKE A FEEDING HISTORY – 0 UP TO 6 MONTHS on page 244 of their manuals, which summarizes Part II of the session.**
- **Read through the list and ask participants to try to learn it.**

SUMMARY: HOW TO TAKE A FEEDING HISTORY – 0 UP TO 6 MONTHS

- Greet the woman and introduce yourself
- Use the mother's and baby's names (if appropriate)
- Ask her to tell you about herself and her baby in her own way (use LISTENING AND LEARNING SKILLS)
- Look at the child's growth chart
- Ask the most important questions (use the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS)
- Be careful not to sound critical (use SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT)
- Try not to repeat questions
- Take time to learn about difficult, sensitive things

- **Ask whether participants have any questions, and try to answer them.**
- **Explain that a summary of this session can be found on pages 239–244 of the *Participant's manual*.**

Notes

Notes (contd)

Notes (contd)

SESSION 32

Taking a feeding history – 0 up to 6 months: exercise

Participants will now practise taking a feeding history for infants aged 0 up to 6 months in the way that they learnt about in Session 31.

Session outline . . . . . 60 minutes

Participants work in groups of four, each with one trainer.

I. Introduce the session . . . . . 10 minutes
II. Conduct the history practice . . . . . 50 minutes

Preparation

- Refer to the Introduction for guidance on facilitating group work.
- Study the notes for the session, so that you are clear about what to do.
- Make sure that copies of Stories 1–5 are available (on cards or paper). They should not have the comments with them.
- Each group of four participants needs two sets of copies – one to give to mothers, one for the observers to follow the story. The counsellors do not see them.
- Give each participant a copy of the local growth chart to fill in for the child in their story.
- You may find that it saves time in the session if you fill in charts yourself for the babies in each of the stories – you will need one set of filled-in charts for each group, to give to the mothers. Fill them in using pencil, so that they can be erased and used again in another session.
- Have loose copies of the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS available for participants.
- Study SECTION 1. INTRODUCE THE SESSION, which includes the preparation for the exercise, so that you can explain to participants what to do.
- Study the section **How to conduct the exercise** at the beginning of the exercise, so that you can guide the pair practice and the discussion.
- Read the comments at the end of each story, to help you with the discussion of each pair practice.
- Decide how you will conduct the exercise: in some situations, participants may have difficulty reading the story quickly. An alternative way to conduct the exercise is for a trainer to play the part of the mother, while one of the participants takes her history. However, this is not as useful as giving participants the opportunity to act as mother and consider the situations they may be faced with.
- Make sure that Answer sheets (COMMENTS ON THE STORIES) are available to give to participants at the end of the session.

As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

I. Introduce the session — 10 minutes

- **Give each participant a copy of:**
  - **the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS**
  - **one of the histories with a growth chart filled in for the baby in the history**
  - **the list of COUNSELLING SKILLS.**
- **Explain what they will do:**
  - Use role-play to practise taking a breastfeeding history. Follow the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS.
  - One of you will be a "mother", one of you will be a "counsellor", and the other one or two participants will be "observers".
  - When you are a "mother", play the part of the mother in the history on your card. The "counsellor" takes your history, and does not have the card.
  - You will each be given a growth chart for the baby in your story – it may already be filled in, or you may need to fill it in yourself. Use pencil for this, so that you can reuse the card in a subsequent session.
  - The "observers" will also be given a copy of the mother's card, so that they can follow the history. The "mother" and "observers" must conceal the card from the "counsellor".
  - The "mother" gives herself and her baby a name.
  - In turn, each member of the group plays the part of a mother, a counsellor and an observer.
- **Explain how the stories are arranged:**
  - First, there is the REASON FOR VISIT, including the mother's complaint, if she has one.
  - Then there is the HISTORY, with six sections, which are the same as the six sections in the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS. There is some information in each section, so it is important to ask questions relating to each section of the form.
- **Ask participants to read their stories through, and to study the growth chart. Allow 3 minutes.**
- **Let them ask you questions about anything that they do not understand.**
- **Explain how to do the history practice:**
  - Remember that in this exercise you are practising taking a history to understand the mother's situation and to try to decide what her difficulty is. You need to use LISTENING AND LEARNING SKILLS, but you are not giving information or suggestions, or trying to solve her difficulty. (You will practise that in SESSION 37: COUNSELLING PRACTICE.)
  - Look back at the form HOW TO TAKE A FEEDING HISTORY – 0 UP TO 6 MONTHS on page 239 of your *Participant's manual*.
  - If you are the "counsellor":
    - Greet the "mother" and ask her how she is. Use her name and her baby's name.
    - Ask one or two open questions to start the conversation, and ask her to tell you about herself and her baby. If appropriate, ask how you can help her.
    - Look at the baby's growth chart.
    - Ask the "mother" questions about things from all six sections of the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS.
    - Use your counselling skills.
    - You can make brief notes on the Job aid, but try not to let it become a barrier.

- If you are the "mother":
  - Try to respond naturally to the "counsellor".
  - When the "counsellor" asks how they can help, read out the REASON FOR VISIT. Answer the "counsellor's" questions from the information in your history, in your own words.
  - Do not read out all the information at once; just tell the "counsellor" things that they have asked about.
  - If the "counsellor" asks closed questions, just say "yes" or "no".
  - If the "counsellor" uses open questions and other LISTENING AND LEARNING SKILLS, give them the information more easily.
  - If the information to answer a question is not in your history, make up information to fit with the history.
- If you are observing:
  - Follow the history practice with your JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS and your copy of the history, and observe how the "counsellor" takes the history.
  - Notice whether the "counsellor" asks about things from all sections of the Job aid, whether they miss important questions, and whether they ask relevant questions.
  - Notice, using your list of COUNSELLING SKILLS, whether the "counsellor" uses open questions and other LISTENING AND LEARNING SKILLS.
  - During discussion, be prepared to first praise what the "counsellor" does right, and then to suggest what they could do better.

II. Conduct the history practice — 50 minutes

How to conduct the exercise

- Ask one pair in the group to practise taking a history, one as "mother" and one as "counsellor". Ask the pair to sit on two chairs, next to each other, and slightly separate from the "observers".
- Give the "observers" a copy of the mother's history to follow.
- Let the "mother" and "counsellor" continue for a while, without interrupting.
- Follow the story in your copy of the *Trainer's guide*. If they are doing well, let them go on until they finish. If they make many mistakes, or get confused, or do not follow the history, stop them, and give them a chance to correct themselves. Ask them how they feel they are doing, and what they think they should do differently.
- When they finish, ask the "observers" to comment, and then give your feedback:
  - Praise what the "counsellor" did well.
  - Comment on how the "mother" did, because what she does can make it easier or more difficult for the counsellor.
  - Discuss whether the "counsellor" understood the "mother's" situation correctly.
  - Discuss how well the "counsellor" took the history, and whether they followed the Job aid.
  - Discuss how well the "counsellor" used counselling skills
  - End your feedback with a (genuine) positive comment.
- Use the COMMENTS ON THE STORIES (page 426), to help the discussion.
- Thank the participants and congratulate them for their efforts.
- Ask another pair to practise. Continue until each participant has practised as "mother", "counsellor" and "observer".

Story 1

Reason for visit: *My mother told me to bring the baby* (baby's name). *Everything is fine.*

History:

1. I give him formula, about 3 bottles a day, with 2 spoonfuls of milk powder in each bottle. He had difficulty in suckling, so I gave him bottle feeds while I tried to breastfeed. He has refused to breastfeed for 2 weeks.
2. He is 6 weeks old and weighs 2.5 kg. He was born in hospital and weighed 2.0 kg. He has 2–3 soft stools a day. They did not measure his length.
3. I didn't go to the antenatal clinic. In hospital, he was in the nursery for 6 hours. The midwives did not talk to me or help me to breastfeed, and I was frightened to ask. They discharged me after 24 hours. I did not know what to do with the baby. My breasts got very full after 2 days and my mother told me to breastfeed.
4. I am 15 years old, and healthy. My nipples are flat and my breasts are painful. I don't know anything about family planning. This is my first visit to a health centre. They make me feel ashamed.
5. This is my first baby.
6. I was at school before the baby came. My mother bought the tins of formula. My father wants me to find a job and a place of my own, to look after myself and the baby.

Story 2

Reason for visit: *My baby* (baby's name) *has diarrhoea.*

History:

1. I breastfeed her often, and she sleeps with me at night. I give her thin cereals in a bottle, 2–3 times a day. I started this when she was about 8 weeks old.
2. She is 4 months old. She was born in hospital, and weighed 3.0 kg, her length was 50 cm. She weighed 4.5 kg at 2 months, and weighs 4.8 kg now. I am not aware of her being measured after birth. When she was about 7 weeks old, she started crying to be fed often; that is why I started cereal feeds. But now she has less appetite and is passing watery stools.
3. She started to breastfeed soon after delivery. The midwife helped me and I had no difficulties.
4. I am aged 30, and well. I rely on breastfeeding for family planning until my periods start again.
5. I had two previous children. I breastfed both without any difficulty.
6. I work on a small farm with my husband and his parents. My mother-in-law helps me very much. She advised me to start cereals, because of the crying.

Story 3

Reason for visit: *I have sore nipples.*

History:

1. I breastfeed my baby many times a day, for about 20–30 minutes each time. He also sleeps with me and feeds at night.
2. He weighed 4.0 kg when he was born. Now he is 3 weeks old and weighs 4.5 kg. He is well. I do not know his length, did not know they have to measure his length.
3. He was born by caesarean section, and was kept in the nursery and bottle fed for 2 days. Since then, I have been trying to breastfeed, but my baby had difficulty in learning to suckle. The midwives suggested bottles, but I did not want to bottle feed. I persisted with breastfeeding until now. Nobody asked me about breastfeeding at the antenatal clinic.
4. I am 26, and healthy. I am disappointed because I really want to breastfeed, but my nipples hurt so much that I will have to give up. They bleed sometimes. And he feeds so often that I think I don't have enough milk.
5. I had one baby before. I breastfed him, but I never had enough milk and he was never satisfied. I gave up after a few weeks.
6. I am divorced, but my mother stays with me and helps me with the children.

Story 4

Reason for visit: *I have come for my 6 weeks' postnatal check-up. Everything is fine.*

History:

1. I breastfeed her quite often. I don't give her anything else, but I have bought a pacifier, which I give her to suck when she cries.
2. I don't know her birth weight or length. She weighs 4.9 kg today. She cries a lot, and doesn't seem satisfied. She passes soft stools several times a day. Otherwise she is well.
3. She was born at home, and started breastfeeding soon after delivery. She had some water for the first few days. My mother helped me to breastfeed.
4. I am 18 years old, and I am worried that breastfeeding will spoil my figure. I want to bottle feed, like the advertisements. I will get some milk, when I have some money.
5. I have not had a baby before.
6. I live at home with my mother, who farms. She helps me a lot but she says that the baby cries a lot because I don't eat enough and I probably don't have enough milk. She thinks she may need other milk too.

Story 5

Reason for visit: *I have a painful swelling in my breast, and I feel feverish.*

History:

1. I breastfeed my baby whenever I am at home, about once in the morning, twice in the evening, and a few times in the night. He suckles for about 5 minutes each time. While I am working, my helper gives him bottle feeds of formula. This started when I went back to work about 1 month ago. Before that I just breastfed.
2. My baby is 4 months old and healthy. He weighed 3.5 kg. Now he weighs 5.9 kg. I don't know how often he passes urine – I am not at home.
3. He was born at home, and I breastfed him straight away. The community midwife helped me. [If she works in a factory and she has a helper at home, she may be covered by social security and therefore could deliver in a social security hospital.]
4. I am 27 years old, and healthy. I had a painful swelling in the other breast soon after I went back to work. It was at the weekend, I continued breastfeeding, and it got better by itself. This time it is worse.
5. I have one older child. I breastfed him for 4 months, until my milk dried up. I started work when he was 2 months old, and bottle fed him when I was out. I was very disappointed when I had to stop breastfeeding.
6. I work in a factory, and I am away from home for about 10 hours every day. I am exhausted when I get home. I am too busy to breastfeed my baby for long. I have a helper who cares for the children. My parents live a long way away.

Comments on the stories

Story 1

The baby refuses to breastfeed because he has been given bottle feeds. The mother did not have early contact, or help to breastfeed in the first day. She needed help for flat nipples. This is her first baby, and the baby was small and had difficulty feeding. But this is not just a breastfeeding situation. She is an adolescent single mother, her father is unsupportive and her mother is not very helpful. The health services are unfriendly and disapproving, and give her the minimum of help. She is too ashamed to ask and just struggles on. You only learn about this serious situation when you ask about her own condition and her social situation.

Story 2

The baby was hungry, probably with a growth spurt. She was growing well on her breast milk alone for the first 2 months, and there were no other difficulties with breastfeeding. She gave dilute cereal feeds because of the crying, but they were not necessary. This has caused diarrhoea and slowing of growth. You know the reason for the diarrhoea by the end of Section 1 of the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS. However, in Section 6, you learn that it is her mother-in-law who advises her. It is very important to know this, as explaining to the mother may not be useful unless you can also talk to her mother-in-law.

Story 3

The mother did not receive the necessary help from the hospital staff to enable her to breastfeed. Her baby is probably poorly attached, which is causing sore nipples (you will find this out later by observing a breastfeed). He is growing, so he must be getting plenty of milk, but he is suckling inefficiently, and needs to suckle often and for a long time. You know what her main problem is early in the history. But it is important to know that she had also had problems breastfeeding her previous baby, so she lacks confidence and knowledge that could help her to breastfeed successfully.

Story 4

The mother is very young and breastfeeding, but not very motivated. She says that everything is fine, but she is worried that it may spoil her figure. Also, she has seen advertisements about formula feeding and would like to do that. The grandmother, even though she tries to be supportive, is making her lose confidence in her milk, by suggesting that she does not have enough. You only learn about these important things quite late in the history, so it is useful to check through all the sections.

Story 5

The mother has mastitis, probably because her baby is only feeding for a short time, and not often enough, so the baby is not emptying the breasts properly. It is important not to stop when you make the diagnosis of mastitis, but to continue to Section 6, so that you learn how busy and tired this mother is. That is important for the management.

Note about the comments

Some things are mentioned in the histories that have not been covered in the sessions – such as advertisements for family planning and formula milk. They are only mentioned in a general way, and do not require much knowledge. If necessary, the trainer should be able to explain the importance of the topic in the history.

- Give participants the Answer sheets (COMMENTS ON THE STORIES) for Session 32.

Notes

Notes (contd)

Notes (contd)

SESSION 33

Expressing breast milk 2

Objectives

After completing this session, participants will be able to:

- list the situations when expressing breast milk is useful
- explain how to stimulate the oxytocin reflex
- rub a mother's back to stimulate the oxytocin reflex
- demonstrate how to select and prepare a container for expressed breast milk
- describe how to store breast milk
- explain to a mother the steps of expressing breast milk by hand

Session outline . . . . . 60 minutes

Participants work in groups of 8–10 with two trainers.

All trainers help to give individual feedback on the exercise.

I.	Introduce the session, present **Slide 33/1**	10 minutes
II.	Demonstrate how to stimulate the oxytocin reflex	15 minutes
III.	Demonstrate how to express breast milk by hand	20 minutes
IV.	Demonstrate breast pumps	10 minutes
V.	Summarize the session	5 minutes

Preparation

- Refer to the Introduction for general guidance on giving a demonstration and for instruction on How to make a model breast.
- Study the notes for the session, so that you are clear about what to do.
- Make sure that you have **Slide 33/1** ready. Alternatively, as there is only one slide in this session, you might prefer to read aloud the objectives on **Slide 33/1** without projecting them onto the screen.
- Obtain some examples of suitable containers to collect expressed breast milk, which would be available to ordinary mothers (for example, cups, jam jars). Look particularly for suitable container with lids or covers.
- Collect samples of any breast pumps that are available in the area, from hospitals or from shops. (If none are available or used, do not give this demonstration.)
- Ask a participant to help you to demonstrate back massage to stimulate the oxytocin reflex. Explain what you want them to do.
- Make sure there is a flipchart or board on which you can write the list of situations when expression is useful.
- Make sure that you have six model breasts for participants to practise the technique of expression in groups.
- Have ready Counselling card 6: How to express breast milk and cup-feed, Counselling card 7: When you are separated from your baby, and the *Guidance on the use of counselling cards*.
- Optional: Ask a mother who is expressing her milk to demonstrate expression. If this is culturally acceptable, and if a mother is available and willing to come to the classroom, ask her to demonstrate expressing her milk.
- Participants will also be asked to observe expression of breast milk during clinical practice.

As you follow the text, remember:

- ▸ indicates an instruction to you, the trainer.
  - ¤ indicates what you say to participants.

I. Introduce the session — 10 minutes

- ▸ Show **Slide 33/1 – Session 33 – objectives** and read out the objectives:

33/1

Session 33: Expressing breast milk 2 – objectives

After completing this session, participants will be able to:

- list the situations when expressing breast milk is useful
- explain how to stimulate the oxytocin reflex
- rub a mother's back to stimulate the oxytocin reflex
- demonstrate how to select and prepare a container for expressed breast milk
- describe how to store breast milk
- explain to a mother the steps of expressing breast milk by hand

- ▸ Make the following points:
  - ¤ In this session, you will learn how to express breast milk effectively. Expressing breast milk is helpful in a number of situations. All mothers may be faced with one or more such situations at some point. Difficulties can arise, but they are often due to poor technique. Mothers also need the support of their families and friends.
  - ¤ Many mothers are able to express plenty of breast milk using rather strange techniques. If a mother's technique works for her, let her continue to do it that way. But if a mother is having difficulty expressing enough milk, teach her a more effective technique.
- ▸ Discuss when it is useful to express breast milk.
  - ¤ *Ask: In which situations is it useful for a mother to express her breast milk?*
- ▸ Remind participants that expression was mentioned in Sessions 19 and 28: Breast conditions 1 and 2 and Session 30: Refusal to breastfeed.
- ▸ Write participants' ideas on a board. Try to develop a list with most of the ideas below.
- ▸ After a few minutes, if participants cannot think of any more, complete the list for them.
  - ¤ Expressing milk is useful to:
    - relieve engorgement
    - relieve blocked duct or milk stasis
    - leave breast milk for a baby when their mother goes out or goes to work
    - feed a low-birth-weight baby who cannot breastfeed
    - feed a sick baby who cannot suckle enough
    - feed a baby who has difficulty in coordinating suckling
    - feed a baby while they learn to suckle from an inverted nipple
    - feed a baby who "refuses", while they learn to enjoy breastfeeding
    - keep up the supply of breast milk when a mother or baby is ill

- prevent leaking when a mother is away from her baby
- help a baby to attach to a full breast
- keep up milk production
- help with breast health conditions, e.g. engorgement (see SESSIONS 19 and 28: BREAST CONDITIONS 1 and 2)
- express breast milk directly into a baby's mouth
- prevent the nipple and areola from becoming dry or sore
- facilitate the transition to another method of feeding or to heat-treat breast milk (see MODULE 7: HIV AND INFANT FEEDING).

¤ So, there are many situations in which expressing breast milk is useful and important, to enable a mother to initiate or to continue breastfeeding.

¤ All mothers should learn how to express their milk, so that they know what to do if the need arises. It is important that all those who care for breastfeeding mothers should be able to teach mothers how to express their milk.

¤ Breast milk can be stored for about 8 hours at room temperature or up to 24 hours in a refrigerator.

II. Demonstrate how to stimulate the oxytocin reflex — 15 minutes

► **Discuss why stimulating the oxytocin reflex is helpful:**

¤ *Ask: What has to happen in the mother's body to make expression of breast milk possible?*

► **Wait for a few replies and then continue.**

► **Encourage participants to recall what they learnt about how breastfeeding works.**

¤ The oxytocin reflex must be active to make milk flow from the breasts.

¤ *Ask: What makes the oxytocin reflex active?*

► **Wait for a few replies and then continue.**

► **Ask participants to remember what they know about the oxytocin reflex, and what helps and hinders it. Ask them to refer to SESSIONS 12 and 24: HOW BREASTFEEDING WORKS 1 and 2, if necessary.**

¤ The baby suckling or touching the mother's breast stimulates the oxytocin reflex. Also, the mother seeing, hearing, touching and thinking about her baby, and the mother feeling calm and confident.

¤ The oxytocin reflex may not work as well when a mother expresses as it does when a baby suckles. A mother needs to know how to help her oxytocin reflex, or she may find it difficult to express her milk.

¤ *Ask: What ways can you think of to stimulate the oxytocin reflex when the baby is not suckling?*

► **Wait for a few replies and then continue.**

► **Ask participants to turn to page 249 of their *Participant's manual* and find the box HOW TO STIMULATE THE OXYTOCIN REFLEX.**

► **Ask participants to read through the box on their own, explaining anything that is not clear.**

► **Demonstrate with a model breast how a mother can stimulate her nipples or massage or stroke her breasts. If a real mother is available, ask her to demonstrate.**

How to stimulate the oxytocin reflex

- Help the mother **psychologically**:
  - Build her confidence.
  - Try to reduce any sources of pain or anxiety.
  - Help her to have good thoughts and feelings about the baby.
- Help the mother **practically**. Help or advise her to:
  - Sit quietly and privately or with a supportive friend.
    Some mothers can express easily in a group of other mothers who are also expressing for their babies.
  - Hold her baby with skin-to-skin contact if possible.
    She can hold her baby on her lap while she expresses. If this is not possible, she can look at the baby. If this is not possible, sometimes even looking at a photograph of her baby helps.
  - Warm her breasts.
    For example, she can apply a warm compress, or warm water, or have a warm shower. Warn her that she should test the temperature to avoid burning herself.
  - Stimulate her nipples.
    She can gently pull or roll her nipples with her fingers.
  - Massage or stroke her breasts lightly.
    Some women find that it helps if they stroke the breast gently with finger tips or with a comb.
    Some women find that it helps to gently roll their closed fist over the breast towards the nipple.
  - Ask a helper to rub her back.

- **Demonstrate how to rub a mother's back; Fig. 33.1 illustrates the technique.**
- **Ask a participant to help you. She should sit at the table resting her head on her arms, as relaxed as possible.**
- **She remains clothed, but explain that with a mother it is important for her breasts and her back to be naked.**
- **Make sure that the chair is far enough away from the table for her breasts to hang free. Explain what you will do, and ask her permission to do it.**
- **Rub both sides of her spine with your thumbs, making small circular movements, from her neck to her shoulder blades, and back again, for 2 or 3 minutes (see box inset in Fig. 33.1).**
- **Ask her how she feels, and whether it makes her feel relaxed.**
  - There are other ways of massaging a mother's back, and they often work well.
- **Ask participants whether they know other kinds of massage that may have the same effect of relaxing the mother and helping her milk to flow.**
- **Ask participants towork in pairs and briefly practise the technique of rubbing a mother's back.**
- **Make sure that each participant practises the technique, and each participant experiences someone massaging their back, including any men in the group.**

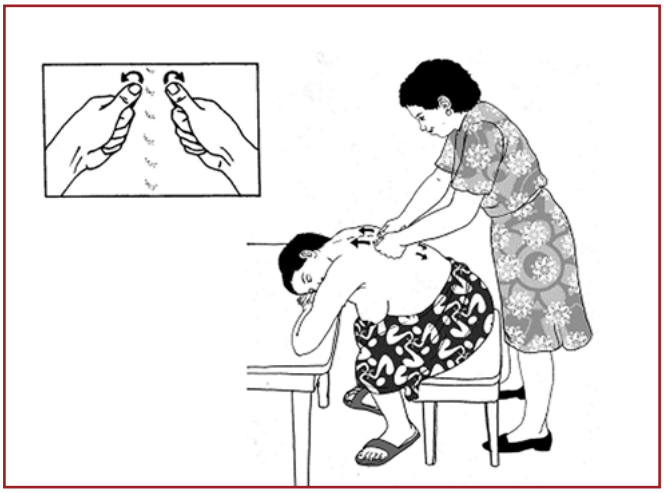


Fig. 33.1 A helper rubbing a mother's back to stimulate the oxytocin reflex

III. Demonstrate how to express breast milk by hand — 20 minutes

- Make these points:
  - Breast milk can be expressed by hand, or by manual or electric pump. Hand expression is the most useful way to express milk. It needs no appliance, so a woman can do it anywhere, at any time.
  - It is easy to hand express when the breasts are soft. It is more difficult when the breasts are engorged and tender. So teach a mother how to express her milk in the first and second day after delivery. Do not wait until the third day, when her breasts are full.
  - **Key point:** A woman should express her own breast milk. The breasts are easily hurt if another person tries. If you are showing a woman how to express, show her on your own body as much as possible, while she copies you. You can uses a model breast if you want to.
  - If you need to touch her to show her exactly where to press her breast, be very gentle and careful not to touch her inappropriately. Put her fingers where she should express, and, if necessary, put your fingers on top of hers to show her how to press.
- Explain how to prepare a container for the expressed breast milk. (Do this demonstration quickly. Do not let it take a long time.)
- Show participants some of the containers to hold the expressed breast milk that you have collected. Go through the following points:

How to prepare a container for expressed breast milk

- Choose a cup, glass, jug or jar with a wide mouth.
- Wash the cup in soap and water (this can be done the day before).
- Pour boiling water into the cup, and leave it for a few minutes. Boiling water will kill most of the germs.
- When ready to express milk, pour the water out of the cup.

- Give the demonstration of how to express breast milk by hand.
- Demonstrate as much as possible on your own body. If you prefer not to use your own body, use a model breast, or practise on the soft part of your arm or cheek. You can draw a nipple and areola on your arm.
- Follow the steps in the box How to express breast milk by hand, explaining what you do.

How to express breast milk by hand

Teach a mother to do this herself. Do not express her milk for her. Touch her only to show her what to do, and be gentle. Teach her to:

- Prepare a clean dry wide mouthed container for the expressed milk.
- Wash her hands thoroughly with soap and water every time before she expresses.
- She needs to wash her breasts only once a day. Frequent washing, especially with soap, dries the sensitive skin of the areola, increasing the risk of fissures.
- Sit or stand comfortably, and hold the container near her breast.
- Put her thumb on her breast **above** the nipple and areola, and her first finger or first two fingers on the breast **below** the nipple and areola, opposite the thumb. She supports the breast with her other fingers (see **Fig. 33.2**).
- Press her thumb and first finger or first two fingers slightly inwards towards the chest wall. She should avoid pressing too far, or she may block the milk ducts.
- Press her breast behind the nipple and areola between her first finger or first two fingers and thumb. She should press on the larger ducts beneath the areola. Sometimes in a lactating breast, it is possible to feel the ducts. They are like pods, or peanuts. If she can feel them, she can press on them.
- Press and release, press and release. This should not hurt – if it hurts, the technique is wrong. At first no milk may come, but after pressing a few times, milk starts to drip out. It may flow in streams if the oxytocin reflex is active.
- Press the areola in the same way from the **sides**, to make sure that milk is expressed from all segments of the breast.
- Avoid rubbing or sliding her fingers along the skin. The movement of the fingers should be more like rolling.
- Avoid squeezing the nipple itself. Pressing or pulling the nipple cannot express the milk. It is the same as the baby sucking only the nipple.
- Express one breast for at least 3–5 minutes until the flow slows; then express the other side; and then repeat both sides. She can use either hand for either breast, and change when they tire.
- Alternate between breasts 5 or 6 times. Stop expressing when the milk no longer flows.
- Explain that to express breast milk adequately takes 20–30 minutes, especially in the first few days when only a little milk may be produced. It is important not to try to express in a shorter time.
- If she is expressing colostrum in the first one or two days, collect it in a 2 or 5 mL syringe as it comes from the nipple. A helper can do this. This avoids wasting the milk, which can happen with a small volume of milk in a large container.
- Some mothers find pushing slightly inwards towards the chest wall at the same time as compressing the breast helps to increase milk flow.

Avoid the following:

- Squeezing the nipple – this can block milk flow.
- Sliding the fingers on the breast – friction can make the breasts sore.

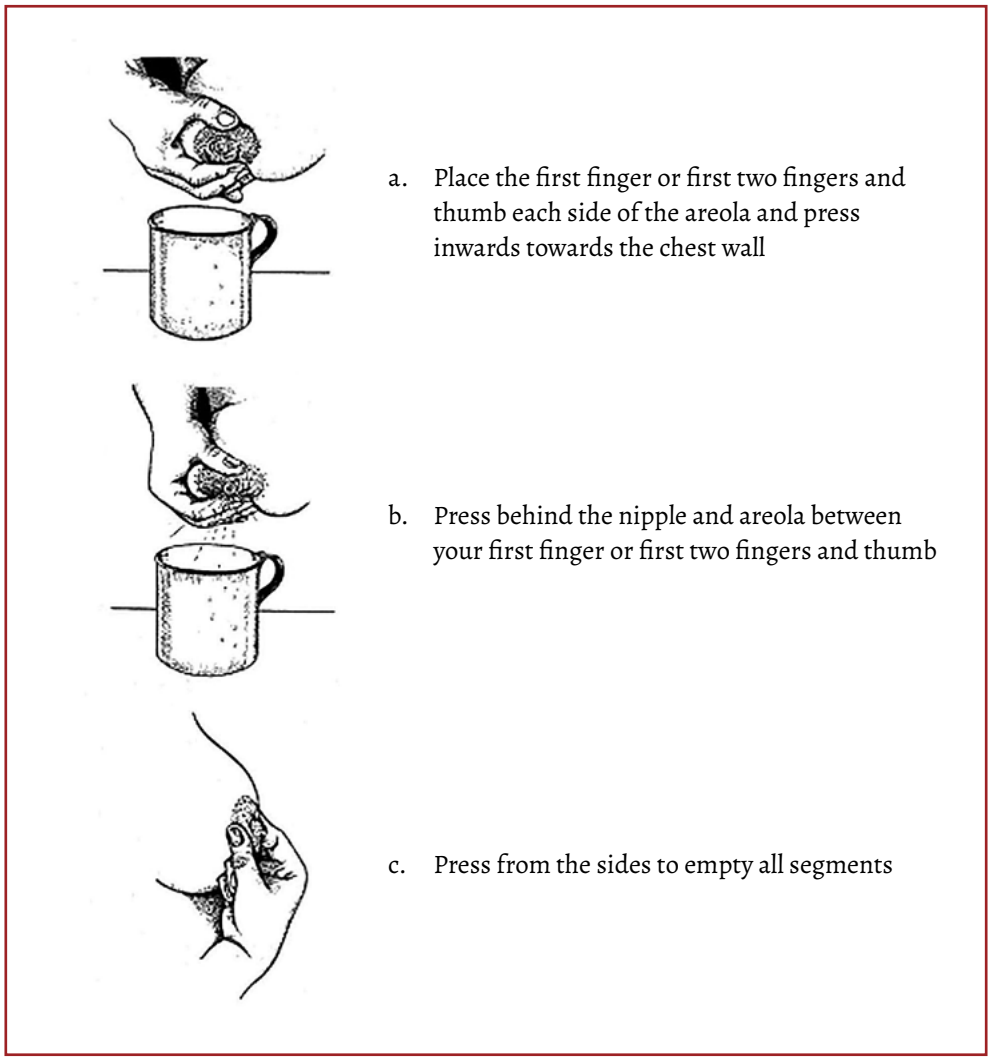


Fig. 33.2 How to express breast milk by hand

- Tell participants that they can find the box How to express breast milk by hand and the figures on pages 250–251 of their *Participant's manual*.
- Review together Counselling card 6: How to express breast milk and cup-feed, and Counselling card 7: When you are separated from your baby. Refer participants to the section in the *Guidance on the use of counselling cards* on Key practices and discussion points for Counselling cards 6 and 7 and remind them about use of the steps Assess, Analyse and Act.

- **Discuss how often to express milk:**
  - *Ask: How often should a mother express her breast milk?*
    Wait for a few replies and then continue.
  - It depends on the reason for expressing the milk, but usually as often as the baby would breastfeed, which is about every 3 hours, or 6–8 times a day.
  - **To establish lactation, to feed a low-birth-weight or sick neonate**, she should start to express milk on the first day, as soon as possible after delivery. She may only express a few drops of colostrum at first, but it helps production of breast milk to begin, in the same way that a baby suckling soon after delivery helps production to begin.
  - She should express as much as she can, as often as her baby would breastfeed. This should be at least every 3 hours, including during the night. If she expresses only a few times, or if there are long intervals between expressions, she may not be able to produce enough milk.
  - **To keep up her milk supply to feed a sick baby**, she should express at least every 3 hours.
  - **To build up her milk supply, if it seems to be decreasing after a few weeks**, she should express very often for a few days (every 2 hours or even every hour), and at least every 3 hours during the night.
  - **To leave milk for a baby while she is out at work**, she should express as much as possible before she goes to work, to leave for her baby. It is also very important to express while at work, to help keep up her supply, to keep her breasts healthy and to reduce leaking. She should express at least twice during working hours, 3-hourly if possible.
  - **To relieve symptoms, such as engorgement, or leaking at work**, she should express only as much as is necessary.
  - **To keep her nipple skin healthy**, she should express a small drop to gently smooth onto the nipple and areola after a bath or shower.
- **Ask participants to practise the technique. Ask them to practise the rolling action of the fingers on a model breast or on their arms. Ask them to make sure that they avoid pinching. Ask them to practise on their own bodies privately later.**
- **Explain how to store expressed breast milk.**
- **Ask participants to read line by line in turns the box HOW TO STORE EXPRESSED BREAST MILK on page 252 in their *Participant's manual*.**

HOW TO STORE EXPRESSED BREAST MILK

- Use appropriate storage containers, such as clean plastic or glass jars with tight lids, and, if possible, a refrigerator. For long-term storage, 10 or more containers will be needed.
- Put the expressed breast milk into a container, cover it, and put it in as cool a place as possible. The amount of expressed breast milk put into one container should not be more than the amount needed for one feed.
- If the amounts of milk expressed are small, add more to the same container during one day, but not after that.
- If no refrigerator is available, expressed breast milk can be kept at room temperature, even in a hot climate, for 6 hours.
- If there is a refrigerator, store the containers of expressed breast milk in the main compartment for up to 24 hours, or in the freezing compartment for up to 3 months.
- Before use, allow frozen milk to defrost in the main compartment, or at room temperature. Warm the milk by standing in a pot of water at hand temperature.
- Use unfrozen milk within 2 hours (or give to an older child or throw away).

IV. Demonstrate breast pumps — 10 minutes

- **Make these points:**
  - If breasts are engorged and painful, it is sometimes difficult to express milk by hand.
  - It can be helpful to express with a pump.
  - A pump is easier to use when the breasts are full. It is not so easy to use when the breasts are soft.
- **Display the breast pumps available in the area. These may include rubber-bulb breast relievers, hand-operated pumps or electric pumps. There are many varieties; some are more efficient than others.**
- **Pass the examples round for participants to examine. Ask whether they have used them, and what their experiences are.**
  - **Do they find the pumps useful?**
  - **Do mothers find them useful?**
  - **What problems have they encountered?**
  - **Do they find them more or less satisfactory than hand expression?**
  - The "rubber-bulb breast relievers" (see **Fig. 33.3**) are the most widely available, but are of limited use and not efficient. They should ONLY be used to relieve engorgement when hand expression is difficult. That is why they are called "breast relievers".
- **Demonstrate how to use a rubber-bulb breast reliever:**
  - **Point out the rubber bulb that creates suction. Point out the glass tube with a wide opening to fit over the nipple, and a swelling in the side to collect milk. Use a model breast to demonstrate how a mother can use the pump.**
- **Follow these steps, and explain what you do:**
  - Compress the rubber bulb to push out the air.
  - Place the wide end of the tube over the nipple.
  - Make sure that the glass touches the skin all around, to make an airtight seal.
  - Release the bulb. The nipple and areola are sucked into the glass.
  - Compress and release the bulb again, several times.
  - After compressing and releasing the bulb a few times, milk starts to flow. The milk collects in the swelling on the side of the tube.
  - Break the seal to empty the milk, and start again.

- **Explain the disadvantages of rubber-bulb breast relievers:**
  - They are difficult to clean properly. Milk may collect in the rubber bulb and it is difficult to clean out. The milk that collects is often contaminated.
  - They are not very efficient, especially when the breasts are soft.
  - They should NOT be used for collecting milk to feed a baby.

Fig. 33.3 Rubber-bulb breast reliever

- **Discuss other kinds of manually operated pump.**
- **Try to obtain one that is locally available, to demonstrate to participants. Make sure that it comes with instructions, and study them and practise using it so that you know how to demonstrate it.**
- **You need to be clear about the parts of the pump that need to be cleaned and sterilized each time it is used, and how to take it apart and put it together again.**
  - There are many different kinds of hand-operated breast pump. They can be quite efficient, and useful in situations without electricity, or when portability is required, such as when travelling.
- **Discuss electric breast pumps briefly.**
  - Electric pumps are often used in hospital, and they can be purchased or hired for home use.
  - Some mothers prefer electric pumps to manual pumps or hand expression. They find them more efficient, and remove more milk than they can by hand. Some mothers, however, find hand expression more convenient and equally effective.
  - Mothers need proper instruction in the use of an electric pump, and which parts need to be cleaned and sterilized after each use, and how to do this.
  - Electric pumps can easily carry infection, which is especially dangerous if more than one woman uses the same pump
  - All mothers should also learn how to hand express, in case of failure of the machine or of electricity.
- **Demonstrate use of an electric pump if one is available.**
- **Tell participants that they should look for an opportunity to observe a mother using a pump when they are doing clinical practice. They should ask her about her experience using the pump, how easy she finds it to use, and whether she is also able to express breast milk by hand.**

V. Summarize the session — 5 minutes

- **Ask participants whether they have any questions, and try to answer them.**
- **Make these points:**
  - Hand expression is generally the most useful way to express breast milk. It is less likely to carry infection than a hand or electric pump, and is available to every woman at any time.
  - It is important for women to learn to express their milk by hand, and not to think that a pump is necessary.
  - To express milk effectively, it is helpful to stimulate the oxytocin reflex and to use a good technique. Stimulating the oxytocin reflex is helpful with pump expression, as well as with hand expression.
- **Explain that a summary of this session can be found on pages 247–253 of the *Participant's manual*.**

Notes

Notes (contd)

SESSION 34

"Not enough milk"

Objectives

After completing this session, participants will be able to:

- list the reliable and possible signs that a baby is not getting enough milk
- decide whether a baby is getting enough breast milk
- describe the common reasons why a baby may have a low intake of breast milk in the first 2 weeks of life
- list the common reasons why a baby may have a low intake of breast milk intake after 2 weeks of age
- describe the common reasons for apparent insufficiency of milk
- decide the cause of the difficulty
- explain the management of real or apparent low milk supply

Session outline . . . . . 60 minutes

Participants work in groups of eight with two trainers for parts II and III, and groups of four with one trainer afterwards.

All trainers help to give individual feedback on the exercise.

I. Introduce the session, present **Slide 34/1** . . . . . 5 minutes
II. Discuss how to decide whether a baby is getting enough milk . . . . . 15 minutes
III. Discuss the reasons why a baby may not get enough breast milk . . . . . 15 minutes
IV. Discuss how to help a mother whose baby is not getting enough breast milk. . . . . 10 minutes
V. Discuss how to help a mother who thinks that she does not have enough breast milk . . . . . 10 minutes
VI. Summarize the session . . . . . 5 minutes

Preparation

- Refer to the Introduction for guidance on facilitating group work.
- Study the notes for the session, so that you are clear about what to do.
- Make sure that you have **Slide 34/1** ready. Alternatively, as there is only one slide in this session, you might prefer to read aloud the objectives on **Slide 34/1** without projecting them onto the screen.
- Prepare flipcharts or boards to write up lists of ideas.
- You will need:
  - A board or a flipchart, on which to write the participants' ideas. This should have enough spaces or sheets of paper for two lists: SIGNS THAT MAKE MOTHERS THINK THEY DO NOT HAVE ENOUGH MILK and REASONS WHY A BABY MAY NOT GET ENOUGH MILK
  - Two sheets of flipchart paper pinned up side by side on the wall for the schema REASONS WHY A BABY MAY NOT GET ENOUGH BREAST MILK. Each sheet has two columns: on the first sheet write the two headings BREASTFEEDING FACTORS and MOTHER: PSYCHOLOGICAL FACTORS at the top, with plenty of space below. On the second sheet, write the headings MOTHER: PHYSICAL CONDITION and BABY'S CONDITION, with space below.
- Make sure that the room is arranged so that participants can see the lists.
- Read the **Further information** sections, so that you are familiar with the ideas that they contain, so that you can answer participants' questions.

As you follow the text, remember:

- ▸ indicates an instruction to you, the trainer.
  - ¤ indicates what you say to participants.

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the session — 5 minutes

- ▸ Show **Slide 34/1 – Session 34 – objectives** and read out the objectives:

34/1

Session 34: "Not enough milk" –objectives

After completing this session, participants will be able to:

- list the reliable and possible signs that a baby is not getting enough milk
- decide whether a baby is getting enough breast milk
- describe the common reasons why a baby may have a low intake of breast milk in the first 2 weeks of life
- list the common reasons why a baby may have a low intake of breast milk intake after 2 weeks of age
- describe the common reasons for apparent insufficiency of milk
- decide the cause of the difficulty
- explain the management of real or apparent low milk supply

- ▸ Ask participants to keep their *Participant's manual* closed.
  - ¤ *Ask: What are the most common reasons that mothers give for giving other food or drinks early?*
- ▸ Wait for a few replies and then continue
  - ¤ One of the most common reasons is that they think they "do not have enough milk".
  - ¤ In SESSION 3: LOCAL INFANT AND YOUNG CHILD FEEDING SITUATION, you may have developed a list of reasons for stopping breastfeeding or for starting complementary foods early.
- ▸ Refer back to that list now, and ask participants whether they identified "not enough milk" as an important cause in their situation.
- ▸ Make these points:
  - ¤ Usually, even when a mother thinks that she does not have enough breast milk, her baby is in fact getting all that they need. Almost all mothers can produce enough breast milk for one or even two babies. They can almost all produce more than their baby needs.
  - ¤ Sometimes a baby does not get enough breast milk. But it is usually because they are not suckling enough, or not suckling effectively (see SESSIONS 12 and 24: HOW BREASTFEEDING WORKS 1 AND 2). It is rarely because their mother cannot produce enough.
  - ¤ Worries about not having enough milk may arise before breastfeeding has been established, in the first 2 weeks after delivery. Then the mother needs help and support to establish breastfeeding.
  - ¤ Difficulties may arise after breastfeeding has been established, after the baby is about 1 month of age. The mother needs help to maintain production of breast milk.
  - ¤ Some mothers worry that they do not have milk at a certain time of day, usually in the evening.
  - ¤ The causes of the difficulties and the needs of mothers in these various situations are sometimes different. However, the same principles of management apply, so we will consider the different situations together.

II. Discuss how to decide whether a baby is getting enough milk — 15 minutes

- **Make these points:**
  - If a mother thinks that she does not have enough milk, you need to understand why she thinks that, and to decide whether the baby is getting enough.
  - *Ask: What makes a mother think that her baby is not getting enough milk?*
- **Write participants' ideas in a list on a flipchart or board.**
- **Continue until you have a list of at least 8 signs, and, if possible, until someone has said "poor weight gain".**
- **Explain which signs are reliable.**
  - There are only two signs that show reliably that a baby is not getting enough milk. These are:
    - poor weight gain
    - passing small amounts of concentrated urine.
- **If either sign is on the participants' list, underline it, and praise the participants for thinking of it.**
- **Explain which signs are possible:**
- **Mark with a tick on the participants' list of signs, any of the following:**
  - Baby not satisfied after breastfeeds
  - Baby cries often
  - Very frequent breastfeeds
  - Very long breastfeeds
  - Baby refuses to breastfeed
  - Baby has hard, dry, or green stools
  - Baby has infrequent small stools
  - No milk comes out when the mother tries to express
  - The breasts did not enlarge (during pregnancy)
  - Milk did not "come in" (after delivery)
  - These are possible signs. They may mean that a baby is not getting enough milk. However, you cannot be sure, and you need to check for reliable signs.
- **Mark with an X all the other signs on the participants' list.**
  - All the other signs are unreliable. They may worry a mother, but they do not mean that her baby is getting insufficient milk.
- **Praise participants for the signs that they thought of.**
- **Ask them to find the list of RELIABLE SIGNS and POSSIBLE SIGNS in the box SIGNS THAT A BABY MAY NOT BE GETTING ENOUGH BREAST MILK, on page 256 of their *Participant's manual*.**
- **Ask two participants to read the list aloud.**

Signs that a baby may not be getting enough breast milk

Reliable signs

- Poor weight gain (growth slower than standard curves)
- Neonate loses more than 10% of birth weight or weighs less than birth weight at 2 weeks
- Passing a small amount (fewer than 6 times a day) of concentrated urine (yellow and strong smelling)

Possible signs

- Baby not satisfied after breastfeeds
- Baby cries often
- Very frequent breastfeeds
- Very long breastfeeds
- Baby refuses to breastfeed
- Baby has hard, dry or green stools
- Baby has infrequent small stools
- No milk comes out when the mother tries to express
- The breasts did not enlarge (during pregnancy)
- Milk did not "come in" (after delivery)

▶ **Explain how to find out whether a baby is getting enough breast milk:**

- **Check the baby's weight gain**: this is the most reliable sign.
- For the first 6 months of life, use the growth charts for infants aged 0–6 months (1 kg per month is not necessary, and not usual). If a baby's weight gain is not parallel to the curves (or is downward), they are not gaining enough weight (see Session 8: building confidence and giving support).
- Look at the baby's growth chart if available, or at any other record of previous weights. If no weight record is available, weigh the baby, and arrange to weigh them again in 1 week's time.
- If the baby is gaining weight and following the curves, then they are getting enough milk.
- However, if no weight record is available, you cannot get an immediate answer.
- **Check the baby's urine output**: this is a useful quick check.
- Ask the mother how often her baby is passing urine.
- By the age of 6 days, babies normally pass urine six or more times a day.
- If the baby is more than 4 weeks old, ask the mother if the urine is dark yellow or "strong" smelling, showing that it is concentrated.
- If a baby is passing plenty of dilute urine, they are getting enough breast milk.
- If the baby is passing urine fewer than 6 times a day, and, if they are more than 4 weeks old, if it is concentrated, then they are not getting enough breast milk.
- This can tell you quickly whether an exclusively breastfed baby is getting enough milk. However, if they are having other drinks, you cannot be sure because these signs may not apply.

III. Discuss the reasons why a baby may not get enough breast milk — 15 minutes

- Ask participants to keep their *Participant's manual* closed again.
- Make this point:
  - If you have decided, using the reliable signs, that a baby is not getting enough breast milk, it is important to find out why, before you can help the mother.
  - *Ask: Can you think of any reasons why a baby may not get enough breast milk?*
- List the participants' suggestions on a board or flipchart.
- Continue if possible until they have suggested at least one "breastfeeding factor" and at least one "psychological factor".
- Show them the flipcharts with the headings shown below.
- Proceed with the review of "not enough milk", filling any gaps and avoiding repetition.

BREASTFEEDING FACTORS	MOTHER: PSYCHOLOGICAL FACTORS	MOTHER: PHYSICAL CONDITION	BABY'S CONDITION

- List participants' correct reasons for a baby not getting enough breast milk under one of the headings.
- You will develop a list of reasons that looks similar to the schema REASONS WHY A BABY MAY NOT GET ENOUGH BREAST MILK on the next page.
- Add important reasons that participants have not thought of.
- Leave out reasons that are not important in your area – for example, in some areas, women may not smoke or drink alcohol.
- As you list each reason, explain it briefly, giving a local example if possible.

REASONS WHY A BABY MAY NOT GET ENOUGH BREAST MILK			
BREASTFEEDING FACTORS	**MOTHER: PSYCHOLOGICAL FACTORS**	**MOTHER: PHYSICAL CONDITION**	**BABY'S CONDITION**
Delayed start Feeding at fixed times Infrequent feeds No night feeds Short feeds Poor attachment Bottles, pacifiers Other foods Other fluids (water, teas)	Lack of confidence Worry, stress Dislike of breastfeeding Rejection of baby Tiredness	Contraceptive pill (estrogen), diuretics Pregnancy Severe malnutrition Alcohol Smoking Retained piece of placenta (rare) Poor breast development (very rare)	Illness Abnormality
These are COMMON		**These are NOT COMMON**	

- **Make these points:**
  - The reasons in the first two columns (BREASTFEEDING FACTORS and MOTHER: PSYCHOLOGICAL FACTORS) are common.
  - Psychological factors are often behind the breastfeeding factors; for example, lack of confidence causes a mother to give artificial feeds; tiredness results in a mother feeding her baby less often.
  - Look for these common reasons first.
  - The reasons in the second two columns (MOTHER: PHYSICAL CONDITION and BABY'S CONDITION) are less common in most settings.
  - So it is not common for a mother to have a physical difficulty in producing enough breast milk.
  - Think about these uncommon reasons only if you cannot find one of the common reasons.
- **Ask participants to look at the list for 2–3 minutes.**
- **Ask whether there are any points that they are not clear about.**
- **Ask which reasons for low milk intake they are aware of in their situation.**
- **Use the Further information section to help you to answer any questions.**
- **Review misconceptions about the causes of a poor milk supply.**
  - Some things are commonly thought to be reason for insufficient breast milk. However, they do not in fact affect the milk supply.
- **Read quickly through the list in the box THESE DO NOT AFFECT THE SUPPLY OF BREAST MILK.**

THESE DO NOT AFFECT THE SUPPLY OF BREAST MILK

- Age of mother
- Sexual intercourse
- Menstruation
- Disapproval of relatives and neighbours
- Returning to a job (if the baby continues to suckle often and the mother is relaxed, etc.)
- Age of baby
- Caesarean section
- Preterm delivery
- Many children
- Simple, ordinary diet

▸ **Summarize the causes of "not enough milk".**

▸ **Emphasize these points:**

- The common reasons for a baby not getting enough milk are breastfeeding factors and psychological factors.
- A physical difficulty in producing breast milk is less often the cause.

▸ **Tell participants that they can find a summary on page 255–257 of their *Participant's manual*.**

IV. Discuss how to help a mother whose baby is not getting enough breast milk 10 minutes

▸ **Gather your group of 4 participants together (other trainers gather their groups).**

▸ **Explain that you will now go through the steps of helping a mother whose baby is not getting enough milk, and decide how to apply the skills that they have learnt.**

▸ **Ask participants in turn to read out the stories in the boxes from page 258–259 of their *Participant's manual*. Then ask them the questions that follow.**

Mona says that she does not have enough milk. She wants to go back to work in a shop soon, and thinks that she had better start giving Ali bottles now, so that he is used to it when she is working. Ali is 2 months old. He weighed 3 kg when he was born and now he weighs 3.4 kg.

- *Ask: Is Ali getting enough milk or not?*

▸ **Wait for a few replies, then continue.**

- He is not getting enough milk. He has only gained 400 g in 2 months.
- *Ask: How can you find the cause of Mona and Ali's problem?*

▸ **Let participants think for a short time and make a few suggestions. Encourage them to think of the skills that they have learnt. Then continue.**

- Go through the following steps:
  - Listen and learn – to learn about psychological factors, and how she feels.
  - Take a history – to understand breastfeeding factors and the mother's medication.

- *Ask: What will you do next to help to find the cause?*

▸ **Wait for a few replies, then continue.**

- Assess a breastfeed – baby's attachment and suckling, and bonding or rejection.
- Examine the baby – for illness or abnormality.

> The history tells you that Ali wants to feed very often. Mona sometimes has sore nipples, so she does not let him feed for very long. Ali was delivered in the local hospital. The delivery was normal and she went home after 6 hours before Ali had breastfed.

- *Ask: What will you do next to help to find the cause?*

▸ **Wait for a few replies then continue.**

- Examine the mother – to learn about her health and nutrition.
- Examine her breasts – for any breast condition.

> When you assess a breastfeed, you see less areola above Ali's mouth, and more below, and his chin is not touching the breast. When he finishes suckling, the nipple looks squashed. Ali is not ill or abnormal, and Mona is healthy.

- *Ask: So what is the cause of Ali not getting enough milk?*

▸ **Wait for a few replies, then continue.**

- He is poorly attached at the breast, and not suckling effectively. Poor attachment is damaging Mona's nipples.
- *Ask: How can you help Mona and Ali?*

▸ **Encourage participants to think how their SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT might help.**

- Use SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT:
  - Praise her for breastfeeding until now, even though nobody helped her.
  - Explain that Ali is not getting enough milk, and her nipples are sore because he is not taking enough of the breast into his mouth, and offer to help her to attach him better.
  - Suggest that she feeds him for longer at each feed, to build up her milk supply,
  - Suggest that when she goes back to work, she considers expressing milk for him, and that she gives it by cup instead of giving bottle feeds.

V. Discuss how to help a mother who thinks that she does not have enough breast milk
10 minutes

▸ **Continue working with your group of 4 participants.**

▸ **Explain that you will now go through the steps of helping a mother who thinks that she does not have enough milk, to see how to apply the skills that you have learnt.**

▸ **Ask participants to take turns to read out the story from the boxes on page 260–261 of their *Participant's manual*. Then ask them the questions that follow.**

Bella says that she does not have enough milk. Her baby Rafa seems to be hungry all the time. Rafa is 6 weeks old. He weighed 3 kg when he was born and now he weighs 4.2 kg.

- *Ask: Is Rafa getting enough milk or not?*

▸ **Wait for a few replies then continue.**

- He is getting all the milk that he needs. He has gained 1.2 kg in 6 weeks, so his growth is following the standard curves.
- *Ask: How can you find the cause of Bella's worries?*

▸ **Let participants think for a short time and make a few suggestions. Encourage them to think of the skills that they have learnt. Then continue.**

- Go through the following steps:
  - Listen and learn – to learn about psychological factors, and how she feels.
  - Take a history – to understand breastfeeding factors and the mother's medication.

The history tells you that Rafa wants to feed about every 2–3 hours, and also several times at night. Feeds take about 5–10 minutes. She gives him drinks of water between feeds, because she thinks he is thirsty. Rafa was delivered in the health centre. The delivery was normal. The midwife helped her to start breastfeeding before she came home. Bella's mother says that Bella's breasts are too small to produce enough milk for a baby as big as Rafa.

- *Ask: What will you do next to help to find the cause of Bella's worries?*

▸ **Wait for a few replies then continue.**

- Assess a breastfeed (see JOB AID: BREASTFEED OBSERVATION) – baby's attachment and suckling, and bonding or rejection.
- Examine the baby – for illness or abnormality.
- Examine the mother – to learn about her health and nutrition.
- Examine her breasts – for any breast condition.

Rafa suckles with his mouth wide open, with more areola visible above his mouth than below. Bella holds him close and facing her, and his chin is close to her breast. When he pauses after about 5 minutes, she takes him off the breast. Bella is quite slim and has small pointed breasts, but you can see some white milk on the nipples when she takes Rafa off. Rafa and Bella are both well.

- *Ask: What is the reason for Bella thinking that she does not have enough milk for Rafa?*

▸ **Wait for a few replies then continue.**

- Bella lacks confidence.
- Bella lacks confidence in her milk, and her mother makes her think that her breasts are too small. Rafa is suckling effectively, but Bella takes him off her breast without letting him finish and come off by himself.
- *Ask: How can you help Bella and Rafa?*

- **Encourage participants to think how skills for building confidence and giving support might help.**
  - Use your SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT.
  - Accept what Bella says about her breasts and her milk.
  - Praise how well Rafa is growing, which shows that he is getting plenty of milk.
  - Praise the white milk that you see at the end of the feed – it is fat-rich hindmilk.
  - Give information in a positive way:
    - Explain that he is suckling well, and getting the milk.
    - Explain that small breasts can produce as much milk as large breasts.
    - Explain that there is plenty of water in breast milk.
  - Suggest that she leaves him on the breast until he finishes and comes off by himself, so that he gets more hind milk, and is more satisfied after each feed.
  - Suggest that she stops giving Rafa drinks of water, because this may make him take less breast milk, and then she may produce less.

VI. Summarize the session — 5 minutes

- **Point out to participants that the way to help a mother who is worried about her milk supply is similar for a mother whose baby is not getting enough milk and for a mother whose baby is getting enough.**
  - Often, poor attachment at the breast is the cause of behaviour that makes a mother think her baby is not satisfied, even though her milk supply is plentiful and her baby is getting all that they need.
  - You need to use your counselling skills, your knowledge about the breastfeeding pattern, and skills to help with positioning and attachment. In most cases, the difficulty can be overcome.
- **Ask participants whether they have any questions, and try to answer them.**
- **Explain that a summary of this session can be found on pages 255–261 of the *Participant's manual*.**

Further information

Weight changes in newborn babies

A newborn baby may lose a little weight in the first few days of life. They should regain their birth weight by the age of 2 weeks. If babies demand feed from the first day, they start gaining weight more quickly than babies who delay. A baby who weighs less than their birth weight at 2 weeks of age is not gaining enough weight.

Passing urine in neonates

Before the age of 6 days, babies may pass urine fewer than 6 times – a useful rule of thumb is: once in the first 24 hours, twice on day 2, 3 times on day 3, 4 times on day 4, and 5 times on day 5.

Before 4 weeks, they concentrate their urine less, even if they are dehydrated, so the sign of concentrated urine is less useful.

Disposable nappies

These absorb urine and make it difficult to decide whether a baby has passed enough urine. If a mother is worried about her milk supply, it is better to use cloth nappies to monitor the baby's urine output, if this is possible for her.

Stool frequency

The stool frequency of infants is very variable.

- In the first 3–4 days, the baby passes dark green meconium. If they are passing meconium after 4–5 days, then they may not be getting enough milk.
- From about 4 days, when the milk "comes in", the stools change to brown or yellow, and the baby passes 2–3 substantial stools each day, and sometimes a small stool with each feed.
- After 3–4 weeks, some babies start to pass stools less often, and may only pass a stool once every 3 or 4 days, sometimes not for a week or more. This is quite normal. However, when the baby does pass a stool, it is usually large and semi-liquid. Small dry stools may be a sign that a baby is not getting enough milk.
- It is also normal for a baby to pass eight or more semi-liquid stools in a day. This is sometimes mistaken for diarrhoea. However, if the baby has diarrhoea, the stools are watery.

Unreliable signs of "not enough milk"

Participants may have suggested some of the following signs that make a mother think that she does not have enough milk. They are all unreliable and do not by themselves indicate that her baby is not getting enough:

- Baby sucks fingers
- Baby sleeps longer after bottle feed
- Baby's abdomen is not rounded after feeds
- Breasts are not full immediately after delivery
- Breasts are softer than before
- Breast milk is not dripping out
- The mother is not feeling her oxytocin reflex
- Family members ask whether there is enough milk
- A health worker said there was not enough milk
- The mother is told she is too young or too old to breastfeed
- The mother is told her baby is too small or too big
- Poor previous experience of breastfeeding
- Breast milk looks thin

These notes may help you to explain the reasons why a baby may not get enough milk.

Breastfeeding factors

Delayed start

If a baby does not start to breastfeed on the first day, their mother's breast milk may take longer to come in, and they may take longer to start gaining weight.

Infrequent feeds

Breastfeeding fewer than 8 times a day in the first 4 weeks, or fewer than 5–6 times a day at an older age, is a common reason why a baby does not get enough milk. Sometimes a mother does not respond to her baby when they cry, or she may miss feeds, because she is too busy or at work. Some babies are content and do not show that they are hungry often enough. They may stop demanding to be fed if no one responds to them. Babies who do not get enough milk may become undernourished, and then become passive, to conserve their energy. In this case, a mother should not wait for her baby to "demand", but should encourage/wake the baby to breastfeed every 3–4 hours. This is commonest in the first few months of life.

No night feeds

If a mother stops night breastfeeds before her baby is ready, her milk supply may decrease.

Short feeds

Breastfeeds may be too short or hurried, so that the baby does not get enough fat-rich hindmilk.

Sometimes a mother takes her baby off her breast after only a minute or two. This may be because the baby pauses, and the mother decides that the baby has finished. Or she may be in a hurry, or she may believe that her baby should stop in order to suckle from the other breast.

Sometimes a baby stops suckling too quickly, for example if they are too hot, because they are wrapped in too many clothes.

Poor attachment

If a baby suckles ineffectively, they may not get enough milk. This is one of the most important reasons for poor weight gain, especially in the first few weeks of life. So ensuring that babies are well attached at the breast soon after birth is an important way to ensure an adequate milk supply.

Bottles and pacifiers

A baby who feeds from a bottle or who sucks on a pacifier may suckle less at the breast, so the supply of breast milk decreases.

Complementary feeds

A baby who has complementary feeds (artificial milks, solids, or drinks including plain water) before 6 months suckles less at the breast, so the breast-milk supply decreases. The mother may notice a decrease in her milk supply, even though the baby continues to gain weight.

Mother: psychological factors

Lack of confidence

Mothers who are very young, or who lack support from family and friends, often lack confidence. Mothers may lose confidence because their baby's behaviour worries them. Lack of confidence may lead a mother to give unnecessary supplements. The formula milk may replace the breast milk.

Worry, stress

If a mother is worried or stressed or in pain, her oxytocin reflex may temporarily not work well. If she is comforted and her stress relieved, the reflex will recover.

Dislike of breastfeeding, rejection of the baby, and tiredness

In these situations, a mother may have difficulty in responding to her baby. She may not hold her baby close enough to attach well; she may breastfeed infrequently, or for a short time. She may give her baby a pacifier when they cry instead of breastfeeding them.

Mother: physical condition

Contraceptive pill

Contraceptive pills, which contain estrogens, may reduce the secretion of breast milk.

Progestagen-only pills and Depo-Provera should not reduce the supply of breast milk, but should not be given before the baby is 4 weeks old.

Diuretics may reduce the breast-milk supply.

Antihistamines have been reported to reduce the supply of breast milk, but there is no research on this.

Pregnancy

If a mother becomes pregnant again, she may notice a decrease in her supply of breast milk.

Severe malnutrition

Severely malnourished women may produce milk that is affected in quality and quantity. If a mother is deficient in micronutrients, the micronutrient content in her breast milk may be reduced. However, a woman who is mildly or moderately undernourished continues to produce milk at the expense of her own tissues, provided her baby suckles often enough. However, this depletes her own body stores.

Alcohol and smoking

Alcohol and cigarettes can reduce the amount of breast milk that a baby takes. Smoking may reduce production of breast milk, possibly by reducing prolactin production.

Retained piece of placenta

This is RARE. A small piece of placenta remains in the uterus, and makes hormones that prevent milk production. The woman bleeds more than usual after delivery, her uterus does not decrease in size, and her milk does not "come in". After the placenta is removed by curettage, her milk supply increases.

Poor breast development

This is VERY RARE. Occasionally, a woman's breasts do not develop and increase in size during pregnancy, and she does not produce much milk. If the mother noticed an increase in the size of her breasts during pregnancy, then poor breast development is not her problem. It is not necessary to ask about this routinely. Ask only if there is a problem.

Hormonal problems

Women who have had haemorrhage leading to hypovolaemic shock at the time of delivery may develop Sheehan's syndrome, as a result of pituitary ischaemia. Prolactin is not secreted.

Women with hypothyroidism and other endocrine disorders may also fail to produce breast milk.

Baby's condition

Illness

A baby who is ill and unable to suckle strongly does not get enough breast milk. If this continues, their mother's milk supply will decrease. The baby fails to gain weight, or loses weight, both because of the illness and because of low milk intake.

Abnormality

A baby who has a congenital problem, such as a heart abnormality, may fail to gain weight. This is partly because they take less breast milk, and partly because of other effects of the condition.

Babies with a deformity such as a cleft palate, or with a neurological problem, or mental disability, often have difficulty in suckling effectively, especially in the first few weeks.

Occasionally, you may not be able to find the cause of a poor milk supply; or the milk supply does not improve (the baby does not gain weight), even though you have done everything you can to help the mother to increase her supply of breast milk. A very small proportion of women may have an unexplained low milk supply – perhaps about 1–2% of women. Then you may need to look for one of the less common causes, and help or refer the mother accordingly.

Occasionally, you may need to help a mother to find a suitable additional source of milk for her baby. We use the term **supplements** to refer to extra milk given to a baby in the first few months. This is different from complementary feeding.

Encourage her to:

- continue breastfeeding as much as possible
- give only the amount of supplement that her baby needs for adequate growth
- give the supplement by cup
- give the supplement only once or twice a day, so that her baby suckles often at the breast and gets as much breast milk as possible.

Notes

SESSION 35

Crying

Objectives

After completing this session, participants will be able to:

- list different reasons why babies may cry
- help families with babies who cry a lot to continue exclusive breastfeeding and not to start unnecessary complementary feeds or supplements

Session outline . . . . . 30 minutes

Participants work in groups of eight with two trainers.

I. Introduce the session, present **Slide 35/1** . . . . . 3 minutes
II. Discuss the reasons why babies cry . . . . . 10 minutes
III. Participants read How to help a family with a baby who cries a lot . . . . . 10 minutes
IV. Demonstrate how to hold and carry a colicky baby . . . . . 5 minutes
V. Summarize the session . . . . . 2 minutes

Preparation

- Refer to the Introduction for guidance on facilitating group work.
- Study the session notes, so that you are clear about what to do.
- Make sure you have **Slide 35/1** ready. Alternatively, as there is only one slide in this session, you might prefer to read aloud the objectives on **Slide 35/1** without projecting them onto the screen.
- Prepare a flipchart or board to write up lists of ideas.
- Ask a male participant to help you to demonstrate how to comfort a baby.
- Read the **Further information** sections, so that you are familiar with the ideas that they contain, so that you can answer participants' questions.

As you follow the text, remember:

▸ indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the session — 3 minutes

- Show **Slide 35/1 – Session 35 – objectives** and read out the objectives:

> 35/1
>
> **Session 35: Crying – objectives**
>
> After completing this session, participants will be able to:
> - list different reasons why babies may cry
> - help families with babies who cry a lot to continue exclusive breastfeeding and not to start unnecessary complementary feeds or supplements

- Ask participants to keep their *Participant's manual* closed.
  - *Ask: What did we say in the previous session were the most common reasons why mothers think that they do not have enough breast milk?*
- Wait for a few replies, and stop when they say "the baby crying too much"
- Make these points:
  - During the first few months, a common reason why a mother thinks that she does not have enough breast milk, is that she, or her family, thinks that her baby is "crying too much".
  - Many mothers start unnecessary supplements or complementary feeds because of their baby's crying. These other feeds often do not make a baby cry less. Sometimes a baby cries more.
  - A baby who cries a lot can upset the relationship between the baby and their mother, and can cause tension among other members of the family.
  - An important way to help a breastfeeding mother is to counsel her about her baby's crying.
- If you developed a list of reasons for stopping breastfeeding or starting other feeds early in SESSION 3: LOCAL INFANT AND YOUNG CHILD FEEDING SITUATION, refer back to that now. Remind participants if they identified crying as one of the common reasons.

II. Discuss the reasons why babies cry — 10 minutes

- Develop a list of reasons why babies may cry a lot:
  - *Ask: What reasons can you think of why babies may cry a lot?*
- Write the replies up on a flipchart.
- Try to develop a list that looks something like this:

REASONS WHY BABIES CRY

Discomfort	(dirty, hot, cold)
Tiredness	(too many visitors)
Illness or pain	(changed pattern of crying)
Hunger	(not getting enough milk, growth spurt)
Mother's food	(any food, sometimes cow's milk)
Drugs mother takes	(caffeine, cigarettes, other drugs)
Colic	
"High-needs" babies	

- Add to the list on the board or flipchart reasons that participants have not thought of.
- Explain the following causes of crying, which may be new to participants:

Hunger due to not getting milk easily:

- A baby who is poorly attached, and not getting milk easily, may demand to be fed very often, and suckle for a long time at each feed.
- The baby may get enough milk and grow, by feeding often, but is not satisfied.

Hunger due to growth spurt:

- In this situation, a baby seems very hungry for a few days, possibly because they are growing faster than before.
- The baby demands to be fed very often.
- This is commonest at the ages of about 2 weeks, 6 weeks and 3 months, but can occur at other times.
- If the baby suckles often for a few days, the supply of breast milk increases, and the baby breastfeeds less often again.

Mother's food:

- Sometimes, a mother notices that her baby is upset when she eats a particular food.
- This is because substances from the food pass into her milk.
- It can happen with any food, and there are no special foods to advise mothers to avoid, unless she notices a problem.
- Babies can become allergic to protein in some foods in their mother's diet. Cow's milk, soy, egg and peanuts can all cause this problem. Babies may become allergic to cow's milk protein after only one or two prelacteal feeds of formula.

Substances the mother takes:

- Caffeine in coffee, tea and colas can pass into breast milk and upset a baby.
- If a mother smokes cigarettes, or takes other drugs, her baby is more likely to cry than other babies.
- If someone else in the family smokes, that also can affect the baby.

Oversupply of breast milk:

- A baby may cry if they are getting too much milk too fast.
- The baby may pull up their legs, as if they have abdominal pain.
- The baby may have loose green stools and a poor weight gain; or may grow well but cry and want to feed often.
- Because of this behaviour, the mother may think that she does not have enough for her baby.
- However, she has plenty of milk, but the baby may be getting too much foremilk and not enough of the hindmilk (see **Further information** in SESSION 30: REFUSAL TO BREASTFEED).

Reflux:

- Babies sometimes cry a lot because of gastro-oesophageal reflux.
- Reflux is when milk and acid from the stomach pass back into the oesophagus, making it sore.
- The baby may regurgitate milk (small vomits).
- Reflux is more common in babies who have been tube fed.
- Babies may cry particularly when they lie down, because milk passes back more easily.
- The baby may cry less when they are held in an upright position, so that the milk does not pass back so easily.
- Symptoms improve as the baby grows (see also **Further information** in SESSION 30: REFUSAL TO BREASTFEED).

- **Colic:**
  - Some babies cry a lot without one of the above causes.
  - Sometimes the crying has a clear pattern.
  - The baby cries continuously at certain times of day, often in the evening.
  - The baby may pull up their legs as if they have abdominal pain.
  - The baby may appear to want to suckle, but it is very difficult to comfort them.
  - Babies who cry in this way may have a very active gut, or wind, but the cause is not clear.
  - This is called "colic".
  - Colicky babies usually grow well, and the crying usually becomes less after the baby is 3 months old.
- **"High-needs" babies:**
  - Some babies cry more than others, and they need to be held and carried more.
  - In communities where mothers carry their babies with them, crying is less common than in communities where mothers like to put their babies down to leave them, or where they put them to sleep in separate cots.

III. Participants read How to help a family with a baby who cries a lot — 10 minutes

- Ask participants to find the section How to help a family with a baby who cries a lot on page 265 of their *Participant's manual*.
- Ask them to read the section aloud, taking turns sentence by sentence, and add additional points from the text that follows, as appropriate.

How to help a family with a baby who cries a lot

Look for a cause

Listen and learn

- Help the mother to talk about how she feels. Empathize with her feelings.
- She may feel guilty and think she is a poor mother. She may feel angry with her baby.
- Other people may make her feel guilty, or they may make her feel that her baby is bad, or naughty, or undisciplined.
- Other people may advise her to give the baby complements or pacifiers.

Take a history

- Learn about the baby's feeding and behaviour.
- Learn about the mother's diet, and whether she drinks a lot of coffee, or smokes or takes any drugs.
- Learn about the pressures that she is under from the family and other people.

Assess a breastfeed

- Check the baby's attachment and positioning, and the length of a feed.
- A baby who is poorly attached may cry because they are not getting the milk easily.

Examine the baby

- Make sure the baby is not ill or in pain. Check the baby's growth.
- If the baby is ill or in pain, treat or refer as appropriate.

Build confidence and give support

Accept

- Accept what the mother thinks about the cause of the problem.
- Accept what she feels about the baby and their behaviour.

Praise what the mother and baby are doing right

- Explain that her baby is growing well, and is not sick.
- Reassure the mother that her breast milk is providing all that her baby needs – there is nothing wrong with it, or with her.
- Her baby is fine – they are not bad or naughty, or in need of discipline.

Give relevant information

- Explain that her baby probably has colic, or "high needs".
- Her baby has a real need for comfort. They are not sick, but may have real pain.
- The crying will become less when the baby is 3–4 months old.
- Medicines for colic are not now recommended. They can be harmful.
- Supplementary feeds are not necessary, and often do not help. Artificially fed babies also have colic. They may develop intolerance or allergy to cow's milk and become worse.
- Suckling at the breast for comfort is safe, but bottles and pacifiers are not safe.

Make one or two suggestions

- What you suggest depends on what you have learnt about the cause of the crying. Common causes may be different in different countries.
- It might help if the mother takes less coffee and tea, and other drinks that contain caffeine, such as colas. If she smokes, suggest that she stops or at least reduces her smoking, and if she does smoke, that she does it only after breastfeeds, not before or during them.
- Ask other members of the family not to smoke in the same room as the baby.
- It might help if the mother stops taking cow's milk and other milk products, or other foods that can cause allergy (soy, peanuts, eggs).
- She should stop taking the food for a week. If the baby cries less, she should continue to avoid the food. If the baby continues to cry as much as before, then that particular food is not the cause of the crying. She can take the food again.
- Do not suggest that she stops these foods if her diet is poor. Make sure that she can eat another energy- and protein-rich food instead, for example, beans.
- If the mother has an oversupply of breast milk:
  - Suggest that she lets the baby suckle from one breast only at each feed.
  - Let the baby continue at the breast until they finish by themself.
  - Explain that if her baby stays on the first breast longer, they will get more fat-rich hindmilk (see also **Further information**, in SESSION 30: REFUSAL TO BREASTFEED).
  - Use only one breast for all feeds during a certain block of time – 4, 6 or 8 hours, depending on how severe the problem is. Then for the next block of time, use the other breast only.
  - If the baby may have reflux, suggest that she tries to feed them in an upright position.
  - It may also help if the baby sleeps propped up and not lying flat.

Give practical help

- Make sure that the baby is well attached at the breast. Improving attachment may alter the baby's behaviour.
- Explain that the best way to comfort a crying baby is to hold them close, with gentle movement and gentle pressure on their abdomen.
- Offer to show her some ways to hold and carry her baby.
- Sometimes it is easier for someone who is not the mother to carry the baby, so that the baby cannot smell the breast milk.
- Show her how to bring up her baby's wind. She should hold them upright, for example in a sitting position, or upright against her shoulder.
- (It is NOT necessary to teach "winding" routinely – only if the baby has colic.)
- If the baby is less than 1 month old, she can try holding and feeding them skin-to-skin in the reclining (leaning back) position (see SESSIONS 14 and 27: POSITIONING A BABY AT THE BREAST 1 and 2).
- Offer to discuss the situation with the mother's family, to talk about the baby's needs and about her need for support. It is important to try to help to reduce family tensions, so that she does not start giving unnecessary supplements.

IV. Demonstrate how to hold and carry a colicky baby — 5 minutes

▶ **Make this introductory point:**

- Babies are most often comforted with closeness, gentle movement and gentle pressure on the abdomen. There are several ways to provide this.

▶ **Give the demonstration:**

- **Hold a doll along your forearm, pressing on its back with your other hand.**
- **Move gently backwards and forwards (see Fig. 35.1a).**
- **Sit down and hold the doll lying face down across your lap. Gently rub the doll's back.**
- **Sit down and hold the doll sitting on your lap, with its back to your chest.**
- **Hold it round the abdomen, gently pressing on the abdomen (see Fig. 35.1b).**
- **Ask a man to help with this demonstration if possible (see Fig. 35.1c).**
- **Ask him to hold the doll upright against his chest, with the doll's head against his throat. He should hum gently, so that a baby would hear his deep voice.**

a. Holding the baby along your forearm

b. Holding the baby round his abdomen, on your lap

c. Father holding the baby against his chest

Fig. 35.1 Some different ways to hold a colicky baby

- Ask participants whether they know of other ways to comfort a crying baby that are common in their community.
- Ask them to demonstrate with a doll.

V. Summarize the session 2 minutes

- Ask participants whether they have any questions, and try to answer them.
- Point out the summary of this section in the box How to help a family with a baby who cries a lot on page 268 of their *Participant's manual*.
- Explain that a summary of this session can be found on pages 263–268 of the *Participant's manual*.

How to help a family with a baby who cries a lot

Look for a cause

Listen and learn	Help the mother to talk about feelings (guilt, anger) Empathize
Take a history	Learn about the baby's feeding and behaviour Learn about the mother's diet, coffee, smoking, drugs Ask about pressures from family and others
Assess a breastfeed	Position at the breast, length of feed
Examine baby	Check for illness or pain (treat or refer as appropriate) Check growth

Build confidence and give support

Accept	Mother's ideas about the cause of the crying Her feelings about her baby and their behaviour
Praise what the mother and baby are doing right (as appropriate)	Her baby is growing well, and is not sick Her breast milk provides all that her baby needs Her baby is fine, not naughty or bad
Give relevant information	The baby has a real need for comfort Crying will decrease when the baby is 3–4 months-old Medicines for colic are not recommended Supplementary feeds are not necessary or helpful; artificially fed babies also have colic Comfort suckling at the breast is safe, bottles and pacifiers are not safe
Make one or two suggestions (as appropriate)	Reduce coffee and tea intake Smoke after not before or during breastfeeds Stop milk, eggs, soy, peanuts (1-week trial, if mother's diet is adequate) Give only one breast for each feed, or block of time; give the other breast at the next feed, or block of time Feed the baby in an upright position
Give practical help	Make sure the baby is well attached at the breast Show the mother and others how to hold and carry baby with close contact, gentle movement and gentle abdominal pressure Offer to discuss the situation with the family

Further information

Crying

- A baby who is “crying too much” may really be crying more than other babies, or their family may be less tolerant of the crying, or less skilled at comforting the baby.
- Families’ response to crying is different in different societies. So also is the way in which parents handle children.
- For example, in societies where babies are carried around more, they cry less.
- If babies sleep with their mothers, they are less likely to cry at night.
- Yet babies themselves vary a lot in how much they cry.
- So it is impossible to say that some patterns are “normal”, and some are not.

Notes

Notes (contd)

SESSION 36

"Not enough milk" and Crying: exercise

Session outline . . . . . 60 minutes

Participants work in groups of 8–10 with two trainers.

All trainers help to give individual feedback on the exercise.

I. Introduce the session . . . . . 5 minutes
II. Facilitate the written exercise . . . . . 55 minutes

Preparation

- Refer to the Introduction for guidance on facilitating group work and written exercises.
- Study the notes for the session, so that you are clear about what to do.
- Make sure that you have a growth chart for each participant to use while doing the exercise, to assess the growth of the babies in the examples. If possible, this should be the new WHO GROWTH CHART, or the local version.
- For the exercise, make sure that Answer sheets are available to give to participants at the end of the session.

As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

I. Introduce the session 5 minutes

► Explain what they will do:

¤ You will now practise what you learnt about in SESSIONS 34 and 35.

¤ The exercise contains short stories about mothers who are worried about their breast-milk supply, or about their babies crying, followed by some questions.

¤ You should answer the questions using the information from SESSIONS 34 and 35, and also from SESSION 8: BUILDING CONFIDENCE AND GIVING SUPPORT.

¤ You can look back at the notes for SESSIONS 8, 34 and 35 in your manual if you wish.

¤ Read the instructions **How to do the exercise** and the **Example** of what to do.

¤ Then write your answers to the questions in the section that says **To answer**.

¤ If possible, use pencil, so that it is easier to correct the answers.

¤ When you are ready, discuss your answers with a trainer. Trainers will give feedback individually as you do the exercise and will give you Answer sheets at the end of the session.

II. Facilitate the written exercise — 55 minutes

How to do the exercise:

- Read through the following stories about mothers who feel that they do not have enough milk, or whose babies are crying "too much".
- Use a growth chart to decide whether a child is growing adequately.
- Write your answers to the questions in pencil in the space after each story.
- When you have finished, discuss your answers with the trainer.

Example:

Mrs M says that she does not have enough milk. Her baby is crying "all the time".

He is 3 months old, and weighs 5.5 kg. Last month he weighed 5.3 kg, and the month before 5.0 kg.

Mrs M manages the family farm by herself, so she is very busy. She breastfeeds her baby about 2–3 times at night, and about twice a day, whenever she has time. She does not give her baby any other food or drink.

What could you say to empathize with Mrs M?
(*You are very busy; it is difficult to find time to feed a baby.*)

Is Mrs M's baby getting enough milk?
(No he is not getting enough – he has only gained 400 g in 2 months, and his growth is not following the standard growth curves.)

What do you think is the cause of Mrs M's baby not getting enough milk?
(Mrs M is not breastfeeding him often enough.)

Can you suggest how Mrs M could give her baby more breast milk?
(Could she take her baby with her so that she could breastfeed him more often?
Could someone bring her baby to her where she is working?
Could she express her breast milk to leave for her baby?)

To answer:

Mrs N's baby is 6 weeks old. She says that her breast milk is not good, and her baby does not seem satisfied.

She weighed 3.4 kg at birth and now weighs 5 kg.

Mrs N's baby cries and wants to feed often, after an hour, or an hour and a half. She sometimes feeds for 30 minutes or more. She cries and wants to breastfeed often at night too, and Mrs N is exhausted. She passes pale urine about 6 times a day.

You assess a breastfeed and you notice that Mrs N holds the baby loosely, her chin does not touch her breast, there is more areola visible below the baby's mouth than above it, and the baby's lips point forward.

Is Mrs N's baby getting as much breast milk as she needs?
(Yes, she is getting as much as she needs. Her growth curve is following the standard curves.)

What may be the reason for her behaviour?
(She is poorly attached to the breast, so she is not suckling effectively. In order to get enough breast milk, she has to feed very often and for a long time.)

What information would you give Mrs N?
(Her baby is getting the breast milk that she needs, but she is not getting it easily.
She could get the milk more easily and would be more content if she takes the nipple into her mouth from below, so that her chin is closer to the breast.)

What practical help would you offer to Mrs N?
(Offer to show her how to improve her baby's attachment at the breast.)

Mrs O says that she is exhausted, and will have to bottle feed her 2-month-old baby.

The baby's growth chart shows that he weighed 2.9 kg at birth, 3.2 kg at 1 month of age and 3.5 kg at 2 months.

He goes to sleep after a breastfeed, but then wakes up very soon and wants to feed again – she cannot count how many times in a day. She thinks that she does not have enough breast milk. While she is talking to you, her baby wants a feed, and you observe him suckling. His mouth is wide open, there is more areola above than below his mouth, and his chin is close to the breast. You cannot see his lower lip as he is close to the breast. After about 2 minutes, he pauses and Mrs O quickly takes him off her breast.

What could you say to show that you accept Mrs O's ideas about her milk?
(*Yes, I see.*
You are worried about your milk?)

Is Mrs O's baby getting enough breast milk?
(No. He is gaining weight slowly. His growth is not following the standard curves)

What is the reason for this?
(She does not let him suckle for long enough.)

What can you suggest to help Mrs O?
(Suggest that she lets her baby stay at the breast for longer at each feed.
She should let her baby continue suckling until he releases the breast himself.
If he pauses, let him just stay at the breast until he suckles again.
If he stays at the breast longer at each feed, he will not need to feed so often.)

Mrs P is 16 years old. Her baby was born 2 days ago and is very healthy. She has tried to breastfeed her twice, but her breasts are still soft, so she thinks that she has no milk and will not be able to breastfeed. Her young husband has offered to buy her a bottle and some formula.

What could you say to accept what Mrs P says about her breast milk?
(*You think that there is no milk in your breasts?*
You are worried about your breast milk?)

What is the reason why Mrs P doubts her ability to breastfeed?
(She lacks confidence, and she lacks knowledge.
Her milk has not "come in" yet – but this is normal.)

What relevant information would you give her?
(Her breasts already have some milk, a special kind called "colostrum".
This is what her baby needs just now.
Explain that if her baby suckles more often, it will help more milk to come in.
In a day or two, her breasts will feel full.)

What practical help could you give Mrs P?
(Offer to help her to put her baby to her breast. Help her when her baby shows, by restlessness or mouthing, that she is ready for a feed.)

Mrs Q says that her baby always cries in the evenings, and seems to be hungry.

He is 6 weeks old, and weighs 5.2 kg. He weighed 3.7 kg when he was born.

Mrs Q's baby has been crying in the evenings since the age of 2 weeks. At other times he breastfeeds well and is more contented. Mrs Q's sister told Mrs Q that she probably does not have enough milk when she is tired in the evening. Her sister suggested that Mrs Q give a bottle feed in the evening, so that she can save up her milk for the night feeds. Mrs Q drinks tea once or twice a day. She does not smoke cigarettes, and she does not drink milk or coffee.

Is Mrs Q's baby getting enough milk?

(Yes – he has gained 1.5 kg in 6 weeks. His growth curve is following the standard curves.)

What is the cause of Mrs Q's baby's crying?

(This is probably colic.
She drinks only a little tea, so caffeine is unlikely to be the cause.)

What are Mrs Q and her baby doing right, that you could praise?

(Her baby is gaining weight well. He is getting all that he needs from her breast milk.)

What three pieces of information would you give to her?

(1. Supplementary feeds are not necessary, and might make the breast milk decrease.
2. Medicines for colic are not recommended.
3. This colicky crying usually decreases after 3–4 months. That seems like a long time to wait, but it does improve in the end.)

What could you suggest that Mrs Q might do, to help her baby meanwhile?

(Discuss different ways to carry and comfort her baby more.)

Mrs R says that her breasts seem to be empty and her baby is hungry.

Her baby is 4 months old, and weighs 5.3 kg. She weighed 3 kg at birth, and at 2 months of age she weighed 4.9 kg.

Mrs R's baby started feeding immediately after delivery, and has demand fed since then. She breastfeeds about 6 times a day and several times in the night, for about 15–20 minutes each time. Recently, she has not seemed satisfied, and Mrs R's breasts do not seem full even before a feed. The baby has never had any other food or drinks, and Mrs R has not had any breast problems. This is her fourth baby and she does not want another, so she has been taking family planning pills since she was 6 weeks old.

You observe a breastfeed, and see more areola above than below the baby's mouth, her mouth is wide open, her lower lip is turned out and her chin touches the breast. She continues suckling for more than 20 minutes, and then stops by herself.

Is Mrs R's baby getting enough milk?

(Not during the last 2 months. For the first 2 months, she gained well, and her growth followed the standard curves.
But from 2–4 months of age, her growth curve has fallen below the standard curve, so she is not getting enough milk.)

What do you think may be the cause of the poor weight gain?

(This may be because Mrs R is taking contraceptive pills.
There does not seem to be any difficulty breastfeeding.
You need to find out if the pill is one that contains estrogen, for example "combined" pills.)

What information would you give Mrs R?

(The low milk supply may be due to the contraceptive pill.
You will try to help her to find another method, and build up her supply again.)

How do you suggest that she feeds her baby meanwhile?

(She should continue to breastfeed her as often as possible, including at night, and for as long as possible at each feed.
If possible, she should avoid giving supplementary feeds, because this may make the baby suckle less at the breast, which could reduce her breast milk more. It would have all the risks and disadvantages of mixed feeding.
Follow the baby up within a week, to check whether her weight is increasing, and whether Mrs R feels that her breasts feel full and her milk supply is increasing. If not, she may have to give the baby one or two supplementary feeds each day by cup, while continuing frequent breastfeeds, until her milk supply does increase (see SESSION 39: INCREASING BREAST MILK AND RELACTATION).

- **Give participants the Answer sheets for Session 36.**
- **If some participants are having difficulties with the exercises, or have not finished them, arrange to help them later.**

Notes

Notes (contd)

SESSION 37

Counselling practice

Participants will now use role-play to practise the counselling skills for listening and learning and taking a breastfeeding history to learn about the mother's situation and to decide what her difficulty is.

Session outline . . . . . 90 minutes

Participants work in groups of four with one trainer, using counselling stories to practise among themselves. All trainers prepare for this session.

I. Prepare for the exercise . . . . . 15 minutes
II. Conduct the pair practice (EXERCISE 37.A) . . . . . 75 minutes

Preparation

- Refer to the Introduction for guidance on facilitating group work.
- Make sure that copies of Counselling stories 1–8 from EXERCISE 37.A are available, on cards or paper. You will need three sets of copies for each group of participants. Choose the stories most relevant to your situation.
- Make sure that each participant has a growth chart for the baby in their story. You may decide to fill in charts for each baby before the session, or you may ask participants to fill in their own growth chart. Ask them to reuse the charts that they used in SESSION 32: TAKING A FEEDING HISTORY – 0 UP TO 6 MONTHS OF AGE: EXERCISE.
- Encourage them to fill the charts in with pencil, so that they can erase the line and reuse the card.
- Make available some spare copies of the COUNSELLING SKILLS CHECKLIST.
- Study SECTION I. PREPARE FOR THE EXERCISE, so that you can explain to participants what to do.
- Study the section **How to conduct the exercise** at the beginning of EXERCISE 37.A, so that you can guide the counselling practice.
- Read the section COMMENTS ON THE COUNSELLING STORIES, which you will find on pages 474 –475. These comments may help you to guide the counselling practice, and the discussion afterwards.
- Decide how you will conduct the exercise.
- In some situations, participants may have difficulty in reading and following the story, so that they do not give correct information when playing the role of the mother. If this happens, an alternative is for a trainer to play the part of the mother, while one of the participants takes her history.

As you follow the text, remember:

- ▸ indicates an instruction to you, the trainer.
- ¤ indicates what you say to participants.

I. Prepare for the exercise — 15 minutes

- **Give each participant a copy of one of the counselling stories; they should also have a growth chart. This may be filled in already for the baby in their story, but if not, ask them to fill it in themselves in pencil.**
- **Explain what they will do:**
  - You will now use role-play to practise using the counselling skills for listening and learning and taking a breastfeeding history, to learn about the mother's situation and to decide what her difficulty is, as you did in SESSION 32: TAKING A FEEDING HISTORY – 0 UP TO 6 MONTHS OF AGE: EXERCISE.
  - However, this time you will complete the counselling process, and use the SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT to help the mother find a way to overcome her difficulty.
  - You will take it in turns to be a "mother", a "counsellor" or an "observer".
  - When you are the "mother", play the part of the mother in the story on your card. Do not let the "counsellor" see your story card.
  - Give yourself and your baby a name, either your own real name, or another.
  - When you are the "counsellor", you have to learn about the mother and baby, and try to help them, using counselling skills.
  - You do not need to practise observation of a breastfeed in this exercise. You will find all that you need to know in the written story. In a real situation, you should always observe as well.
  - Other participants in the group are "observers". They should observe how the "counsellor" uses counselling skills and takes a history, and decide whether the counsellor understands the mother's difficulties correctly and offers appropriate help.
- **Ask participants to read their stories through, and to study or prepare the growth chart.**
- **Allow 5 minutes. They can ask you questions about anything that they do not understand.**
- **Make sure that each participant has a copy of the COUNSELLING SKILLS CHECKLIST.**
- **Explain how to do the practice.**
  - If you are the "counsellor":
    - Greet the "mother", and introduce yourself.
    - Ask for her name and her baby's name, and then try to use them.
    - Ask one or two open questions about how she and the baby are, and how you can help her.
    - Use your counselling skills. Try to use at least one example of each of the skills.
    - Take a breastfeeding history. Practise asking the most relevant questions. Ask at least one question from each section of the history.
    - Use your SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT, to give the mother whatever help you decide is necessary.
  - If you are the "mother":
    - Answer one of the "counsellor's" open questions with your reason for coming. This is the sentence at the top of the story. For example, for Counselling story 1, say "My milk is not good. (Baby's name) cries too much".
    - Then respond to what your "counsellor" says. If the "counsellor" asks you some questions, answer them from what is written. If you cannot answer a question from what is written, make up an answer to fit with your story.
    - If your "counsellor" uses good LISTENING AND LEARNING SKILLS, and makes you feel that they are interested, you can tell them more.
    - When the "counsellor" gives you information and suggests what you can do, respond as you think a mother would respond, whether you think what she says is helpful.

- ¤ If you are observing:
  - Use your COUNSELLING SKILLS CHECKLIST, and observe which skills the "counsellor" uses, and which they do not use. Mark on your checklist in pencil when you observe the "counsellor" using a skill correctly.
  - Try to decide whether the "counsellor" has understood the "mother's" situation correctly, and whether they have asked the most relevant questions and given appropriate help.
  - During discussion, be prepared to praise what the role-players do right, and to suggest what they could do better.

- ► **Give a copy of the mother's story to the "observers", so that they can follow it. The "counsellor", however, should not have a copy of the mother's story.**

II. Conduct the pair practice — 75 minutes

- ► **Ask two participants to practise one of their stories. Ask them to sit on two chairs, next to each other, and slightly separate from the observers.**
- ► **Let the pair continue for a while, without interrupting.**
- ► **Follow the story in your copy of the *Trainer's guide*. If they are doing well, let them go on until they finish. If they make a lot of mistakes, or get confused, or do not follow the story, stop them, and give them a chance to correct themselves. Ask them how they feel they are doing, and what they think has gone wrong.**
- ► **Ask other participants in the group to say what they have observed. Then say what you think,**
- ► **Praise what they do right, and then comment on the following:**
  - **How well the "counsellor" used their counselling and history-taking skills**
  - **Whether the "counsellor" understood the mother's situation correctly, and gave appropriate help.**
- ► **Use the COMMENTS ON THE COUNSELLING STORIES to help the discussion. They tell you:**
  - **The main points in the story that the participants should learn about**
  - **The most important skills that the "counsellor" should practise.**
- ► **If necessary, let the pair try again, at least for a short time.**
- ► **Try to finish with them doing some things well.**
- ► **Thank them and congratulate them for their efforts.**
- ► **Ask another pair to practise.**
- ► **Make sure that each member of the group has a chance to be a "counsellor" at least once.**

Comments on the counselling stories

These notes emphasize the main points of each story, to help you to comment on participants' practice.

Counselling story 1

The baby is gaining less than 500 g a month, so he is not getting enough milk. The mother is too busy to respond to the baby, so she does not breastfeed him often enough.

Participants practise empathizing about the difficulties she is under at home, and they should learn that she is thinking of giving bottle feeds. They can practise making suggestions – for example, that she takes her baby with her, or that the 7-year-old sibling brings the baby to her mother instead of giving him a pacifier. They may offer to talk to her family about her baby's needs.

Counselling story 2

This story emphasizes the importance of finding out about a mother's previous experience of breastfeeding during an antenatal visit. This mother has had bad experiences and is at risk of failing to breastfeed, so she needs extra support. Participants practise giving the mother information, and building her confidence that she can breastfeed this time, without making her feel criticized.

Counselling story 3

This baby gained weight well when exclusively breastfed, but has not done well since he started bottle feeds. The mother is very young, and at special risk of failing, so she needs extra help. She is also under pressure from the baby's father to bottle feed. Participants practise suggesting that the mother stops bottle feeding, without making her feel criticized. They should also offer to discuss the situation with the family. Talking to the mother alone may not help.

Counselling story 4

This baby is "failing to thrive" because breastfeeding was not established in the postnatal period. The mother and baby were both perfectly healthy.

Participants practise encouraging a young and inexperienced mother to try to relactate. They practise giving her confidence that she can have enough breast milk to feed her baby without using tinned milk.

Counselling story 5

This is a low-birth-weight baby who is getting enough milk, and doing well. His slow suckling is normal, but it worries his mother. She lacks confidence, partly because she has a fertility problem, and this baby took a long time to conceive. She needs lots of extra support, especially as her husband is not very helpful.

Participants practise building her confidence that she does have enough milk, and that her baby is growing and will be bigger and stronger before long. It is important to avoid telling her that everything is alright, and that she should not worry. They should empathize with her worry.

Counselling story 6

This is another young mother. Her baby is doing well, but she is at risk of pressures to bottle feed, this time from her friend. She feels insecure in her relationship with the baby's father, and is worried about not being able to go out at night, and about losing her figure. Participants practise giving support, and talking about the mother's social concerns. The counsellor should not just explain the benefits of breastfeeding.

Counselling story 7

This story illustrates the need to encourage mothers to continue and increase breastfeeding both when a child is sick and until a child is 2 years old or more. The diet of this family is poor, and breast milk is helpful both to provide essential nutrients, and to help the baby to recover from diarrhoea.

Participants practise accepting the mother's ideas about her child's illness, informing her that breastfeeding is helpful for a child with diarrhoea, to encourage her to continue.

Counselling story 8

This story illustrates some of the problems of working mothers. A mother's supply of breast milk may decrease when her baby starts having bottles of formula milk. This mother had problems with a previous baby also. She is well motivated to try to express breast milk for this baby, and to ask her sister to feed her by cup.

Participants practise explaining to the mother how to express her breast milk and feed it by cup; and about the importance of expressing while she is at work to help keep up the supply, even if she cannot save it for her baby. The counsellor can also suggest that the mother tries to give up smoking.

Counselling stories

Counselling story 1: "My milk is not good. (Baby's name) cries too much."

Age of baby: 3 months
Weight aged 2 weeks: 2.9 kg
Weight today: 3.7 kg

Baby's feeding now: Exclusive breastfeeding. Baby sleeps with you at night, and breastfeeds when he can during the day – maybe 3 times.

Baby's health and behaviour: He is well. He seems to cry a lot. Your 7-year-old daughter carries him round much of the day, and he sucks on a pacifier. You have no idea how many times he urinates – you are not there to see. You wash about 3 or 4 nappies or cloths a day, but he may not get changed every time he wets.

Pregnancy, delivery, early feeds: Baby born at home. Breastfed from soon after delivery.

Mother's condition: You are aged 32, and healthy. You do not smoke or drink. You are not using any family planning method. You feel tired, and think that bottle feeding might help.

Previous infant feeding: 5 babies, all breastfed; 3 at present under 5 years of age.

Family and social situation: You are very busy with housework and work in the fields. Your mother-in-law expects you to do everything, and it is difficult to find time to feed the baby.

Counselling story 2: "I will bottle feed this next baby. I am not able to breastfeed."

Antenatal visit

Mother's condition: You are aged 28, and healthy. You are 6 months pregnant. Before you had your first baby you wanted very much to breastfeed. Your breasts and nipples are average in size.

Previous infant feeding: You have 2 children already. Your first baby was born by caesarean section, after an obstructed labour. The baby was put into the nursery for 5 days, and was given some bottle feeds. You tried to breastfeed her after 5 days, but she did not want to suckle, and cried every time you put her to the breast. You could not get her to suckle properly, and the nurses advised you to continue giving bottles. You were very disappointed, and felt that you had failed. The baby was often ill with diarrhoea during the first year of life.

Your second baby was born vaginally. No one talked to you about breastfeeding. You put the baby to the breast during the first day, but you had very sore nipples. You struggled on despite the pain, for 4 weeks. Then your nipples were so cracked and bleeding that you gave him a bottle for a few days to allow the nipples to heal. Then he refused to start breastfeeding again.

Family and social situation: You are a nurse in a children's ward. You will take your maternity leave, and you have saved up some more leave, so that you can stay home for 4 months after the baby is born. You live very near the hospital, and your sister stays with you and looks after the children while you work.

Counselling story 3: "(Baby's name) is always crying and my breast milk is drying up."

Age of baby: 10 weeks
Birth weight: 2.8 kg
Weight at 1 month: 3.4 kg
Weight now: 3.8 kg

Baby's feeding now: You breastfeed 4–5 times a day and sometimes once in the night. You also give two bottle feeds of formula milk each day. You put 1/2 scoops of milk powder into each bottle. You started this when the baby was 4 weeks old. He also has a pacifier to stop him crying so much.

Baby's health and behaviour: The baby cried a lot when he was small. He still cries a lot, but usually quietens when you give him a bottle. He had diarrhoea for a few days last month, but that has stopped. He suckles less at the breast now than he did before.

Pregnancy, delivery, early feeds: Delivered at home. Breastfed from the first day.

Mother's condition: You are aged 23 and healthy. You had an intrauterine device (IUD) fitted at 6 weeks.

Previous infant feeding: This is your first baby.

Family and social situation: You are a housewife. Your mother lives nearby and helps. Your husband complains when the baby cries. He wants you to give bottle feeds to keep the baby quiet so that he can sleep at night. A friend of his at work suggested it.

Counselling story 4: "(Baby's name) is very thin and she is constipated."

Age of baby: 2 months
Birth weight: 2.8 kg
Weight at 1 month: 3.2 kg
Weight now: 3.5 kg

Baby's feeding now: You feed the baby formula milk from a bottle. You make about 3–4 bottles a day. You put about 2 spoons of milk powder into each bottle. When you do not have any formula milk, you make a feed from cereal and water. You breastfeed the baby sometimes, for comfort, but there is only a little milk coming out.

Baby's health and behaviour: Your baby cries a lot, but she is very small and weak. She does not pass stools very often, and they are small and dry. You think she is constipated. She urinates about 3–4 times a day, sometimes only twice, and her urine is sometimes dark yellow.

Pregnancy, delivery, early feeds: Normal. Baby delivered in hospital at night. You put her to the breast the next morning, after the doctor checked her. There was no milk coming out, and the baby was not very interested in suckling. So you started bottle feeds while you waited for your breast milk to come, but it did not come in properly.

Mother's condition: You are aged 19, and healthy. You do not smoke or drink. You will start on contraceptive pills when your periods start again.

Previous infant feeding: This is your first baby.

Family and social situation: You are a housewife. Your husband is a driver and is away from home a lot. Your mother has been helping you to bottle feed the baby.

Counselling story 5: "(Baby's name) cannot suckle properly."

Age of baby: 4 weeks
Birth weight: 1.5 kg
Weight aged 3 weeks: 1.80 kg
Weight today: 1.95 kg

Baby's feeding now: Breastfeeding only.

Baby's health and behaviour: He suckles slowly and takes a long time, and he keeps stopping to rest in the middle of a feed.

Pregnancy, delivery, early feeds: He was born preterm, very weak, at about 32 weeks, and was in the special care unit for 2 weeks. He was fed by nasogastric tube for 1 week, and then by cup. You stayed in the hospital, and expressed your milk 3-hourly for your baby. You expressed enough for him at that time. He started breastfeeding about 1 week ago.

Mother's condition: You are 27 and only became pregnant after 3 years of marriage. You think that you do not have enough breast milk – your breasts do not seem very full. You are very upset, and feel that you are failing as a mother.

Previous infant feeding: This is your first baby.

Family and social situation: Your husband is a farmer, and wants lots of strong children. He has not shown much interest in this sick, small baby.

Counselling story 6: "My milk is drying up, and I will have to bottle feed (baby's name). Which formula is best?"

Age of baby: 2 months
Birth weight: 3.5 kg
Weight now: 5.3 kg

Baby's feeding: Breastfeeding only until now.

Baby's health and behaviour: Very healthy. Now sleeps in a cot. You get up to feed her about once in the night, if she cries. She passes urine at least 6 times a day.

Pregnancy, delivery, early feeds: Normal pregnancy; delivered in hospital. Your baby stayed in the nursery. You did not see her for 24 hours. Then she was brought to you for 3-hourly for breastfeeding. She may have had a bottle while she was in the nursery.

Mother's condition: You are aged 18. You would not mind breastfeeding, if it is easy. But your friend bottle feeds and tells you that you are silly to bother. You are worried that if you continue to breastfeed, your breasts may sag, and your partner will lose interest in you. You want to be able to go out at night.

Previous infant feeding: This is your first baby.

Family and social situation: You live in town. Your baby's father has a job as a labourer, and he gives you money, but not very regularly. Your parents live far away, and you do not see them often.

Counselling story 7: "(Baby's name) often has diarrhoea – should I stop breastfeeding?"

Age of baby: 11 months
Weight at 2 months: 4.5 kg
Weight at 6 months: 7.5 kg
Weight at 8 months: 7.5 kg
Weight today: 8.2 kg

Baby's feeding now: He breastfeeds on demand. He sleeps with you and breastfeeds at night. He is also taking rice and vegetables 3 times a day.

Baby's health and behaviour: Several times he has had diarrhoea, and the health worker has shown you how to make oral rehydration fluids. She has advised you to continue giving him rice and other food. The diarrhoea is better now, but you think that it is time to stop breastfeeding. Perhaps breastfeeding causes the diarrhoea.

Pregnancy, delivery, and early feeds: Born at home, and started breastfeeding soon after delivery. No problems.

Mother's condition: You are aged 29 and healthy. You have Depo-Provera injections for family planning. You are not worried about being pregnant.

Previous infant feeding: 4 previous children, all breastfed for about 2 years.

Family and social situation: Your husband is a subsistence farmer, and you live on cereals and vegetables. You get water from a nearby stream.

Counselling story 8: "My breast milk is getting less. What can I do?"

Age of baby: 3 months
Birth weight: 4.0 kg
Weight at 1 month: 5.0 kg
Weight at 2 months: 5.6 kg
Weight now: 6.2 kg

Baby's feeding now: You breastfeed whenever you are at home. When you are at work, she has bottle feeds of formula milk. You started bottle feeds when you went back to work last month. Sometimes she has bottle feeds at night too.

Baby's health and behaviour: She is very well at the moment.

Pregnancy, delivery, early feeds: She was born in hospital, delivered by forceps. She was kept in the nursery for about 6 hours, but then roomed-in with you. You needed help to start breastfeeding, but since then there have been no problems.

Mother's condition: You are aged 23, and healthy. You smoke about 15 cigarettes a day.

You had an IUD fitted soon after delivery. You want very much to breastfeed longer.

Previous infant feeding: You had one previous child now aged 5 years. You tried to continue breastfeeding while you were at work. But you had leaking of breast milk when you were on duty, and then your baby refused to suckle. You were really upset about this, and feel that you failed your baby, even though she did not get ill.

Family and social situation: You returned to work in an office when your baby was 2 months old. Your sister cares for your children while you are at work.

COUNSELLING SKILLS CHECKLIST

Name of counsellor:

Name of observer:

Date of visit:

(✓ for Yes and X for No)

Did the counsellor:

Use LISTENING AND LEARNING SKILLS:

- ☐ Keep the head level with mother/parent/caregiver?
- ☐ Pay attention (eye contact)?
- ☐ Remove barriers (tables and notes)?
- ☐ Take time? Allow the mother/caregiver time to talk?
- ☐ Use appropriate touch?
- ☐ Ask open questions?
- ☐ Use responses and gestures that showed interest?
- ☐ Reflect back what the mother/caregiver said?
- ☐ Empathize – showing that he or she understood how the mother/caregiver feels?
- ☐ Avoid using words that sound judging?

Use SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT:

- ☐ Accept what the mother/caregiver thinks and feels?
- ☐ Recognize and praise what the mother/caregiver and baby are doing right?
- ☐ Give practical help?
- ☐ Give a little, relevant information?
- ☐ Use simple language?
- ☐ Make one or two suggestions, not commands?

Notes

SESSION 38

Feeding low-birth-weight and sick babies

Objectives

After completing this session, participants will able to:

- describe why why breast milk is the best food for low-birth-weight babies
- describe why it is important to continue breastfeeding or giving breast milk when an infant is sick or jaundiced
- help a mother of a low-birth-weight or sick baby to give her baby breast milk
- help a mother to feed her baby by cup

Session outline . . . . . 60 minutes

Participants are all together for a lecture presentation by one trainer. All trainers need to give individual feedback for the exercise.

I.	Introduce the session, present **Slide 38/1**	3 minutes
II.	Present **Slides 38/2** to **38/15**	20 minutes
III.	Demonstrate how to feed a baby by cup	10 minutes
IV.	Explain how much milk to give to a baby	10 minutes
V.	Facilitate the written exercise (EXERCISE 38.A)	15 minutes
VI.	Summarize the session	2 minutes

Preparation

- This session has been allocated one hour. However, depending on their work situation, some participants may need to spend more time on this topic. As you prepare, consider how much of the basic material and **Further information** your group needs. If necessary, try to allow more time.
- Refer to the Introduction for guidance on giving a presentation with slides and giving a demonstration.
- Study the **Slides 38/1** to **38/15** and the text that goes with them, so that you are able to present them.
- Read the following so that you can discuss them with the participants, and refer them to their own copies of these references:
  - *Acceptable medical reasons for use of breast-milk substitutes*[1]
  - *Guidelines on optimal feeding of low birth-weight infants in low- and middle-income countries.*[2]
- To demonstrate how to feed a baby by cup:
  - Obtain some small cups that could be used to feed low-birth-weight babies, and that are easily available in the community. Medicine measures or egg cups are suitable. Use small tea cups if nothing smaller is available.
  - They should be easy to clean, without ridges if possible.
  - Have some water (for "milk") and a teaspoon available to demonstrate cup-feeding and spoon-feeding with a doll.
  - If used locally, obtain a *paladai* feeding spoon to demonstrate.
- Decide whether you will include SECTION IV. EXPLAIN HOW MUCH MILK TO GIVE A BABY and the written exercise in the following section. This may not be relevant for some groups of participants. Have a flipchart or board available if you do include it.

[1] WHO, UNICEF. Acceptable medical reasons for use of breast-milk substitutes. Geneva: World Health Organization; 2009 (WHO/NMH/NHD/09.01; WHO/FCH/CAH/09.01; http://apps.who.int/iris/bitstream/10665/69938/1/WHO_FCH_CAH_09.01_eng.pdf).

[2] Guidelines on optimal feeding of low birth-weight infants in low- and middle-income countries. Geneva: World Health Organization; 2011 (http://www.who.int/maternal_child_adolescent/documents/9789241548366.pdf).

- Have ready for review COUNSELLING CARD 6: HOW TO EXPRESS BREAST MILK AND CUP-FEED, COUNSELLING CARD 7: WHEN YOU ARE SEPARATED FROM YOUR BABY, and the *Guidance on the use of counselling cards*.
- Read the **Further information** sections, so that you are familiar with the ideas that they contain, so that you can answer participants' questions.

As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the session — 3 minutes

► Show **Slide 38/1 – Session 38 – objectives** and read out the objectives:

38/1

Session 38: Feeding low-birth-weight and sick babies – objectives

After completing this session, participants will be able to:

- describe why breast milk is the best food for low-birth-weight babies
- describe why it is important to continue breastfeeding or giving breast milk when an infant is sick or jaundiced
- help a mother of a low-birth-weight or sick baby to give her baby breast milk
- help a mother to feed her baby by cup

► Make these points:

¤ Breast milk is the best milk for all babies. It is especially valuable for babies who are low birth weight or sick.

¤ In this session, we discuss low-birth-weight babies in detail first and then babies who are sick.

¤ *Ask: What do you understand by the term low birth weight?*

► Wait for a few replies and then continue.

¤ The term **low-birth-weight baby** includes any baby with a birth weight of less than 2500 g. Low-birth-weight babies may be **preterm**, that is, born before 37 weeks of gestation, or they may be born at term but **small for gestational age**.

¤ Low-birth-weight babies, whether they are term or preterm, are at particular risk of infections and of becoming ill. Low birth weight is responsible for approximately 60–80% of all neonatal deaths.

¤ In many countries, 15–20% of all babies are low birth weight. In this country, ... % of all babies are low birth weight.

¤ *Ask: Do low-birth-weight babies have difficulties breastfeeding? If so, what difficulties do they have?*

► Wait for a few replies and then continue.

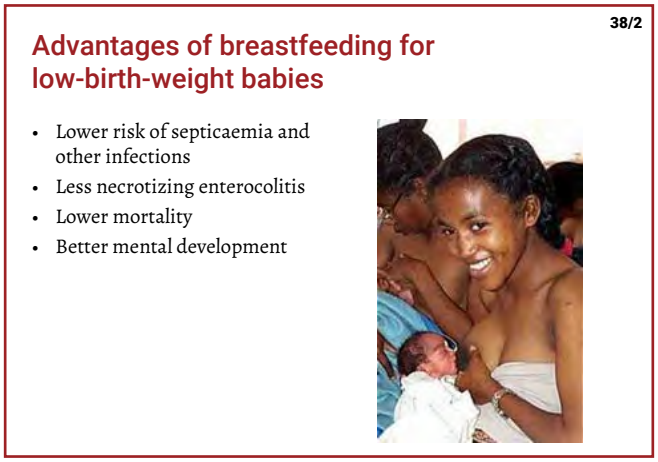
► Possible responses from the participants might include:

- Preterm low-birth-weight babies are not able to suckle strongly at the breast because they are not sufficiently mature.
- They need more of some nutrients than breast milk can provide.
- It can be difficult for mothers to express enough breast milk.

- There is some truth in all these statements, but in fact many low-birth-weight babies can breastfeed effectively much earlier than we believed in the past.
- If you developed a list of reasons for stopping breastfeeding in SESSION 3: LOCAL INFANT AND YOUNG CHILD FEEDING SITUATION, refer back to that now. Remind participants if they identified low birth weight or sickness as one of the common reasons.

II. Present **Slides 38/2** to **38/15** 20 minutes

► Show **Slide 38/2 – Advantages of breastfeeding for low-birth-weight babies** and make the points that follow:



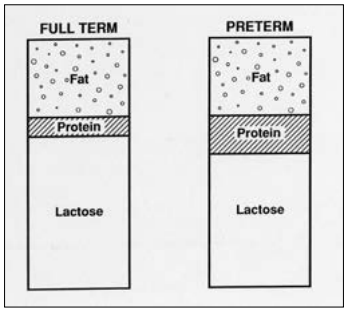
¤ Low-birth-weight babies benefit from breast milk: it reduces the risk of septicaemia and other infections and of **necrotizing enterocolitis** (a severe gut disease), so it reduces their mortality. It also improves their mental development.

¤ Artificial feeding is even more dangerous for low-birth-weight babies than it is for full-term babies.

▶ Show **Slide 38/3 – Full-term and preterm breast milk** and make the points that follow:

38/3

What is the difference between these breast milks?



- In SESSIONS 11 and 23: WHY BREASTFEEDING IS IMPORTANT 1 and 2, we looked at the composition of term breast milk. This chart compares full-term and preterm milk. There are important differences between the breast milk produced by a mother of a preterm baby and the mother of a term baby.
- *Ask: What difference does this chart show?*

▶ Wait for a few replies and then continue.

- It shows that preterm breast milk contains more protein than full-term milk.
- To grow well, preterm babies need milk with more protein than full-term babies.
- Much of the extra protein in preterm milk consists of **anti-infective factors**, which give preterm babies the protection that they need.
- So the best food for a low-birth-weight baby is their own mother's milk. It is more easily digested and absorbed than formula milk. If a baby cannot suckle strongly enough to feed themself, encourage their mother to express her milk for the baby. It is always better than formula milk, and it is something very special that she can do for her very small baby.
- Breast milk contains all the nutrients that a low-birth-weight baby needs, if they weigh 1500 g or more. Babies who weigh less than 1500 g need supplements of calcium, phosphorous and vitamin D. All low-birth-weight babies need iron from the age of 6 weeks after birth.
- If at first a mother cannot express enough breast milk, give her baby supplements of pasteurized breast milk donated by another woman, until the baby's mother can express enough, if it is acceptable to the mother, and if the policy of the country allows.
- If neither the mother's milk nor donor breast milk are available, give preterm formula milk for infants who weigh less than 1500 g, or standard formula milk for infants who weigh more than 1500 g.

▸ Show **Slide 38/4 – Expressing breast milk on the day of birth** and make the points that follow:

- If a baby cannot suckle, they will need to be given expressed breast milk by intragastric tube or cup. Mothers need skilled help to learn to do this.
- The mothers in these pictures are expressing breast milk on the first day after delivery.
- Help a mother to start expressing her milk within 6 hours of delivery if possible, and to express at least every 3 hours (see SESSIONS 17 and 33: EXPRESSING BREAST MILK 1 and 2). This stimulates the production and flow of breast milk until her baby is able to breastfeed.
- *Ask: What do you notice about the milk that the mother on the left is expressing?*

▸ Wait for a few replies and then continue.

- It is yellow. It is colostrum.
- Colostrum is particularly important for low-birth-weight babies, because it helps to protect them against infections. Expressing soon after delivery helps to ensure that a baby gets colostrum. If the mother can express even a millilitre or two, it is valuable for her baby.
- *Ask: How is the colostrum being collected in the pictures on the right?*

▸ Wait for a few replies and then continue.

- A helper is collecting it in a small syringe.
- If a mother can only express a few drops, it can be difficult to collect in a cup. A helper can collect it with a syringe directly from the nipple and it can be given to the baby directly from the syringe, as in the lower picture.

▸ Show **Slide 38/5 – Methods of feeding low-birth-weight babies** and make the points that follow:

38/5

Methods of feeding low-birth-weight babies

Gestational age, weeks	Approximate weights, g	Oral feeding method
Before 32	1000–1500	Intragastric feeding
32–34	1300–1800	Cup for most feeds Try breastfeeding
33–35	1600–2000	Breastfeeding for part of feed Feed by cup or tube to ensure enough
34–36	1800–2200	Coordinated breastfeeding May need some supplements

- **Slide 38/5** summarizes different ways to feed low-birth-weight preterm babies, according to their approximate gestational age and weight.
- However, babies vary in how their ability to breastfeed develops, so it is necessary to observe babies as they grow, and to watch how they behave at the breast and how they respond when offered a feed. It is important to feed them according to their readiness for each feeding method, rather than according to their age or weight.
- **Table 38.1** gives more details of how low-birth-weight babies develop readiness to feed. The table is also useful for babies who are sick or clinically unstable, who may respond in a similar way, and need the same feeding methods.

▸ Ask participants to find **Table 38.1** on page 286 of their *Participant's manual*, and to follow it as you show **Slide 38/5** and explain these points:

- Babies of less than 28 weeks' gestational age make few mouthing movements, and may not be able to take any oral feeds. They need intravenous feeding. Oral feeds can begin as soon as the baby tolerates them.
- Between 28 and 31 weeks, a baby may start to open their mouth, put their tongue forward and make licking movements. However, suckling is ineffective, and the baby cannot coordinate suckling and breathing, so intragastric feeding is needed.
- Between 32 and 34 weeks, a baby starts to root and tries to attach to the breast, and suckles weakly. It is important to let the baby try because the experience helps development. However, it is not possible to breastfeed fully. Cup-feeding is possible and this gives the baby the experience of taking feeds orally, which also helps development. Intragastric feeds may still be necessary for some feeds, or for part of a feed.
- From between 33 and 35 weeks, a baby can root and attach to the breast more actively, and may have periods of organized suckling, when they can take milk from the breast effectively. There are usually long pauses between periods of suckling. Breastfeeding is still only possible for part of a feed, and cup-feeding or another alternative is necessary to ensure adequate intake.
- From between 34 and 36 weeks, many babies can coordinate suckling well, though cup feeds may be necessary for some feeds. After 36 weeks, most babies can breastfeed fully.

Table 38.1 Readiness for feeding

Range of birth weight, g	Gestational age, weeks	Behaviour at the breast	Response when offered expressed breast milk by cup	Feeding readiness
<1000	<28	No definite mouthing	Does not put tongue forward No licking	Intravenous feeding needed
1000–1500	28–31	Occasional, ineffective suckling attempts	Opens mouth, puts tongue forward, licks milk Cannot coordinate breathing and swallowing	Intragastric feeding
1300–1800	32–34	May root and attach to breast Weak suckling attempts	Opens mouth, puts tongue forward, licks milk Able to coordinate breathing and swallowing	Cup or other alternative feeding method for most feeds Try breastfeeding
1600–2000	33–35	Able to root and attach to the breast May have periods of organized suckling with long pauses	As above and able to suck at the milk from a cup and other alternatives	Breastfeed for part of feed Cup or other alternative to ensure adequate intake
1800–2200	34–36	Able to suckle effectively at the breast	Able to suck at milk from the cup and other alternative feeding methods	Breastfeed, and may need some supplements by cup or other alternative

▸ Show **Slide 38/6 – Intragastric tube feeding before 32 weeks** and make the points that follow:

- ¤ This slide shows a baby who is less than about 32 weeks' gestational age being fed by intragastric tube. Give expressed breast milk from the baby's mother if possible.
- ¤ The mother can let her baby suck on her finger while they are having the tube feeds. This probably stimulates the baby's digestive tract, and may help with weight gain. **She must always wash her hands beforehand**.

▸ Show **Slide 38/7 – Cup-feeding, spoon-feeding, *paladai*** and make the points that follow:

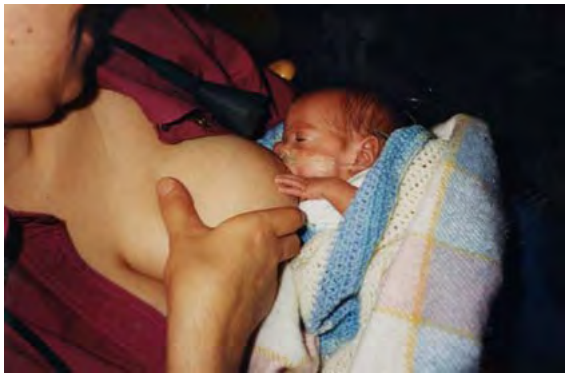
▸ These babies are between 32 and 34 weeks' gestational age, and are taking feeds from a small cup, as on the left, and from a spoon, as on the right.

- ¤ In the lower picture is a *paladai*, which is used in some countries, particularly in South Asia.
- ¤ You can start trying to give cup feeds once or twice a day while a baby is still having most of their feeds by tube. If they take cup feeds well, you can reduce the tube feeds.
- ¤ Some babies at this age are able to breastfeed quite well for short periods, so, if possible, try them at the breast before using another method.
- ¤ Cup and spoon feeds give a baby valuable experience of taking food by mouth, and the pleasure of taste. They stimulate the baby's digestion. Many babies show signs of wanting to take things into their mouths at this stage, yet they are not able to suckle effectively at the breast.
- ¤ A *paladai* is about 6–7 cm long. Milk or other liquid is put in the bowl and the spout goes into the baby's mouth. This has the disadvantage that the carer can easily pour the milk into the baby's mouth, instead of letting the baby lap it with their tongue, as they do with a cup (see Section III).

► Show **Slide 38/8 – Partial breastfeeding: 33–35 weeks** and make the points that follow:

38/8

Partial breastfeeding: 33–35 weeks



- This baby is between 33 and 35 weeks' gestational age, and has already started suckling on the breast. A mother should put her baby to her breast as soon as they are well enough. The baby may only root for the nipple and lick it at first, or they may suckle a little.
- You can see that the baby still has a nasogastric tube in place. The mother should continue giving expressed breast milk by cup or tube, to make sure that the baby gets all they need.
- When a low-birth-weight or sick baby starts to suckle effectively, they may pause during feeds quite often and for quite long periods. For example, they may take 4–5 sucks and then pause for up to 4 or 5 minutes.
- *Ask: What should the baby's mother do if her baby stops suckling?*

► Wait for a few replies and then continue.

- Leave them on the breast so that they can suckle again when they are ready.
- It is important not to take the baby off the breast too quickly. A low-birth-weight baby can continue for up to an hour if necessary, but a sick baby may not have enough energy.
- Offer a cup feed after the breastfeed. Or offer alternate breast and cup feeds.

- Show **Slide 38/9 – Ensure good attachment** and make the points that follow:

- This baby is now over 36 weeks' gestational age, and can take all that he needs directly from the breast. Low-birth-weight babies may feed more frequently than larger babies, and they may take long slow feeds. Supplements from a cup may occasionally be necessary.
- *Ask: What do you think of this baby's attachment?*

▶ **Wait for a few replies and then continue.**

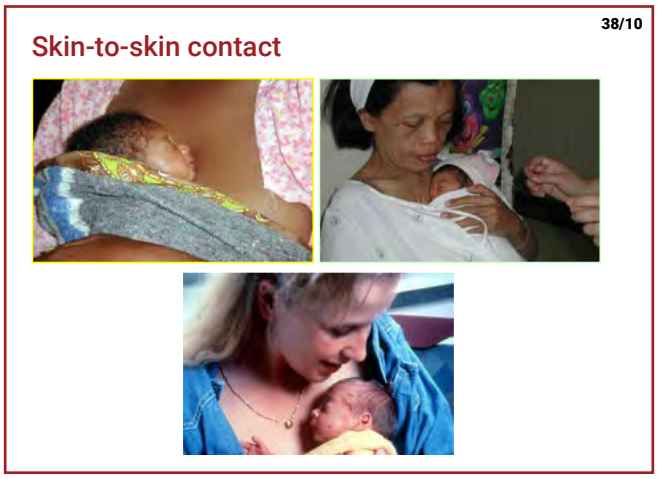
- It is good. There is more areola above the baby's mouth, his mouth is wide open, his lower lip is turned out and his chin is touching the breast.
- Make sure that the baby is well positioned and attached, because it makes effective breastfeeding possible sooner.
- Follow babies up and weigh them regularly to make sure that they are getting all the breast milk that they need.

▶ **Turn off the projector and give the following demonstration.**

▶ **Demonstrate with a doll the following positions for holding a low-birth-weight baby for breastfeeding.**

- The best positions for a mother to hold her low-birth-weight baby at the breast are:
  - across her body, holding the baby with the arm on the opposite side to the breast
  - the underarm position.
- See figures in SESSIONS 14 and 27: POSITIONING A BABY AT THE BREAST 1 and 2, on pages 181 and 356 in the *Trainer's guide* and pages 82 and 194 in the *Participant's manual*.
- In both of these positions, she supports her baby's body on her arm and supports and controls the baby's head with her hand. Low-birth-weight and sick babies need more support for the head than larger babies. However, the mother should be careful only to support the head and not to put pressure on it.

▸ Show **Slide 38/10 – Skin-to-skin contact** and make the points that follow:



- *Ask: What do you think of how these mothers are holding their babies?*

▸ Wait for a few replies and then continue.

- They are giving them skin-to-skin contact.
- If a baby is well enough, the best place for this is between the mother's breasts, inside her clothes, so that the baby's body is touching her body.
- If a baby is too sick to move, the mother can make contact with her hand on the baby's body.
- *Ask: What are the benefits of holding a baby skin-to-skin?*

▸ Encourage participants to think of some of the following benefits. When they have suggested a few of them tell them the others.

- Skin-to-skin contact:
  - helps breastfeeding because the baby is close to the breast, so they learn to respond to the breast and develop their feeding skills
  - stimulates prolactin secretion, so it helps a mother to produce breast milk
  - helps a mother and baby to bond, probably because it stimulates oxytocin secretion
  - keeps the baby warm by the warmth of the mother's body; the baby does not use up energy to keep warm; there is less need for an incubator, and the baby gains weight better
  - makes the baby's heart work better, and makes their breathing more regular, so they need less oxygen
  - results in the baby crying less and sleeping better.
- So, encourage the mother of a low-birth-weight or stable sick baby to hold the baby in skin-to-skin contact as much as possible, to encourage breastfeeding and for all these other benefits. Cup or tube feeds can be given while the baby is in skin-to-skin contact.

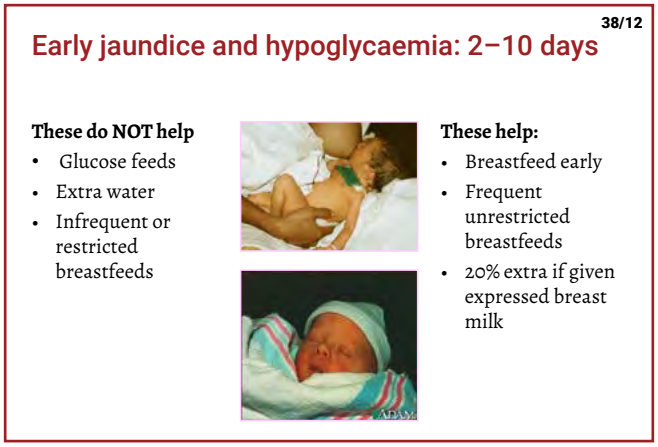
▸ Show **Slide 38/11 – Kangaroo mother care** and make the points that follow:

- *Ask: How are the mothers in this slide holding their babies?*

▸ Wait for a few replies and then continue.

- They are holding them in skin-to-skin contact. The babies are held in place by a binder around the mothers' bodies.
- This is called **kangaroo mother care**. The babies are held in skin-to-skin contact like this for much of the day and night. Mothers can walk about and do other activities with the baby in this position. Kangaroo mother care is very helpful for the babies' breastfeeding and general development.

▸ Show **Slide 38/12 – Early jaundice and hypoglycaemia: 2–10 days** and make the points that follow:



- **Jaundice** and **hypoglycaemia** are problems that can affect newborn babies and interfere with their feeding.
- The babies in the slide both have jaundice, which is a yellow colour of the skin and eyes, owing to high levels of **bilirubin** in the blood. The most common kind of jaundice is early jaundice, which occurs between the 2nd and 10th days of life.
- *Ask: In your experience, how do health workers feed babies with jaundice? Are they given feeds of glucose water? Artificial feeds? Are their mothers advised to stop breastfeeding?*

▸ Let participants report briefly on their experience. Then continue.

- It is routine in some hospitals to give babies fluids such as glucose water to clear jaundice. But research has now shown that extra fluids do not help.
- Jaundice is more common and worse among babies who do not get enough breast milk.
- Extra fluids such as water or glucose water do not help, because they reduce the baby's intake of breast milk. If there is a delay starting to breastfeed, or if breastfeeds are infrequent or restricted in any way, jaundice is more likely. Artificial milk feeds may interfere with breastfeeding in all the ways discussed earlier (see also Sessions 79 and 80: Health-care practices 1 and 2).

- To help prevent jaundice from becoming severe, babies need more breast milk.
  - They should start to breastfeed early, soon after delivery.
  - They should have frequent, unrestricted breastfeeds.
  - Babies fed on expressed breast milk should have 20% extra milk.
- Early feeds are particularly helpful, because they are colostrum. Colostrum has a mild purgative effect, which helps to clear **meconium** (the baby's first dark stool). Bilirubin is excreted in the stool, so colostrum helps to both prevent and clear jaundice.
- **Hypoglycaemia** means that the baby's blood sugar is too low.
- *Ask: Do many babies where you work develop hypoglycaemia? Do the doctors and nurses worry a lot about hypoglycaemia?*

▶ Let participants report briefly on their experience. Then continue.

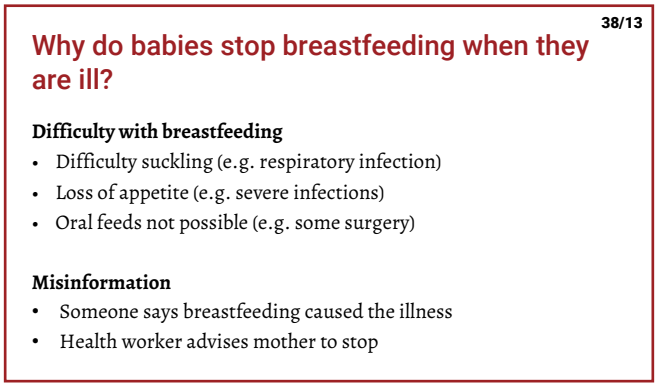
- Full-term healthy babies are not at risk of hypoglycaemia, and do not need to be given tests or extra feeds to prevent hypoglycaemia.
- Low-birth-weight and sick babies are at risk of hypoglycaemia. To reduce the risk:
  - keep the baby warm, for example with skin-to-skin contact
  - start breastfeeding or give expressed colostrum within the first hour after birth.
- If the baby is unable to breastfeed, and colostrum or expressed breast milk are not available, the baby may need other feeds such as glucose or formula milk, or intravenous fluids.
- *Ask: Why do babies often stop breastfeeding when they are ill?*

▶ Wait for a few replies and then continue.

- *Ask: Is it necessary to stop breastfeeding a baby for these reasons?*

▶ Wait for a few replies and then continue.

▶ Show **Slide 38/13 – Why do babies stop breastfeeding when they are ill?** and make the points that follow:



- Sometimes a baby has difficulty with breastfeeding, for example:
  - A respiratory infection, or sore mouth, for example, infection with *Candida* (thrush), may make suckling difficult.
  - An infection may make the baby lose their appetite, and refuse to breastfeed, or suckle less than before.
  - Very sick neonates, or babies who need surgery, may be unable to take oral feeds.
- Sometimes mothers stop breastfeeding because they have been misinformed; for example, someone says that breastfeeding caused the illness.
- However, breast milk does not make a baby ill (though occasionally substances in the mother's food cause colicky crying, see SESSION 35: CRYING).
- A health worker may advise a mother to stop breastfeeding, for example, when her baby has diarrhoea.

► Show **Slide 38/14 – Breastfeeding of sick babies** and make the points that follow:

► Look at the top half of the slide and review these points:

¤ If a baby stops breastfeeding when they are ill:

- they get less nourishment
- they lose more weight
- they take longer to recover
- they lack the comfort of suckling
- their mother's breast milk is likely to decrease
- they may refuse to start breastfeeding again when they are well.

► Look at the lower half of the slide, and review these points:

¤ If a baby continues to breastfeed when they are ill:

- they get the best nourishment
- they lose less weight
- they recover more quickly (especially from diarrhoea)
- they are comforted by suckling
- production of breast milk continues
- the baby is more likely to continue breastfeeding when they are well.

▶ Show **Slide 38/15 – How to help breastfeeding if a baby is sick** and make the points that follow:

- This slide summarizes how to help a mother to continue to breastfeed her sick baby.
- **If the baby is in hospital:**
  - Admit the mother too, so that she can stay with her baby and breastfeed them. Encourage mothers to spend as much time with their baby as possible. Unless there is a complication in the baby's condition, do not restrict the amount of time the mother can spend with her baby.
  - Encourage the mother to express her milk when she is with her baby.
  - Encourage her to hold her baby skin-to-skin for as long as possible each day, or to use kangaroo mother care if the baby's condition is stable. Some mothers find that skin-to-skin care or kangaroo mother care helps their milk to flow, and gives their babies more opportunity to breastfeed often.
- **If the baby can suckle well:**
  - Encourage the mother to breastfeed more often. She can increase the number of breastfeeds up to 12 times a day or more. Sometimes a baby loses their appetite for other foods, but continues to want to breastfeed. This is quite common with children who have diarrhoea. Sometimes a baby likes to breastfeed more when they are ill than before, and this can increase the supply of breast milk.
- **If the baby suckles, but less than before at each feed:**
  - Suggest that the mother gives more frequent feeds, even if they are shorter.
- **If the baby is not able to suckle, or refuses, or is not suckling enough:**
  - Babies who are sick may be breastfed slowly and may need to be fed with a gastric tube or cup for a time. Help the mother to express her milk, and give it by cup or spoon.
  - Let the baby continue to suckle when they are willing. Even babies on intravenous fluids may be able to suckle, or to have expressed breast milk.
- **If the baby is unable to take expressed milk from a cup:**
  - It may be necessary to give the expressed breast milk through a nasogastric tube for a few feeds.
- **If the baby cannot take oral feeds:**
  - Encourage the mother to express her milk to keep up the supply for when her baby can take oral feeds again. She should express as often as her baby would feed, including at night (see Sessions 17 and 33: Expressing breast milk 1 and 2). She may be able to store her milk, or donate it to another baby.
- **Usually, as a baby starts to recover, they start to breastfeed again. Encourage the mother to do the following:**
  - Breastfeed her baby; full-term babies resume breastfeeding faster than low-birth-weight babies.
  - If a baby refuses at first, help them to start again (see Session 30: Refusal to breastfeed).
  - Breastfeed often to build up her supply of breast milk (see Session 39: Increasing breast milk and relactation).

III. Demonstrate how to feed a baby by cup — 10 minutes

- Cups and other alternative feeding methods are used when a baby is unable to take a full feed from the breast, or if the mother is unavailable.

▶ **Discuss why cup feeding is safer than bottle feeding:**

- *Ask: Why are cups safer and better than bottles for feeding a baby?*

▶ **Wait for a few replies. Then go through any of the following points that they have not mentioned.**

- Cups are easy to clean with soap and water if boiling is not possible.
- Cups are less likely than bottles to be carried around for a long time, giving bacteria time to breed.
- A cup cannot be left beside a baby, for the baby to feed themself. The person who feeds a baby by cup has to hold the baby and look at them, and give them some of the contact they need.
- A cup does not interfere with suckling at the breast. However, if the baby is term and is able to breastfeed, they may refuse to feed from a cup. If a baby is low birth weight or sick, this is not so likely to happen.
- Cup-feeding is associated with less risk of diarrhoea, ear infections and tooth decay.
- A cup enables a baby to control their own intake, at their own pace.
- The baby sits semi-upright to cup-feed, which reduces the risk of aspiration. **Milk must not be poured into the baby's mouth**.

▶ **Discuss other alternative oral feeding methods:**

- A *paladai* is a little cup with a long pointed lip traditionally used for feeding infants in some cultures, especially in South Asia (see **Slide 38/7**). It is quite convenient to use, but the carer has to be careful not to pour the milk into the baby's mouth too fast.
- Spoon-feeding takes longer than cup-feeding.
- You need three hands to spoon-feed: to hold the baby, the cup of milk and the spoon. Mothers often find it difficult, especially at night.
- Some mothers give up spoon-feeding before the baby has had enough. Some spoon-fed babies do not gain weight well.
- However, if a baby is very ill, for example with difficult breathing, it is sometimes easier to use a spoon than a cup.

▶ **Make these points about the volume of breast milk:**

- If a mother is expressing more milk than her low-birth-weight baby needs:
  - Let her express the second half of the milk from each breast into a different container. Let her offer the second half of the expressed breast milk first. Her baby then gets more of the fat- and calorie-rich milk that comes towards the end the feed; this helps the baby to get the extra energy that they need, which helps them to grow faster.
- If a mother can only express very small volumes at first:
  - Give her baby whatever breast milk she can produce. Even very small amounts help to prevent infection. Help the mother to feel that this small amount is valuable.
  - This helps her confidence, and will help her to produce more milk. Supplement if necessary with donated breast milk, if it is acceptable to the mother, and if the policy of the country allows.

▶ **Give the demonstration of cup-feeding (see Fig. 38.1). Follow these steps:**

- **Put some water into one of the small cups.**
- **Prepare a doll, wrapping it with a cloth to hold its hands by its side, and to help to support its back. Put another small cloth on the doll's front, to protect its clothes from any spilled milk.**
- **Hold the doll on your lap, closely, with it sitting upright or semi-upright. Explain that a baby should not lie down as if it were being bottle or breastfed.**

- Hold the small cup or glass to the doll's lips. Tip it so that the water just reaches the lips. Point out that the edges of the cup touch the outer part of the baby's upper lip, and the cup rests lightly on the lower lip. This is normal when a person drinks.
- Explain that at this point, a real baby becomes quite alert, and opens their mouth and eyes. The baby makes movements with the mouth and face, and starts to take the milk into their mouth with their tongue. Babies more than about 36 weeks' gestation try to suck.
- Some milk may spill from the baby's mouth. Spilling is more common in babies of more than about 36 weeks' gestation, and less common with smaller babies, because of their different stages of development.
- You should not pour the milk into a baby's mouth – just hold the cup to their lips.
- Explain that when a baby has had enough, they will close their mouth and will not take any more at this feed. If the baby has not taken the calculated amount, they may take more next time, or they may need feeds more often. Measure the baby's intake over 24 hours, not just at each feed.

► Demonstrate with a doll what happens when you try to feed a baby with a spoon. You need to hold the cup and the spoon, or you need to put the cup down and take milk from it. The procedure is more awkward.

¤ Mothers often find spoon-feeding difficult, especially at night. Some mothers give up spoon-feeding before the baby has had enough. Some spoon-fed babies do not gain weight well. However, if a baby is very ill, for example with difficult breathing, it is sometimes easier to use a spoon than a cup.

► Demonstrate using a *paladai* (if locally used). Hold the baby in the same way, put milk into the *paladai*, and give it to the baby through the pointed lip. Explain the need to let the baby lick up the milk, and the importance of not pouring the milk into their mouth.

► Tell participants that the technique is described in the box HOW TO FEED A BABY BY CUP on page 293 of their *Participant's manual*. There is no need to read the box out to the participants.

HOW TO FEED A BABY BY CUP

- Wash your hands.
- Wrap the baby in a cloth to hold their hands by their side, and to support their back.
- Hold the baby sitting upright or semi-upright on your lap.
- Put a cloth in front to protect the baby's clothes from spilled milk.
- Place the estimated amount of milk for one feed into the cup.
- Hold the small cup of milk to the baby's lips.
  - Tip the cup so that the milk just reaches the baby's lips.
  - The cup rests lightly on the baby's lower lip, and the edges of the cup touch the outer part of the baby's upper lip.
- The baby becomes alert, and opens their mouth and eyes.
  - A low-birth-weight baby starts to take the milk into their mouth with their tongue.
  - A full-term or older baby sucks the milk, spilling some of it.
- **Do not pour** the milk into the baby's mouth. Just hold the cup to their lips and let them take it themself (sipping or lapping).
- When the baby has had enough, they will close their mouth and will not take any more. If the baby has not taken the calculated amount, they may take more next time, or you may need to feed them more often.
- Measure the baby's intake over 24 hours – not just at each feed.

► Ask participants to observe the cup-feeding in **Fig. 38.1**, to look at COUNSELLING CARD 6: HOW TO EXPRESS BREAST MILK AND CUP-FEED and COUNSELLING CARD 7: WHEN YOU ARE SEPARATED FROM YOUR BABY and to refer to the sections in the *Guidance on the use of counselling cards* on KEY PRACTICES AND DISCUSSION POINTS FOR COUNSELLING CARDS 6 and 7.

Fig. 38.1 Feeding a baby by cup

IV. Explain how much milk to give a baby — 10 minutes

- Ask participants to turn to page 294 of their *Participant's manual* and find the box AMOUNT OF MILK TO GIVE TO BABIES WHO CANNOT BREASTFEED.
- Read through the box, while they follow in their *Participant's manual*.
- Write on a flipchart or board:
  - BABIES 2500 G OR MORE: 150 mL/kg PER DAY
  - BABIES LESS THAN 2500 G: 60 mL/kg FOR THE FIRST DAY
    - EACH DAY ADD 20 mL/kg UP TO 180–200 mL/kg

AMOUNT OF MILK TO GIVE TO BABIES WHO CANNOT BREASTFEED

What milk to give

- Choice 1: expressed breast milk (if possible from the baby's mother, or from a donor); this may be pasteurized or heat-treated according to local policy.
- Choice 2: formula milk made up according to the instructions and World Health Organization (WHO) guidelines.

Amount of milk to give

Babies who weigh 2.5 kg or more

- 150 mL milk/kg body weight per day.
- Divide the total into 8 feeds, and give 3-hourly.

Babies who weigh less than 2.5 kg (low birth weight)

- Start with 60 mL/kg body weight per day.
- Increase the total volume by 20 mL/kg per day, until the baby is taking a total of 180–200 mL/kg per day.
- Divide the total into 8–12 feeds, to feed every 2–3 hours.
- Continue until the baby weighs 1800 g or more, and is fully breastfeeding.

Check the baby's 24-hour intake.

The size of individual feeds may vary.

▶ **Make these points:**

- It is normal for the amount of milk that a baby takes at each feed to vary, whatever the method of feeding, including breastfeeding.
- Babies feeding by cup or breastfeeding supplementer (see SESSION 39: INCREASING BREAST MILK AND RELACTATION) may take more or less than the calculated amount. If possible, offer a little extra, but let the baby decide when to stop.
- If a baby takes a very small feed, offer extra at the next feed, or give the next feed early, especially if the baby shows signs of hunger.
- Assess a baby's 24-hour intake. Give extra by intragastric tube only if the 24-hour total is not enough.
- Low-birth-weight babies need only very small volumes during the early days. If the mother can express even a small amount of colostrum, it is often all that her baby needs.

V. Facilitate the written exercise — 15 minutes

Explain what to do:

Ask participants to find EXERCISE 38.A. on page 295 of their *Participant's manual*.

Ask them to read the section **How to do the exercise**.

If they are going to answer the optional Question 1, they should also read the **Example**.

Then they should answer the questions **To answer**.

EXERCISE 38.A FEEDING LOW-BIRTH-WEIGHT AND SICK BABIES

How to do the exercise:

- For Question 1 (*optional*), use the information in the box AMOUNT OF MILK TO GIVE TO BABIES WHO CANNOT BREASTFEED, to calculate how much milk the baby needs. Read the **Example**.
- For Questions 2 and 3, explain briefly how you would advise the mother about feeding her baby.

Example:

Mabel's baby was born 8 weeks early, and cannot yet suckle strongly. Mabel is expressing her milk and feeding her baby 3-hourly by cup. He weighs 1.6 kg, and it is the 5th day.

How much milk should Mabel give at each feed today?

A low-birth-weight baby needs 60 mL/kg on the first day
On the fifth day, he will need (60 + 20 + 20 + 20 + 20) mL/kg = 140 mL/kg
Mabel's baby weighs 1.6 kg, so he will need:
1.6 × 140 = 224 mL on the 5th day
He feeds 3-hourly, so he has 8 feeds each day
So at each feed he needs 224 ÷ 8 mL = 28 mL of expressed breast milk
(Mabel should offer a little more than this if possible, for example, 30 mL. This also allows for spillage.)

To answer:

Question 1 (*optional*)

Baby Anna was born at 31 weeks' gestation and cannot yet suckle. She weighs 1.5 kg and you are tube feeding her with her mother's expressed breast milk. This is the second day she has taken oral feeds. You are feeding her 2-hourly.

How much will you give at each feed?

(Baby Anna needs 1.5 × (60 + 20) mL = 120 mL/day
If she has 12 feeds per day, she needs 10 mL per feed
You are tube feeding, so you do not need to give extra.)

Question 2

Mona has just delivered a baby 6 weeks before her expected date. He weighs 1500 g, and is being observed in the special care unit. Mona wants to breastfeed, but she is worried that her baby will not be able to.

What could you say to empathize with Mona?

(*You are worried about your baby, aren't you?*)

What could you say to build her confidence?

(Possibilities include:

- *Many babies as small as your baby can breastfeed.*
- *It is good that you want to breastfeed – your milk will help your baby.*)

Question 3

Baby Zora is 3 days old and today her eyes and skin look slightly yellow. Her mother breastfeeds her 3–4 times a day, and she also gives Zora glucose water between breastfeeds.

What relevant information would you give to Zora's mother?

(Jaundice at this age is common and not usually serious.
Breast milk can help jaundice to clear.)

How would you advise her mother to feed Baby Zora now?

(Advise her to breastfeed Zora more often.
Suggest that she stops giving the feeds of glucose water, and gives extra breastfeeds instead.)

VI. Summarize the session 2 minutes

- Ask participants whether they have any questions, and try to answer them.
- Explain that a summary of this session can be found on pages 283–297 of the *Participant's manual*.

Further information

Low-birth-weight babies

Whenever possible, low-birth-weight babies should be under the care of a health worker with specialist training. However, this information may help you if specialist care is not easily available.

Extra nutrients

Babies with very low birth weight (1000–1500 g) or extremely low birth weight (less than 1000 g) need extra nutrients in addition to breast milk for a time, in particular calcium, phosphorus and vitamin D. Breast milk with additional nutrients protects against infection better than artificial feeds. Breast milk contains essential nutrients and protective factors that are not available in any formula milk.

"Learning" to feed from a bottle

Some health workers believe that a low-birth-weight baby has to learn to feed from a bottle before they can feed from the breast. They suggest that sucking from a bottle is an earlier and easier stage of development. However, this is not necessary. Research has shown that breastfeeding is less stressful for a low-birth-weight baby than sucking from a bottle. Bottle feeding can make it more difficult for a baby to progress to suckling from the breast.

Giving a baby breast milk from another mother

If a mother cannot express as much breast milk as her baby needs, you may need to give the baby supplements. It is often useful to give supplements of breast milk from another mother, which has many advantages over artificial feeds. If HIV infection is a concern in the area, one possibility is to heat-treat the donated milk. Heat destroys HIV viruses, because they are very sensitive to heat. However, heat also destroys some of the anti-infective factors in the breast milk. If you give a baby supplements of either formula milk or heat-treated donated breast milk, continue to give as much as possible of the mother's own breast milk. Even a small amount of fresh breast milk can give a baby anti-infective factors that give valuable protection.

Time of first oral feed

If oral feeding is possible as soon as a baby is born, the first feed should be given within the first 2 hours, and every 2–3 hours thereafter, to prevent hypoglycaemia (low blood sugar).

Until the mother has put the baby to her breast and there is evidence the baby is receiving colostrum, give feeds of donated breast milk, if available. If breast milk is not available, give glucose water or formula milk. Glucose water is not necessary for well, term babies who are not at risk of hypoglycaemia.

Weight as a guide to feeding method

Gestational age is a better guide to a baby's feeding ability than weight. However, it is not always possible to know gestational age. Many babies start to take milk from the breast when they weigh about 1300–1500 g. Many can breastfeed fully when they weigh about 1600–1800 g or less.

Development of coordinated suckling

Babies can already swallow and suck long before 32 weeks. From about 32 weeks, many babies can suckle from the breast, and some can breastfeed fully from this age, but they may have difficulty in coordinating suckling, swallowing and breathing. They need to pause during a breastfeed to breathe. They can suckle effectively for a short time, but they often cannot suckle long enough to take all the breast milk that they need. By about 36 weeks, most babies can coordinate suckling and breathing, and they can take all that they need by breastfeeding. However, a baby may feed well sometimes, but tire and feed poorly at other times. If a baby suckles poorly, offer a cup feed after the breastfeed. If they are hungry, they will take milk from the cup. If the baby has had enough, they will not take milk from the cup.

Jaundice

Participants may ask about other kinds of jaundice. They may have heard of "breast-milk jaundice". The following notes may help you to answer their questions.

Severe jaundice

If jaundice is very severe in any baby, then it may be necessary to test their level of bilirubin, to see whether the baby needs phototherapy. One way to decide whether jaundice is severe is to see where it reaches on the baby's body. If it is visible below the baby's umbilicus, then it may be advisable to refer the baby to be tested.

Prolonged jaundice

Prolonged jaundice starts after the 7th day of life, and continues for some weeks. Sometimes it is due to a serious illness in the baby. Sometimes it is due to substances in the mother's milk – then it is called "breast-milk jaundice". Breast-milk jaundice is mild, and usually harmless. It clears by itself after some weeks.

If a baby has prolonged jaundice, check their weight, look for signs of infection (especially urinary infection) and feel for liver enlargement.

If the baby is well, feeding well and gaining weight, and their liver is not enlarged, they probably have breast-milk jaundice. This is harmless, and it is quite safe to continue breastfeeding.

If the baby is ill, with poor weight gain or an enlarged liver, then the jaundice is likely to be due to a more serious illness. Breast milk is not the cause. Refer the baby to hospital, and continue breastfeeding.

Haemolytic jaundice

Jaundice is sometimes due to haemolysis of the baby's blood, for example if there is ABO incompatibility. This more serious kind of jaundice may appear on the first day of life, the bilirubin may rise above 20 mg/dL, and the baby may need light treatment (phototherapy). Breastfeeding should continue, and it is important to help the mother, to enable her to breastfeed while her baby is receiving treatment.

Phototherapy

Phototherapy is often used to treat jaundice. Make sure that the mother gives the baby plenty of breast milk by cup or tube, or by breastfeeding frequently. Sometimes jaundiced babies are sleepy and suckle less at the breast. If necessary, the mother can express her milk and give extra milk by cup.

Special needs babies

Participants may ask about babies with special needs, such as twins, Down syndrome or cleft lip. Breastfeeding these babies can take extra time and patience, and their mothers need extra help and support. Some babies need to be stimulated to breastfeed often enough and for long enough at each feed. Some babies gain weight slowly, even if they receive enough breast milk. Breastfeeding and bonding may be even more important for special needs babies than for other babies. The topic is not covered at length in this course, because it is important for health workers to learn how to care for healthy babies before they try to help in more difficult situations, and all the same skills are necessary.

The principles of caring for special needs babies are the same as for all babies:

- Encourage the mother to begin breastfeeding as soon as possible after birth.
- Position and attach the baby well, and help them to take a big mouthful of breast.
- If the baby cannot suckle strongly, show the mother how to express her milk.
- Feed the expressed breast milk with a cup or spoon until the baby is able to suckle well.

It is important to let a baby explore the breast and try to attach in their own way. Some babies with disabilities manage much better than we expect them to.

Below are some practical suggestions about positioning that may be helpful for babies who have difficulty attaching or suckling. Try different techniques with a baby, until you find what is best for them.

The modified underarm position

This may be helpful with babies who feed more easily in an upright position, for example, babies with a cleft palate. The baby sits upright, facing their mother, with their legs along her side, and their feet at her back. The baby may sit on the bed, or be supported with a pillow. The mother supports the baby's back with her arm, and their head with her hand. However, some babies with cleft palate breastfeed satisfactory in a more lying-down position.

The straddle position

This is an alternative way for a baby to sit upright to breastfeed. The baby sits up facing their mother, with their legs on either side of her leg or abdomen.

Notes

Notes (contd)

SESSION 39

Increasing breast milk and relactation

Objectives

After completing this session, participants will able to:

- describe the main requirements for increasing the supply of breast milk
- explain the procedure for increasing the supply of breast milk if the baby is willing to suckle
- describe the use of the breastfeeding supplementer

Session outline . . . . . 60 minutes

Participants are all together for a lecture presentation by one trainer.
If Optional alternative 1 is chosen over alternative 2, an additional 5 minutes will be needed.

I.	Introduce the session, present **Slide 39/1**	3 minutes
II.	Discuss how to help a mother to increase her supply of breast milk	15 minutes
III.	Demonstrate how to use a breastfeeding supplementer	15 minutes
IV.	Demonstrate other ways to give supplements	10 minutes
V.	Optional alternative 1: Talk to a mother with experience of relactation	15 minutes
VI.	Optional alternative 2: Facilitate the written exercise (EXERCISE 39.A).	10 minutes
VII.	Show **Slides 39/2** and **39/3**	5 minutes
VIII.	Summarize the session	2 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides and giving a demonstration.
- Study the notes for the session and the SLIDES 39/1 to 39/3 and the text that goes with them, so that you are able to present them.

Before the course:

- Find out what methods are used locally to give babies extra milk if they cannot get all that they need directly from the breast – e.g. dripping milk down the breast, dipping a cotton swab in milk for the baby to suck.
- Decide whether you will conduct Optional alternative 1 or 2.
- If anyone in the area (either a health worker or another mother) has experience of relactation, or of using a supplementer, you may want to choose Option 1.
- If so, ask the person if they would be willing to come and talk to the participants about their experience. Make sure that they know the time when the session will be, where to come, and any other necessary arrangements.
- If you are not able to find such a person, then plan on Option 2, and do the short exercise and show and discuss the **Slides 39/2** and **39/3**.

Before the session:

- Obtain the following items for the demonstration:
  - a fine feeding tube and some tape for dressings (e.g. zinc oxide tape)
  - a cup or other container for milk
  - a 5 mL or 10 mL syringe, with a short length (about 5 cm) of fine tubing attached to the adaptor
  - a dropper, if locally available.
- Ask a participant to help you to demonstrate the breastfeeding supplementer. Explain what you want them to do.
- Read the **Further information** sections, so that you are familiar with the ideas that they contain, so that you can answer participants' questions.

As you follow the text, remember:

- ► indicates an instruction to you, the trainer.
  - ¤ indicates what you say to participants.

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the session — 3 minutes

► Show **Slide 39/1 – Session 39 – objectives** and read out the objectives:

39/1

Session 39: Increasing breast milk and relactation – objectives

After completing this session, participants will be able to:

- describe the main requirements for increasing the supply of breast milk
- explain the procedure for increasing the supply of breast milk if the baby is willing to suckle
- describe the use of the breastfeeding supplementer

► Make these points:

- ¤ If a mother's supply of breast milk is reduced, she needs to increase it.
- ¤ This often happens when there is a breastfeeding difficulty and the baby does not get enough milk.
- ¤ If a mother has stopped breastfeeding, she may want to start again. This is called **relactation**.
- ¤ The situations in which mothers may want to relactate include when:
  - a baby has been sick and has not suckled for a time
  - a baby has been artificially fed, but the mother wants now to try breastfeeding
  - a baby becomes ill or fails to thrive on artificial feeds
  - the mother has been sick and stopped feeding her baby
  - a woman who had a baby of her own before adopts a baby
  - a natural or man-made disaster has occurred and there are orphaned babies or babies who were artificially fed or partially breastfed prior to the emergency.
- ¤ The same principles and methods apply for increasing a reduced supply and for relactation, so we describe them both together.
- ¤ Relactation is more difficult and takes longer. The mother must be well motivated and she needs a lot of support to succeed. Sometimes, it is also necessary to use the methods described in Management of refusal to breastfeed in Session 30: Refusal to breastfeed.

II. Discuss how to help a mother to increase her supply of breast milk 15 minutes

- **Discuss the principles of the method:**
  - *Ask: What is the most important thing for a woman to do to increase her supply of breast milk?*
- **Let participants make two or three suggestions. Ask them to refer back to the diagram in their *Participant's manual* about the hormone prolactin, in SESSIONS 12 and 24: HOW BREASTFEEDING WORKS 1 and 2.**
- **Then continue with the answer below.**
  - The most important thing for her to do is to let her baby suckle often, to stimulate her breasts and increase prolactin secretion. If her baby does not suckle often, her breast milk will not increase, whatever else you do. Of course, the baby must be well attached at the breast.
  - In the past, people often advised mothers to "rest more, eat more, drink more".
  - These are not effective by themselves.
  - Eating more does not by itself increase a woman's milk supply.
  - However, if she is undernourished, she needs to eat more to build up her strength and energy. If she is not undernourished, food and warm nourishing drinks may help her to feel confident and relaxed.
  - Many mothers notice that they are more thirsty than usual when they are breastfeeding, especially near the time of a feed. They should drink to satisfy their thirst. However, taking more fluid than they want does not increase their supply of breast milk.
  - In most communities, experienced women know of some form of **lactogogue**. Lactogogues are special foods, drinks or herbs that people believe increase a mother's supply of breast milk. They do not work like drugs, but may help a woman to feel confident and relaxed.
- **Ask participants to find the box HOW TO HELP A WOMAN TO INCREASE HER SUPPLY OF BREAST MILK on page 300 of their *Participant's manual*.**
- **Ask them to read out in turn the steps of the method.**
- **After each step, explain points that are not clear and answer any questions.**

How to help a woman to increase her supply of breast milk

- Try to help the mother and baby at home if possible. Sometimes, it is helpful to admit them to hospital for a week or two, especially if the mother may feel pressure to use a bottle again at home, but **only if** there is enough skilled help available in hospital.
- Discuss with the mother the reason for her poor milk supply.
- Explain what she needs to do to increase her supply. Explain that it takes patience and perseverance.
- Use all the ways you have learnt to build her confidence. Help her to feel that she can produce breast milk again or increase her supply. Try to see her and talk to her every day at least once.
- Make sure that she has enough to eat and drink.
- If you know of a locally valued lactogogue, encourage her to take that.
- Encourage her to rest more, and to try to relax when she breastfeeds.
- Explain that she should keep her baby near her, give them plenty of skin-to-skin contact, and do as much as possible for them herself. Grandmothers can help if they take over other responsibilities – but they should not care for the baby at this time. Later they can do so again.
- Explain that the most important thing is to **let her baby suckle more often** – at least 10 times in 24 hours, more if the baby is willing.
  - She can offer her breast every 2 hours.
  - She should let the baby suckle whenever they seem interested.
  - She should let the baby suckle longer than before at each breast.
  - She should keep the baby with her and breastfeed at night.
  - Sometimes it is easiest to get a baby to suckle when they are sleepy.
- Make sure that her baby attaches well to the breast.
- Discuss how to give other milk feeds, while she waits for breast milk to come.
- Show her how to give the other feeds from a cup, not from a bottle. She should not use a pacifier.
- If her baby refuses to suckle on an "empty" breast, help her to find a way to give the baby milk while they are suckling, for example, with a dropper or a breastfeeding supplementer (see below).
- Discuss how much of the other feeds to give. To start with, she should give the full amount of artificial feed for a baby of their weight (150 mL/kg body weight per day; see box Amount of milk to give to babies who cannot breastfeed, in Session 38: Feeding low-birth-weight and sick babies) or the same amount that the baby has been having before. As soon as some breast milk comes, she can reduce the daily total by 30–60 mL each day.
- Divide the total amount of milk for a day by the number of feeds (8,10 or 12), to decide how much to give for each feed, and add a small amount for spillage.
- Check the baby's weight gain and urine output, to make sure that they are getting enough milk.
  - If the baby is not gaining weight, do not reduce the artificial feed for a few days.
  - If necessary, increase the amount of artificial milk for a day or two.
  - Some women can decrease the amount by more than 30–60 mL each day.

- **Explain the following points:**
  - The length of time that it takes for a woman's supply of breast milk to increase varies very much. It helps if the mother is strongly motivated, and if her baby is willing to suckle frequently. But the mother should not worry if it takes longer than expected. Try to reassure her that the milk will come, and build her confidence .
  - If a baby is still breastfeeding sometimes, the supply of breast milk increases in a few days. If a baby has stopped breastfeeding, it may take 1–2 weeks or more before much breast milk comes.
  - It is easier to relactate if a baby is very young (less than 2 months) than if they are older (more than 6 months). However, it is possible at any age.
  - It is easier if a baby stopped breastfeeding recently, than if they stopped a long time ago. However, it is possible at any time.
  - A woman who has not breastfed for years can produce milk again, even if she is post-menopausal. For example, a grandmother can breastfeed a grandchild.

III. Demonstrate how to use a breastfeeding supplementer — 15 minutes

- **Explain why a supplementer is useful:**
  - A **breastfeeding supplementer** is a device for giving a baby a supplement while they are suckling at a breast that is not producing enough milk.
  - A hungry baby may suckle at an "empty" breast a few times, but they may become frustrated and refuse to suckle any more – especially if they have become used to sucking from a bottle.
  - To stimulate a breast to produce milk, it is necessary for a baby to suckle. A breastfeeding supplementer helps to get the baby to continue suckling.
- **Give the demonstration.**
- **Ask the participant who will help you, to sit comfortably, holding a doll as if they are breastfeeding. See also Fig. 39.1.**
- **Follow these steps:**
  - **Show this equipment to the group:**
    - **a cup or other container for milk (expressed breast milk, or artificial milk)**
    - **a fine plastic tube, for example a nasogastric tube. If the tube has an "adaptor" end, cut it off. Also, at the end of the tube that will go into the baby's mouth, cut a small hole in the side, in addition to the hole at the end**
    - **tape, such as zinc oxide tape, to hold the end of the tube in place on the breast.**
  - **Ask the "mother" to hold one end of the tube along her breast, so that it goes into the "baby's" mouth with her nipple.**
  - **If it is possible with her clothed, help her to tape the tube in place on her breast. (Alternatively, demonstrate taping the tube to a model breast.)**
  - **Put the free end of the tube into the cup (which would normally have milk in it).**
  - **Find a convenient place for the cup. It may be possible to put it on a table nearby, or it may be easier for the "mother" to hold it.**
  - **Explain that the tube works like a drinking straw. As the baby suckles on the breast, they will get milk from the cup through the tube.**
  - **If the baby gets milk, they continue to suckle and stimulate the breast. This starts the production of breast milk. As breast milk is produced, the amount of milk taken from the cup decreases, and eventually the supplementer is no longer needed.**

- Explain that it is important that the baby gets the milk fast enough to reward them for stimulating the breast, but not too fast, or they will not stimulate the breast for long enough.

- Raise the cup, and explain that this makes the milk flow more quickly, so it is easier for the baby to get. Lower the cup, and explain that this makes the milk flow more slowly.
- Tie a knot in the tube. Explain that a common problem is not being able to find a very fine tube. If the tube is not fine enough, the milk flows too fast. Tying a knot in the tube is a useful way to slow the flow. (Other possibilities include pinching the tube, or putting a paper-clip on it.)

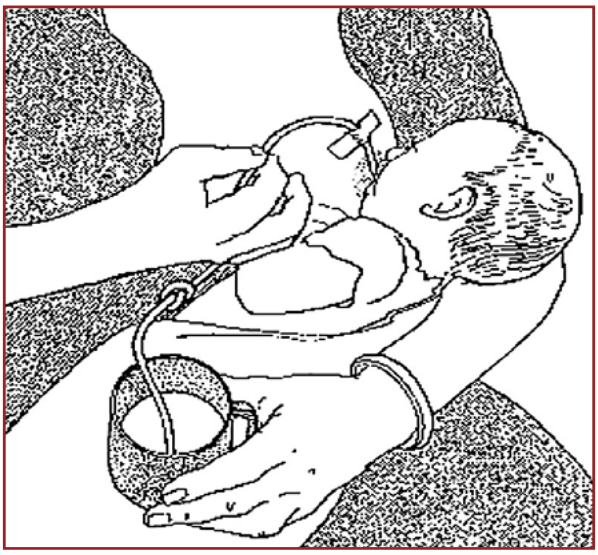


Fig. 39.1 Using a breastfeeding supplementer

- Ask participants to turn to page 302 of their *Participant's manual*, where they will find the box HOW TO HELP A MOTHER TO USE A BREASTFEEDING SUPPLEMENTER, which describes the method.

HOW TO HELP A MOTHER TO USE A BREASTFEEDING SUPPLEMENTER

Show the mother how to:

- Use a fine nasogastric tube, or other fine plastic tubing, and a cup to hold the milk. If there is no very fine tube, use the best available.
- Cut a small hole in the side of the tube, near the end of the part that goes into the baby's mouth (this is in addition to the hole at the end).
- Prepare a cup of milk (expressed breast milk or artificial milk) containing the amount of milk that her baby needs for one feed. (Calculate the total for the day and divide by the number of feeds in one day – see page 499 in the *Trainer's guide*, or page 294 in the *Participant's manual*.)
- Put one end of the tube along her nipple, so that her baby suckles the breast and the tube at the same time. Tape the tube in place on her breast.
- Put the other end of the tube into the cup of milk.
- Tie a knot in the tube if it is wide, or put a paper-clip on it, or pinch it. This controls the flow of milk, so that her baby does not finish the feed too fast.
- Control the flow of milk so that her baby suckles for about 30 minutes at each feed if possible. (Raising the cup makes the milk flow faster, lowering the cup makes the milk flow more slowly.)
- Let her baby suckle at any time that they are willing – not just when the mother is using the supplementer.
- Clean and sterilize the tube of the supplementer and the cup each time she uses them.

V. Demonstrate other ways to give supplements 10 minutes

- **Show participants some of these other ways to give a baby a supplement while they are suckling at the breast.**
  - These methods are useful if a baby does not suckle strongly at the breast, or if a mother finds a supplementer difficult.
- **Show and explain how to use a syringe:**
  - Use a 5 mL or 10 mL syringe.
  - Fix a length of fine tubing to the adaptor, about 5 cm in length; for example, a piece cut from a fine feeding tube, including the adaptor end of the feeding tube.
- **Explain that the mother measures the milk for a feed into a small cup.**
  - She fills the syringe with milk from the cup.
  - She puts the end of the tube into the corner of her baby's mouth, and presses out the milk slowly as the baby suckles.
  - She refills the syringe and continues until her baby has had the complete feed.
  - She should try to make the feed continue for 30 minutes (about 15 minutes at each breast).
- **Show and explain how to use a dropper.**
  - The mother measures the milk for a feed into a cup.
  - She drops the milk into her baby's mouth from the dropper as they suckle.
- **Show and explain how to drip milk down the breast.**
  - Drip expressed breast milk down the breast and nipple, using a spoon or small cup. Position the baby at the breast so that they lick the milk drops. Slowly put the nipple into the baby's mouth, and help them to attach to the breast. You may need to continue for 3–4 days before the baby can suckle strongly.

V. Optional alternative 1: Talk to a mother with experience of relactation 15 minutes

- **Ask the mother and baby whom you have invited, to join the class. Introduce them, thank the mother for coming, and ask her again if she is willing to talk to the class.**
- **Ask one participant to talk to the mother, to ask about her experience, why she needed to relactate, and how long it took for her milk to come.**
- **This is an opportunity for the participant to practise her counselling and history-taking skills.**
- **Ask the mother to demonstrate the method that she used, or that she still uses.**
- **Compare her experience to the method described.**

VI. Optional alternative 2: Facilitate the written exercise — 10 minutes

- Explain what to do:
- Ask participants to read the instructions How to do the exercise and the **Example** of what to do on page 303 of their *Participant's manual*. Then they should answer the question **To answer**.

Exercise 39.A Relactation

How to do the exercise:

- Use the information in the box Amount of milk to give to babies who cannot breastfeed on page 294 in your Participant's manual, to calculate the total amount of milk the baby needs.
- Use the information in the box How to help a woman to increase her supply of breast milk on page 300 in your *Participant's manual*, to decide how to decrease the milk as the mother relactates (see third point from the bottom in the box).

Example:

Ada died soon after her baby was born. Ada's mother will look after the baby, and she wants to breastfeed him. She breastfed all her own children. The youngest is 12.

Ada's baby is now 4 weeks old and weighs 4.5 kg. Ada's mother will let the baby suckle, and she will feed the baby formula milk with a supplementer, while she waits for her breast milk to come back.

How much artificial milk should Ada's mother give to the baby in total each day at the beginning?

Each day the baby needs 150 mL/kg
So she needs (150 × 4.5) = 675 mL milk in total each day

After a few days, when Ada's mother starts to produce a little milk, she will start to reduce the amount of artificial milk by 30 mL each day.

How much milk will she give on the first day that she reduces the amount?

She will give (675 – 30) mL = 645 mL

How much milk will she give the next day?

She will give (645 – 30) mL = 615 mL

To answer:

A baby aged 2 months has been bottle fed for 1 month. She has become very ill with diarrhoea, and formula milk feeds make the diarrhoea worse. Her mother breastfed satisfactorily for the first 4 weeks, and wants to relactate. The baby seems willing to suckle at the breast. You will feed the baby donated expressed breast milk by cup while her mother's supply of breast milk builds up. You will reduce the volume of expressed breast milk by 30 mL per day. The baby weighs 4.0 kg.

How much expressed breast milk will you give the baby by cup each day at the beginning?

(Give a total of 600 mL each day.)

How much expressed breast milk will you give the baby on the first day that you reduce the amount?

(570 mL)

How much expressed breast milk will you give on the tenth day of reducing the amount?

(300 mL)

How much milk will you give at each feed, if you feed the baby 10 times a day?

(The baby will need 30 mL; put 35 mL into the cup, as it is difficult to suck every drop.)

How many days should it take from when you start to reduce the amount to when you stop giving expressed breast milk altogether?

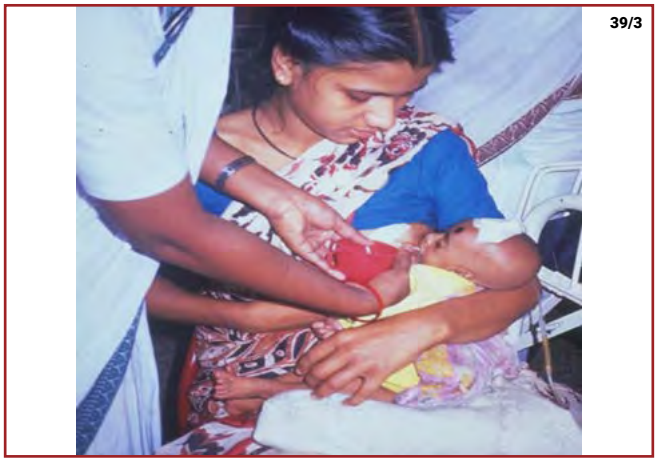
(Cup feeds should stop after about 20 days.)

VII. Show **Slides 39/2** and **39/3** 5 minutes

- Show **Slide 39/2 – Breastfeeding supplementer 1** and make the points that follow:

  - This slide shows a mother breastfeeding her baby and using a breastfeeding supplementer.
  - She bottle fed her baby and he became ill with diarrhoea, and then refused to breastfeed again.
  - The mother decided to start breastfeeding again, and to use the supplementer to get her baby to suckle.
  - You can see the cup that has formula milk in it, and the tube going from the cup to the mother's breast and into the baby's mouth.
  - After about 10 days, the mother was producing enough breast milk, and she was able to stop giving formula milk.

- Show **Slide 39/3 – Breastfeeding supplementer 2** and make the points that follow:



  - This slide shows another mother using a breastfeeding supplementer, in a similar way. This time you see the arrangement from above.

VIII. Summarize the session 2 minutes

- Ask participants whether they have any questions, and try to answer them.
- Explain that a summary of this session can be found on pages 299–305 of the *Participant's manual*.

Further information

Induced lactation

A woman who has never breastfed, or who has never been pregnant, can also produce breast milk for an adopted child. This is called **induced lactation**. If participants ask, assure them that it is well established that this is possible. However, they may find it difficult to believe, and discussing it may take a lot of time. This can be very distracting, so you may want to ask them to discuss it in break time rather than during the course. For practical aspects, see the information below.

Doctors sometimes prescribe drugs (metoclopramide or domperidone) to increase the supply of breast milk. They work by increasing prolactin secretion. However, these drugs should not be used routinely. They are mainly useful to increase the milk supply if a mother is expressing her milk regularly, or when a baby is already suckling frequently. They are not effective if the milk is not being removed regularly.

Induced lactation – practical aspects

Even if a woman has never been pregnant, if an adopted baby suckles often, milk will come after a few weeks. It is helpful to use a breastfeeding supplementer to encourage suckling. It can be very meaningful emotionally for a woman to experience this aspect of motherhood, if she has been unable to conceive her own child. The amount of breast milk that she can produce varies, and she may not be able to breastfeed the child fully. This is because without the hormonal changes of pregnancy, her breasts have not been prepared for lactation. In some settings, a woman can be given hormones to prepare her breasts, but this has not been scientifically studied.

Mixed feeding and HIV

Relactation may involve mixed feeding of the infant with formula and breast milk while the supply of breast milk builds up. In settings where HIV infection is a problem, this needs to be considered, as mixed feeding increases the risk of transmission of HIV infection to the infant. A woman who wants to relactate should be counselled and tested for HIV, and retested after 3 months. She should be advised about safe sexual intercourse while she is breastfeeding. If she is HIV positive at any time, she should be counselled about her method of infant feeding. She may choose not to relactate.

Notes

Notes (contd)

Notes (contd)

SESSION 40

Sustaining breastfeeding

Objectives

After completing this session, participants will able to:

- help mothers to continue to breastfeed for up to 2 years or beyond
- support breastfeeding when they see mothers and babies for other reasons

Session outline . . . . . 60 minutes

Participants work in groups of 8–10 with two trainers.
If adding the optional section, an additional 15 minutes will be needed.

I. Introduce the session, present **Slide 40/1** . . . . . 3 minutes
II. Discuss health workers' role in sustaining breastfeeding . . . . . 10 minutes
III. Explain the use of the JOB AID: POSTNATAL CONTACTS and the JOB AID: ONGOING CONTACTS . . . . . 10 minutes
IV. Demonstrate how health workers can help to sustain breastfeeding (**Slides 40/2** and **40/3**, DEMONSTRATIONS 40.A and 40.B) . . . . . 10 minutes
V. Facilitate the written exercise (EXERCISE 40.A) . . . . . 25 minutes
VI. Discuss breastfeeding support groups (*optional*) . . . . . 15 minutes
VII. Summarize the session . . . . . 2 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides, giving a demonstration and facilitating written exercises.
- Study the notes for the session, so that you are clear about what to do.
- For **Slides 40/2** and **40/3**, decide which alternative is most suitable for your situation, alternative 1 (Slide a) or alternative 2 (Slide b).
- Ask a participant to help you with DEMONSTRATIONS 40.A and 40.B, to play the part of Ester. Explain what you want her to do. Prepare a growth chart for Ester's baby.
- Decide whether you wish to include the optional section DISCUSS BREASTFEEDING SUPPORT GROUPS. You can ask participants to study this by themselves, or include it at another time.
- Read the **Further information** sections, so that you are familiar with the ideas that they contain, so that you can answer participants' questions.

As you follow the text, remember:

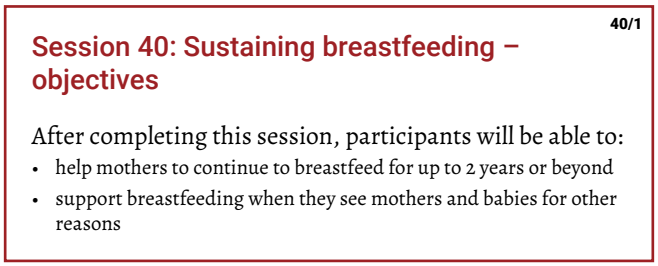
► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the session — 3 minutes

- Show **Slide 40/1 – Session 40 – objectives** and read out the objectives:



- Make these points:
  - In this session, we discuss how you can use the skills that you have learnt to support mothers to breastfeed their babies as recommended.
  - *Ask: What are the recommendations for infant feeding that we discussed in Session 1?*
- Wait for a few replies and then continue.
  - They are: start breastfeeding within an hour after birth, breastfeed exclusively for 6 months, and continue breastfeeding up to 2 years or beyond, with adequate complementary feeding from 6 months.
  - *Ask: Do mothers feed their babies according to these recommendations?*
- Wait for a few replies and then continue.
  - No – many mothers do not feed their babies this way.
  - In some communities, many mothers stop breastfeeding exclusively, or they may stop breastfeeding completely, after a few weeks or months.
- Look back at your conclusions from Session 3: Local infant and young child feeding situation and remind participants what they decided about the communities that they work in.
  - *Ask: Why do you think that mothers stop breastfeeding exclusively or completely sooner than recommended?*
- Let participants give their ideas, and then add any of the following points that they have not thought of themselves.
  - Mothers may stop breastfeeding, among other reasons, because:
    - of the attitudes and beliefs in their communities
    - they have to resume work outside home
    - health-care practices are not supportive.
  - *Ask: What can we do to enable more mothers to sustain breastfeeding according to the recommendations?*
- Let participants make some suggestions about what can be done, then continue with the following points.
  - Changes can be made with school and public education, and with social mobilization. If you have the opportunity to work with other sectors, use it to advocate for improved infant feeding practices and to identify areas of joint interest and concrete action.
  - Mothers' groups can enable women to support each other, and to sustain breastfeeding. Health workers can identify existing groups to work with, or encourage women to form groups. They should make sure that the groups have information, give them some training, and refer mothers to them and receive referrals from them.
  - **Key point**: However, health workers have an essential role to support and encourage women to breastfeed their babies, as part of their regular work. If they do not actively support breastfeeding, they may hinder it by mistake.
  - Facility-based and community-based health workers, and peer counsellors, have a very important role.

- Baby-friendly practices in hospitals or at home deliveries, including antenatal preparation, can increase the numbers of women who initiate breastfeeding. But for mothers to establish and sustain good feeding practices, they need both baby-friendly deliveries and continuing support after delivery.
- Research has shown that the more times a mother has support from a health worker or peer counsellor who has been trained in breastfeeding counselling, the more likely she is to sustain breastfeeding.
- This support should be given to all mothers, at specified times, when help is most likely to be effective, and when mothers can expect it. We should not wait until a problem arises, or until a mother has already started mixed feeding, before we offer help.
- We call these times when a health worker helps a mother "contacts" because they can happen in different places: in hospital, or in a clinic, or on a community or home visit. The task that is needed at a particular contact is usually the same wherever the contact takes place, and whoever is responsible for doing it.
- The clinical and counselling skills that you have learnt during this course should enable you to give mothers the help that they need during any of the contacts.
- But in order to ensure that you know what you have to do in your job, the times and purposes of possible contacts need to be identified, and the tasks that should be performed for each of them described.

II. Discuss health workers' role in sustaining breastfeeding — 10 minutes

- **Discuss the principles of the method:**
  - *Ask: What is the most important thing for a woman to do to increase her supply of breast milk?*
- **Ask participants to turn to page 309 of their *Participant's manual*, where they will find the box SEVEN+ CONTACTS TO SUSTAIN BREASTFEEDING.**
- **Explain:**
  - This box lists the basic seven contacts that all mothers need, and the ongoing contacts that are more variable.
  - Most of the contacts are already included in the Baby-Friendly Hospital Initiative, or can be built into other programmes, such as for neonatal survival. They may be done by different health workers, in a health facility or in the community. They may be done by peer counsellors, who are specially trained for the task.
  - The exact timing of the different contacts can vary according to local policy and services. But in each district or country, they should be the same for all mothers and infants.
  - It is important to think of the contacts as a connected sequence, to specify the tasks that need to be done at each contact, and to make sure that appropriate health workers or peer counsellors are trained and supervised to do these tasks. The contacts are included in the child's health records, and recorded when they have been done.
- **Ask participants in turn each to read aloud one point from the list.**
- **Discuss any points that are not clear.**

Seven+ contacts to sustain breastfeeding

Contact 1 – Antenatal

- The health worker discusses benefits and management of breastfeeding, including about early skin-to-skin contact, to prevent surprises.
- At a second antenatal contact, the health worker discusses more details and the mother's concerns.

Contact 2 – At delivery, in a maternity facility or at home

- The baby is placed on the mother's naked chest immediately after delivery for early skin-to-skin contact, and allowed to crawl to the breast to attach and suckle.

Contact 3 – Postnatal 1, within 24 hours

- This may be within 6 hours in a maternity facility (by the birth attendant), or on the first day after a home delivery.
- The health worker counsels the mother; helps her to position and attach the baby at the breast; and informs her about follow-up support and mothers' groups.

Contact 4 – Postnatal 2, at 2–4 days

- The health worker checks the condition of the mother and baby; follows up on previous contacts; observes a breastfeed; counsels the mother about any difficulties; helps with positioning and attachment; explains the feeding pattern; and encourages exclusive breastfeeding.

Contact 5 – Postnatal 3, at 5–8 days

- The health worker checks the condition of the mother and baby; follows up on previous contacts; observes a breastfeed; counsels the mother about any difficulties; helps with positioning and attachment; explains the feeding pattern; and encourages exclusive breastfeeding.

Contact 6 – Postnatal 4, between 14 and 28 days

- The health worker checks the condition of the mother and baby; follows up on previous contacts; observes a breastfeed; counsels the mother about any difficulties; helps with positioning and attachment; explains the feeding pattern; and encourages exclusive breastfeeding.

Contact 7 – Postnatal 5, between 6 and 8 weeks

- This may take place at the mother's postpartum contact (6 weeks).
- The health worker checks the condition of the mother and baby; makes sure that breastfeeding is going well; counsels the mother about any difficulties; and encourages exclusive breastfeeding.

Ongoing contacts – after 2 months

- These should take place at all growth monitoring and Immunization contacts, or when the mother and baby are in contact for illness or family planning.
- The health worker checks that breastfeeding is going well; counsels the mother about any difficulties; encourages exclusive breastfeeding up to 6 months; and, from 6 months, introduction of complementary foods with continued breastfeeding to 2 years.
- Mothers who are living with HIV may need referral for further individual counselling, according to national policy.

III. Explain the use of the Job aid: Postnatal contacts and Job aid: Ongoing contacts
10 minutes

- **Make these points:**
  - For health workers to carry out the postnatal contacts efficiently, it is useful to have simple job aids to remind them what to do each time. These can be collected into a small notebook that they can keep with them to refer to if necessary.
  - The procedures for Contact 1 (Antenatal) and Contact 2 (At delivery) are covered in Sessions 79 and 80: Health-care practices 1 and 2.
  - Here we will look at Job aids for:
    1. postnatal contacts 1–5
    2. ongoing contacts.
- **Ask participants to look at page 310 of their *Participant's manual* and to find the box Job aid: Postnatal contacts.**
- **Ask them to take turns reading points aloud.**
- **Discuss where in the course the knowledge and skills needed for each point have been covered.**
- **Make these additional points:**
  - It is especially important to discuss breastfeeding when you weigh or measure the length of a baby. Growth monitoring is a helpful way to know whether a baby is getting enough breast milk. Poor growth is an important sign that a mother and baby need help (see Session 8: Building confidence and giving support, and Session 34: "Not enough milk").
  - If a mother does not have a growth chart, or if you cannot weigh a baby, you can still talk about breastfeeding. You should have a good idea whether breastfeeding is going well, from the baby's appearance and behaviour. You can ask about the baby's urine output.
- **Ask participants to look at page 311 of their manuals and to find the box Job aid: Ongoing contacts.**
- **Read it through and discuss the points in the same way as for the Job aid: Postnatal contacts.**

Job aid: Postnatal contacts

- Use counselling skills – Listening and learning skills and Skills for building confidence and giving support
- Follow up on previous observations and questions

Ask:

- How is breastfeeding going – how many times, length of feeds, comfort, condition of breasts
- Is the baby receiving other fluids or foods, bottles, dummies?
- Baby's health and behaviour
- Pregnancy, delivery, early feeds
- Mother's condition and family planning
- Previous infant feeding experience
- Family and social situation – support at home, work

Observe:

- Condition of the mother
- Condition of the baby
- A breastfeed – including condition of the breasts
- Child's growth curve – weight and/or length/height, as appropriate

Help the mother to:

- Position and attach her baby if necessary
- Express milk and cup-feed her baby – if necessary, if not done before

Explain or recap as needed:

- How milk "comes in"
- Feeding pattern – demand feeding (baby with mother, respond day and night, let baby finish first breast, offer second)
- Exclusive breastfeeding – supplements not needed
- Signs the baby has what they need – passing urine, contented

Respond to any other questions and worries:

- Help (including possible referral) if needed with any difficulties:
  - Poor (or excessive) weight gain
  - Concerns about "not enough milk"
  - Concerns about baby's crying
  - Suckling difficulties
  - Flat, inverted or large nipples
  - Sore nipples
  - Engorgement
  - Mastitis
  - Refusal to feed

JOB AID: ONGOING CONTACTS

- Use counselling skills – LISTENING AND LEARNING SKILLS and SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT
- Follow up on previous observations and questions

Ask:

- How is breastfeeding going – how many times, length of feeds, comfort, condition of breasts?
- Is the baby receiving other fluids or foods, bottles, dummies?
- Baby's health and behaviour
- Pregnancy, delivery, early feeds
- Mother's condition and family planning
- Previous infant feeding experience
- Family and social situation – support at home, work

Observe:

- (Condition of the mother)
- Condition of the baby
- (A breastfeed, including condition of the breasts, if there is any difficulty)
- Growth monitoring – check baby's weight and/or length/height, as appropriate

Discuss:

- The importance of exclusive breastfeeding to 6 months
- Introduction of complementary foods from 6 months – AFATVRH: age-appropriate, frequency, amount, thickness, variety, responsive feeding and hygiene
- Continuing to demand feed as often as the infant wants, day and night
- Family support – talk to family if possible
- Family planning
- Preparation for returning to work
- Any other questions

Respond to any other questions and worries:

- Help (including possible referral) if needed with any difficulties:
  - Poor (or excessive) weight gain
  - Concerns about "not enough milk"
  - Concerns about baby's crying
  - Suckling difficulties
  - Flat, inverted or large nipples
  - Sore nipples
  - Engorgement
  - Mastitis
  - Refusal to feed

IV. Demonstrate how health workers can help to sustain breastfeeding 10 minutes

► **Explain what health workers can do:**

- When a mother brings her baby to a health facility for a routine procedure, for example, weighing or immunization, and if everything is satisfactory, the health worker often says nothing. She may only tell a mother if something is wrong.
- Mothers are sometimes confused or even upset if a health worker says nothing, or sounds critical. They may not feel encouraged to come again.
- Health workers are often short of time, but they can use the time that they have to say something encouraging and supportive.
- Every time you see a mother, try to build her confidence. Use your counselling skills.
  - Praise her for what she and her baby are doing right.
  - Give relevant information, and suggest something appropriate.

► **Write on the board:**

PRAISE

INFORM

SUGGEST

► **Give an example:**

► Show **Slide 40/2a**.

OR

► Show **Slide 40/2b**.

- *Ask: What do you think of how this health worker is talking to the baby's mother?*

► Let participants give their opinions. They should be able to give the answer.

- The health worker is **criticizing** and making the mother feel stupid.
- She is reducing the mother's confidence.

► Show **Slide 40/3a**.

OR

► Show **Slide 40/3b**.

¤ *Ask: What do you think of how the health worker is talking to the baby's mother now?*

► Let participants give their opinions. They will probably think of the answer below.

¤ The health worker is **praising** the mother's good practice.

¤ Later, she can suggest starting complementary foods, in addition to continuing to breastfeed.

► Demonstrate the skill:

► Ask a participant to play the part of Ester in DEMONSTRATIONS 40.A and 40.B, while you read out her story and play the part of the health worker.

► Ask her to stand near you, while you weigh the baby, fill in his growth chart and give it to her.

DEMONSTRATION 40.A SAYING TOO LITTLE

Read out the story:

Ester has brought her baby Dan for weighing at 5 months. He is exclusively breastfed, and perfectly well. He has gained 800 g in the last month, and now weighs 7 kg.

Play the health worker:

Health worker: (Pretend to weigh Ester's baby and mark his growth chart. Do not say anything while you do this. When you have finished, hand Ester the growth chart and say what follows.)

Health worker: *All right Ester, thank you. Make sure that you keep Dan's growth chart carefully and come back next month.*

¤ *Ask: Is what the health worker said to Ester helpful? Will Ester think that it is worth coming back, especially if Dan is well?*

► Let participants give their opinions briefly.

¤ What the health worker said did not help Ester or encourage her to come back.

► Explain that you will now see Ester again, and this time you will say three things to her.

¤ After weighing Dan and filling in his growth chart, you will praise Ester, you will give her some relevant information, and you will suggest something.

DEMONSTRATION 40.B SUSTAINING BREASTFEEDING

Health worker: (As you pretend to weigh the baby) *How are you feeding Dan?*
Ester: *Just breastfeeding, whenever he wants to.*

Health worker: *Oh, that's good.*
(As you fill in his growth chart)
Look at Dan's growth line now! What do you think of that?
Ester: *It is going up, isn't it? Does that mean that he is gaining weight?*

Health worker: *Yes, Dan gained quite a lot of weight last month – and that is just on your breast milk.* (**praise**)
You know, breastfeeding helps to keep a child healthy up to the age of 2 years or more. (**information**)
Have you thought about starting some other food yet, as well as continuing to breastfeed? (**suggestion**)

- *Ask: Is it helpful to say these things to Ester? Did weighing Dan and talking to Ester take much longer than weighing and saying nothing?*

▸ Let participants give their opinions. Then give yours:.

- Saying these things to Ester is helpful and supports breastfeeding.
- It does not take much longer than weighing and saying nothing.

V. Facilitate the written exercise — 25 minutes

▸ Ask participants to do EXERCISE 40.A, on pages 313–314 of their *Participant's manual*.

▸ Explain what to do:

- Ask participants to read the instructions HOW TO DO THE EXERCISE, and the **Example** of what to do. Then answer the questions **To answer**.

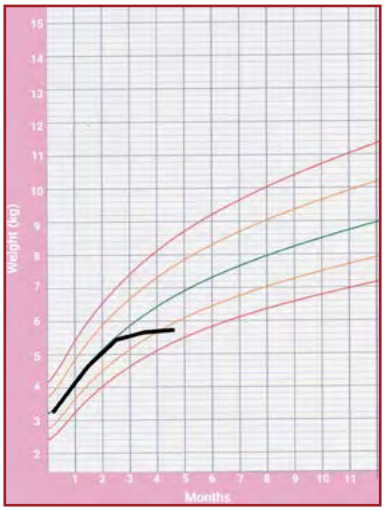
EXERCISE 40.A SUSTAINING BREASTFEEDING WITH GROWTH MONITORING

How to do the exercise:

- Study the growth charts of the following babies, and the short notes that go with them.
- Read the **Example** of Baby 1 for which the answers are given.
- Then look at the charts **To answer** for Babies 2, 3, 4 and 5, and answer the questions about them.
- When you are ready, discuss your answers with the trainer.

Example:

Baby 1 is exclusively breastfed. She slept with her mother until 8 weeks ago. Now she sleeps in a separate bed.



What is Baby 1's mother doing that you could praise?
(Her mother has breastfed exclusively all this time.)

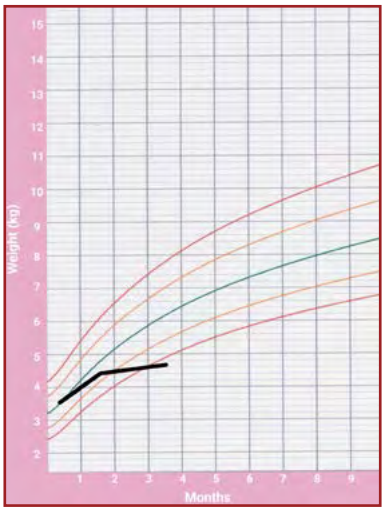
What do you think about Baby 1's recent weight gain?
(Her growth is slowing down.)

Why may this have happened?
(She stopped having night feeds.)

What would you suggest to his mother about feeding her now?
(Let her baby sleep with her again, to breastfeed at night.
Soon she should add complementary foods.)

To answer:

Baby 2 has come for immunization. Her mother says that she is well. She is a very good baby and cries very little. She only wants to feed about 4–5 times a day, which her mother finds helpful, because she is very busy.



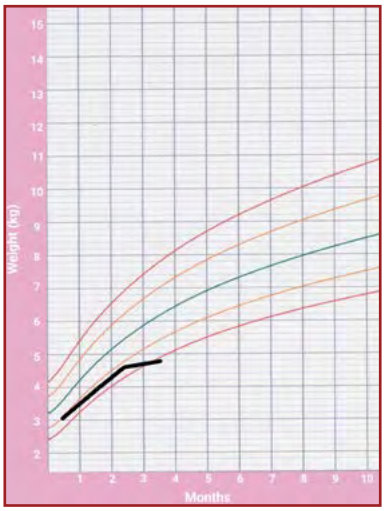
What could you say to show that you accept how Baby 2's mother feels?
(*You find it helpful to have a contented baby?*)

What do you think of Baby 2's weight gain?
(She is gaining weight too slowly.)

What is the reason?
(She does not breastfeed often enough.)

What would you like to suggest to Baby 2's mother about feeding her?
(Could she feed her more often? She need not wait for her to show signs of hunger.)

Baby 3 was exclusively breastfed until last month. Now her mother gives her drinks of water, because the weather is hot and she seems so thirsty.



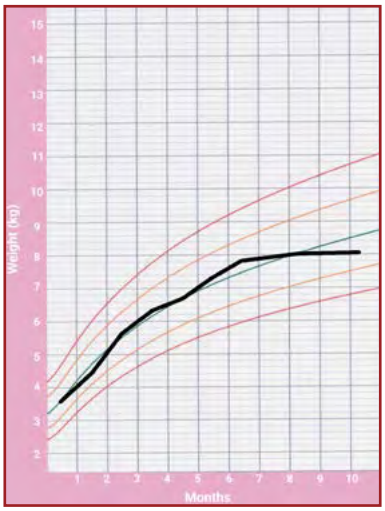
What do you think of Baby 3's weight gain?
(She gained very well for the first 2 months, but last month she has gained too slowly.)

What is the reason for her weight this month?
(She has been having drinks of water.
Note: Giving water may make a baby suckle less at the breast and take less breast milk.)

What relevant information could you give to Baby 3's mother? Try to give positive information.
(Breast milk contains all the water that a baby needs, even in hot weather.)

What would you suggest to Baby 3's mother?
(*Can you breastfeed more often if she is thirsty, instead of giving drinks of water?*)

Baby 4 has come for measles immunization. She breastfeeds frequently by day, and sleeps with her mother and breastfeeds at night. Two months ago, her mother started to give her thin cereal porridge once a day.



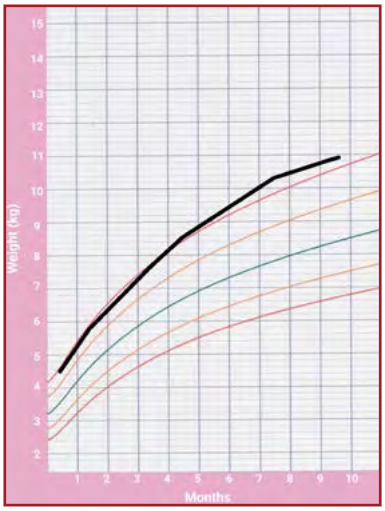
What is Baby 4's mother doing right?
(She is breastfeeding frequently by day and by night.)

What do you think of Baby 4's weight gain?
(She gained weight well for the first 6 months of life, but since then he has stopped growing.)

What do you think is the reason for the change?
(She is not getting enough complementary food.
Note: At this age, breast milk alone is not enough.)

What two things would you suggest to Baby 4's mother?
(1. Give Baby 4 energy-rich and nutrient-rich complementary foods 4–5 times a day.
2. Continue breastfeeding day and night, in addition to giving more food. Think of breastfeeding until she is 2 years old.)

Baby 5's mother has come for help with family planning. When you have given her this help, you ask about the baby. She was exclusively breastfed until the age of 6 months. Since then, she has had complementary food at first twice, and more recently four times, a day. She continues to breastfeed at night and several times during the day.



What do you think about Baby 5's growth?

(She is growing very well.
Note: She is not "overweight". Her growth line is following the standard curve.)

What can you say to praise her mother?

(*You must be pleased that she is doing so well, mainly because you are feeding her in such a healthy way.*)

What would you suggest to her mother about breastfeeding?

(It would be a good idea to continue breastfeeding until she is at least 2 years old.)

VI. Discuss breasteeding support groups (*optional*) 15 minutes

- Ask participants to find the box BREASTFEEDING SUPPORT GROUPS on page 315 of their *Participant's manual*.
- Ask them to read out the points in the box in turn.
- Discuss each point in relation to the local situation and experience.

BREASTFEEDING SUPPORT GROUPS

- A group may be started by a health worker; by an existing women's group; by a group of mothers who feel that breastfeeding is important; or by mothers who meet in the antenatal clinic or maternity facility and who want to continue to meet and help each other.
- A group of breastfeeding mothers meets together every 1–4 weeks, often in one of their homes, or somewhere in the community. They can have a topic to discuss, such as "The advantages of breastfeeding" or "Overcoming difficulties".
- They share experiences, and help each other with encouragement and with practical ideas about how to overcome difficulties. They learn more about how their bodies work.
- The group needs someone who is accurately informed about breastfeeding, to train them. They need someone who can correct any mistaken ideas and suggest solutions to difficulties. This helps the group to be positive and not to complain. This person could be a health worker, until someone in the group has learnt enough to play this role.
- The group needs a source of information whom they can refer to if they need help. This could be a health worker trained in breastfeeding, whom they see from time to time. The group also needs up-to-date materials to educate themselves about breastfeeding. The health worker can help them to get these.
- Mothers can also help each other at other times, and not only at meetings. They can visit each other when they are worried or depressed, or when they don't know what to do.
- Breastfeeding support groups can provide an important source of contact for socially isolated mothers.
- They can be a source of support that builds mothers' confidence about breastfeeding and reduces their worries.
- They can give a mother the extra help that she needs, from women like herself, that health services cannot give.

VII. Summarize the session 2 minutes

- Ask participants whether they have any questions, and try to answer them.
- Explain that a summary of this session can be found on pages 307–315 of the *Participant's manual*.

Further information

Complementary foods

For further information about complementary feeding, see the following, which is recommended to accompany this course:

- Infant and young child feeding: model chapter for textbooks for medical students and allied health professionals. Geneva: World Health Organization; 2009 (http://www.who.int/maternal_child_adolescent/documents/9789241597494/en/).

HIV and infant feeding

Mothers who are HIV positive should receive appropriate counselling and may choose to stop breastfeeding at birth, or from 6 or 12 months of age. This depends on the national policy, including the policy for use of antiretroviral drugs for HIV-positive women, and the policy for testing of infants. Individual advice about the use of replacement feeds should be provided for mothers choosing to stop breastfeeding. For more information, refer to the same model chapter for textbooks.

Notes

Notes (contd)

Notes (contd)

SESSION 41

Clinical practice session 3: Taking a feeding history – 0 up to 6 months

Objectives

After completing this session, participants will be able to:

- take a feeding history using the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS and appropriate counselling skills
- use the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS, to help decide whether a mother has difficulty with breastfeeding and how to counsel her

Session outline . . . . . 120 minutes

Participants are together as a class led by one trainer, to prepare for the session, and to discuss it afterwards.

Participants work in small groups of 3–4, each with one trainer for the clinical practice session in a ward or clinic.

I. Prepare the participants . . . . . 20 minutes
II. Conduct the clinical practice . . . . . 95 minutes
III. Summarize the session . . . . . 5 minutes

Preparation

- Make sure that you know where the clinical practice will be held and what times you are expected there. Visit the wards or clinics if you have not done so before. Introduce yourself to the staff members in charge, and make sure that they are prepared for the session (see *Director's guide*).
- Study the instructions on the following pages, and ask all trainers who will lead groups to study the instructions also.
- Make sure that you are clear about how this clinical practice differs from the clinical practice sessions on listening and learning and assessing a breastfeed; and on building confidence and giving support and positioning a baby.
- Arrange for the various groups of three or four to see mothers in:
  - a health centre or clinic
  - a paediatric ward
  - a special care baby unit (including where breast milk is expressed)
  - a postnatal ward (if there are insufficient mothers with babies in other settings)
  - an antenatal clinic (each group should do this once).
- Groups may stay in one place for the whole exercise, or they may spend some time in one place and some time in another, depending on the numbers of mothers, and how far the various settings are from each other.
- If any groups have not yet observed a newborn baby in contact with their mother, try to arrange for them to do so on this occasion.
- Make sure you have enough dolls for each group of participants.
- Make available a copy of the JOB AID: FEEDING HISTORY, 0 UP TO 6 MONTHS for each participant and trainer.
- Make sure that there are copies of the CLINICAL PRACTICE DISCUSSION CHECKLIST for each trainer.
- Make sure there is a copy of the COUNSELLING SKILLS CHECKLIST available for each participant and trainer, and also have some spares.

- Make sure there is a copy of the JOB AID: BREASTFEED OBSERVATION available for each participant.
- Make sure participants take the following with them to the clinical practice session: COUNSELLING CARD 3: GOOD ATTACHMENT, COUNSELLING CARD 4: BREASTFEEDING POSITIONS, and the *Guidance on the use of counselling cards*.

As you follow the text, remember:

- ▸ indicates an instruction to you, the trainer.
  - ¤ indicates what you say to participants.

I. Prepare the participants — 20 minutes

- ▸ One trainer leads a preparatory session with all participants and the other trainers together.
- ▸ If you have to travel to another facility for the clinical practice session, hold the preparatory session in the classroom before you leave. If necessary, this can take place on the evening or the morning before the clinical session.
- ▸ Explain the following to the participants:
  - ¤ You are going to continue to practise assessing a breastfeed and using LISTENING AND LEARNING SKILLS and SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT.
  - ¤ If there is an opportunity, you will practise helping a mother to position her baby at the breast, or to overcome any difficulty.
  - ¤ If possible, you will observe and help a mother to express her breast milk.
  - ¤ It is useful for any mother to learn to hand-express her milk, so you can offer to show any suitable woman how to express.
- ▸ Explain where participants will go: explain where the groups will go to, and what kinds of mothers they will be working with during this clinical practice.
- ▸ Give each participant a copy of the COUNSELLING SKILLS CHECKLIST and explain what it is:
  - ¤ This checklist is a summary of all the counselling, assessing and history-taking skills that you have learnt.
  - ¤ Refer to it during clinical practice and counselling exercises, to remind you of the different skills to practise.
- ▸ Explain what participants should take with them:
  - ¤ You will need to take with you one copy of the JOB AID: FEEDING HISTORY– 0 UP TO 6 MONTHS, one copy of the COUNSELLING SKILLS CHECKLIST, one copy of the JOB AID: BREASTFEED OBSERVATION and pencil and paper to make notes.
  - ¤ You will also need to take with you copies of COUNSELLING CARD 3: GOOD ATTACHMENT, COUNSELLING CARD 4: BREASTFEEDING POSITIONS, and the *Guidance on the use of counselling cards*.
  - ¤ Each group or pair of participants should have a doll to use for teaching mothers.
  - ¤ You do not need to take anything else – no books, manuals or handbags.
- ▸ Explain how participants will work:
  - ¤ Start work as a group of 3–4, with one participant taking a history from a mother, and the trainer giving feedback with the whole group together.
  - ¤ Then you will divide into two pairs, and the trainer can divide their time between the two pairs, to observe, comment and help where necessary.

- Explain what participants should do when they talk to a mother:
  - One participant should take a full breastfeeding history from the mother, using all six sections of the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS.
  - Use your LISTENING AND LEARNING SKILLS, and try not to ask too many questions.
  - Practise thinking of the most relevant questions for this mother.
  - Practise your SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT, and avoid giving a lot of advice.
  - If a mother has a breastfeeding difficulty, try to decide the reason, and how to help her. If it is a difficulty that you have not discussed in class or are unsure about, talk to the trainer before you help the mother or suggest what she should do.
  - When you are counselling the mother, you can share the Counselling cards with her, if needed.
- Explain what to do in the ward:
  - Take it in turns to talk to a mother and take the feeding history for a baby aged 0 up to 6 months.
  - The other participants should stand quietly in the background.
  - Make **specific** observations of the participant-counsellor's counselling skills.
  - Mark a tick on your COUNSELLING SKILLS CHECKLIST when the participant-counsellor uses a skill, to help you remember for the discussion.

II. Conduct the clinical practice 95 minutes

These notes are for the trainers. Trainers should read them to ensure that they know what to do. There is no need to read these notes to the participants.

- Take your group to a ward or clinic.
  - Groups should go to various parts of the health facility, depending on where mothers are available.
  - They can visit more than one area if necessary, provided these are not too far apart.
- Conduct the session in the same way as CLINICAL PRACTICE SESSIONS 1 and 2, except that after taking a history from one mother as a group of 3–4, participants work in pairs. Pairs should stay close to their trainer, so that they can ask for help and feedback.
- Help pairs to find mothers in different situations to talk to. Look out for any situation in which you may find a mother with a breast condition that would help participants to learn. Encourage the whole group to observe the mother and to talk to her briefly.
- Try to ensure that each participant takes a full history from at least one mother, observes another participant taking a history, and participates in feedback from both. If possible, each participant should work with two or more mothers.
- Discuss how to help mothers:
  - If a mother needs help with breastfeeding, let participants help her. However, first discuss with them what they plan to do, to make sure that it is appropriate.
  - If necessary, take participants where the mother cannot hear what you are saying while you discuss what to do. Then return to the mother to give the help.
  - Discuss the difficulty and its management with the staff in charge of the ward or clinic. It is important that you and the staff say the same things to the mother, so that you do not confuse her. The staff will be responsible for following up the mother and baby.

- Discuss the participants' performance:
  - When the group, or a pair, have finished, take them away from the mother, and discuss what they did and what they learnt.
  - Ask them to tell you about the mother, what she is doing well, whether she has any difficulties, and what they would suggest to help her.
  - Go through the CLINICAL PRACTICE DISCUSSION CHECKLIST, to help you to conduct the discussion.
  - Discuss what they learnt from the mother, and whether her situation is common or unusual. Discuss what else it might be possible to do in other, similar situations.

Optional

- If time permits, or if there are only a small number of mothers and babies available, you may choose to bring the groups together to discuss the clinical practice as a class.

Back in the classroom

- Ask participants to fill in their COMPETENCY PROGRESS FORM.
- They should record each competency that they practised during the session.
- If there are some competencies that they have not yet practised, help them to find an opportunity in the next clinical practice.

III. Summarize the session 5 minutes

- Ask participants whether they have any questions, and try to answer them.
- Explain that a summary of this session can be found on pages 317–323 of the *Participant's manual*.

CLINICAL PRACTICE DISCUSSION CHECKLIST

Practical skills are best developed by introducing and demonstrating the skills, observing participants as they practise the skills, and giving feedback to participants on how well they performed. Feedback should include praising participants for things done well, and giving gentle suggestions for how to overcome difficulties. Use the checklist below to help guide your feedback discussions.

Questions to ask after each participant completes their turn practising (either in the clinic or using counselling stories)

To the participant who practised:

- What did you do well?
- What difficulties did you have?
- What would you do differently in the future?

To the participants who observed:

- What did the participant do well?
- What difficulties did you observe?

LISTENING AND LEARNING SKILLS (give feedback on the use of these skills in all practical sessions)[1]

- Which LISTENING AND LEARNING SKILLS did you use?
- Was the mother willing to talk?
- Did the mother ask any questions? How did you respond?
- Did you empathize with the mother? Give an example.

SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT (give feedback on the use of these skills during clinical practice sessions after Session 10)[1]

- Which SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT were used?
  (check especially for praise and for two relevant suggestions)
- Which skills were most difficult to use?
- What was the mother's response to your suggestions?

KEY MESSAGES FOR COMPLEMENTARY FEEDING (give feedback on the use of these skills in Sessions 53 and 54 [Clinical practice sessions 5 and 6])[2]

- Which messages for complementary feeding did you use? (check especially for "only a few relevant messages")
- What was the mother's response to your suggestions?

General questions to ask at the end of each clinical practice session (in the clinic or using counselling stories)

- What special difficulties or situations helped you to learn?
- What was the most interesting thing that you learnt from this clinical practice session?

[1] See list of skills at the end of the session.
[2] See list of KEY MESSAGES FOR COMPLEMENTARY FEEDING on page xiv of the *Participant's manual* and page xvi of the *Trainer's guide*.

Job aid: Feeding history – 0 up to 6 months

Mother's name: **Date:**

Baby's name: **Baby's age:**

Particular concerns about feeding of child:

FEEDING

- Milk (breast milk, formula, cow's milk, other)
- Frequency of milk feeds
- Length of breastfeeds/quantity of other milks
- Night feeds
- Other foods in addition to milk (when started, what, frequency)
- Other fluids in addition to milk (when started, what, frequency)
- Use of bottles and how cleaned
- Feeding difficulties (breastfeeding/other feeding)

HEALTH

- Growth chart (birth weight, weight now; length at birth, length now)
- Urine frequency per day (6 times or more)
- Stools (frequency, consistency)
- Illnesses

PREGNANCY, BIRTH AND EARLY FEEDS (where applicable)

- Antenatal care
- Feeding discussed at antenatal care
- Delivery experience
- Rooming-in
- Prelacteal feeds
- Postnatal help with feeding

MOTHER'S CONDITION AND FAMILY PLANNING

- Age
- Health – including nutrition and medications
- Breast health
- Family planning

PREVIOUS INFANT FEEDING EXPERIENCE

- Number of previous babies
- How many breastfed and for how long
- If breastfed – exclusive or mixed fed
- Other feeding experiences

FAMILY AND SOCIAL SITUATION

- Work situation
- Economic situation
- Family's attitude to infant feeding practices

Job aid: Breastfeed observation

Mother's name: **Date:**

Baby's name: **Baby's age:**

Signs that breastfeeding is going well:	Signs of possible difficulty:
GENERAL	
Mother:	**Mother:**
☐ Mother looks healthy	☐ Mother looks ill or depressed
☐ Mother relaxed and comfortable	☐ Mother looks tense and uncomfortable
☐ Signs of bonding between mother and baby	☐ No mother/baby eye contact
Baby:	**Baby:**
☐ Baby looks healthy	☐ Baby looks sleepy or ill
☐ Baby calm and relaxed	☐ Baby is restless or crying
☐ Baby reaches or roots for breast if hungry	☐ Baby does not reach or root
BREASTS	
☐ Breasts look healthy	☐ Breasts look red, swollen, or sore
☐ No pain or discomfort	☐ Breast or nipple painful
☐ Breast well supported with fingers away from nipple	☐ Breasts held with fingers on areola
BABY'S POSITION	
☐ Baby's head and body in line	☐ Baby's neck and head twisted to feed
☐ Baby held close to mother's body	☐ Baby not held close
☐ Baby's whole body supported	☐ Baby supported by head and neck only
☐ Baby approaches breast, nose to nipple	☐ Baby approaches breast, lower lip/chin to nipple
BABY'S ATTACHMENT	
☐ Baby's mouth open wide	☐ Baby's mouth not open wide
☐ Lower lip turned outwards	☐ Lips pointing forward or turned in
☐ Baby's chin touches breast	☐ Baby's chin not touching breast
☐ More areola seen above baby's top lip	☐ More areola seen below bottom lip
SUCKLING	
☐ Slow, deep sucks with pauses	☐ Rapid shallow sucks
☐ Cheeks round when suckling	☐ Cheeks pulled in when suckling
☐ Baby releases breast when finished	☐ Mother takes baby off the breast
☐ Mother notices signs of oxytocin reflex	☐ No signs of oxytocin reflex noticed

Counselling skills checklist

Name of counsellor:

Name of observer:

Date of visit:

(✓ for Yes and X for No)

Did the counsellor:

Use Listening and learning skills:

☐ Keep the head level with mother/parent/caregiver?

☐ Pay attention (eye contact)?

☐ Remove barriers (tables and notes)?

☐ Take time? Allow the mother/caregiver time to talk?

☐ Use appropriate touch?

☐ Ask open questions?

☐ Use responses and gestures that showed interest?

☐ Reflect back what the mother/caregiver said?

☐ Empathize – showing that he or she understood how the mother/caregiver feels?

☐ Avoid using words that sound judging?

Use Skills for building confidence and giving support:

☐ Accept what the mother/caregiver thinks and feels?

☐ Recognize and praise what the mother/caregiver and baby are doing right?

☐ Give practical help?

☐ Give a little, relevant information?

☐ Use simple language?

☐ Make one or two suggestions, not commands?

COMPETENCY PROGRESS FORM

After each clinical practice, put a tick in the boxes for each skill you have practised.

For each mother and baby that you see, you can put a tick in one or more box.

Discuss your progress with your trainer, and try to practise as many competencies as possible.

CORE COMPETENCIES

1. Use LISTENING AND LEARNING SKILLS (using list of 6 skills)			
2. Use SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT (using list of 6 skills)			
3. Assess a breastfeed (using JOB AID: BREASTFEED OBSERVATION)			
4. Position a baby at the breast • sitting • lying down • reclining • after caesarian section • other			
5. Help a mother to attach her baby at the breast • cradle hold • underarm • with the opposite arm • other			
6. Explain to a mother the optimal pattern of breastfeeding (unrestricted or demand feeding)			
7. Help a mother to express her milk by hand			
8. Help a mother to cup-feed her baby			
9. Plot and interpret a child's growth chart			
10. Take a breastfeeding history			
11. Inform a woman about optimal infant feeding (early contact, exclusive breastfeeding for 6 months, and continued breastfeeding to 2 years)			
12. Counsel a pregnant woman about breastfeeding (advantages and management)			

COMPOUND COMPETENCIES			
13. Help a woman to initiate breastfeeding within an hour after delivery			
14. Support exclusive breastfeeding for the first 6 months of life			
15. Help a mother to continue breastfeeding up to 2 years of age or beyond			
16. Help a mother with "not enough milk"			
17. Help a mother with a baby who cries frequently			
18. Help a mother whose baby is refusing to breastfeed			
19. Help a mother who has flat or inverted nipples			
20. Help a mother with engorged breasts			
21. Help a mother with sore or cracked nipples			
22. Help a mother with mastitis			
23. Help a mother to breastfeed • a low-birth-weight baby • a sick baby • twins			
24. Help a mother to increase her breast milk or to start breastfeeding again			
25. Counsel a woman living with HIV antenatally about feeding choices			

Notes

Notes (contd)

Notes (contd)

SESSION 42

Clinical practice session 4: Counselling mothers in different situations

Objectives

After completing this session, participants will be able to:

- counsel a pregnant woman about breastfeeding
- use the JOB AID: POSTNATAL CONTACTS
- help mothers at all postnatal contacts after normal and operative delivery who have difficulty breastfeeding
- counsel mothers with different breast conditions
- counsel mothers with low-birth-weight babies and twins
- counsel mothers with sick children
- counsel mothers who are mixed feeding before 6 months of age

Session outline . . . . . 120 minutes

Participants are together as a class led by one trainer, to prepare for the session, and to discuss it afterwards.

Participants work in small groups of 3–4, each with one trainer, for the clinical practice session in a ward or clinic.

I. Prepare the participants . . . . . 20 minutes
II. Conduct the clinical practice . . . . . 95 minutes
III. Summarize the session . . . . . 5 minutes

Preparation

- Make sure that you know where the clinical practice will be held and what times you are expected there. Visit the wards or clinics if you have not done so before. Introduce yourself to the staff members in charge, and make sure that they are prepared for the session (see *Director's guide*).
- Study the instructions on the following pages, and ask all trainers who will lead groups to study the instructions also.
- Make sure that you are clear about how this clinical practice differs from previous clinical practice sessions.
- Make available copies of the JOB AID: POSTNATAL CONTACTS for each participant.
- Make available spare copies of the COUNSELLING SKILLS CHECKLIST, the JOB AID: BREASTFEED OBSERVATION and the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS.
- Make sure that there are copies of the CLINICAL PRACTICE DISCUSSION CHECKLIST for each trainer.
- Make sure participants take the following with them to the clinical practice session: COUNSELLING CARD 3: GOOD ATTACHMENT, COUNSELLING CARD 4: BREASTFEEDING POSITIONS, and the *Guidance on the use of counselling cards*.

As you follow the text, remember:

- ▶ indicates an instruction to you, the trainer.
- ¤ indicates what you say to participants.

I. Prepare the participants — 20 minutes

- **One trainer leads a preparatory session with all participants and the other trainers together.**
- **If you have to travel to another facility for the clinical practice session, hold the preparatory session in the classroom before you leave. If necessary, this can take place on the evening or the morning before the clinical session.**
- **Explain the objectives of the exercise:**
  - You are going to practise using the JOB AID: POSTNATAL CONTACTS, and all the clinical and counselling skills that you have learnt.
  - You will work as far as possible with mothers in different situations from those that you met in CLINICAL PRACTICE SESSION 3.
- **Explain what participants should take with them:**
  - Take with you:
    - copies of the JOB AID: POSTNATAL CONTACTS
    - one copy of the SEVEN+ CONTACTS TO SUSTAIN BREASTFEEDING
    - copies of the JOB AID: BREASTFEED OBSERVATION
    - the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS, to refer to if necessary
    - one copy of the COUNSELLING SKILLS CHECKLIST
    - pencil and paper to make notes.
  - Each group or pair of participants should have a doll to use for teaching mothers.
  - You do not need to take anything else – no books, manuals or handbags.
- **Explain how participants will work:**
  - You will work in pairs, as in previous clinical practice. Each trainer circulates between the two pairs in their group, to observe, to help where necessary, and to give feedback.
- **Remind participants what to do when they talk to a mother:**
  - Learn all that you can about the mother's situation and her breastfeeding experiences, and practise using your LISTENING AND LEARNING SKILLS, and history-taking skills.
  - Assess a breastfeed, and examine the mother and baby if necessary.
  - Practise building the mother's confidence and giving her support.
  - Help the mother, or suggest something helpful if you can.
  - Use the JOB AID: POSTNATAL CONTACTS to remind you of all the tasks that you need to complete.

II. Conduct the clinical practice — 95 minutes

These notes are for the trainers. Trainers should read them to ensure that they know what to do. There is no need to read these notes to the participants.

- Take your group to a ward or clinic:
  - Groups should go to different parts of the health facility, so that they see mothers in different situations.
- Conduct the session in the same way as previous clinical practice sessions.
- Help pairs of participants to find mothers and babies to talk to and work with.
- Circulate between the pairs, to help them if necessary.
- If a mother has a difficulty, participants can help her. Discuss with them what they do, to make sure that they give appropriate help.
- If possible, ask a responsible member of staff of the facility to be with you when you help a mother.
- Discuss the mother's situation with the staff who are caring for her. This helps to ensure that suggestions and help are consistent, and that the difficulty is followed up.
- Discuss the participants' performance:
- When a pair have finished talking to a mother, take them away from the mother, and discuss what they did and what they learnt.
- Ask them to tell you about the mother, what she is doing well, whether she has any difficulties, and what they would suggest to help her.
- Go through the CLINICAL PRACTICE DISCUSSION CHECKLIST, to help you to conduct the discussion.
- Go through the JOB AID: POSTNATAL CONTACTS, to make sure that the participants completed all the necessary tasks.
- Discuss what they learnt from the mother, and whether her situation is common or unusual. Discuss what else it might be possible to do in other similar situations.

Optional

- If time permits, or if there are only a small number of mothers and babies available, you may choose to bring the groups together to discuss the clinical practice as a class.

Back in the classroom

- Ask participants to fill in their COMPETENCY PROGRESS FORM.
- They should record each competency that they practised during the session.
- Review which competencies they have and have not practised during the course.
- Discuss how they can try to practise the others when they are back at their place of work.

III. Summarize the session — 5 minutes

- Ask participants whether they have any questions, and try to answer them.
- Explain that a summary of the session can be found on pages 325–333 of the *Participant's manual*.

Clinical practice discussion checklist

Practical skills are best developed by introducing and demonstrating the skills, observing participants as they practise the skills, and giving feedback to participants on how well they performed. Feedback should include praising participants for things done well, and giving gentle suggestions for how to overcome difficulties. Use the checklist below to help guide your feedback discussions.

Questions to ask after each participant completes their turn practising (either in the clinic or using counselling stories)

To the participant who practised:

- What did you do well?
- What difficulties did you have?
- What would you do differently in the future?

To the participants who observed:

- What did the participant do well?
- What difficulties did you observe?

Listening and learning skills (give feedback on the use of these skills in all practical sessions)[1]

- Which listening and learning skills did you use?
- Was the mother willing to talk?
- Did the mother ask any questions? How did you respond?
- Did you empathize with the mother? Give an example.

Skills for building confidence and giving support (give feedback on the use of these skills during clinical practice sessions after Session 10)[1]

- Which Skills for building confidence and giving support were used? (check especially for praise and for two relevant suggestions)
- Which skills were most difficult to use?
- What was the mother's response to your suggestions?

Key messages for complementary feeding (give feedback on the use of these skills in Sessions 53 and 54 [Clinical practice sessions 5 and 6])[2]

- Which messages for complementary feeding did you use? (check especially for "only a few relevant messages")
- What was the mother's response to your suggestions?

General questions to ask at the end of each clinical practice session (in the clinic or using counselling stories)

- What special difficulties or situations helped you to learn?
- What was the most interesting thing that you learnt from this clinical practice session?

[1] See list of skills at the end of the session.
[2] See list of Key messages for complementary feeding on page xiv the *Participant's manual* and page xvi of the *Trainer's guide*.

JOB AID: POSTNATAL CONTACTS

- Use counselling skills – listen to the mother, build her confidence
- Follow up on previous observations and questions

Ask:

- How is breastfeeding? – how many times, length of feeds, comfort, condition of breasts
- Is the baby receiving other fluids or foods, bottles, dummies?
- Baby's health and behaviour
- Pregnancy, delivery, early feeds
- Mother's condition and family planning
- Previous infant feeding experience
- Family and social situation – support at home, work

Observe:

- Condition of the mother
- Condition of the baby
- Observe a breastfeed – including condition of breasts
- Child's growth curve – weight and length, as appropriate

Help the mother to:

- Position and attach her baby if necessary
- Express milk and cup-feed her baby – if necessary, if not done before

Explain or recap as needed:

- How milk "comes in"
- Feeding pattern – demand feeding (baby with mother, respond day and night, let baby finish first breast, offer second)
- Exclusive breastfeeding – supplements not needed
- Signs baby has what they need – passing urine, contented

Respond to any other questions and worries

- Help (including possible referral) if needed with any difficulties:
  - Poor (or excessive) weight gain
  - Concerns about "not enough milk"
  - Concerns about baby's crying
  - Suckling difficulties
  - Flat, inverted or large nipples
  - Sore nipples
  - Engorgement
  - Mastitis
  - Refusal to feed

Seven+ contacts to sustain breastfeeding

Contact 1 – Antenatal

- The health worker discusses benefits and management of breastfeeding, including about early skin-to-skin contact, to prevent surprises.
- At a second antenatal contact, the health worker discusses more details and the mother's concerns.

Contact 2 – At delivery, in a maternity facility or at home

- The baby is placed on the mother's naked chest immediately after delivery for early skin-to-skin contact, and allowed to crawl to the breast to attach and suckle.

Contact 3 – Postnatal 1, within 24 hours

- This may be within 6 hours in a maternity facility (by the birth attendant), or on the first day after a home delivery.
- The health worker counsels the mother; helps her to position and attach the baby at the breast; and informs her about follow-up support and mothers' groups.

Contact 4 – Postnatal 2, at 2–4 days

- The health worker checks the condition of the mother and baby; follows up on previous contacts; observes a breastfeed; counsels the mother about any difficulties; helps with positioning and attachment; explains the feeding pattern; and encourages exclusive breastfeeding.

Contact 5 – Postnatal 3, at 5–8 days

- The health worker checks the condition of the mother and baby; follows up on previous contacts; observes a breastfeed; counsels the mother about any difficulties; helps with positioning and attachment; explains the feeding pattern; and encourages exclusive breastfeeding.

Contact 6 – Postnatal 4, between 14 and 28 days

- The health worker checks the condition of the mother and baby; follows up on previous contacts; observes a breastfeed; counsels the mother about any difficulties; helps with positioning and attachment; explains the feeding pattern; and encourages exclusive breastfeeding.

Contact 7 – Postnatal 5, between 6 and 8 weeks

- This may take place at the mother's postpartum contact (6 weeks).
- The health worker checks the condition of the mother and baby; makes sure that breastfeeding is going well; counsels the mother about any difficulties; and encourages exclusive breastfeeding.

Ongoing contacts – after 2 months

- These should take place at all growth monitoring and Immunization contacts, or when the mother and baby are in contact for illness or family planning.
- The health worker checks that breastfeeding is going well; counsels the mother about any difficulties; encourages exclusive breastfeeding up to 6 months; and, from 6 months, introduction of complementary foods with continued breastfeeding to 2 years.
- Mothers who are living with HIV may need referral for further individual counselling, according to national policy.

JOB AID: BREASTFEED OBSERVATION

Mother's name: **Date:**

Baby's name: **Baby's age:**

Signs that breastfeeding is going well:	Signs of possible difficulty:
GENERAL	
Mother:	**Mother:**
☐ Mother looks healthy	☐ Mother looks ill or depressed
☐ Mother relaxed and comfortable	☐ Mother looks tense and uncomfortable
☐ Signs of bonding between mother and baby	☐ No mother/baby eye contact
Baby:	**Baby:**
☐ Baby looks healthy	☐ Baby looks sleepy or ill
☐ Baby calm and relaxed	☐ Baby is restless or crying
☐ Baby reaches or roots for breast if hungry	☐ Baby does not reach or root
BREASTS	
☐ Breasts look healthy	☐ Breasts look red, swollen, or sore
☐ No pain or discomfort	☐ Breast or nipple painful
☐ Breast well supported with fingers away from nipple	☐ Breasts held with fingers on areola
BABY'S POSITION	
☐ Baby's head and body in line	☐ Baby's neck and head twisted to feed
☐ Baby held close to mother's body	☐ Baby not held close
☐ Baby's whole body supported	☐ Baby supported by head and neck only
☐ Baby approaches breast, nose to nipple	☐ Baby approaches breast, lower lip/chin to nipple
BABY'S ATTACHMENT	
☐ Baby's mouth open wide	☐ Baby's mouth not open wide
☐ Lower lip turned outwards	☐ Lips pointing forward or turned in
☐ Baby's chin touches breast	☐ Baby's chin not touching breast
☐ More areola seen above baby's top lip	☐ More areola seen below bottom lip
SUCKLING	
☐ Slow, deep sucks with pauses	☐ Rapid shallow sucks
☐ Cheeks round when suckling	☐ Cheeks pulled in when suckling
☐ Baby releases breast when finished	☐ Mother takes baby off the breast
☐ Mother notices signs of oxytocin reflex	☐ No signs of oxytocin reflex noticed

Job aid: Feeding history – 0 up to 6 months

Mother's name: **Date:**

Baby's name: **Baby's age:**

Particular concerns about feeding of child:

FEEDING

- Milk (breast milk, formula, cow's milk, other)
- Frequency of milk feeds
- Length of breastfeeds/quantity of other milks
- Night feeds
- Other foods in addition to milk (when started, what, frequency)
- Other fluids in addition to milk (when started, what, frequency)
- Use of bottles and how cleaned
- Feeding difficulties (breastfeeding/other feeding)

HEALTH

- Growth chart (birth weight, weight now; length at birth, length now)
- Urine frequency per day (6 times or more)
- Stools (frequency, consistency)
- Illnesses

PREGNANCY, BIRTH AND EARLY FEEDS (where applicable)

- Antenatal care
- Feeding discussed at antenatal care
- Delivery experience
- Rooming-in
- Prelacteal feeds
- Postnatal help with feeding

MOTHER'S CONDITION AND FAMILY PLANNING

- Age
- Health – including nutrition and medications
- Breast health
- Family planning

PREVIOUS INFANT FEEDING EXPERIENCE

- Number of previous babies
- How many breastfed and for how long
- If breastfed – exclusive or mixed fed
- Other feeding experiences

FAMILY AND SOCIAL SITUATION

- Work situation
- Economic situation
- Family's attitude to infant feeding practices

COUNSELLING SKILLS CHECKLIST

Name of counsellor:

Name of observer:

Date of visit:

(✓ for Yes and X for No)

Did the counsellor:

Use LISTENING AND LEARNING SKILLS:

- ☐ Keep the head level with mother/parent/caregiver?
- ☐ Pay attention (eye contact)?
- ☐ Remove barriers (tables and notes)?
- ☐ Take time? Allow the mother/caregiver time to talk?
- ☐ Use appropriate touch?
- ☐ Ask open questions?
- ☐ Use responses and gestures that showed interest?
- ☐ Reflect back what the mother/caregiver said?
- ☐ Empathize – showing that he or she understood how the mother/caregiver feels?
- ☐ Avoid using words that sound judging?

Use SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT:

- ☐ Accept what the mother/caregiver thinks and feels?
- ☐ Recognize and praise what the mother/caregiver and baby are doing right?
- ☐ Give practical help?
- ☐ Give a little, relevant information?
- ☐ Use simple language?
- ☐ Make one or two suggestions, not commands?

Competency progress form

After each clinical practice, put a tick in the boxes for each skill you have practised.

For each mother and baby that you see, you can put a tick in one or more box.

Discuss your progress with your trainer, and try to practise as many competencies as possible.

Core competencies			
1. Use Listening and learning skills (using list of 6 skills)			
2. Use Skills for building confidence and giving support (using list of 6 skills)			
3. Assess a breastfeed (using Job aid: Breastfeed observation)			
4. Position a baby at the breast • sitting • lying down • reclining • after caesarian section • other			
5. Help a mother to attach her baby at the breast • cradle hold • underarm • with the opposite arm • other			
6. Explain to a mother the optimal pattern of breastfeeding (unrestricted or demand feeding)			
7. Help a mother to express her milk by hand			
8. Help a mother to cup-feed her baby			
9. Plot and interpret a child's growth chart			
10. Take a breastfeeding history			
11. Inform a woman about optimal infant feeding (early contact, exclusive breastfeeding for 6 months, and continued breastfeeding to 2 years)			
12. Counsel a pregnant woman about breastfeeding (advantages and management)			

COMPOUND COMPETENCIES			
13. Help a woman to initiate breastfeeding within an hour after delivery			
14. Support exclusive breastfeeding for the first 6 months of life			
15. Help a mother to continue breastfeeding up to 2 years of age or beyond			
16. Help a mother with "not enough milk"			
17. Help a mother with a baby who cries frequently			
18. Help a mother whose baby is refusing to breastfeed			
19. Help a mother who has flat or inverted nipples			
20. Help a mother with engorged breasts			
21. Help a mother with sore or cracked nipples			
22. Help a mother with mastitis			
23. Help a mother to breastfeed • a low-birth-weight baby • a sick baby • twins			
24. Help a mother to increase her breast milk or to start breastfeeding again			
25. Counsel a woman living with HIV antenatally about feeding choices			

Notes

MODULE 5

Complementary feeding

SESSION 43

The importance of complementary feeding

Objectives

After completing this session, participants will be able to:

- explain the importance of continuing breastfeeding
- define complementary feeding
- explain why there is an optimal age for children to start complementary feeding
- list the Key messages from this session
- list their current practices related to complementary feeding

Session outline . . . . . 60 minutes

Participants are all together for a lecture presentation by one trainer, followed by group work with all trainers.

I.	Introduce the session, present **Slide 43/1**	1 minute
II.	Discuss sustaining breastfeeding (**Slide 43/2**)	5 minutes
III.	Define complementary feeding (**Slide 43/3**)	2 minutes
IV.	Discuss the optimal age to start complementary feeding (**Slides 43/4** to **43/7**)	35 minutes
V.	Examine the role of the health worker and the health facility (**Slide 43/8**, EXERCISE 43.A)	15 minutes
VI.	Summarize the session	2 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides and facilitating group discussion.
- Study the **Slides 43/1** to **43/8** and the text that goes with them, so that you are able to present them.
- You need a flipchart and markers.
- Prepare a flipchart paper with the questions for the working groups.
- Write the two Key messages from this session on a flipchart page:
  - KEY MESSAGE 1: BREASTFEEDING FOR 2 YEARS OR LONGER HELPS A CHILD TO DEVELOP AND GROW STRONG AND HEALTHY.
  - KEY MESSAGE 2: STARTING OTHER FOODS IN ADDITION TO BREAST MILK AT 6 COMPLETED MONTHS HELPS A CHILD TO GROW WELL.
- Arrange the words so that the first message can be uncovered with the second message still covered. (One way to do this is to have a sheet of blank flipchart paper with tape on each side at the top. Move this cover down as needed.)
- You need tape or other means of fixing the page to the wall or board.
- You need paper or cards for participants to write their recommendations on.
- Have ready COUNSELLING CARD 16: START COMPLEMENTARY FEEDING WHEN YOUR BABY REACHES 6 MONTHS for Section IV, and the *Guidance on the use of counselling cards*.

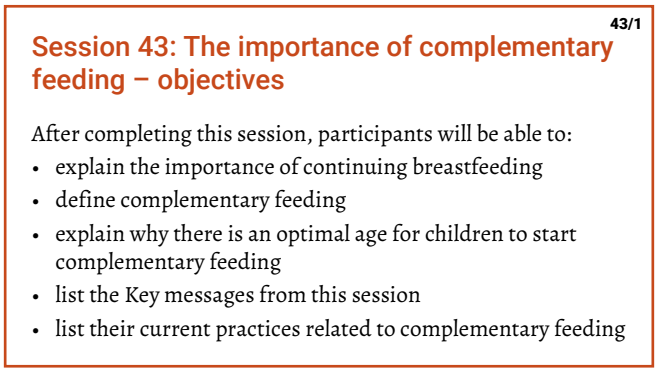
As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

I. Introduce the session — 1 minute

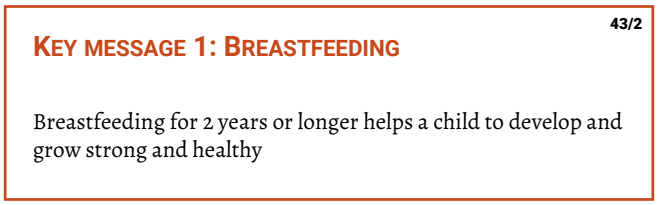
- **Make these points:**
  - The period from 6 months of age until 2 years is of critical importance in a child's growth and development. As health workers, you have an important role in helping families during this time.
  - During the next few sessions, we will develop a list of 10 Key messages to discuss with caregivers about complementary foods.
  - Ask participants to write down the most frequent recommendations or information that they give to caregivers about feeding children aged 6 up to 24 months.
- **After participants have written on the paper or card provided to them, collect these and give them to the trainer who is conducting Session 48.**
  - We will come back to these recommendations in Session 48.
- **Show Slide 43/1 – Session 43 – objectives and read out the objectives:**



II. Discuss sustaining breastfeeding — 5 minutes

- *Ask: Why is it important to continue breastfeeding after 6 months?*
- **Wait for a few responses and then continue.**
- **Make these points:**
  - In Sessions 11 and 23, we discussed the importance of continued breastfeeding. From 6 up to 12 months, breastfeeding continues to provide more than half, or about 60%, of the child's nutritional needs, and from 12 up to 24 months, at least one third, or about 40%, of their nutritional needs.
  - As well as nutrition, breastfeeding continues to provide protection to the child against many illnesses and provides closeness and contact that helps psychological development.
  - So, remember to include this key point when talking about a baby aged over 6 months.

► Show **Slide 43/2 – KEY MESSAGE 1: BREASTFEEDING** and ask a participant to read out the Key message:



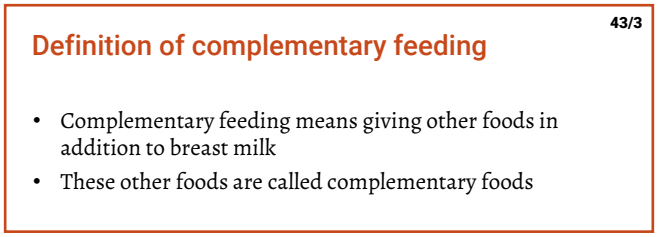
- ¤ Feeding counsellors like you can do a lot to support and encourage women who want to breastfeed their babies. You can help to protect good practices in a community. If you do not actively support breastfeeding, you may hinder it by mistake.
- ¤ Every time you see a mother, try to build her confidence. Praise her for what she and her baby are doing right. Give relevant information, and suggest something appropriate.
- ¤ Children who are not receiving breast milk should receive another source of milk and need special attention. There are special recommendations for feeding the non-breastfed child aged 6 up to 24 months. We will be looking at these recommendations in the later sessions.

III. Define complementary feeding — 2 minutes

► Make these points:

- ¤ An age is reached when breast milk alone is insufficient to meet the child's nutritional needs, and at this point complementary foods must be added. Let us examine what complementary feeding means.

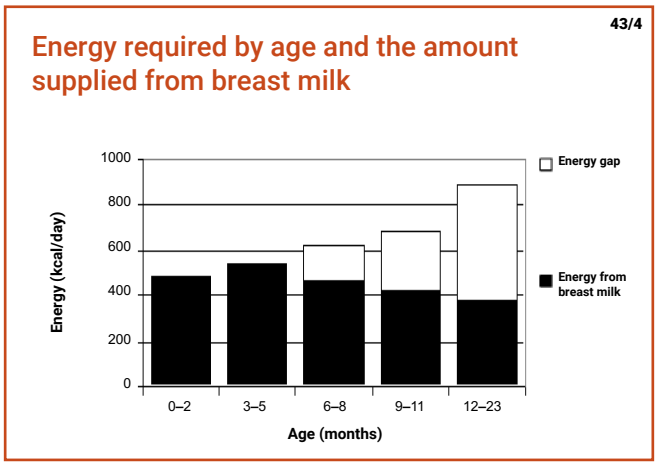
► Show **Slide 43/3 – Definition of complementary feeding** and read out the definition:



- ¤ These additional foods and liquids are called complementary foods, as they are additional or complementary to breast milk, rather than adequate on their own as the diet. Complementary foods must be nutritious foods and in adequate amounts, so the child can continue to grow.
- ¤ The term "complementary feeding" is used to emphasize that this feeding complements breast milk rather than replacing it. Effective complementary-feeding activities include support to continue breastfeeding.
- ¤ During the period of complementary feeding, the young child gradually becomes accustomed to eating family foods. Feeding includes more than just the foods provided. **How** the child is fed can be as important as **what** the child is fed.

IV. Discuss the optimal age to start complementary feeding 35 minutes

- **Make these points:**
  - Families may decide a young child is ready for complementary foods because they notice certain developmental signs such as reaching for food when others are eating, or starting to get teeth.
  - Families may decide the baby needs additional foods because they are showing what they believe to be signs of hunger. Signs such as the baby putting their hands to the mouth may be normal developmental signs, not signs of hunger.
  - Sometimes a family may decide to start complementary feeding because they believe that the baby will breastfeed less and the mother will be able to be away from the baby more.
  - Families may start complementary foods because a baby under 6 months of age is not gaining weight adequately.
  - A family may be influenced by what other people say to them about starting complementary foods. They may listen to a neighbour, their mother, a health worker or even advertisements for baby-food products.
  - Knowing why families start complementary foods helps you to decide how to assist them.
  - For example, a mother may give foods to a very young baby because she thinks she does not have enough breast milk. Once you understand her reason, you can give her appropriate information.
  - Complementary feeding should be started when the baby can no longer get enough energy and nutrients from breast milk alone. For most babies, this is 6 completed months of age.
  - Waiting to introduce complementary foods until a baby is 6 months old gives a baby's digestive system time to develop to better cope with solid foods. At that age, a baby has grown so that there is more space in the mouth and the tongue has the skills to move food from the front to the back of the mouth for swallowing.
- **Explain energy needs:**
  - Our body uses food for energy to keep alive, to grow, to fight infection, and to move around and be active. Food is like the wood for the fire – if we do not have enough good wood, the fire does not provide good heat or energy. In the same way, if young children do not have enough good food, they will not have the energy to grow and be active.
- **Show Slide 43/4 – Energy required by age and the amount supplied from breast milk and make the points that follow:**



  - This slide represents the energy required by age, with the darker part corresponding to the energy supplied by breast milk.
  - Now you will work in groups answering the questions listed on the flipchart.

- **Show participants the questions to be answered:**
  - Why do the columns become taller as the child ages?
  - What does the dark colour of the bar show?
  - When does the gap between the total energy needs and the energy provided by breast milk begin?
  - What happens to the size of the gap?
  - How can the energy gap be filled?
- **Divide the participants into four groups and provide flipchart paper for them to summarize the results of their discussion.**
- **After about 5 minutes of discussion, bring all participants together.**
- **Ask one group to present the results of the discussion and ask the other groups to add any additional information.**
- **Fill any gaps or missing information; avoid repetition of what has already been covered by participants:**
  - On this graph, each column represents the total energy needed at a specific age. The columns become taller to indicate that more energy is needed as the child becomes older, bigger and more active. The dark part shows how much of this energy is supplied by breast milk (*point to the dark area on the graph*).
  - You can see that from about 6 months onwards, there is a gap between the total energy needs and the energy provided by breast milk. The gap increases as the child gets bigger (*point to the white area on the graph*).
  - This graph illustrates an "average" child and the nutrients supplied by breast milk from an "average" mother. A few children may have higher needs and the energy gap would be larger. A few children may have smaller needs and thus a smaller gap.
  - Therefore, for most babies, 6 months of age is a good time to start complementary foods. Complementary feeding from 6 completed months helps a child to grow well and be active and content.
- **Show Slide 43/5 – KEY MESSAGE 2: WHEN TO START COMPLEMENTARY FEEDING and ask a participant to read out the Key message:**

  - After 6 months, babies need to learn to eat thick porridge and pureed and mashed foods. These foods fill the energy gap more than liquids.

- At 6 completed months of age, it becomes easier to feed thick porridge, puree and mashed food because babies:
  - show interest in other people eating and reach for food
  - like to put things in their mouth
  - can control their tongue better to move food around their mouth
  - start to make up and down "munching" movements with their jaws.
- In addition, at this age, babies' digestive systems are mature enough to begin to digest a range of foods.
- Now you will work in groups again.

Show participants the questions to be answered:

- Groups 1 and 3 will answer the following question: WHAT MIGHT HAPPEN IF COMPLEMENTARY FOODS ARE STARTED TOO SOON (BEFORE 6 MONTHS)?
- Groups 2 and 4 will answer the following question: WHAT MIGHT HAPPENS IF COMPLEMENTARY FOODS ARE STARTED TOO LATE (OLDER THAN 6 MONTHS)?

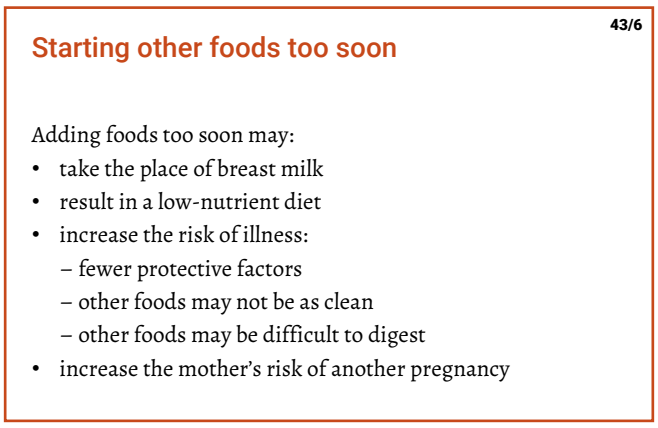
Provide each group with flipchart paper to summarize the results of their discussion.

After about 5 minutes of discussion, bring all participants together.

Ask one group discussing what migh happen when starting complementary foods too soon to present the results of their discussion; ask the other group to add any additional information.

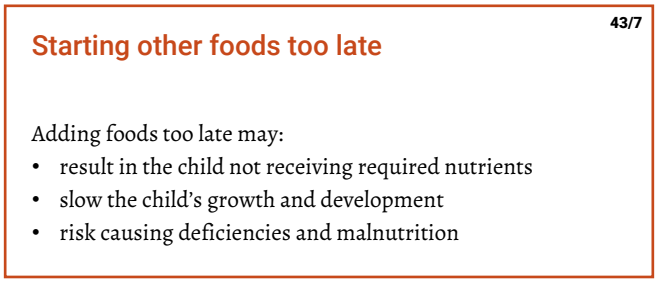
Fill any gaps or missing information; avoid repetition of what has already been covered by participants.

Show Slide 43/6 – Starting other foods too soon and make the points that follow:



- Adding complementary foods too soon may:
  - take the place of breast milk, making it difficult to meet the child's nutritional needs
  - result in a diet that is low in nutrients if thin, watery soups and porridges are used because these are easy for babies to eat
  - increase the risk of illness because fewer of the protective factors in breast milk are consumed
  - increase the risk of diarrhoea because the complementary foods may not be as clean or as easy to digest as breast milk
  - increase the risk of wheezing and other allergic conditions because the baby cannot yet digest and absorb non-human proteins well
  - increase the mother's risk of another pregnancy if breastfeeding is less frequent.

- Ask one group discussing what might happen when starting complementary foods too late to present the results of their discussion; ask the other group to add any additional information.
- Fill any gaps or missing information; avoid repetition of what has already been covered by participants:
- Show **Slide 43/7 – Starting other foods too late** and make the points that follow:



  - Starting complementary foods too late is also a risk, because the child:
    - does not receive the extra food required to meet their growing needs
    - grows and develops more slowly
    - might not receive the nutrients needed to avoid malnutrition and deficiencies, such as anaemia from lack of iron.
- Ask participants to turn to COUNSELLING CARD 16: START COMPLEMENTARY FOODS WHEN THE BABY REACHES 6 MONTHS and the section in the *Guidance on the use of counselling cards* on KEY PRACTICES AND DISCUSSION POINTS for that Counselling card; point out the information that is relevant to starting complementary feeding at 6 months.

V. Examine the role of the health worker and the health facility 15 minutes

- **Make these points:**
  - Parents of young children may receive information about feeding their child from many sources, such as families, health-facility personnel and community members.
  - Here is Maria and her mother. Maria is 10 months old and has come to the health facility regularly for immunizations and health checks.
- **Show Slide 43/8 – Maria and her mother and introduce EXERCISE 43.A ASSESS YOUR PRACTICES with the points that follow:**

  - Now, let us make a list of feeding- or nutrition-related activities that Maria or her mother could have found on their visit to you or your health facility.
  - Turn to page 340 of your *Participant's manual* (page 567 of the *Trainer's guide*). Think about the health facility where you work. When young children come to your facility – both well and sick children – what activities occur related to nutrition?
  - Fill in the table with the activities that occur. You may add comments to help clarify your marks in the table. For example, if all children who attend the well-baby clinic are weighed and measured but those who attend sick-baby clinic are just weighed, you can note this. For another example, if all children who see a nutritionist receive some nutrition counselling or discussion but children who do not see the nutritionist do not, you can note this.
- **Trainers go around their group as they are writing, to ensure that participants understand the exercise. Encourage participants to think of their own situations. Allow about 10 minutes for this exercise.**
- **Return to the larger group. Briefly summarize the findings of the exercise by asking the following questions.**
  - *Ask: What are the practices that occur most frequently at your place of work? What are the practices that occur least frequently?*
- **Make these points:**
  - The nutritional status of a child affects their overall health. Health is not only growth and development but also the ability to fight off illness and to recover from illness. This means the nutritional status of children is important to all health staff, and that all health staff should promote good feeding practices.
  - Creating a health-facility environment that gives importance to children's nutrition will go a long way in promoting children's health.

Exercise 43.A Assess your practices

Does this practice occur?	With all children	With some children	Does not occur	Comments
Weigh the child				
Measure the child's length				
Look at the child's growth chart				
Discuss how the child is feeding				
Note on the child's chart that feeding was discussed				
Carry out demonstrations of young children's food preparations and feeding techniques				
Make home visits to assess foods and feeding practices				
Other activities				

Most-frequent activities occurring in your health facility:

Least-frequent activities occurring in your health facility:

VI. Summarize the session 2 minutes

- **Ask participants whether they have any questions, and try to answer them.**
- **Make these points:**
  - In this session, we discussed the importance of adequate and timely complementary feeding.
  - We had two Key messages:
    - KEY MESSAGE 1: BREASTFEEDING FOR 2 YEARS OR LONGER HELPS A CHILD TO DEVELOP AND GROW STRONG AND HEALTHY
    - KEY MESSAGE 2: STARTING OTHER FOODS IN ADDITION TO BREAST MILK AT 6 COMPLETED MONTHS HELPS A CHILD TO GROW WELL
- **Display the flipchart pages with the Key messages from this session. Keep these messages displayed throughout the course.**
- **Explain that a summary of this session can be found on pages 337–341 of the *Participant's manual*. The list of Key messages can be found on page xiv of the *Participant's manual*.**

Notes

Notes (contd)

SESSION 44

Foods to fill the energy gap

Objectives

After completing this session, participants will be able to:

- list the local foods that can help fill the energy gap
- explain the reasons for recommending using foods of a thick consistency
- describe ways to enrich a child's food
- list the Key message from this session

Session outline . . . . . 45 minutes

Participants are all together for a lecture presentation by one trainer.

I.	Introduce the session, present **Slides 44/1** and **44/2**	2 minutes
II.	Outline foods that can fill the energy gap	15 minutes
III.	Demonstrate using a thick consistency of food (**Slides 44/3** and **44/4**)	10 minutes
IV.	Discuss ways to enrich a child's foods (**Slide 44/5**)	15 minutes
V.	Summarize the session	3 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides and giving a demonstration.
- Study the **slides 44/1 to 44/5** and the text that goes with them, so that you are able to present them.
- You need a flipchart and markers.
- Write the Key message from this session on a flipchart page. Keep it covered until later in the session: KEY MESSAGE 3: FOODS THAT ARE THICK ENOUGH TO STAY ON THE SPOON GIVE MORE ENERGY TO THE CHILD.
- You need tape or other means of fixing the page to the wall or board.
- You need a bowl or plate that would be used when feeding a young child.
- Find out whether germinated flours or fermented porridge are used in the area. If so, include the relevant section.
- Adapt lists of foods to reflect those available locally.
- You need food demonstration equipment as described in the box EQUIPMENT FOR DEMONSTRATION OF CONSISTENCY on page 572. Practise the demonstration beforehand.
- Check whether an Integrated Management of Childhood Illness (IMCI) food box for the variety of available foods has been developed for the country.

Equipment for demonstration of consistency

- Extra table or tray in case porridge spills.
- Two empty see-through containers that will each hold 200 mL when filled to the top, for the "stomach". This could be a drinking glass, or a plastic container such as a soft drink bottle, cut to the right size. Sharp scissors or knife to cut the soft drink bottles, if needed.
- Measuring jug or other means to measure 200 mL.
- 400 mL made-up porridge/gruel from a suitable local staple. Make up to a thick consistency, so that it stays easily on the spoon when the spoon is tilted.
- Divide the cooked porridge into two even portions:
  - One portion put in a bowl or container that holds at least 500 mL. Later, you will stir water into this portion.
  - The other portion you will use undiluted. The container size does not matter.
- Extra water (about 200 mL) to dilute the porridge.
- A large eating spoon.
- Cleaning materials to tidy up afterwards, including hand-washing facilities.
- This session can be conducted with a second trainer or a participant helping with carrying out the demonstration while the first trainer speaks.
- Practise this demonstration, to ensure the quantities of porridge are right for the "stomach". The first portion should be about twice as much (after dilution) as the stomach size. The second portion should all fit in with none left over and the stomach full.

As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

I. Introduce the session — 2 minutes

▸ **Make these points:**

- ¤ We talked earlier that as a baby grows and becomes more active, an age is reached when breast milk alone is not sufficient to meet the child's needs. This is when complementary foods are needed.
- ¤ In the previous session, we saw a graph of the energy needed by the growing child and how much is provided by effective breastfeeding.

▸ **Show Slide 44/1 – Session 44 – objectives and read out the objectives:**

44/1

Session 44: Foods to fill the energy gap – objectives

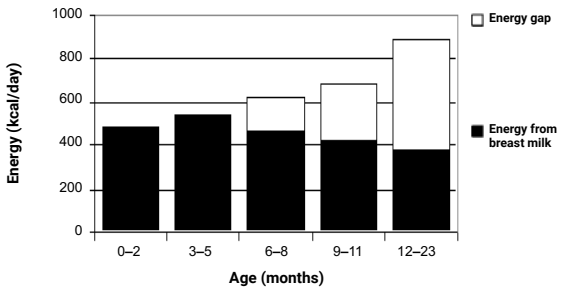
After completing this session, participants will be able to:

- list the local foods that can help fill the energy gap
- explain the reasons for recommending using foods of a thick consistency
- describe ways to enrich a child's food
- list the Key message from this session

▸ **Show Slide 44/2 – Energy required by age and the amount supplied by breast milk again and ask the question:**

44/2

Energy required by age and the amount supplied from breast milk



- ¤ *Ask: Why do you think the gap becomes bigger as the child grows older (point to white space)?*

▸ **Wait for a few replies and then continue.**

- ¤ As the young child gets older, breast milk continues to provide energy; however, the child's energy needs have increased as the child grows.
- ¤ *Ask: What will happen if these gaps are not filled?*
- ¤ If these gaps are not filled, the child will stop growing or grow only at a slow rate. The child who is not growing well may also be more likely to become ill or to recover less quickly from an illness.
- ¤ As health workers, you have an important role to help families use appropriate complementary foods and feeding techniques to fill the gaps.

II. Outline foods that can fill the energy gap — 15 minutes

- **Make these points:**
  - Think of the child's bowl or plate (*hold up the child's bowl*).
  - The first food we may think of to put in the bowl is the family staple. Every community has at least one staple or main food.
  - You will make a list of staples available in your community or region.
- **Divide participants into groups by region.**
- **Ask each group to complete a flipchart with the following information:**

STAPLES AVAILABLE IN COMMUNITY	FED TO CHILDREN YES/NO	MONTHS AVAILABLE

- **After about 5 minutes, bring back the participants to a plenary session, after leaving their flipcharts posted on the wall for you to refer to.**
- **Make the following points, referring to the lists the different groups made:**
  - As you indicated, staples may be:
    - cereals, such as rice, wheat, maize/corn, oats or millet
    - starchy roots such as cassava, yam or potato
    - starchy fruits such as plantain or breadfruit.
  - All foods provide some energy. However, people generally eat large amounts of these staples and they provide much of the energy needed. Staples also provide some protein and other nutrients, but they cannot provide all the nutrients needed on their own. The staple must be eaten with other foods for a child to get enough nutrients.
  - Staples generally need preparation before eating. They may just need to be cleaned and boiled, or they may be milled into flour or grated and then cooked to make bread or porridge.
  - Sometimes staple foods are specially prepared for young children; for example, wheat may be the staple and bread dipped in soup is the way it is used for young children. It is important that you know what the main staples are that families eat in your area. Then you can help them to use these foods for feeding their young children.
  - Look again at the list of staples that you made on the flipcharts and staples that are given to young children.

- *Ask: Are all staples available given to young children?*

▸ **Wait for a few replies and then continue.**

- In your regions (*mention what is in the list*) are given to young children, while (*mention what is in the list*) are not given to them.
- We need to be aware of this when talking with parents about what to feed their young children.

▸ **Make these points:**

- In rural areas, families often spend much of their time growing, harvesting, storing and processing the staple food. In urban areas, the staple is often bought, and the choice depends on cost and availability.
- You included in the lists you made the availability of staples; let's look at your lists.
- *Ask: Does the staple used in this community depend on where you live or on the time of the year?*

▸ **Wait for a few replies and then continue.**

- Preparing the staple may take a lot of the caregiver's time. Sometimes a family will use a more expensive staple that requires less preparation or less fuel for cooking, rather than use a cheaper staple.

III. Demonstrate using a thick consistency of food — 10 minutes

▸ **Introduce the next section with these points:**

- We have the staple in the child's bowl. Let us say this child will have (*give local example, potato, rice …*) The food may be thin and runny, or it may be thick and stay on the spoon.
- Often families are afraid that thick foods will be difficult to swallow, be stuck in the baby's throat, or give the baby constipation. Therefore, they add extra liquid to the foods to make it easier for the young child to eat. Sometimes extra liquid is added so that it will take less time to feed the baby.
- It is important for you to help families understand the importance of using a thick consistency in foods for young children.

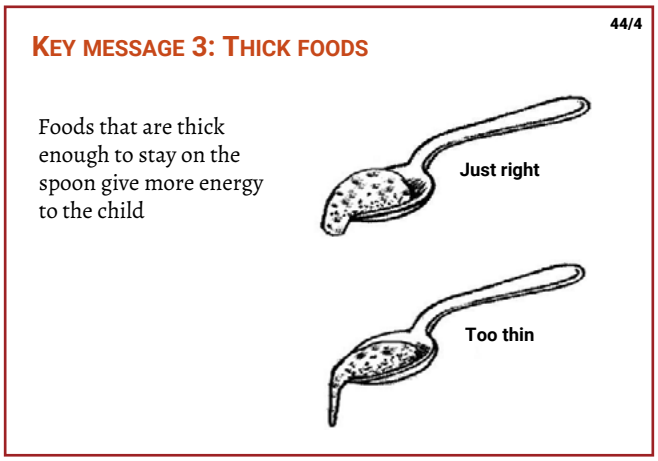
▸ **Show Slide 44/3 – Stomach size: 8 months and make the points that follow:**

- This is (boy's name). He is 8 months old. At this age, (name's) stomach can hold about 200 mL at one time. This is the amount that fits into this container.

- **Show the empty see-through container that holds 200 mL.**

(Name's) mother makes his porridge from maize flour. His mother is afraid (name) will not be able to swallow the porridge, so she adds extra water.

- **Use one portion of the made-up porridge and dilute this portion of porridge to at least twice the volume and show to participants.**
  - Now the porridge looks like this (thin and watery).
  - *Ask: Can all this thin porridge fit in his stomach?*
- **Wait for a few replies and then continue.**
- **Spoon or pour the porridge into the see-through container "stomach" as you ask the question. Wait for a response and then continue.**
  - No, it cannot all fit in his stomach; there is still porridge left in the bowl. (Name's) stomach would be full before he had finished the bowlful. So (name) would not get all the energy he needs to grow.
  - (Name's) mother has talked with you, the health worker, and you have suggested that she give thick porridge. The mother makes the porridge using the same amount of maize but does not add extra water. The porridge looks like this (thick).
- **Use the other portion of the made-up porridge but do not dilute it. Show the participants how thick it is. Spoon all the porridge into the see-through container "stomach" as you ask the question.**
  - *Ask: Can all this thick porridge fit in (name's) stomach?*
- **Wait for a few replies and then continue.**
  - Yes. (Name) can eat a bowlful, which will help meet his energy needs.
- **Now, use a spoon to demonstrate the consistency of the porridge.**
  - Look at the consistency of the porridge on the spoon. This is a good way to show families how thick the food preparation should be. The food should be thick enough to stay easily on the spoon without running off when the spoon is tilted.
  - If families use a blender to prepare the baby's foods, this may require extra fluid. It may be better to mash the baby's food instead, so that less fluid is added.
  - Porridge or food mixtures that are so thin that they can be fed from a feeding bottle, or poured from the hand, or that the child can drink from a cup, do not provide enough energy or nutrients.
  - The consistency or thickness of foods makes a big difference to how well that food meets the young child's energy needs. Foods of a thick consistency help to fill the energy gap.
  - So when you are talking with families, give this Key message:
- **Show Slide 44/4 – KEY MESSAGE 3: THICK FOODS and ask a participant to read out the Key message:**



IV. Discuss ways to enrich a child's food — 15 minutes

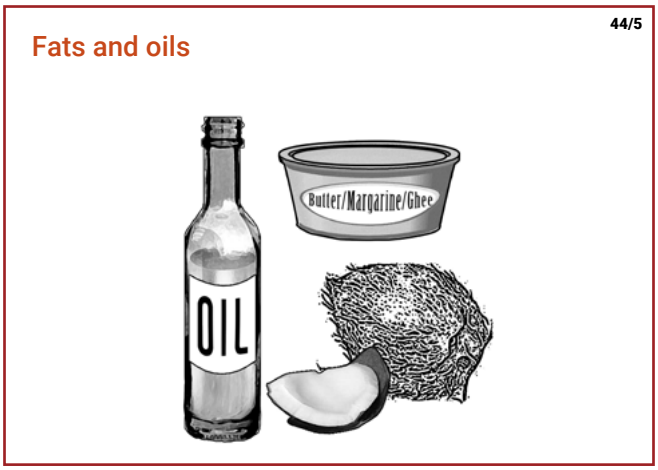
- **Continue with these points:**
  - Similar to the porridge, when soups or stews are given to young children, they may be thin and dilute and fill the child's stomach. There may be good foods in the soup pot, but few of the food ingredients are given to the child. It is mostly the watery part of the soup that is given.
  - *Ask: How could families make the young child's food more energy rich?*
- **Wait for a few replies and then continue.**
- **Divide participants into four groups. Ask them to brainstorm about how families could make the young child's food more energy rich.**
- **After about 5 minutes of discussion, ask participants to get back to their places.**
- **Ask one group to present the results of their discussion; ask the other groups to add any additional points.**
- **Ask participants to turn to page 344 of their *Participant's manual* and find the box WAYS TO ENRICH A CHILD'S FOOD. Refer to the list included in the box, considering what the participants already mentioned.**

WAYS TO ENRICH A CHILD'S FOOD

Foods can be made more energy and nutrient rich in a number of ways:

- For a porridge or other staple:
  - Prepare with less water and make a thicker porridge. Do not make the food thin and runny.
  - Toast cereal grains before grinding them into flour. Toasted flour does not thicken so much, so less water is needed to make porridge.
- For a soup or stew:
  - Take out a mixture of the solid pieces in the soup or stew, such as beans, vegetables, meat and the staple. Mash this to a thick puree and feed it to the child instead of the liquid part of the soup.
- Add energy- or nutrient-rich food to the porridge, soup or stew, to enrich it. This enriching is particularly important if the soup is mostly liquid with few beans, vegetables or other foods in it.
  - Replace some (or all) of the cooking water with fresh or soured milk, coconut milk or cream.
  - Add a spoonful of milk powder after cooking.
  - Mix legume, pulse or bean flour with the staple flour before cooking.
  - Stir in a paste made from nuts or seeds, such as groundnut paste (peanut butter) or sesame seed paste (tahini/sim sim).
  - Add a spoonful of margarine, ghee or oil.

► Show **Slide 44/5 – Fats and oils** and make the points that follow:



► Ask participants to turn to page 345 of their *Participant's manual* and find the box FATS AND OILS.

► Ask participants to take it in turns to read out the points.

FATS AND OILS

- Fats and oils are concentrated sources of energy. In situations where a child's energy intake is low, a little oil or fat (no more than half a teaspoon per meal), can be added to the child's bowl of food (after cooking), to give extra energy in a small volume. The addition of fatty/oily foods also makes thicker porridge or other staple softer and easier to eat.
- Fats and oils can also be used for frying foods, or spread on foods such as bread. The fat or oil should be fresh, as it can go bad with storage.
- If a large amount of oil is added, the child may become full before they have eaten all the food. This means they may get the energy from the oil but fewer of the other nutrients because they eat less food overall.
- If a child is growing well, extra oil is usually not needed. The child who takes too much oil or fried foods can become overweight.
- Sugar, jaggery and honey are also energy rich and can be added to foods in small quantities to increase the energy concentration. However, these foods do not contain any other nutrients.
- Caregivers need to watch that sugary foods do not replace other foods in the diet – for example, sweets, sweet biscuits and sugary drinks used instead of a meal for a young child.
- Essential fatty acids are needed for a child's growing brain and eyes, and for healthy blood vessels. These essential fatty acids are present in breast milk.
- For children aged over 6 months who are not breastfed, good sources of essential fatty acids are fish, avocado, nut pastes and vegetable oil. Animal-source foods also provide essential fatty acids (see SESSION 45: FOODS TO FILL THE IRON AND VITAMIN A GAPS).

► ***Optional***: If fermented porridge or germination of grain for flour is used in your area, ask participants to turn to page 346 of their *Participant's manual* and find the box FERMENTED PORRIDGE OR GERMINATION OF GRAIN FOR FLOUR. Ask participants to take it in turns to read out the points.

Fermented porridge or germination of grain for flour

Fermented porridge

- Fermented porridge can be made in two ways – the grain can be mixed with water and set to ferment overnight or longer before cooking, or the grain and water are cooked into porridge and then fermented. Sometimes, some of a previous batch of the fermented porridge (starter) is added to speed up the process of fermentation. Porridge made from germinated grain can also be fermented.
- The advantages of using fermented porridge are:
  - It is less thick than plain porridge, so more grain/flour can be used for the same amount of water. This means each cupful of porridge contains more energy and nutrients than plain (unfermented) porridge.
  - Children may prefer the taste of "sour" porridge and so eat more.
  - The absorption of iron and some other minerals is better from the soured porridge.
  - It is more difficult for harmful bacteria to grow in soured porridge, so it can be kept for a day or two.
- Grain is also fermented to make alcohol. However, the short fermentation talked about here to make fermented porridge will not make alcohol or make the child drunk!

Germinated or sprouted flour

- Cereal or legume seeds are soaked in water and then left to sprout. The grains are then dried (sometimes toasted) and ground into flour. A family can do this at home but it is more common to buy flour that is already germinated.
- Mixed flours that include germinated (or malted) flour in addition to the main flour may be available in the store.
- If families in your area use germinated grain, the following ways can be used to make a thicker and more nutritious porridge:
  - Use this germinated flour to make porridge. This type of flour does not thicken much during cooking, so less water can be used.
  - Add a pinch of the germinated flour to cooked thick porridge that has cooled a little bit. The porridge should be boiled again for a few minutes after adding the germinated flour. This addition will make the porridge softer and easier for the child to eat.
- Germination also helps more iron to be absorbed.

V. Summarize the session — 3 minutes

- ▸ **Ask participants whether they have any questions, and try to answer them.**
- ▸ **Make these points:**
  - ¤ In this session, we talked about the importance of filling the energy gap.
  - ¤ We had one Key message:
    - Key message 3: Foods that are thick enough to stay on the spoon give more energy to the child
- ▸ **Display the flipchart page with the Key message from this session. Keep this message together with previous Key messages displayed throughout the course.**
- ▸ **Explain that a summary of this session can be found on pages 343–346 of the *Participant's manual*. The list of Key messages can be found on page xiv of the *Participant's manual*.**

Notes

SESSION 45

Foods to fill the iron and vitamin A gaps

Objectives

After completing this session, participants will be able to:

- list the local foods that can fill the nutrient gaps for iron and vitamin A
- explain the importance of animal-source foods
- explain the importance of legumes
- explain the use of processed complementary foods
- explain the fluid needs of the young child
- list the Key messages from this session

Session outline . . . . . 80 minutes

Participants are all together for a lecture presentation by one trainer.

I.	Introduce the session, present **Slide 45/1**	2 minutes
II.	Outline foods that can fill these gaps – iron (**Slide 45/2**)	15 minutes
III.	Discuss the importance of animal-source foods (**Slide 45/3**)	5 minutes
IV.	Discuss the importance of legumes (**Slide 45/4**)	5 minutes
V.	Discuss iron absorption	5 minutes
VI.	Outline foods than can fill the vitamin A gap (**Slides 45/5** and **45/6**)	5 minutes
VII.	Discuss the use of fortified complementary foods	10 minutes
VIII.	Discuss the use of micronutrient powders	10 minutes
IX.	Discuss the fluid needs of the young child	5 minutes
X.	Conduct Exercise 45.A What is in the bowl?	15 minutes
XI.	Summarize the session	3 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides.
- Study the **Slides 45/1** to **45/6** and the text that goes with them, so that you are able to present them.
- You need a flipchart and markers.
- Write the three Key messages from this session on a flipchart page. Keep it covered until later in the session:
  - Key message 4: Animal-source foods are especially good for children, to help them grow strong and lively
  - Key message 5: Peas, beans, lentils, nuts and seeds are good for children
  - Key message 6: Dark-green leaves and yellow-coloured fruit and vegetables help a child to have healthy eyes and fewer infections
- You need tape or other means of fixing the page to the wall or board.
- You need a bowl or plate that would be used when feeding a young child.
- You need examples of locally available processed complementary foods (empty packets are suitable).

- Adapt lists of foods to reflect those available locally. Review the section on the use of animal-source foods and adapt it if necessary for the local situation.
- Have ready COUNSELLING CARD 17: FOOD VARIETY, COUNSELLING CARD 21: HOW TO ADD MICRONUTRIENT POWDER (MNP) TO COMPLEMENTARY FOODS, and the *Guidance on the use of counselling cards*.
- Read the **Further information** sections, so that you are familiar with the ideas that they contain, so that you can answer participants' questions.

As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the session — 2 minutes

► Make these points:

¤ So now, our child has an energy-rich, thick staple in their bowl to help fill the energy gap (*hold up the child's bowl*).

¤ In a similar way, there are also gaps for iron and vitamin A.

► Show **Slide 45/1 – Session 45 – objectives** and read out the objectives:

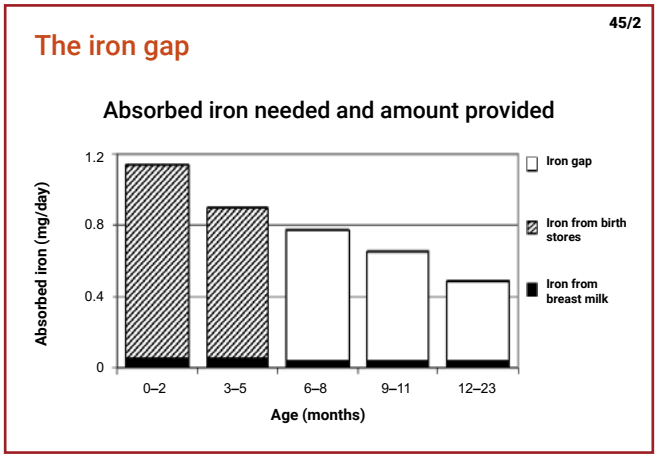
45/1

Session 45: Foods to fill the iron and vitamin A gaps – objectives

After completing this session, participants will be able to:
- list the local foods that can fill the nutrient gaps for iron and vitamin A
- explain the importance of animal-source foods
- explain the importance of legumes
- explain the use of processed complementary foods
- explain the fluid needs of the young child
- list the Key messages from this session

II. Outline foods that can fill these gaps – iron 15 minutes

- **Make these points:**
  - The young child needs iron to make new blood, to assist in growth and development and to help the body to fight infections.
- **Show Slide 45/2 – The iron gap**
- **Ask participants to turn to their neighbours and in groups of 2–3, examine the image of Slide 45/2 on page 349 in the *Participant's manual* and discuss the following questions (listed on the flipchart):**
  - What happens to the amount of iron needed by the child over time?
  - For how long does iron from birth stores cover the needs of the child?
  - For how long does breast milk provide iron?
  - At what age does a child usually first experience an iron gap?
  - What happens if the child does not have enough intake of iron to fill this gap?



- **Make these points, referring to the responses by the participants:**
  - In this graph, the top of each column represents the amount of absorbed iron that is needed per day by the child. A full-term baby is born with good stores of iron to cover their needs for the first 6 months (*point to the striped area*).
  - The black area along the bottom of the columns shows us that there is some iron provided by breast milk all the time breastfeeding continues (*point to the black area*).
  - The young child grows faster in the first year than in the second year. This is why the need for iron is higher when the child is younger.
  - However, the iron stores are gradually used up over the first 6 months, so after that time we see a gap between the child's iron needs and what they receive from breast milk. This gap needs to be filled by complementary foods (*point to white area – this is the iron gap*).
  - If the child does not have enough iron, they will become anaemic and will be more likely to get infections and to recover slowly from infections. The child will also grow and develop slowly.
  - Zinc is another nutrient that helps children to grow and stay healthy. It is usually found in the same foods as iron, so we assume that if a child is eating foods that are rich in iron, they are also receiving zinc.
  - Your goals, as health workers, are:
    - to identify local foods and food preparations that are rich sources of iron
    - to assist families to use these iron-rich foods to feed their young children.

III. Discuss the importance of animal-source foods — 5 minutes

- **Make this point:**
  - We will now look at the importance of animal-source foods in the child's diet.
- **Read the following section only if meat is eaten in your area.**

OMIT THIS SECTION IF MEAT IS NOT EATEN IN THE AREA

- **Make these points:**
  - Foods from animals, the flesh (meat) and organs/offal such as liver and heart, as well as milk, yoghurt, cheese and eggs are rich sources of many nutrients.
  - *Ask: Which of these foods are commonly given to children in your area?*
- **Wait for a few replies and then continue.**
- **List the replies on the flipchart.**
  - The flesh and organs of animals, birds and fish (including shellfish and tinned fish), are the best sources of iron and zinc.
  - Liver is a good source of not only iron but also vitamin A.
  - Animal-source foods should be eaten daily, or as often as possible. This is especially important for the non-breastfed child.
  - Some families do not give meat to their young children because they think it is too hard for the children to eat. Or they may be afraid there will be bones in fish that would make the child choke.
  - *Ask: What are some ways of making these foods easier for the young child to eat?*
- **Wait for a few replies and then continue.**
  - Some ways of making these foods easier to eat for young children are to:
    - cook chicken liver or other meat with rice or other staple or vegetables, and then mash them together
    - scrape meat with a knife to make soft small pieces
    - pound dried fish, so the bones are crushed to powder and then sieve before mixing with other foods.
  - Animal-source foods may be expensive for families. However, to add even small amounts of an animal-source food to the meal adds nutrients. Organ meats such as liver or heart are often less expensive and have more iron than other meats.

End of meat section

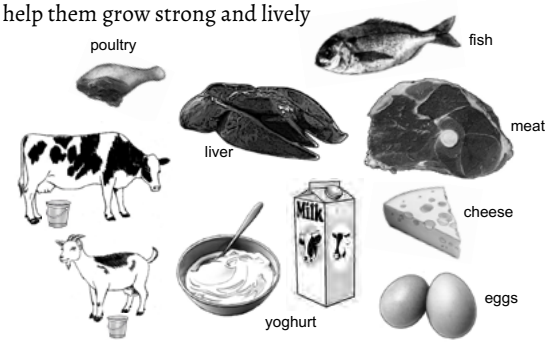
- **Read the following section for all areas, whether meat is eaten or not. Make the following points:**
  - Foods from animals, such as milk and eggs, are good for children because they are high in protein and other nutrients. However, milk and milk products, such as cheese and yoghurt, are not good sources of iron.
  - Milk fat (cream) contains vitamin A, so foods made from whole milk are good sources of vitamin A.
  - Foods made from milk (whole milk or skimmed or powdered milk) and any food containing bones, such as pounded dried fish, are good sources of calcium to help bones to grow strong.
  - Egg yolk is another source of nutrients and rich in vitamin A.
  - It can be hard for children to meet their iron needs without a variety of animal-source foods in their diet. Fortified or enriched foods, such as fortified flours, pasta, cereals or instant foods made for children, help to meet these nutrient needs.
  - Some children may need supplements if they do not eat enough iron-containing foods or if they have particularly high needs for iron.
  - When talking with families, give this Key message:

► Show **Slide 45/3(A or B) – KEY MESSAGE 4: ANIMAL-SOURCE FOODS** and ask a participant to read out the Key message:

45/3A

KEY MESSAGE 4: ANIMAL-SOURCE FOODS

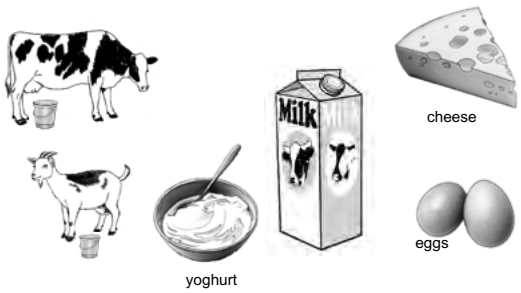
Animal-source foods are especially good for children, to help them grow strong and lively



45/3B

KEY MESSAGE 4: ANIMAL-SOURCE FOODS

Animal-source foods are especially good for children, to help them grow strong and lively



IV. Discuss the importance of legumes — 5 minutes

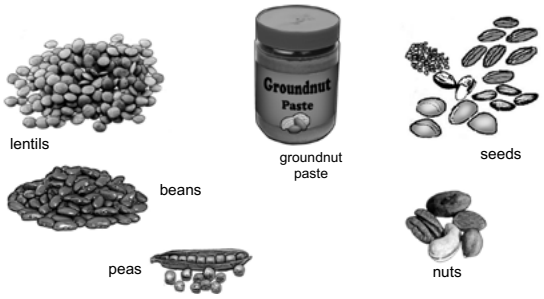
¤ Legumes or pulses such as beans, peas and lentils as well as nuts and seeds, are good sources of protein. Legumes are a source of iron as well.

► Show **Slide 45/4 – KEY MESSAGE 5: LEGUMES** and read out the Key message:

45/4

KEY MESSAGE 5: LEGUMES

Peas, beans, lentils, nuts and seeds are also good for children



¤ *Ask: What types of legumes are used in the area?*

► Wait for a few replies and then continue.

► List the replies on the flipchart.

¤ *Ask: What are ways that legumes, nuts and seeds could be prepared that would be easier for the child to eat and digest?*

► Wait for a few replies and then continue.

► Refer to participants' replies as you make these points.

- ¤ Some ways these foods could be prepared in a form that would be easier for the child to eat and digest are:
  - Soak beans before cooking and throw away the soaking water.
  - Remove skins by soaking raw seeds and then rubbing the skins off before cooking.
  - Boil beans, then sieve to remove coarse skins.
  - Toast or roast nuts and seeds and pound to a paste.
  - Add beans/lentils to soups or stews.
  - Mash cooked beans well.
- ¤ Eating a variety of foods at the same meal can improve the way the body uses the nutrients. For example, combining a cereal with a pulse (for example, rice and beans), or adding a milk product to a cereal or grain (maize meal with milk) is helpful.

V. Discuss iron absorption — 5 minutes

► Make these points:

- ¤ Pulses and dark-green leaves are sources of iron.
- ¤ However, it is not enough that a food has iron in it, the iron must also be in a form that the child can absorb and use.

► Ask participants to turn to page 351 of their *Participant's manual* and find the box IRON ABSORPTION.

► Ask participants to take turns to read out the points.

IRON ABSORPTION

The amount of iron that a child absorbs from food depends on:

- the amount of iron in the food
- the type of iron (iron from meat and fish is better absorbed than iron from plants and eggs)
- the types of other foods present in the same meal (some **increase** iron absorption and others **reduce** absorption)
- whether the child has anaemia (more iron is absorbed if the child has anaemia).

Eating these foods at the same meal increases the amount of iron absorbed from eggs and plant foods such as cereals, pulses, seeds and vegetables:

- foods that are rich in vitamin C, such as tomato, broccoli, guava, mango, pineapple, papaya, orange, lemon and other citrus fruits
- small amounts of the flesh or organs/offal of animals, birds, fish and other sea foods.

Iron absorption is decreased by:

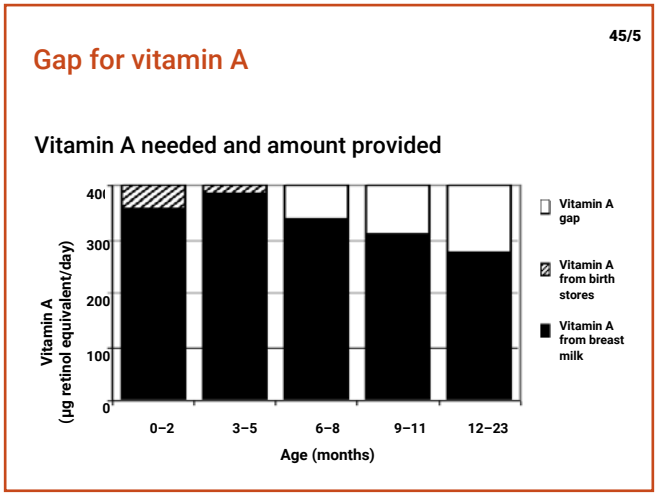
- drinking teas and coffee
- foods that are high in fibre such as bran
- foods that are rich in calcium.[1]

[1] Foods that are rich in calcium such as milk and cheese inhibit iron absorption, but are needed for calcium intake.

- **Display the flipchart page with the Key messages from this section. Keep these messages together with previous Key messages displayed throughout the course.**
  - We have two more Key messages:
    - KEY MESSAGE 4: ANIMAL-SOURCE FOODS ARE ESPECIALLY GOOD FOR CHILDREN, TO HELP THEM GROW STRONG AND LIVELY
    - KEY MESSAGE 5: PEAS, BEANS, LENTILS, NUTS AND SEEDS ARE ALSO GOOD FOR CHILDREN
- **If a programme for iron supplementation exists in your area, mention it here.**

VI. Outline foods that can fill the vitamin A gap — 5 minutes

- **Make these points:**
  - (*Show bowl*) We now have a staple in our child's bowl to fill the energy gap, and foods that will help to fill the iron gap.
  - Another important nutrient is vitamin A, which is needed for healthy eyes and skin and to help the body fight infections.
- **Show Slide 45/5 – Gap for vitamin A and make the points that follow:**



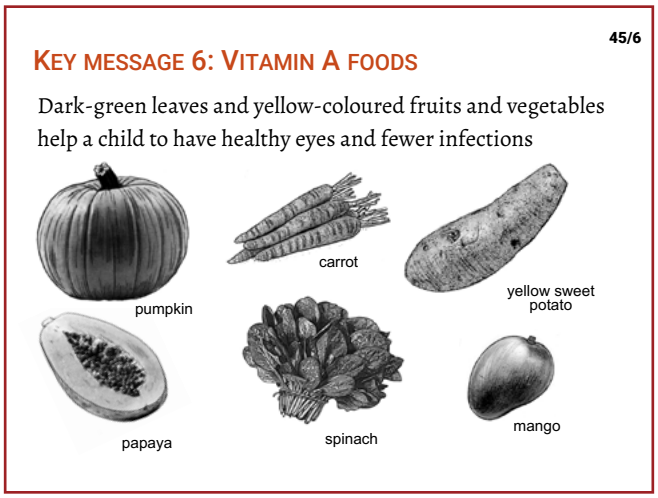
  - Again, on this graph, the top of each column represents the amount of vitamin A that the child needs each day. Breast milk supplies a large part of the vitamin needed, provided the child continues to receive breast milk and the mother's diet is not deficient in vitamin A. As the young child grows, there is a gap for vitamin A that needs to be filled by complementary foods (*point to the white area – this is the gap to be filled*).
  - Good foods to fill this gap are dark-green leaves and yellow-coloured vegetables and fruits.
  - Other sources of vitamin A that we have mentioned already are:
    - organ foods/offal (liver) from animals
    - milk and foods made from milk such as butter, cheese and yoghurt
    - egg yolks
    - margarine, dried milk powder and other foods fortified with vitamin A.
  - Unbleached red palm oil is also rich in vitamin A.
  - Vitamin A can be stored in a child's body for a few months. Encourage families to feed foods that are rich in vitamin A as often as possible when these foods are available, ideally every day. A variety of vegetables and fruits in the child's diet helps to meet many nutrient needs.

- Remember breast milk supplies much of the vitamin A required. A child that is not breastfed needs a diet rich in vitamin A.
- In many countries vitamin A supplementation programmes are available, for example Integrated Management of Childhood Illness (IMCI).

► **If a programme for vitamin A supplementation exists in your area, mention it here.**

► **Show Slide 45/6 – Key message 6: Vitamin A foods and make the following point:**

- When talking with caregivers, give this Key message:



► **Read the Key message from the slide.**

► **Display the flipchart page with the Key message from this section. Keep this message displayed throughout the course.**

VII. Discuss the use of fortified complementary foods — 10 minutes

► **Make these points:**

- In some areas, there are fortified complementary foods available. For example, flour or a baby cereal with added iron and zinc.
- *Ask: What products do you see in your area that are fortified?*

► **Wait for a few replies, and then continue.**

- Fortified processed complementary foods may be sold in packets, cans or jars, or from food stalls. These may be produced by international companies and imported, or they may be made locally. They may also be available through food programmes for young children.

► **Ask participants to turn to page 352 of their *Participant's manual* and find the box FORTIFIED PROCESSED COMPLEMENTARY FOODS. Ask participants to take turns to read out the points.**

Fortified processed complementary foods

When discussing fortified processed complementary foods with caregivers, there are some points to consider:

What are the main contents or ingredients?
The food may be a staple or cereal product or a flour. It may have some vegetables, fruit or animal-source foods in it.

Is the product fortified with micronutrients such as iron, vitamin A or other vitamins?
Added iron and vitamins can be useful, particularly if there are few other sources of iron-containing foods in the diet.

Does the product contain ingredients such as sugar and/or oil to add energy?
These added ingredients can make these products a useful source of energy, if the child's diet is low in energy. Limit use of foods that are high in sugar and oil/fat but with few other nutrients.

What is the cost compared to similar home-produced foods?
If processed foods are expensive, spending money on them may result in families being short of money.

Does the label or other marketing imply that the product should be used before 6 months of age or as a breast-milk substitute?
Complementary foods should not be marketed or used in ways that undermine breastfeeding. To do so is a violation of the *International code of marketing of breast-milk substitutes*[1] and subsequent resolutions, and it should be reported to the company concerned and the appropriate government authority.

VIII. Discuss the use of micronutrient powders — 10 minutes

▸ Make these points:

- We will now discuss multiple micronutrient powders (MNPs) for home-fortification of complementary foods.
- **Why use MNPs?**
- A diet of foods with too few micronutrients will harm the health and development of young children from 6 up to 24 months of age.
- MNPs are vitamin and mineral powders that can be added directly to soft or mushy semi-solid or solid cooked foods prepared in the home, to improve the nutritional quality of foods for young children.
- The single-serving sachets allow families to fortify a young child's food at an appropriate and safe level.

▸ Ask participants to turn to page 353 of their *Participant's manual* and find the section How to add MNPs to complementary foods. Read it through with them.

- **How to add MNPs to complementary foods**

1. Wash the hands with soap and water.
2. Prepare cooked food – thick porridge, mashed potato, or any soft or mushy semi-solid or solid food.
3. Make sure that the food is at a temperature ready for eating.
4. Do NOT add the MNPs to hot food: if the food is hot, the iron will change the colour and taste of the food.
5. Do NOT add the MNPs to any liquids (water, tea or watery porridge): in cold liquids, MNPs lump and don't mix well but float on top; the iron will dissolve instantly and change the colour and taste of the food.
6. Separate a small portion of the soft or mushy semi-solid or solid cooked food within the child's bowl.
7. Pour the entire contents of one sachet of MNPs into the small portion of food:
   - Shake the unopened sachet to ensure that the powder is not clumped.
   - Tear open the sachet and pour the entire contents into the small amount of food.
   - Mix the sachet contents and the small portion of food well.

[1] International code of marketing of breast-milk substitutes. Geneva: World Health Organization; 1981 (http://www.who.int/nutrition/publications/code_english.pdf).

8. Feed the child this small portion of food, so that they will eat all of the micronutrients in the first few spoonfuls, before giving the rest of the meal.
9. The food should be consumed within 30 minutes of mixing with the MNPs.
10. You can add the entire packet of MNPs to any meal. However, only one sachet of MNPs should be given during a day.

- Ask participants to look at COUNSELLING CARD 21: HOW TO ADD MICRONUTRIENT POWDER (MNP) TO COMPLEMENTARY FOODS, and in the *Guidance on the use of counselling cards* at the KEY PRACTICES AND DISCUSSION POINTS for that Counselling card. Tell them to notice that what is in the booklet is exactly what has been discussed.
- Read through the remaining sections on MNPs on page 353 of the *Participant's manual*.
  - **Possible side-effects of MNPs**
  - Any side-effects are minimal and usually harmless/of short duration.
    - Colour of stool: dark stool indicates that iron is being absorbed into the child's body.
    - Consistency of stool: the child may have softer stools or a mild form of constipation during the first 4–5 days.
  - Use of MNPs complements vitamin A supplementation, but does not replace it. Both are needed.
  - Accidental overdosing is highly unlikely. In order to reach toxicity levels, as many as 20 sachets would have to be consumed.
  - **Who should NOT be given MNPs?**
  - Children receiving ready-to-use therapeutic food (RUTF) for management of severe acute malnutrition should not be given MNPs.
  - Stop giving MNPs during treatment for malnutrition (milk-fortified corn–soy blend [CSB++] and ready-to-use supplementary food [RUSF]), as children are already getting extra iron and the vitamins they need.
  - Also stop giving MNPs to a child with a fever and who is being treated for an infectious disease.
  - **Note:** In malaria-endemic areas, MNPs (and other measures that provide iron such as syrup and drops) can be given; however, other measures to prevent, diagnose and treat malaria should also be implemented.

IX. Discuss the fluid needs of the young child — 5 minutes

- Make these points:
  - A baby who is exclusively breastfeeding receives all the liquid they need in the breast milk and does not require extra water. Likewise, a baby who is under 6 months of age and only receiving replacement milk does not need extra water.
  - However, when other foods are added to the diet, the baby may need extra fluids.
  - How much extra fluid to give depends on what foods are eaten, how much breast milk is taken and the child's activity and temperature. Offer fluids when the child seems thirsty.
  - Extra fluid is needed if the child has a fever or diarrhoea.
  - *Ask: What types of drinks are given to young children aged between 6 and 24 months?*
- Wait for a few responses and then continue.
- Ask participants to turn to page 354 of their *Participant's manual* and find the box FLUID NEEDS OF THE YOUNG CHILD. Ask participants to take it in turns to read out the points.

Fluid needs of the young child

- Water is good for thirst. A variety of pure fruit juices can be used also. Too much fruit juice may cause diarrhoea and may reduce the child's appetite for foods.
- Drinks that contain a lot of sugar may actually make the child thirstier, as their body has to deal with the extra sugar. If packaged juice drinks are available in your area, find out which ones are pure juices and which ones have added sugar. Fizzy drinks (sodas) are not suitable for young children.
- Teas and coffee reduce the iron that is absorbed from foods. If they are given, they should not be given at the same time as food, or within 2 hours before or after food.
- Sometimes a child is thirsty during a meal. A small drink will satisfy the thirst and they may then eat more of their meal.
- Drinks should not replace foods or breastfeeding. If a drink is given with a meal, give only small amounts and leave most until the end of the meal. Drinks can fill up the child's stomach, so that they do not have room for foods.
- Remember that children who are not receiving breast milk need special attention and special recommendations. A non-breastfed child aged 6 up to 24 months needs approximately 2–3 cups of water per day in a temperate climate, and 4–6 cups of water per day in a hot climate. This water can be incorporated into porridges or stews, but clean water should also be offered to the child several times a day, to ensure that the infant's thirst is satisfied.

X. Conduct Exercise 45.A What is in the bowl? 15 minutes

▸ **Ask the participants to sit in their groups. Ask them to turn to page 355 of their *Participant's manual*, to Exercise 45.A What is in the bowl?**

▸ **Explain the exercise:**

- Now we will put these recommendations or Key messages into practice. Each group has a picture of a mother feeding a child from a bowl. In your group, think of the foods available to families in your area that could be used to form one meal for a young child (*assign each group a child's age – 7 months, 10 months, 12 months, 15 months*).
- Although we talk about types of foods such as staples, legumes, foods from animals, dark-green leaves and yellow-coloured fruits and vegetables, and so on, it is easier and more natural for caregivers to think in terms of the meals they usually prepare or foods that taste good together.
- Families may give complementary foods that are:
  - specially prepared foods
  - the usual family foods that are modified to make them easy to eat and provide enough nutrients.
- For example, a caregiver may specially prepare a porridge for the baby while the rest of the family eats rice and bean stew. Or, the caregiver may take some suitable foods out of the family meal and mash these foods to a soft consistency that is easy for the young child to eat.
- In this exercise, try to use foods that would be eaten in an average family meal in your area, not a rich family.
- At this time, focus on an example of foods a family could use. We will discuss the quantity of food to give later.
- You will describe your meal to the other groups and give the Key messages connected with the foods you have chosen.

▸ **Trainers sit with their group, helping as needed. Aim to get foods listed that reflect the Key messages learnt so far (Key messages 1–6). However, it is not necessary to use all 6 Key messages with one meal. If unsuitable foods are listed, gently discuss why these foods might be considered and whether others might be used instead. Allow 7 minutes to decide on the meal and why they choose each food. Remind participants that they can find a list of the Key messages on page xiv of their *Participant's manual*.**

- Go back to the whole group. Ask one person from each group to present their meal. Ask the whole group if the "bowl" includes foods that match the Key messages, pointing out the foods in the bowl using COUNSELLING CARD 17: FOOD VARIETY, as Key messages are mentioned.
- Thank participants at the end for their meal suggestions. Display the exercise sheets so the groups can see them.

EXERCISE 45.A WHAT IS IN THE BOWL?

Choose foods that are available to families in your area to form one meal for a young child, aged _____

What are the Key messages you could give for the foods that you have chosen?

XI. Summarize the session 3 minutes

- **Ask participants whether they have any questions, and try to answer them.**
- **Make these points:**
  - In the last two sessions, we talked about the recommendations about foods for young children.
  - The most difficult gaps to fill are usually for:
    - energy
    - iron and zinc
    - vitamin A.
  - In the previous sessions, we saw the KEY MESSAGES 1, 2 and 3 (*point to where they are displayed*):
    - KEY MESSAGE 1: BREASTFEEDING FOR 2 YEARS OR LONGER HELPS A CHILD TO DEVELOP AND GROW STRONG AND HEALTHY
    - KEY MESSAGE 2: STARTING OTHER FOODS IN ADDITION TO BREAST MILK AT 6 MONTHS HELPS A CHILD TO GROW WELL
    - KEY MESSAGE 3: FOODS THAT ARE THICK ENOUGH TO STAY ON THE SPOON GIVE MORE ENERGY TO THE CHILD
  - In this session, there were three new Key messages to use with families, to discuss ways to fill the gaps for iron and vitamin A.
- **Point to the flipchart page with the three Key messages from this session:**
  - KEY MESSAGE 4: ANIMAL-SOURCE FOODS ARE ESPECIALLY GOOD FOR CHILDREN, TO HELP THEM GROW STRONG AND LIVELY
  - KEY MESSAGE 5: PEAS, BEANS, LENTILS, NUTS AND SEEDS ARE GOOD FOR CHILDREN
  - KEY MESSAGE 6: DARK-GREEN LEAVES AND YELLOW-COLOURED FRUIT AND VEGETABLES HELP A CHILD TO HAVE HEALTHY EYES AND FEWER INFECTIONS
- **Keep these messages together with previous Key messages displayed throughout the course.**
- **In some areas, there are supplementation programmes for other important micronutrients, for example iodine. If such programmes exist in your area, mention them here.**
- **Explain that a summary of this session can be found on pages 349–355 of the *Participant's manual*. The list of Key messages can be found on page xiv of the *Participant's manual*.**

Further information

Iron

Absorbed iron is referred to in the text. This is the iron that passes into the body after it has been released from food during digestion. Only a small proportion of the iron present in food is absorbed. The rest is excreted in the faeces.

If a baby is born preterm or of low birth weight, these body stores will be less, so these babies will need iron supplements, usually iron drops, from about 2 months of age.

If fresh liquid milk is given to young children, it should be boiled or pasteurized (see SESSION 49: HYGIENIC PREPARATION OF FEEDS).

It is very difficult, if not impossible, for young children to meet the recommended intake of iron and zinc from foods unless meats are eaten regularly, ideally daily, or as frequently as possible. Organ meats are highest in iron. Mineral and vitamin supplements may be needed by children who do not have meat.

In some parts of the world, iron pots are used for cooking. Iron absorption is increased by cooking in iron pots, particularly if the food is acidic.

Vitamin A

If a mother is deficient in vitamin A during pregnancy, the baby will have lower stores at birth and there will be less vitamin A in the breast milk. Supplements may be used for pregnant and newly delivered mothers in areas where vitamin A deficiency is common.

Fluids

Large quantities of artificial sweeteners such as saccharin or aspartame are not good for young children. When tea is referred to in the text, this includes black tea, green tea and herbal or bush teas.

Notes

SESSION 46

Variety, frequency and quantity of feeding

Objectives

After completing this session, participants will be able to:

- explain the importance of using a variety of foods
- describe the frequency of feeding complementary foods
- outline the quantity of complementary food to offer
- list the recommendations for feeding a non-breastfed child
- list the Key messages from this session

Session outline . . . . . 60 minutes

Participants are all together for a lecture presentation by one trainer.

I. Introduce the session, present **Slide 46/1** . . . . . 2 minutes
II. Discuss the importance of using a mixture or variety of foods (**Slides 46/2** to **46/4**) . . . . . 20 minutes
III. Discuss the frequency of feeding complementary foods (**Slides 46/5** to **46/8**) . . . . . 15 minutes
IV. Outline the quantity of complementary food to be offered (**Slide 46/9**) . . . . . 10 minutes
V. Conduct Exercise 46.A Amounts to give . . . . . 10 minutes
VI. Summarize the session . . . . . 3 minutes

Preparation

Participants are all together for a lecture presentation by one trainer, followed by group work with all trainers.

- Refer to the Introduction for guidance on giving a presentation with slides and facilitation of working group discussion.
- Study the **Slides 46/1** to **46/9** and the text that goes with them, so that you are able to present them. Make sure, particularly, that you understand the graphs so you can explain these clearly to the participants.
- Determine the local measures to use in the box Amounts of food to offer. Show approximate amounts using a common local cup, bowl or other containers.
- You need a flipchart and markers.
- Write the Key messages from this session on a flipchart page. Keep it covered until later in the session:
  - Key message 7: A growing child needs 2–4 meals a day, plus 1–2 snacks if hungry: give a variety of foods
  - Key message 8: A growing child needs increasing amounts of food
- You need tape or other means of fixing the page to the wall or board.
- Have ready Counselling card 12: The non-breastfed child from 6 up to 24 months, Counselling card 16: Start complementary feeding when your baby reaches 6 months, Counselling card 17: Food variety, Counselling card 18: Complementary feeding from 6 up to 9 months, Counselling Card 19: Complementary feeding from 9 up to 12 months and Counselling card 20: Complementary feeding from 12 up to 24 months, and the *Guidance on the use of counselling cards*.
- Read the **Further information** sections, so that you are familiar with the ideas that they contain, so that you can answer participants' questions.

As you follow the text, remember:

- ▸ indicates an instruction to you, the trainer.
  - ¤ indicates what you say to participants.

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the session — 2 minutes

- ▸ Make these points:
  - ¤ We have discussed what types of food help to fill the gaps in children over 6 months of age. However, just offering suggestions for the types of food is not enough information for the caregivers.
  - ¤ Ask: *What other questions are caregivers likely to have about feeding young children?*
- ▸ Wait for a few replies and then continue.
  - ¤ Caregivers need to know what amount of food to give and how often to give it. They may also ask about how to feed a child who does not want to eat. This will be discussed in a later session.
- ▸ Show **Slide 46/1 – Session 46 – objectives** and read out the objectives:

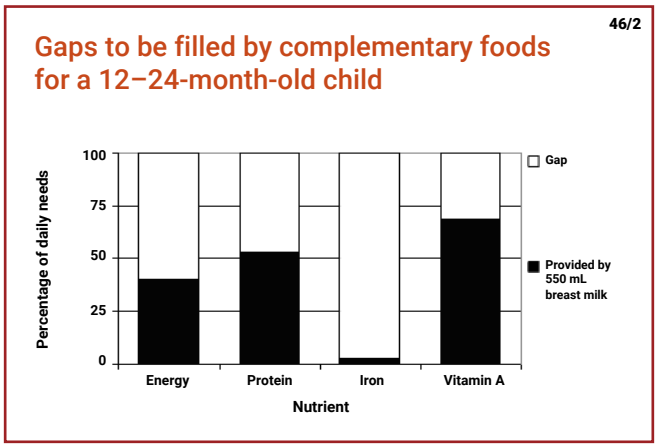
46/1

Session 46: Variety, frequency and quantity of feeding – objectives

After completing this session, participants will be able to:
- explain the importance of using a variety of foods
- describe the frequency of feeding complementary foods
- outline the quantity of complementary food to offer
- list the recommendations for feeding a non-breastfed child
- list the Key messages from this session

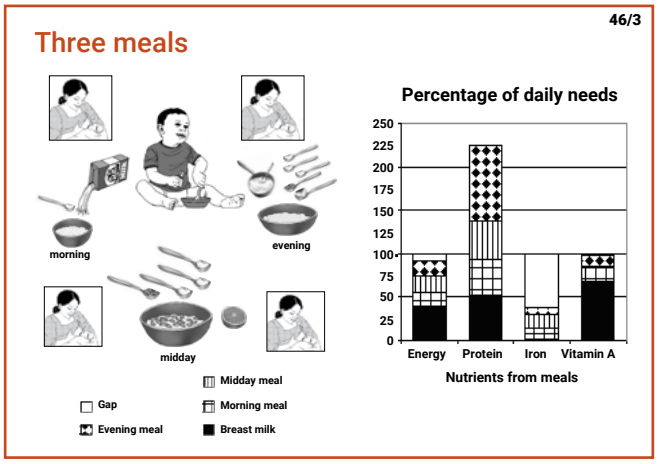
II. Discuss the importance of using a mixture or variety of foods 20 minutes

- **Make these points:**
  - Most adults and older children eat a mixture or variety of foods at mealtimes. In the same way, it is important for young children to eat a mix of good complementary foods. Often the food preparations of the family meals include all or most of the appropriate complementary foods that young children need.
  - When you build on the usual food preparations in a household, it is easier for families to feed their young children a diet with good complementary foods.
  - Earlier we looked at the difference between the young children's needs and the amount of energy, vitamin A and iron supplied by breast milk. If we put the day's needs on to one graph, it looks like this:
- **Show Slide 46/2 – Gaps to be filled by complementary foods for a 12–24-month-old child and make the points that follow:**



  - In Sessions 11 and 23 of this course, we talked about the importance of breastfeeding and the nutrients breast milk can supply in the second year of life.
  - On this graph, the top line represents how much energy, protein, iron and vitamin A are needed by an "average" child aged 12–23 months. The dark section in each column indicates how much breast milk supplies at this age if the child is breastfeeding frequently.
  - Notice that:
    - Breast milk provides important amounts of energy and nutrients even in the second year.
    - None of the columns are full. There are gaps to be filled by complementary foods.
    - The biggest gaps are for iron and energy.
  - Now we will look at an example of a day's food for a young child.
- **Distribute participants into two groups. Each group will analyse the printout of one slide related to the percentage of needs. Group 1 will have the Slide 46/3 (three meals). Group 2 will analyse Slide 46/5 (three meals and two snacks)**
- **Make the following points:**
  - Each group will work with one trainer/facilitator.
  - The groups should analyse what nutrients each meal provides and discuss whether the foods are filling the energy and nutrient gaps; which gaps are filled and which gaps remain; and how the gaps could be covered.
- **After about 10 minutes restart the plenary session.**

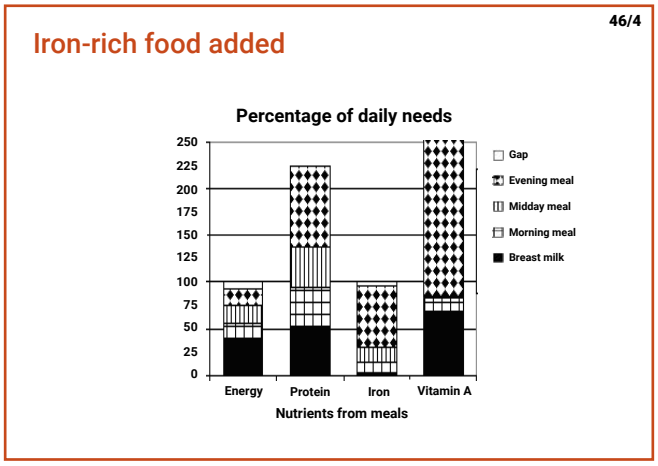
- Show **Slide 46/3 – Three meals**.
- Make the points that follow and show how each meal builds on the graph:
  - This is (child's name) who is 15 months old. The daily needs for this age of child is shown by the line at 100%.



  - (Name) continues breastfeeding[1] as well as eating complementary foods. The breast milk gives energy, protein, some iron and vitamin A *(show where breast milk is on the graph – dark area at bottom)*.
  - This is what he has to eat in a day in addition to breastfeeding:
    - **Morning**: a bowl of thick porridge, with milk and a small spoon of sugar (*show where this meal is on the graph*).
    - **Midday**: a full bowl of food – three big spoonfuls of rice, one spoonful of beans and half an orange. The vitamin C in the orange helps the iron in the beans to be absorbed (*show where this meal is on the graph*).
    - **Evening**: a full bowl of food – three big spoonfuls of rice, one spoonful of fish, one spoonful of green leaves (*show where this meal is on the graph*).
  - (Name's) family give him a variety of good foods and a good quantity at each meal. He has a staple plus some animal-source foods, beans, a dark-green vegetable and a citrus fruit.
- Ask the representative of group 1 to point out: (1) what nutrients the morning meal provides; (2) what nutrients the midday meal provides; and (3) what nutrients the evening meal provides.
- Then ask them to indicate whether the foods are filling the energy and nutrients gaps; which gaps are filled; and which gaps remain.
- Ask other participants to add anything they find missing.
  - *Ask: How could the child get more iron? If the diet has an iron gap, what other nutrient is likely to be missing? What are good sources of this nutrient?*
  - *What could be done to fill the energy gap?*
- Fill in gaps from the key information below:
  - The protein and vitamin A gaps are more than filled. However, these meals do not fill this child's needs for iron or energy.
  - *Ask: How could this child get more iron?*
- Wait for a few replies and then continue.
  - If meat is eaten in the area, (name) could get more iron if he ate an animal-source food that is high in iron, such as liver or other organ meat. Animal-source foods are special foods for children. These foods should be eaten every day, or as often as possible.
  - If meat is eaten in the area, (name's) family could give him a spoonful of liver instead of the fish. This fills his iron gap, as shown in the following graph.

[1] Approximately 550 mL of breast milk per day.

▸ Show **Slide 46/4 – Iron-rich food added** and make the points that follow:



- ¤ However, the energy gap is still not filled. Next, we will look at ways of filling this gap.
- ¤ If foods fortified with iron are available, these could be used to help fill the iron gap.

▸ Remind participants of iron-fortified foods, if they were discussed in the previous session, then continue:

- ¤ If an iron-rich food is not available, you as the health worker may need to recommend using a micronutrient supplement to ensure the child gets sufficient iron and other micronutrients.
- ¤ Another nutrient where it is difficult to fill the gap from family foods is zinc. The best sources of zinc in the diet are meat and fish, the same foods as iron-rich foods.
- ¤ Foods fortified with zinc can be used when it is not possible for a young child to eat enough meat, fish or liver.
- ¤ However, in the graph, the energy gap is still not filled. Next, we will look at ways of filling this gap.

III. Discuss the frequency of feeding complementary foods 15 minutes

- ¤ *Ask: What could be done to fill the energy gap?*

▸ Discuss participants' responses and fill in any gaps/missing information.

▸ Make these points:

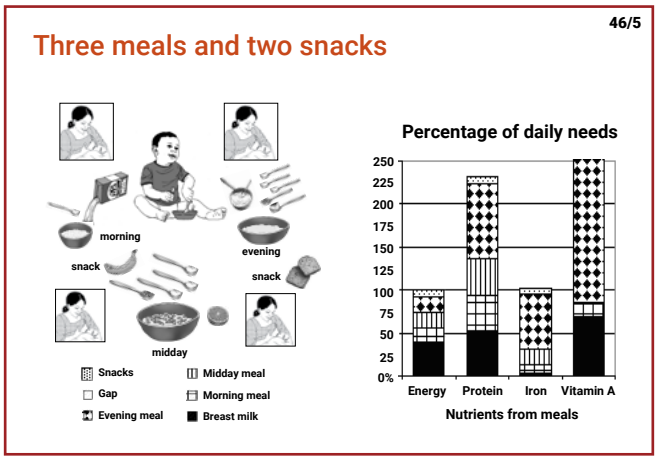
- ¤ (Name) is already eating a full bowl of food at each meal. There is no space in his stomach for more food at mealtimes.
- ¤ *Ask: What can you suggest to (name's) family to help fill the energy gap?*

▸ Wait for a few replies and then continue.

- ¤ (Name's) family can give him some food more often. They do not need to cook more meals. They can give some extra foods between meals that are easy to prepare. These extra foods are in addition to the meals – they should not replace them.
- ¤ These extra foods are often called snacks. However, they should not be confused with foods such as sweets, crisps or other processed foods,[1] which may include the term "snack foods" in their name.
- ¤ *Ask: Can you name some foods that are healthy snacks in your community and would be easy to feed this child? Are there also poor-value snacks? What are they?*

[1] Give examples of local processed foods that might be called snack foods.

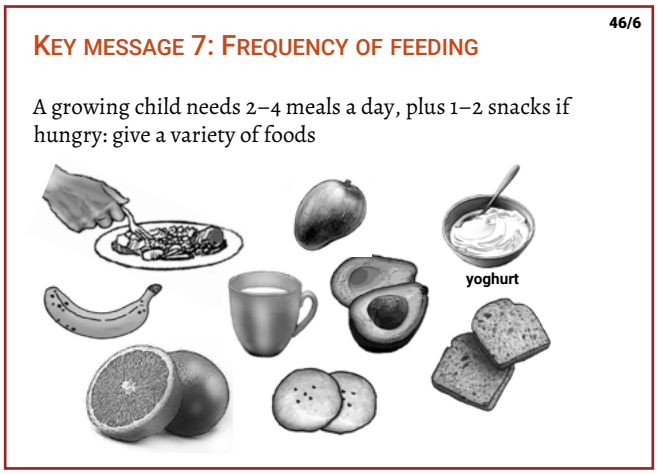
- Wait for a few replies and then continue.
  - Good snacks provide both energy and nutrients. Yoghurt and other milk products; bread or biscuits spread with butter, margarine, nut paste or honey; fruit; bean cakes; and cooked potatoes[1] are all good snacks.
  - Poor-value snacks are ones that are high in sugar but low in nutrients. Examples of these are fizzy drinks (sodas), sweet fruit drinks, sweets/candy, ice lollies and sweet biscuits.
  - These snacks may be easy to give; however, the child still needs to be helped and supervised while eating, to ensure that snacks are eaten.
- Show **Slide 46/5 – Three meals and two snacks**[2] and make the points that follow:



- Ask the representative of group 2 to point out : (1) what nutrients the morning meal provides; (2) what nutrients the midday meal provides; (3) what nutrients the evening meal provides; and (4) what nutrients the snacks provide.
- Then ask them to indicate whether the foods are filling the energy and nutrients gaps; which gaps are filled; and which gaps remain.
- Ask other participants to add anything they find missing.
- Make the following points, referring to what participants already mentioned and avoiding repetitions.
  - (Name) has two snacks added in the day – some banana in the mid-morning and a piece of bread in the mid-afternoon. These snacks help to fill his energy gap so he can grow well. Now all the gaps are filled.
  - In the last two sessions, we discussed the variety of foods needed to meet a child's needs. Suggest that families try each day to give a dark-green vegetable or yellow-coloured fruit or vegetable and an animal-source food, in addition to the staple food.
  - When you are talking with caregivers, give this key message:

[1] Cooked moist foods (such as potatoes) should not be kept more than 1 hour if there is no refrigeration.
[2] Liver instead of fish in evening meal.

▸ Show **Slide 46/6 – KEY MESSAGE 7: FREQUENCY OF FEEDING** and read out the Key message:

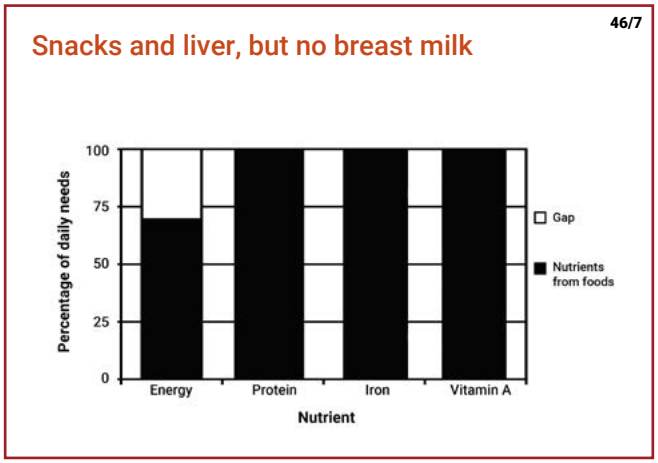


- When you are talking with a family about feeding their young child more frequently, suggest some options for them to consider. It can be difficult to feed a child frequently if the caregiver has many other duties and if additional foods are expensive or hard to obtain.
- Other family members can often help. Assist the family to find solutions that fit their situation.

▸ Make these points:

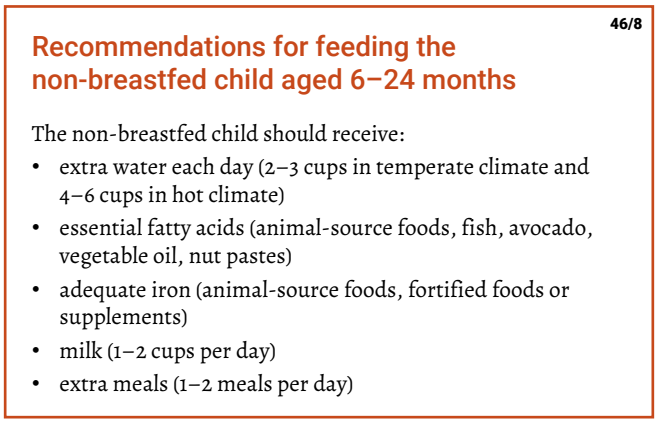
- Now we will look at feeding the non-breastfed child. We have mentioned in previous sessions that a child who does not receive breast milk needs special attention to ensure they get sufficient food.

▸ Show **Slide 46/7 – Snacks and liver, but no breast milk** and make the points that follow:



- If the child is not taking any breast milk and is eating the foods listed earlier, including the snacks and liver, the chart would look like this.
- There is still a very large gap for energy. One way to increase the energy intake is to give this child 200–240 mL (two half-cups) of milk (full-fat cow's milk or milk from another animal or formula milk [if affordable, acceptable and available]) plus other dairy products, eggs and other animal-source foods.
- If no animal-source foods are included in the diet, fortified complementary foods or nutrient supplements are needed for a child to meet their nutrient needs.
- A child who does not have breast milk needs special attention to ensure they receive sufficient food.
- Children over 6 months of age who are not receiving breast milk need 1–2 cups of milk (where one cup is equal to 250 mL) and an extra 1–2 meals per day in addition to the amounts of food recommended. We will be looking at the amounts of food to offer children of different ages later in this session.
- *Ask: What other recommendations have we discussed in previous sessions for children over 6 months of age who are not receiving breast milk?*

- Wait for a few replies and then continue by displaying the next slide.
- Show **Slide 46/8 – Recommendations for feeding the non-breastfed child aged 6–24 months** and make the points that follow:



- In previous sessions we said that these children:
  - should have extra water each day, particularly in hot climates, to ensure that their thirst is satisfied: 2–3 cups in a temperate climate and 4–6 in hot climates
  - should have essential fatty acids in their diet – from animal-source foods, fish, avocado, vegetable oil and nut pastes
  - should have adequate iron. If they are not receiving animal-source foods, then fortified foods or iron supplements should be considered.
- In this session, we said that these children should receive 1–2 cups of milk per day and an additional 1–2 meals.

IV. Outline the quantity of complementary food to be offered — 10 minutes

- Make these points:
  - When a child starts to eat complementary foods, they need time to get accustomed to the new taste and texture of the foods. A child needs to learn the skill of eating. Encourage families to start with 2–3 spoonfuls of the food twice a day.
  - Gradually increase the amount and the variety of foods as the child gets older. By 12 months of age, a child can eat a small bowl or full cup of mixed foods at each meal, as well as snacks between meals. Children vary in their appetite – these are guidelines.
  - As the child develops and learns the skills of eating, they progress from very soft, mashed food, to foods with some lumps that need chewing, and to family foods. Some family foods may need to be chopped for longer if the child finds them difficult to eat.
  - *Ask: What amounts of food do the families in the area give to their young children?*
- Wait for a few replies and then continue.
- Ask participants to turn to page 358 of their *Participant's manual* and find the box AMOUNTS OF FOOD TO OFFER, showing the age, texture of the food offered and the amount of food an average child will usually eat at each meal.
- Ask a participant to read out the first age group. Then ask another participant to read out the next age group until all the age groups are read out.

AMOUNTS OF FOOD TO OFFER

Age	Texture	Frequency	Amount of food an average child will usually eat at each meal[1]
6–8 months	Start with thick porridge, well-mashed foods Continue with mashed family foods	2–3 meals per day plus frequent breastfeeds Depending on the child's appetite, 1–2 snacks may be offered	Start with 2–3 tablespoonfuls per feed increasing gradually to ½ of a 250 mL cup
9–11 months	Finely chopped or mashed foods, and foods that baby can pick up	3–4 meals plus breastfeeds Depending on the child's appetite, 1–2 snacks may be offered	½ of a 250 mL cup/bowl
12–23 months	Family foods, chopped or mashed if necessary	3–4 meals plus breastfeeds Depending on the child's appetite, 1–2 snacks may be offered	¾ to one 250 mL cup/bowl
If the baby is not breastfed, give in addition: 1–2 cups of milk per day, and 1–2 extra meals per day.			

► Continue with these points:

- As you can see in this chart, as the child gets older, the amount of food offered increases. Give as much as the child will eat, with active encouragement.[2]
- When you are talking with families, give this Key message:

► Show **Slide 46/9 – KEY MESSAGE 8: AMOUNT OF FOOD** and read out the key message:

46/9

KEY MESSAGE 8: AMOUNT OF FOOD

A growing child needs increasing amounts of food

[1] Adapt the chart to use a suitable local cup/bowl to show the amount. The amounts assume an energy density of 0.8–1.0 kcal/g.
[2] Active encouragement of feeding is discussed in another session.

V. Conduct Exercise 46.A Amounts to give — 10 minutes

- **Make these points:**
  - As you talk with caregivers, a frequent question you are asked may be how much and how often to give food. To practise these amounts, we will now do a drill. A drill is not a test. It is a way to help you learn to recall the amounts with speed and confidence.
  - I will say an age of a child. The first person I call on will say how often to feed and how much food to give at the main meal.
  - If the person cannot answer or answers incorrectly, we go to the next person. When the correct answer is given, I say a different age of child and we continue.
  - Before we start, take 2 minutes to look again at the box on page 359 of your *Participant's manual*.
- **Keep the pace lively and the mood cheerful. Congratulate participants as they improve in their ability to answer correctly or more quickly. If the group is very large, this drill can be conducted in the smaller groups, with the trainer for each group asking the questions.**

Exercise 46.A Amounts to give

Age of child	Frequency	Amount at each meal
6 months 2 days	Two times per day	2 to 3 tablespoonfuls
22 months	Three to four meals (may offer 1–2 snacks)	¾ to 1 cup
8 months	Two to three times per day (may offer 1–2 snacks)	up to ½ cup
12 months	Three to four meals (may offer 1–2 snacks)	¾ to 1 cup
7 months	Two to three times per day (may offer 1–2 snacks)	up to ½ cup
15 months	Three to four meals (may offer 1–2 snacks)	¾ to 1 cup
9 months	Three to four meals (may offer 1–2 snacks)	½ cup
13 months	Three to four meals (may offer 1–2 snacks)	¾ to 1 cup
19 months	Three to four meals (may offer 1–2 snacks)	¾ to 1 cup
11 months	Three to four meals (may offer 1–2 snacks)	½ cup
21 months	Three to four meals (may offer 1–2 snacks)	¾ to 1 cup
3 months	A trick question!	Only breastfeeding

- **The drill ends when all the participants have had an opportunity to answer and when you feel they are answering with confidence. You can repeat the ages if needed, to give everyone enough opportunities to practise. Thank participants for their participation.**

VI. Summarize the session 3 minutes

- Ask participants whether they have any questions, and try to answer them.
- Make these points:
  - In this session, we talked about how much to feed a young child and how often to feed.
  - We also talked about the recommendations for feeding a child who is not receiving breast milk.
- Point to the flipchart page with the two Key messages from this session:
  - KEY MESSAGE 7: A GROWING CHILD NEEDS 2–4 MEALS A DAY, PLUS 1–2 SNACKS IF HUNGRY: GIVE A VARIETY OF FOODS
  - KEY MESSAGE 8: A GROWING CHILD NEEDS INCREASING AMOUNTS OF FOOD
- Keep these messages together with previous Key messages displayed throughout the course.
- Explain that a summary of this session can be found on pages 357–359 of the *Participant's manual*. The list of Key messages can be found on page xiv of the *Participant's manual*.

Further information

The amounts of food included in the table are recommended when the energy density of the meals is about 0.8–1.0 kcal/g.

If the energy density of the meals is about 0.6 kcal/g, recommend the mother to increase the energy density of the meal (adding special foods) or increase the amount of food per meal. For example:

- for 6–8 months, increase gradually to ⅔ of a cup
- for 9–11 months, give ¾ of a cup
- for 12–23 months, give a full cup.

Find out what the energy content of complementary foods is in your setting and adapt the table according to this information.

Counsel the mother/caregiver to feed the child using the principles of responsive feeding, recognizing the signs of hunger and satiety. These signs should guide the amount of food given at each meal and the need for snacks.

Notes

Notes (contd)

SESSION 47

Gathering information on complementary feeding practices

Objectives

After completing this session, participants will be able to gather information on complementary feeding practices by:

- demonstrating appropriate use of counselling skills
- observing a mother and child
- using the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS

Session outline . . . . . 90 minutes

Participants are all together for a lecture presentation and demonstration by one trainer, followed by group work with all trainers.

I. Introduce the session, present **Slide 47/1** . . . . . 2 minutes
II. Demonstrate gathering information on complementary feeding practices (DEMONSTRATION 47.A) . . . 30 minutes
III. Practise gathering information using the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS . . . . . 55 minutes
IV. Summarize the session . . . . . 3 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation, giving a demonstration and facilitating group work.
- Make sure you have **Slide 47/1** ready. Alternatively, as there is only one slide in this session, you might prefer to read aloud the objectives on **Slide 47/1** without projecting them onto the screen.
- You need a flipchart and marker.
- You need a typical bowl that a young child would use – one for each group.
- Have ready copies of the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS for the practice – one copy for each participant.
- Have ready the FOOD CONSISTENCY PICTURES – one set for each group.
- You need one set of stories for each group for food-intake practice. Cut as shown. Keep the growth chart with the relevant story.
- Ask two trainers/facilitators to assist with DEMONSTRATION 47.A. Show them the text and forms. Ask them to read through it and to practise. The FOOD CONSISTENCY PICTURES, a JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS and a bowl will be needed, plus the growth chart.
- Have ready COUNSELLING CARD 17: FOOD VARIETY, COUNSELLING CARD 18: COMPLEMENTARY FEEDING FROM 6 UP TO 9 MONTHS, COUNSELLING CARD 19: COMPLEMENTARY FEEDING FROM 9 UP TO 12 MONTHS and COUNSELLING CARD 20: COMPLEMENTARY FEEDING FROM 12 UP TO 24 MONTHS, and the *Guidance on the use of counselling cards*.
- Read through the SUGGESTED ALTERNATIVE METHODOLOGIES section and decide whether this is appropriate for your group.

As you follow the text, remember:

- ► indicates an instruction to you, the trainer.
  - ¤ indicates what you say to participants.

I. Introduce the session — 2 minutes

- ► Make these points:
  - ¤ If you are going to counsel a mother or caregiver on complementary feeding, you need to find out what her child is eating.
  - ¤ This is quite complicated because children eat different things at different times in a day.
  - ¤ In Session 15, you looked at the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS. You learnt how to take a feeding history.
  - ¤ Now we are going to look at assessing the intake of complementary foods.
- ► Ask participants to turn to page 330 of their *Participant's manual*, to remind themselves of the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS.
- ► Show **Slide 47/1 – Session 47 – objectives** and read out the objectives:

47/1

Session 47: Gathering information on complementary feeding practices – objectives

After completing this session, participants will be able to gather information on complementary feeding practices by:
- demonstrating appropriate use of counselling skills
- observing a mother and child
- using the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS

II. Demonstrate gathering information on complementary feeding practices — 30 minutes

- ► Make these points:
  - ¤ We have learnt about assessing a breastfeed. We talked about how important it is to observe a mother and her baby, and the breastfeed itself. Observation is just as important when you are gathering information about complementary feeding, as it is when you assess a breastfeed.
- ► Ask participants to turn to page 363 of their *Participant's manual* and find the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS (page 618 in *Trainer's Guide*). Make these points:
  - ¤ A useful way to find out what a child eats is to ask the caregiver what the child ate yesterday. This information can be used to praise the good feeding practices that are there already and to identify any Key messages to help improve practices.
  - ¤ The JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS helps you to do this.
  - ¤ The caregiver is asked to recall everything the child consumed the previous day. This includes all foods, snacks, drinks, breastfeeds, other liquids and any vitamin or mineral supplements.
  - ¤ As you can see, the first column has questions about feeding practices. As you listen to the caregiver, put a tick mark in the column to mark if the practice occurred the previous day.
  - ¤ You will see that most of the questions in the first column are closed questions. When you use this tool with a caregiver to gather information, you should use your counselling skills, including open questions. We will see how the Job aid is used in a demonstration later.

- **Distribute the FOOD CONSISTENCY PICTURES to the participants (if not on the back of the REFERENCE TOOL: FOOD INTAKE – 6 UP TO 24 MONTHS). Point out how the pictures are different.**
  - If you ask a caregiver about the consistency of the food – whether it was thin or thick – there might be some confusion about how thick you mean. Therefore, here are pictures to show a thick and a thin consistency.
  - You show the FOOD CONSISTENCY PICTURES to the caregiver and ask which drawing is most like the food they gave to the child.
  - After you have listened to find out what the feeding practices are, you can praise some of the practices you wish to reinforce.
  - After you have taken the history and filled in the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS, you then choose two or three Key messages to give. It is important to listen to the caregiver first, so that you gather all the information on complementary feeding before you decide which Key messages to give to them. There is a column on the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS to indicate which items you discussed in more detail and gave a Key message about.
  - Put your initials at the Key message you gave.
  - Ask: *Why is it important to choose just 2–3 Key messages to give the caregiver?*
- **Wait for a few replies and then continue.**
  - It is important to choose just 2–3 Key messages at a visit, so the caregiver is not overwhelmed.
  - Discuss the Key messages you think are most important at this time and that the caregiver thinks that they can do.
- **Ask participants to turn to page 364 and the REFERENCE TOOL: FOOD INTAKE – 6 UP TO 24 MONTHS. This can be found on page 619 of the *Trainer's guide*. Ask one participant to read the first question on feeding practice, the recommended practice and the Key message, then another participant to read the next practice.**
- **Answer questions as needed about the practices. (Make sure the participants notice the differences between the recording form and the reference form.)**
  - Feeding techniques to assist the child to learn to eat will be discussed in Session 48. We will discuss feeding the child who is ill in Session 50.
  - The other Key messages have already been introduced.
  - On page 362 in your *Participant's manual*, there are instructions on how to use the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS.
- **Ask participants to take turns to read out the instructions.**

Instructions for completing the Job aid: Food intake – 6 up to 24 months

1. Greet the mother/caregiver. Explain that you want to talk about the child's feeding.
2. Fill out the child's name, birth date, age in completed months or years and today's date.
3. Ask to see the growth chart and observe the pattern of the growth.
4. Start with:
   (Mother/caregiver name), let us talk about what (child's name) ate yesterday.
5. Continue with:
   As we go through yesterday, tell me all (name) ate or drank, meals, other foods, water or breastfeeds.
   What was the first thing you gave (name) after he woke up yesterday?
   Did (child's name) eat or drink anything else at that time or breastfeed?
6. If the caregiver mentions a preparation, such as a porridge or stew, ask them for the ingredients in the porridge or stew.
7. Then continue with:
   What was the next food or drink or breastfeed (child's name) had yesterday?
   Did (child's name) eat/drink anything else at that time?
8. Remember to "walk" through yesterday's events with the caregiver, to help them remember all the food/drinks/breastfeeds that the child had.
9. Continue to remind the caregiver you are interested in what the child ate and drank yesterday (caregivers may talk about what the child eats/drinks in general).
10. Clarify any points or ask for further information as needed.
11. Mark on the Job aid: Food intake – 6 up to 24 months the practices that are present. If appropriate, show the caregiver the pictures of thin and thick consistency (for porridge and mixed foods). Ask them which drawing is most like the food they gave the child. Was it thick, did it stay on the spoon and hold a shape on the plate, or was it thin and did it flow off the spoon and not hold its shape on the plate?
12. Praise practices you wish to encourage. Offer two or three Key messages as needed and discuss how the caregiver might use this information.
13. If the child is ill on that day and not eating, give the Key message 10: Encourage the child to drink and eat during illness, and provide extra food after illness to help them recover quickly.
14. See the child another day and use the Job aid: Food intake – 6 up to 24 months when they are eating again.

- Now we will see this Job aid: Food intake – 6 up to 24 months in use. During the demonstration, you can find the child's growth chart and follow the completed Job aid: Food intake – 6 up to 24 months on page 366 of your *Participant's manual*. Later, you will use a Job aid: Food intake – 6 up to 24 months with mothers in a clinical practice session.
- In this demonstration, listen for open questions and other Listening and learning skills that we discussed in Session 5.

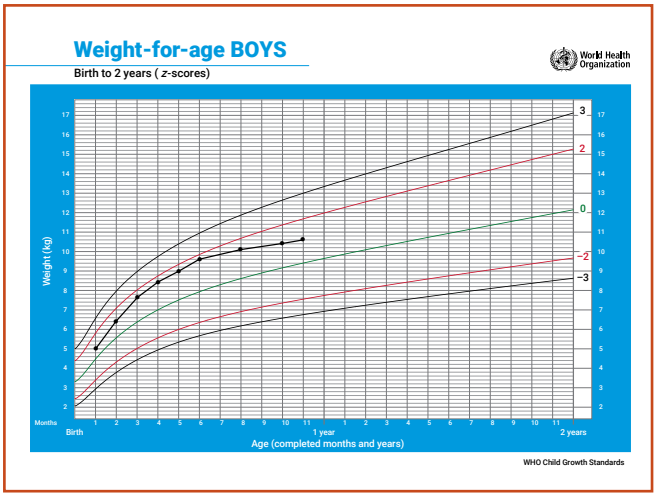
▸ **Ask the two trainers/facilitators whom you prepared to assist. One person is the mother and one is the health worker who fills in the Job aid: Food intake – 6 up to 24 months. The health worker also has the counselling cards that will help them in counselling the mother.**

▸ **Set the room out with seating with no desk or barrier between the health worker and mother. If the health worker needs a desk to write on, place it to one side (right-hand side if the health worker writes with the right hand). They are already sitting. The health worker has a Job aid: Food intake – 6 up to 24 months, Food consistency pictures and a typical bowl. The mother has a growth chart for the child.**

▸ **Find out the mother's and child's "names", then introduce the demonstration:**

- (Name) is 11 months old. (Mother's name) has brought him to the health centre for immunization. While he is there the health worker notices that (name's) weight line is only rising slowly though he is generally healthy. So the health worker asks (mother's name) to talk to her about how (name) is eating.
- This corresponds to the ASSESS phase you can find in your *Guidance on the use of counselling cards*. Please open your booklet to find the section on INFANT AND YOUNG CHILD FEEDING THREE-STEP COUNSELLING, where you will find STEP 1: ASSESS – ASK, LISTEN AND OBSERVE. Let's now pay attention to the demonstration.

DEMONSTRATION 47.A LEARNING WHAT A CHILD EATS



Health worker: *Thank you for coming today. (Mother's name), your child's weight line is going upwards, which shows that he has grown since I last saw him. Because (child's name) lost some weight when he was ill, the line needs to rise some more. Could we talk about what (child's name) ate yesterday?*
(show growth chart)

Mother: *I am pleased that he has put on some weight, as (child's name) has been ill recently and I was worried that he might have lost weight.*

Health worker: *I can see you are anxious about his weight.*
Mother: *Yes. I was wondering whether I was feeding him the right sorts of food.*

Health worker: *Perhaps we could go through everything that (child's name) ate or drank yesterday?*
Mother: *Yes, I can tell you about that.*

Health worker: *What was the first thing you gave (child's name) after he woke up yesterday?*
Mother: *First thing, he breastfed. Then about one hour later, he had a small amount of bread with butter, and several pieces of papaya.*

Health worker: *Breastfeeding, then bread, butter and some pieces of papaya. That is a good start to the day. What was the next food or drink or breastfeed that he had yesterday?*
Mother: *At mid-morning, he had some porridge with milk and sugar.*

Health worker: *Which of these drawings is most like the porridge you gave to (child's name)?*
(show FOOD CONSISTENCY PICTURES)

Mother: *This one – the more runny one (points to the thin consistency).*

Health worker: *Was there anything else that (child's name) had at midday yesterday?*
Mother: *Oh yes, he had a small glass of fresh orange juice.*

Health worker: *That is a healthy drink to give to (child's name). After this meal at midday, what was the next thing he ate?*
Mother: *Let's see, he didn't eat anything more until we all ate our evening meal. He breastfed a few times in the afternoon. In the evening, he ate some rice, a spoonful of mashed greens and some mashed fish.*

Health worker: **(show FOOD CONSISTENCY PICTURES)**	*Breastfeeding will help (child's name) to grow and to stay healthy. It is good that you are still breastfeeding. Which of these pictures looks most like the food the baby ate in the evening?*
Mother:	*This thicker one. I mashed up the foods together and it looked like that.*
Health worker:	*Did (child's name) eat or drink anything more for the evening meal yesterday?*
Mother:	*No, nothing else.*
Health worker:	*After that or during the night, what other foods or drinks did (child's name) have?*
Mother:	*(Child's name) breastfeeds during the night but he had no more foods.*
Health worker: **(show typical bowl)**	*Using this bowl, can you show me about how much food (child's name) ate at his main meal yesterday?*
Mother:	*(Points to bowl) About half of that bowl.*
Health worker:	*Thank you. Who helps (child's name) to eat, or does he eat by himself?*
Mother:	*Oh, yes. (Child's name) needs help. Usually I help him, but sometimes if my mother or sister is there, they will help also.*
Health worker:	*Is (child's name) taking any vitamins or minerals?*
Mother:	*No, not now.*
Health worker:	*Thank you for telling me so much about what (child's name) eats.*

▸ **Make the following points:**

- Now we will have the "counsellor" going through the ANALYSE step of the counselling process, "thinking out loud" about the information the mother provided. The "counsellor" will review what the mother said and was recorded in the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS, comparing the findings with the age-appropriate feeding recommendations, as included in the REFERENCE TOOL: FOOD INTAKE – 6 UP TO 24 MONTHS.
- As you can see from the example form on page 366 in your *Participant's manual* (page 615 in the *Trainer's guide*), the health worker has gathered information on the foods the child ate in the previous day and filled in the first column.
- The "counsellor" will demonstrate the process and may engage you to determine what you have heard.

This part of the process is facilitated by the trainer/facilitator acting as counsellor. They may ask all or some of the questions to the participants, as part of the process of analysis of information provided by the mother.

- Let us go through the questions:
- *Ask: Is the growth curve heading upwards?*

▸ **Wait for a few replies and then continue.**

- Yes; however it is only going upwards very slowly.
- *Ask: Does the child receive breast milk?*

▸ **Wait for a few replies and then continue.**

- Yes, frequently. A practice to praise.
- *Ask: How many meals were of a thick consistency?*

▸ **Wait for a few replies and then continue.**

- Two, the porridge and the evening meal of rice, mashed greens and fish. However, the soup given at lunch time was thin, so this might be something to discuss with the mother.

▸ **The variety of foods eaten is looked at next.**

- *Ask: Did the child eat an animal-source food yesterday?*

▸ **Wait for a few replies and then continue.**

- Yes, fish in the evening.
- *Ask: Did he eat a dairy product?*

▸ **Wait for a few replies and then continue.**

- Yes, there was milk on the porridge.
- *Ask: Did he eat pulses or nuts yesterday?*

▸ **Wait for a few replies and then continue.**

- Yes, beans at midday. And the child had juice with the meal, which helps iron absorption.
- *Ask: Did the child eat a dark-green or yellow-coloured fruit or vegetable yesterday?*

▸ **Wait for a few replies and then continue.**

- Yes, some papaya in the morning, some green vegetables in the evening, maybe some green or yellow vegetables in the pot at midday. If you need to, you can ask for more information about the kinds of vegetables. However, do not ask many questions about details if the answers are not important. In this example, you have learnt by listening that the child had some green vegetables and a yellow fruit, so has met the recommendation. You do not need to ask more questions about types of vegetables.

▸ **Then we check the frequency of meals and the amount of food.**

- *Ask: How many meals and snacks did the child have?*

▸ **Wait for a few replies and then continue.**

- Three meals and one snack.
- *Ask: Is three meals and one snack adequate for this child aged 11 months?*

▸ **Wait for a few replies and then continue.**

- Yes, it is adequate.
- *Ask: Was the quantity of food eaten at the main meal adequate for the child's age?*

▸ **Wait for a few replies and then continue.**

- Yes, the child is 11 months old and received about half of a bowl.
- *Ask: Does the mother assist with eating?*

▸ **Wait for a few replies and then continue.**

- Yes.
- *Ask: Was the child given any vitamins or mineral supplements?*

▸ **Wait for a few replies and then continue.**

- Not at this time. There is no Key message about vitamins or mineral supplements. However, if the child is not eating animal-source foods and is not likely to eat them, he may need an iron supplement.
- *Ask: Was the child healthy and eating?*

▸ **Wait for a few replies and then continue.**

- Yes.

▸ **Make the following points.**

- This summary helps you to pick out the practices to praise and specific Key messages to give to this mother. If the mother has not mentioned that the child has received some of the food items or practices listed in the column, then the health worker should ask the mother directly. If an answer is unclear, you can ask for more information.
- Now the "counsellor" has to ACT; that is the third step of the counselling process. To do that, they need to choose which practices to praise and two or three Key messages to discuss.
- *Ask: What practices of this mother could you praise and support to continue?*

- **Wait for a few replies and then continue.**
- **Write the points that participants suggest on the flipchart. Refer to these responses as you make the following points.**
  - This mother had many good practices you could praise and support:
    - continuing breastfeeding
    - frequent meals and snacks
    - variety of foods used, including staple, some animal-source foods, fruit and vegetables
    - thick consistency for some meals
    - assistance with eating.
  - *Ask: What are the main points to give relevant information on? What Key message could you give to this mother?*
- **Wait for a few replies and then continue.**

Completed Job aid: Food intake – 6 up to 24 months for Demonstration 47.A

Enter a ✓ in the Yes column if the practice is in place.

Enter your initials if a message is given (see Reference tool: Food intake – 6 up to 24 months for the message)

Job aid: Food intake – 6 up to 24 months

Child's name:

Date of birth: **Age of child at visit:** 11 months

Feeding practice	Yes / number where relevant	Key message given
Growth appropriate?	Growth curve raising slowly	
Child received breast milk?	✓	
How many meals of a thick consistency did the child eat yesterday? (use Food consistency pictures as needed)	2	Yes
Child ate an animal-source food yesterday (meat/fish/offal/bird/eggs)?	✓	
Child ate a dairy product yesterday?	✓	
Child ate pulses, nuts or seeds yesterday?	✓	
Child ate a dark-green or yellow vegetable or yellow fruit yesterday?	✓	
Child ate sufficient number of meals and snacks yesterday, for their age?	✓	
Quantity of food eaten at main meal yesterday appropriate for child's age?	✓	
Caregiver assisted the child at mealtimes?	✓	
Child took any vitamin or mineral supplements?	—	
Child ill or recovering from an illness?	—	

- After you had praised the practices, you would then discuss:
  - the amount of food in each meal – suggest increasing so that by 12 months the child has a full bowl
  - making the food a thick consistency at each meal (remember the bean and vegetable meal was thin).

- **Ask participants to pay attention to the third part of the process of counselling. This phase will include the use of Counselling cards.**
- **After the process is over, make the following point:**
  - For this particular child, the growth curve was only rising very slowly. Therefore, the amount of food at each meal and giving a thick consistency are particularly important suggestions to discuss.
  - Gather all the information first and then discuss practices that could be improved with the mother, giving the relevant Key messages.
  - The health worker put her initials at the Key messages she discussed.
  - You will have an opportunity to practise how to gather information on feeding practices with actual mothers later in the course; for now, we will practise with each other.
- **Ask participants whether they have any questions, and try to answer them.**

III. Practise gathering information using the Job aid: Food intake – 0 up to 6 months
55 minutes

- **Sit in the small groups of 3–4 participants and one trainer. Explain what they will do:**
  - You will now use role-play to practise gathering information to assess complementary feeding practices.
  - You will take turns to be a "mother" or a "health worker". When you are the "mother", play the part of the story on your card. The "health worker" gathers information about your child's feeding. The other participants in the group observe.
- **Give each participant one of the Stories for food-intake practice (pages 620–622 of the *Trainer's manual*). Each group of participants should have a set of four stories plus growth charts and counselling cards, so that each participant can have a different one to practise. There are extra stories if the group is larger than four or if there is extra time available.**
- **Give each participant a blank Job aid: Food intake – 6 up to 24 months.**
- **Make sure each group has a set of the Food consistency pictures and a child's bowl.**
- **Ask participants to read through their own story to themselves. Allow 2 minutes, and then continue with the explanation:**
  - You are the only one in your group with that story. Do not let the others see it. Look only at your own story.
  - When you are the "mother":
    - Give yourself and your child names and tell them to your "health worker".
    - Answer the health worker's questions from your story. Do not give all the information at once.
    - If the information to answer a question is not in your story, make up information to fit with the history.
  - If your health worker uses good Listening and learning skills, and makes you feel that they are is interested, you can tell them more.
  - When you are the "health worker":
    - Greet the "mother" and introduce yourself. Ask for her name and her baby's name, and use them.
    - Ask one or two open questions to start the conversation and to find out in general how the child is.

- Explain that you would like to learn about how her child is eating. Ask the mother to tell you about the child's eating on the previous day. Prompt as needed. Fill out the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS as you listen.
- Try to praise the things the mother is doing right. At the end of the counselling session, try to think of suggestions you would make and Key messages to give to the mother.
- Use the Counselling card you consider appropriate for the case.

¤ When you are observing:

- Follow the pair practice with the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS and observe whether the "health worker" gathers useful information.
- Notice which counselling skills the health worker uses and which they do not use.
- After the role-play, be prepared to praise what the health worker does right, and suggest what they could do better.

► Trainers each sit with one group of three or four participants. Make sure that the participants understand the exercise and do it as intended – and that the "mother" does not give all the information at once.

► Follow the story in your *Trainer's guide*. If the pair is doing well, let them go on until they finish. If they make many mistakes, or get confused, stop them, and give them a chance to correct themselves. Ask them how they feel they are doing, and what they think they could do differently.

► Discuss the role-play briefly in each small group.

► Ask the "mother" how she felt, did she say all she wanted to, or did she feel restricted?

► Ask the other participants in the group to say what they observed.

► Then say what you think. Praise what the pair did right and then comment on how well the "health worker" gathered information.

► In particular, go through with the group the points to praise the "mother" for. Make sure that the relevant Key messages were focused on.

¤ If necessary, let the pair try again, at least for a short time. Try to finish the exercise with participants doing some things well. Thank the pair and congratulate them for their efforts.

¤ Ask another pair to practise. Make sure each member of the group has a chance to be a "health worker" at least once.

► Summarize the session in the small group or return to the large group for this.

IV. Summarize the session 3 minutes

► Ask participants whether they have any questions, and try to answer them.

► Make these points:

¤ In this session, we looked at various ways of gathering information on complementary feeding practices. This included observation, listening, using growth charts and asking questions.

¤ We also discussed the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS, which will be used in CLINICAL PRACTICE SESSION 5 (Session 53).

► Explain that a summary of the session can be found on pages 361–367 of the Participant's manual.

Completed Job aid: Food intake – 6 up to 24 months for Demonstration 47.A

Enter a ✓ in the Yes column if the practice is in place.

Enter your initials if a message is given (see Reference tool: Food intake – 6 up to 24 months for the message)

Job aid: Food intake – 6 up to 24 months

Child's name:

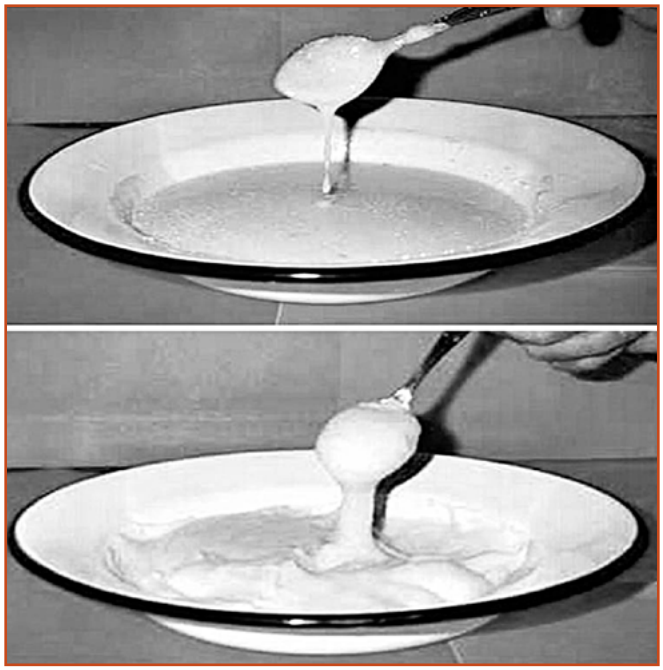
Date of birth: **Age of child at visit:**

Feeding practice	Yes / number where relevant	Key message given
Growth appropriate?		
Child received breast milk?		
How many meals of a thick consistency did the child eat yesterday? (use Food consistency pictures as needed)		
Child ate an animal-source food yesterday (meat/fish/offal/bird/eggs)?		
Child ate a dairy product yesterday?		
Child ate pulses, nuts or seeds yesterday?		
Child ate a dark-green or yellow vegetable or yellow fruit yesterday?		
Child ate sufficient number of meals and snacks yesterday, for their age?		
Quantity of food eaten at main meal yesterday appropriate for child's age?		
Caregiver assisted the child at mealtimes?		
Child took any vitamin or mineral supplements?		
Child ill or recovering from an illness?		

Reference tool: Food intake – 6 up to 24 months

Feeding practice	Ideal feeding practice	Key messages to help counsel mothers
Growth appropriate?		*Look at the shape of the growth curve of the child: is the child growing?*
Child received breast milk?	Yes	Breastfeeding for 2 years or longer helps a child to develop and grow strong and healthy
How many meals of a thick consistency did the child eat yesterday? (use Food consistency pictures as needed)	3 meals	Foods that are thick enough to stay on the spoon give more energy to the child
Child ate an animal-source food yesterday (meat/fish/offal/bird/eggs)?	Animal-source foods should be eaten daily	Animal-source foods are especially good for children, to help them grow strong and lively
Child ate a dairy product yesterday?	Try to give dairy products daily	Animal-source foods are especially good for children, to help them grow strong and lively
Child ate pulses, nuts or seeds yesterday?	If meat is not eaten, pulses or nuts should be eaten daily, with an iron enhancer such as a vitamin-C-rich food	Peas, beans, lentils, nuts and seeds are good for children
Child ate a dark-green or yellow vegetable or yellow fruit yesterday?	A dark-green or yellow vegetable or yellow fruit should be eaten daily	Dark-green leaves and yellow-coloured fruits and vegetables help the child to have healthy eyes and fewer infections
Child ate sufficient number of meals and snacks yesterday, for their age?	Child 6–8 months: 2–3 meals plus 1–2 snacks if hungry Child 9–24 months: 3–4 meals plus 1–2 snacks if hungry	A growing child needs 2–4 meals a day, plus 1–2 snacks if hungry: give a variety of foods
Quantity of food eaten at main meal yesterday appropriate for child's age?	Child 6–8 months: gradually increased to approx. ½ cup at each meal Child 9–11 months: approx. ½ cup at each meal Child 12–24 months: approx. ¾–1 cup at each meal	A growing child needs increasing amounts of food
Caregiver assisted the child at mealtimes?	Yes, assists with learning to eat	A young child needs to learn to eat: encourage and give help … with lots of patience
Child took any vitamin or mineral supplements?	Vitamin and mineral supplements may be needed if child's needs are not met by food intake	*Explain how to use vitamin and mineral supplements if they are needed*
Child ill or recovering from an illness?	Continue to eat and drink during illness and recovery	Encourage the child to drink and eat during illness, and provide extra food after illness to help them recover quickly

Food consistency pictures



Stories for food-intake practice

Story 1

Child is 15 months old. Healthy, growing well and eating normally. Breastfeeds frequently.

- Early morning: Breastfeed, half bowlful of thick porridge, milk and small spoonful of sugar
- Mid-morning: Small piece of bread with nothing on it, breastfeed
- Midday: Three large spoonfuls of rice, two spoonfuls of mashed beans (¾ of a bowl), pieces of mango (¼ of a bowl), drink of water
- Mid-afternoon: Breastfeed, one small biscuit/cookie
- Evening: Two large spoonfuls of rice, one large spoon of mashed fish, two large spoonfuls of green vegetables (¾ of a bowl), drink of water
- Bedtime: Breastfeed
- During night: Breastfeed

Story 2

Child is 9 months old. Not ill at present. Not difficult to feed. Not breastfeeding.

- Early morning: Half cup of cow's milk, half bowl of thin porridge, spoonful of sugar
- Mid-morning: Half a mashed banana, small drink of fruit drink
- Midday: Thin soup, one spoonful of rice, and one spoonful of mashed beans (half-full bowl), drink of water
- Mid-afternoon: Sweet biscuit, ½ cup of cow's milk
- Evening: Two spoonfuls of rice, one spoonful of mashed meat and vegetable from family meal (half a bowl), drink of water
- Bedtime: Piece of bread with no spread, ½ cup cow's milk
- During the night: Drink of water

Story 3

Child is 18 months old. Not ill at present. Not difficult to feed. Breastfeeds.

- Early morning: Full bowl of thick porridge with sugar, breastfeed
- Mid-morning: Cup of diluted fruit drink
- Midday: Three spoonfuls of rice, three spoonfuls of mashed beans and vegetables from the family meal (one full bowl), ½ cup of diluted fruit drink
- Mid-afternoon: Large piece of bread with jam, breastfeed
- Evening: Whole mashed banana, one sweet biscuit, cup of diluted fruit drink
- Bedtime: Breastfeed
- During the night: Breastfeed

Story 4

Child is 12 months old. Growing very slowly.

- Early morning: Breastfeed. Half a bowl of thin porridge
- Mid-morning: Two small spoonfuls of mashed banana, breastfeed
- Midday: Four spoonfuls of thin soup, one spoonful of mashed meat/vegetables/potato from the soup (¾ of a bowl), breastfeed
- Mid-afternoon: Breastfeed, two spoonfuls of mashed mango
- Evening: Two spoonfuls of mashed meat/vegetable/potato from family meal (less than ½ a bowl), breastfeed
- Bedtime: Breastfeed, sweet biscuit mashed in cow's milk (¼ of cup).
- During the night: Breastfeed

Story 5

Child is 6½ months old and healthy. Growing well. Easy to feed. Has recently started complementary feeds.

- Early morning: Breastfeeds
- Mid-morning : Three spoonfuls of thin porridge with milk, breastfeeds
- Midday: breastfeeds
- Mid-afternoon : breastfeeds
- Evening : Three spoonfuls of mashed family meal – potato, fish, carrots. Thick consistency
- Bedtime: Breastfeed
- During night : Breastfeeds

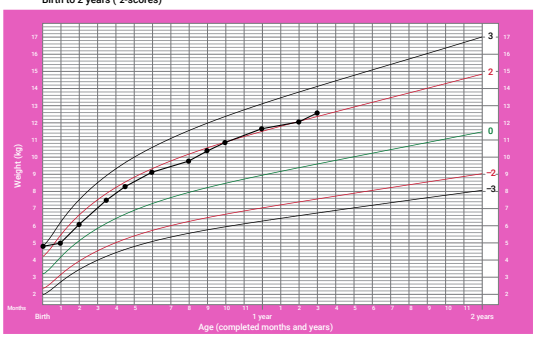
Story 6

Child is 8 months old. Not ill. Does not show much interest in eating.

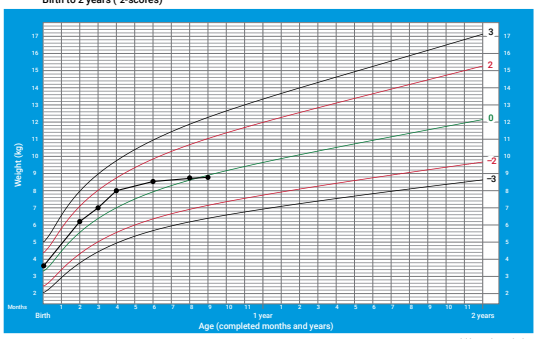
- Early morning: Breastfeed, two spoonfuls of thin porridge with milk and sugar (less than ½ a bowl)
- Mid-morning: Breastfeed
- Midday: One spoonful of rice, one spoonful of mashed beans, small piece of egg, one spoonful of mashed greens, from the family meal (½ a bowl). Drink of water.
- Mid-afternoon: One sweet biscuit, breastfeed
- Evening: One piece of bread with some butter, breastfeed
- Bedtime: Breastfeed
- During the night: Breastfeed

Weight charts for stories

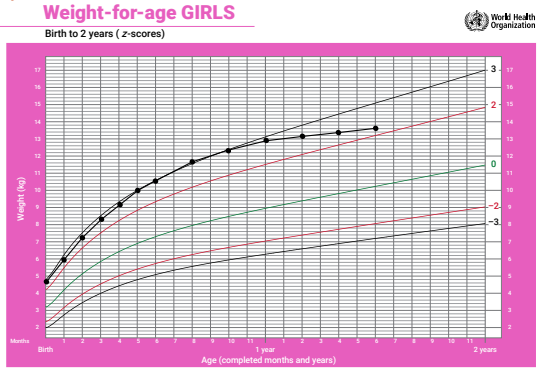
Story 1



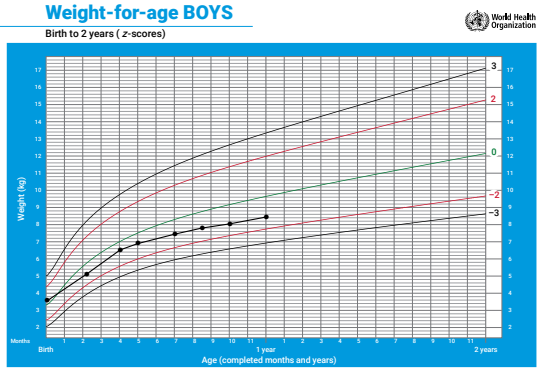
Story 2



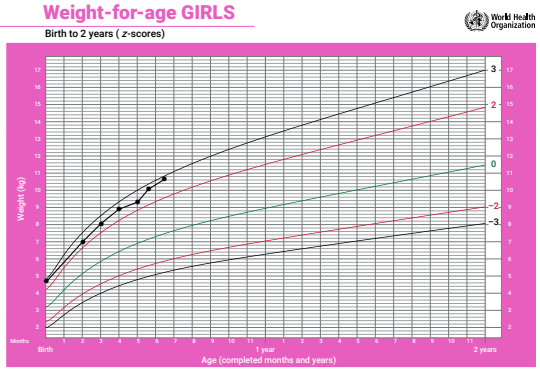
Story 3



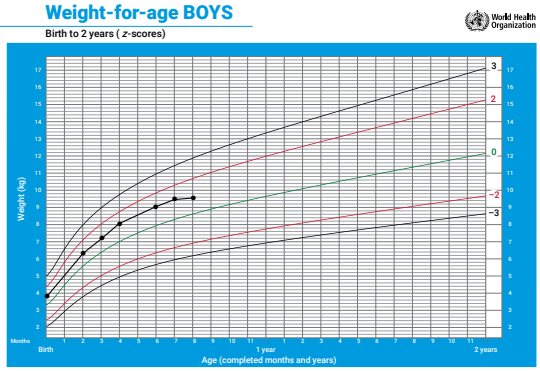
Story 4



Story 5



Story 6



Notes on stories for trainers to refer to during feedback

Story 1

Female child age 15 months. Growing well along z-score 2.

- Mother is still breastfeeding frequently
- Received 3 meals of a thick consistency
- Ate fish (animal-source food)
- Had milk on porridge
- Ate beans at midday
- Ate greens with evening meal and mango at midday
- Had 3 meals and 2 snacks
- Amount of food for a 15-month-old child is ¾ to one cup (250 mL) per meal. This child had a half-cup in the morning. However, quantities at other meals were appropriate
- Mid-morning snack was bread with nothing on it
- Suggest discussing quantities of food per meal for a child aged 15 months
- Suggest healthy snacks to offer – e.g. putting margarine or peanut butter on the bread or biscuit

Story 2

Male child age 9 months. Birth weight between 0 and 2 z-scores. Grew well until 4th month but the child's growth poor since then.

- Mother is not breastfeeding
- Received one meal of a thick consistency (evening meal) but other two meals were thin
- Ate meat (animal-source food)
- Had cow's milk – 1½ cups = 375 mL (this child is not breastfeeding so should receive 1–2 cups of milk per day)
- Ate beans at midday
- Although ate vegetables it is not clear from story whether these were green or yellow
- Had 3 meals and 3 snacks
- Received ½ a bowl of food for meals (at 9 months should be receiving ½ a bowl)
- Suggest making morning porridge and midday soup of a thicker consistency
- As child is not breastfeeding should have 3–4 meals + 1 snack + an extra 1–2 meals per day. Suggest that one of the snacks (e.g. mid-afternoon) is larger in quantity so this would count as an extra meal
- Suggest enriching porridge with peanut butter, oil or margarine. Suggest giving an extra ½ cup of milk per day. Suggest putting some margarine or peanut butter on the bread at bedtime

Story 3

Female child age 18 months. Growth good to 10 months but growth curve beginning to flatten. Mother is still breastfeeding.

- Received 2 meals of a thick consistency (early morning and midday meals)
- No animal-source foods
- Ate beans at midday
- Although ate vegetables with midday meal, it is not clear from story whether these were green or yellow
- Had 3 meals and 1 snack (mid-afternoon) – the mid-morning snack was a drink of diluted fruit juice
- Received full bowl of food for early-morning and midday meals, but the evening meal was less than one bowl – at 18 months should be receiving ¾ to 1 full bowl
- Suggest a larger quantity of food at the evening meal, e.g. staple, animal-source food and green/yellow vegetables
- Suggest a healthy snack mid-morning
- Suggest breastfeeds and water for drinks, or undiluted fruit juice rather than diluted fruit drinks
- Suggest giving some animal-source foods each day if possible
- Suggest increasing the energy of the morning porridge with oil, peanut butter or margarine

Story 4

Male child age 12 months. Poor growth since 5 months of age. Mother is still breastfeeding.

- Evening meal of thick consistency, but early morning porridge and midday meal of a thin consistency
- Meat given at the midday and evening meals
- Ate mango
- Had 3 meals and 3 snacks, which is appropriate frequency of feeds for a 12-month-old child who is breastfeeding
- Received ½ a bowl of porridge in the early morning and the evening meal was not a full bowl. At 12 months, the child should be receiving ¾ to 1 full bowl
- Suggest making the food thicker
- Suggest giving a larger quantity of food at meals – ¾ to 1 full bowl
- Suggest increasing the energy of the morning porridge with oil, peanut butter or margarine

Story 5

Female child age 6½ months. Child has just started complementary feeds. Growing well.

- Appropriate number of meals and amount per day – 2 meals; 2–3 tablespoons
- Suggest making porridge thicker

Story 6

Male child age 8 months. Child had good growth until 6 months but now growth curve flattening. Mother is still breastfeeding frequently.

- Midday meal of thick consistency, but early-morning porridge of a thin consistency
- Small piece of egg given at the midday meal
- Ate mashed greens at midday
- Had 2 meals and 2 snacks (the evening "meal" was more like a snack) – a child of 8 months who is breastfeeding should receive 2–3 meals a day
- At 8 months the child should be receiving ½ a bowl of food 3 times a day. The quantity of food offered to this child was less than ½ bowl in the morning and evening
- Suggest making the porridge thicker
- Suggest giving a larger quantity of food 3 times a day – ½ a bowl
- Suggest increasing the energy of the morning porridge with oil, peanut butter or margarine
- If possible, suggest increasing the amount of animal-source foods given daily

Suggested alternative methodologies

Facilitators prepare Demonstration 47.A in advance (facilitator mother and facilitator counsellor).

- Ask participants to follow along using the Job aid: Food intake – 6 up to 24 months.
- Facilitators demonstrate the Assess step (Demonstration 47.A) and the facilitator-counsellor completes the Job aid: Food intake – 6 up to 24 months..
- The facilitator-counsellor pauses during the Analyse step to "think out loud", reviewing for participants what they have has heard the mother say about how the child is fed, and comparing this to the age-appropriate feeding recommendations. The facilitator-counsellor then prioritizes any challenges the mother-caregiver faces in feeding the child, and decides what is most important to discuss with the mother/caregiver at this moment. The facilitator-counsellor demonstrates this process, but can engage the participants to determine what they have heard by asking the questions on pages 612–614.
- The facilitator-counsellor then turns back to the facilitator-mother to continue the third (Act) step, modelling the conversation and process of negotiation. The facilitator-counsellor praises those behaviours that are being done well, and selects a portion of the information from the age-appropriate counselling card that is most appropriate to the mother's/caregiver's situation (determined from setting priorities in the Analyse step), discussing it with the mother/caregiver, and asking the mother to repeat the agreed-upon behaviour. The facilitator-counsellor reinforces important information by repeating Key messages appropriate to the Counselling card.
- With participants: review and complete together/or talk through the Job aid: Food intake – 6 up to 24 months.
- Discuss and summarize.

Notes

SESSION 48

Responsive feeding

Objectives

After completing this session, participants will be able to:

- describe feeding practices and their effect on the child's intake
- explain to families specific techniques to encourage a young child to eat
- list the Key message from this session

Session outline . . . . . 60 minutes

Participants are all together for a lecture presentation by one trainer.

I. Introduce the session, present **Slide 48/1** . . . . . 7 minutes
II. Describe feeding care practices and their effect on intake (**Slides 48/2** and **48/3**, Demonstrations 48.A–48.C) . 35 minutes
III. Examine Counselling cards for age-appropriate responsive feeding . . . . . 15 minutes
IV. Summarize the session . . . . . 3 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides and giving a demonstration.
- Study the **Slides 48/1** to **48/3** and the text that goes with them, so that you are able to present them.
- Have ready the feeding recommendations that participants wrote down in Session 43.
- Ask two participants to assist with the Demonstrations 48.A, 48.B and 48.C.
- For the demonstrations you need a spoon, a feeding bowl with some mashed food in it, a biscuit or piece of bread or other finger food, a cloth to use as a bib and a basin, water, soap and towel for hand-washing. You also need a mat or chairs to sit on while feeding the child; whatever is common in your area.
- You need a flipchart and markers.
- Prepare a flipchart with the list of Responsive feeding practices. Keep it covered until needed.
  - Assist children to eat, being sensitive to their cues or signals
  - Feed slowly and patiently, encourage but do not force
  - Talk to children during feeding, with eye-to-eye contact
- Write the Key message from this session on a flipchart page. Keep it covered until later in the session:
  - Key message 9: A young child needs to learn to eat: encourage and give help …with lots of patience.
- Have ready Counselling card 16: Start complementary feeding when your baby reaches 6 months, Counselling card 18: Complementary feeding from 6 up to 9 months, Counselling Card 19: Complementary feeding from 9 up to 12 months and Counselling card 20: Complementary feeding from 12 up to 24 months, and the *Guidance on the use of counselling cards*.

As you follow the text, remember:

- ▸ indicates an instruction to you, the trainer.
  - ¤ indicates what you say to participants.

I. Introduce the session — 7 minutes

- ▸ Make these points:
  - ¤ Health workers like you frequently give information to caregivers about feeding their young child. We will now look at the recommendations and suggestions that you give and that you wrote down in Session 43.
- ▸ Make two columns on the flipchart. Write WHAT TO FEED at the top of one column and HOW TO FEED at the top of the other. Read out the recommendations on complementary feeding that participants wrote on paper in Session 43, one by one. Remember these were the most frequent recommendations or information that participants give to caregivers about feeding young children. After you read out each recommendation, put a tick mark in the column that relates to the recommendation. For example, the recommendation GIVE FRUITS or GIVE ANIMAL-SOURCE FOODS or GIVE MORE FOOD go in the WHAT column; the recommendation PAY ATTENTION TO THE CHILD WHILE FEEDING or WASH YOUR HANDS BEFORE FEEDING THE CHILD go in the HOW column.
  - ¤ *Ask: What do you see? Which type of information do you give most often?*
- ▸ Wait for a few replies and then continue.
  - ¤ *Ask: Which column has the most tick marks in it?*
- ▸ (It is probably the WHAT column.) Wait for a few replies and continue.
  - ¤ Often health workers talk about what foods to give the child. Yet, when we listen to families, they say, "my child does not eat enough" or "my child is very difficult to feed".
  - ¤ Imagine a young child first eating. What comes to mind?
  - ¤ When a child is learning to eat, they often eat slowly and are messy. They may be easily distracted.
  - ¤ The child may make a face, spit some food out and play with the food. This is because the child is learning to eat.
  - ¤ A child needs to learn how to eat, to try new food tastes and textures.
  - ¤ A child needs to learn to chew, move food around the mouth and swallow food.
  - ¤ The child needs to learn how to get food effectively into the mouth, how to use a spoon and how to drink from a cup.
  - ¤ Therefore, it is very important also to talk to caregivers and offer suggestions about how to encourage the child to learn to eat the foods offered.This can help families to have happier mealtimes.
- ▸ Show **Slide 48/1 – Session 48 – objectives** and read out the objectives:

48/1

Session 48: Responsive feeding – objectives

After completing this session, participants will be able to:
- describe feeding practices and their effect on the child's intake
- explain to families specific techniques to encourage young children to eat
- list the Key message from this session

II. Describe feeding care practices and their effect on intake 35 minutes

▸ **Large-group discussion: ask participants:**

- What are the signs that a child is developmentally ready for complementary foods? How does this change as the child ages?
- At what age do caregivers in your community expect young children to be able to eat by themselves?

▸ **Make these points:**

- A child needs food, health and care to grow and develop. Even when food and health care are limited, good caregiving can help make best use of these limited resources.
- Care refers to the behaviours and practices of the caregivers and family that provide the food; health care; stimulation; and emotional support necessary for the child's healthy growth and development.
- An important time to use good care practices is at mealtimes – when helping young children to eat.

▸ **Uncover the first RESPONSIVE FEEDING PRACTICE on the flipchart list, and make these points:**

- The first RESPONSIVE FEEDING PRACTICE to look at is: ASSIST CHILDREN TO EAT, BEING SENSITIVE TO THEIR CUES OR SIGNALS.
- At about 6 months, a young child is developmentally ready for complementary foods.
- Signs that a child is developmentally ready for complementary foods are:
  - staying in a sitting position and holding their head steady
  - coordinating their eyes, hands and mouth so that they can look at the food, pick it up and put it in their mouth by themselves
  - swallowing food – babies who are not ready will push their food back out, so they get more round their face than they do in their mouths.
- Children need to learn to eat. Eating solid foods is a new skill and, at first, the child will eat slowly and may make a mess. It takes lots of patience to teach children to eat.
- The child needs help and time to develop this new skill, to learn how to eat, to try new food tastes and textures.
- At first, the young child may push food out of their mouth. This is because they do not have the skill of moving it to the back of their mouth to swallow it.
- Caregivers may think that this pushing out of food means the child does not want to eat. Talk with them about children needing time to learn to eat, just as they need time to learn to walk and to learn other skills.
- *Ask: At what age do caregivers in your community expect young children to be able to eat by themselves?*

▸ **Wait for a few replies and then continue.**

- A child's ability to pick up a piece of solid food, hold a spoon or handle a cup increases with age and practice.
- Children under 2 years of age need assistance with feeding.
- However, this assistance needs to adapt so that the child has opportunities to feed themself, as they are able.
- A child may eat more if they are allowed to pick up foods with their newly learnt finger skills from about 9–10 months of age.
- The child may be at least 15 months old before they can eat a sufficient amount of food by self-feeding. At this age, they are still learning to use utensils and will still need assistance.
- Families tend to feed their young children in one of three different ways:
  - One way is **high control** of the feeding by the caregiver, who decides when and how much the child eats. This may include force-feeding.
  - Another feeding style is that the children are left to feed themselves. The caregiver believes that the child will eat if hungry. The caregiver may also believe that when the child stops eating they have had enough to eat.
  - The third style is feeding in response to the child's cues or signals, using encouragement and praise.
- The easiest way to see the difference in these three feeding styles is to demonstrate them.

▸ **Introduce the three DEMONSTRATIONS 48.A, 48.B and 48.C.**

- Ask the two participants whom you prepared to give DEMONSTRATIONS 48.A, 48.B and 48.C. One participant plays the part of a child aged about 18 months and another participant is the "caregiver". Have the items for the demonstration ready.
- Now we see demonstrations of three ways to feed a young child. After each demonstration, we will discuss what it shows.

DEMONSTRATION 48.A CONTROLLED FEEDING

The "young child" is sitting next to the caregiver (or on the caregiver's knees). The caregiver prevents the child from putting their hands near the bowl or the food.

The caregiver spoons food into the child's mouth.

If the child struggles or turns away, they are brought back to the feeding position.

The child may be slapped or forced if they do not eat.

The caregiver decides when the child has eaten enough and takes the bowl away.

- *Ask: What style of feeding did we see here?*

▸ **Wait for a few replies and then continue.**

- This is an example of controlled feeding. Children may not learn to regulate their intake, which may lead to obesity and food refusal later.
- *Ask: How do you think this child feels about eating?*

▸ **Wait for a few replies and also ask the "child" how they felt.**

- The "child" may feel eating is very frightening and uncomfortable. They may feel scared.
- Now we see another way of feeding a young child.

DEMONSTRATION 48.B LEAVE TO THEMSELVES

The "young child" is on the floor sitting on a mat.

The caregiver puts a bowl of food beside the child with a spoon in it.

The caregiver turns away and continues with other activities (nothing too distracting for those watching).

The caregiver does not make eye contact with the child or help very much with feeding.

The child pushes food around the bowl, looks to the caregiver for help, eats a little, cannot manage a spoon well, tries with their hands but drops the food; the child gives up and moves away.

The caregiver says, "Oh, you aren't hungry" and takes the bowl away.

- *Ask: What style of feeding did we see here?*

▶ **Wait for a few replies and then continue.**

- This is an example of feeding by leaving children to do it themselves. If the child has a poor appetite or is too young to manage the skills of eating, this can result in malnutrition.
- *Ask: How do you think this child feels about eating?*

▶ **Wait for a few replies and also ask the "child" how they felt.**

- The "child" may feel eating is very difficult. They may be hungry or sad.
- Now we see a third way of feeding a young child.

DEMONSTRATION 48.C RESPONSIVE FEEDING

The caregiver washes the child's hands and their own hands and then sits level with the child. The caregiver keeps eye contact and smiles at the child. Using a small spoon and an individual bowl, small amounts of food are put to the child's lips and the child opens their mouth and takes it a few times.

The caregiver praises the child and makes pleasant comments – "Aren't you a good boy", "Here is lovely dinner", while feeding slowly.

The child stops taking food by shutting his mouth or turning away. The caregiver tries once – "Another spoonful of lovely dinner?". The child refuses and the caregiver stops feeding.

The caregiver offers a piece of food that the child can hold – bread crust, biscuit or something similar. "Would you like to feed yourself?" The child takes it, smiles and sucks/munches it.

The caregiver encourages "You want to feed yourself, do you?"

After a minute, the caregiver offers a bit more from the bowl. The child starts taking spoonfuls again.

- *Ask: How did the child feel this time about feeding?*

▶ **Wait for a few replies. Ask the "child" too.**

- The child may feel happy about eating. He may like the contact and the praise and enjoy feeding himself.
- *Ask: What style of feeding did we see in the last demonstration?*

▶ **Wait for a few replies and then continue.**

- In this last demonstration, the caregiver was feeding the child in response to the child's cues.
- The child's cue or signal that he is hungry may include restlessness, reaching for food or crying.
- Cues or signals that he does not want to eat more may include turning away, spitting out food or crying.
- Caregivers need to be aware of their child's cues, interpret them accurately, and respond to them promptly, appropriately and consistently.

▶ **Uncover the second RESPONSIVE FEEDING PRACTICE on the flipchart list.**

- Now we have another RESPONSIVE FEEDING PRACTICE: FEED SLOWLY AND PATIENTLY, ENCOURAGE BUT DO NOT FORCE.
- *Ask: What good practices did we see in the last demonstration that we could encourage?*

▶ **Write participants' responses on the flipchart and then continue.**

- We could encourage many good responsive feeding practices here. When you are talking with caregivers, notice what practices they are doing that you can praise.
- Offer a few suggestions for other practices they could try.
- Some practices you can suggest are listed in your *Participant's manual*.

► Ask participants to turn to page 370 of their *Participant's manual* and find the box RESPONSIVE FEEDING TECHNIQUES. Ask participants to take it in turns to read out the points.

RESPONSIVE FEEDING TECHNIQUES

- Respond positively to the child, with smiles, eye contact and encouraging words
- Feed the child slowly and patiently, with good humour
- Try different food combinations, tastes and textures, to encourage eating
- Wait when the child stops eating and then offer again
- Give finger foods that the child can feed themself
- Minimize distractions if the child loses interest easily
- Stay with the child through the meal and be attentive

► Uncover the third RESPONSIVE FEEDING PRACTICE on the flipchart list, and make these points:

- The third RESPONSIVE FEEDING PRACTICE to encourage is: TALK TO CHILDREN DURING FEEDING, WITH EYE-TO-EYE CONTACT.
- Feeding times are periods of learning and love. Children may eat better if feeding times are happy.
- Feed when the child is alert and happy. If the child is sleepy or over-hungry and upset, they may not eat well.
- Regular mealtimes and a focus on eating without distractions may also help a child to learn to eat.
- When you talk with a caregiver, ask who feeds the child.
- Children are more likely to eat well if they like the person who is feeding them.
- Give positive attention for eating, not just attention when eating poorly.
- Older siblings may help with feeding but may still need adult supervision to ensure the young child is actively encouraged to eat and that the sibling does not take their food.
- Now we will examine the Counselling cards for age-appropriate responsive feeding.

III. Activity: Examine Counselling cards for age-appropriate responsive feeding 15 minutes

► Divide participants into four groups and ask each group to take off one of the Counselling cards:

- Group 1 will examine COUNSELLING CARD 16: START COMPLEMENTARY FEEDING WHEN YOUR BABY REACHES 6 MONTHS and the section in the *Guidance on the use of counselling cards* on KEY PRACTICES AND DISCUSSION POINTS for that Counselling card.
- Group 2 will examine COUNSELLING CARD 18: COMPLEMENTARY FEEDING FROM 6 UP TO 9 MONTHS and the section in the *Guidance on the use of counselling cards* on KEY PRACTICES AND DISCUSSION POINTS for that Counselling card.
- Group 3 will examine COUNSELLING CARD 19: COMPLEMENTARY FEEDING FROM 9 UP TO 12 MONTHS and the section in the *Guidance on the use of counselling cards* on KEY PRACTICES AND DISCUSSION POINTS for that Counselling card.
- Group 4 will examine COUNSELLING CARD 20: COMPLEMENTARY FEEDING FROM 12 UP TO 24 MONTHS and the section in the *Guidance on the use of counselling cards* on KEY PRACTICES AND DISCUSSION POINTS for that Counselling card.
- Each group should discuss the responsive feeding practices observed in the counselling card.

► After about 10 minutes, bring all participants back into their places.

► Ask each group to report back to the large group.

► Summarize and fill in any gaps.

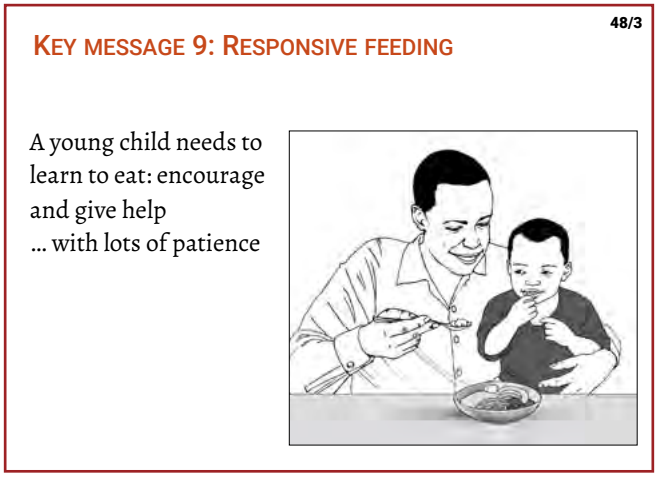
▸ Show **Slide 48/2 – Feeding situation** and ask the question:

- *Ask: What can we see in this feeding situation that could encourage the young child to eat?*

▸ **Write participants' responses on the flipchart and then continue. Refer to the responses as you make these points:**

- The overall feeding environment may also affect food intake. This includes:
  - sitting with the family or other children at mealtimes, so the child sees them eating
  - sitting with others eating, to provide an opportunity to offer extra food to the young child
  - using a separate bowl for the child, so the caregiver can see the amount eaten
  - talking with the child
  - encouraging all the family to help with responsive feeding practices.
- In this session, we saw three responsive feeding practices to encourage (point to list):
  - Assist children to eat, being sensitive to their cues or signals
  - Feed slowly and patiently, encourage but do not force
  - Talk to children during feeding, with eye-to-eye contact

▸ Show **Slide 48/3 – Key message 9: Responsive feeding** and read out the message:



IV. Summarize the session 3 minutes

- Ask participants whether they have any questions, and try to answer them.
- Make these points:
  - In this session, we discussed the importance of feeding and care practices to assist in feeding a young child.
  - We learnt another Key message in this session.
- Point to the flipchart page with the Key message from this session:
  - KEY MESSAGE 9: A YOUNG CHILD NEEDS TO LEARN TO EAT: ENCOURAGE AND GIVE HELP … WITH LOTS OF PATIENCE
- Keep this message together with previous key messages displayed throughout the course.
- Explain that a summary of this session can be found on pages 369–370 of the *Participant's manual*. The list of Key messages can be found on page xiv in the *Participant's manual*.

Notes

SESSION 49

Hygienic preparation of feeds

Objectives

After completing this session, participants will be able to:

- explain ways of assisting clean and safe feeding of young children
- demonstrate how to prepare a cup hygienically for feeding a baby

Session outline . . . . . 30 minutes

Participants are all together for a lecture presentation by one trainer.

I. Introduce the session, present **Slide 49/1** . . . . . 7 minutes
II. Explain the requirements for clean and safe feeding (**Slides 49/2** to **49/7**) . . . . . 20 minutes
III. Summarize the session . . . . . 3 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides.
- Study the **slides 49/1** to **49/7** and the text that goes with them, so that you are able to present them.
- Have ready COUNSELLING CARD 13. GOOD HYGIENE (CLEANLINESS) PRACTICES PREVENT DISEASE, and the *Guidance on the use of counselling cards*.

As you follow the text, remember:

▸ indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

I. Introduce the session — 7 minutes

▸ Show **Slide 49/1 – Session 49 – objectives** and read out the objectives:

49/1

Session 49: Hygienic preparation of feeds – objectives

After completing this session, participants will be able to:

- explain the requirements for clean and safe feeding of young children
- demonstrate how to prepare a cup hygienically for feeding

II. Explain the requirements for clean and safe feeding — 20 minutes

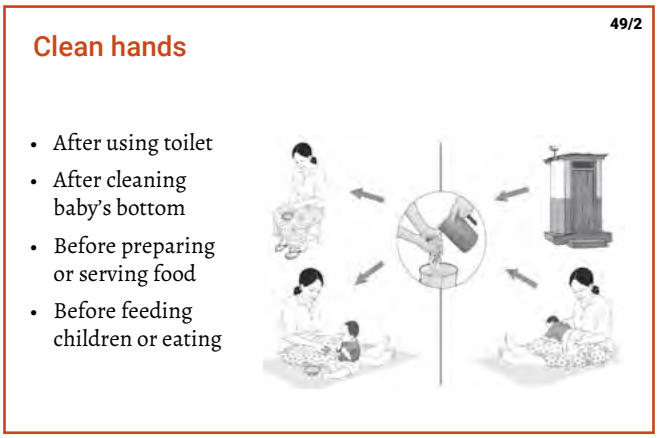
▸ **Make these points:**

- A baby who is not breastfed is at increased risk of illness for two reasons:
  - Replacement feeds may be contaminated with organisms that can cause infection.
  - The baby lacks the protection provided by the breast milk.
- After 6 months of age, all children require complementary feeds. Clean, safe preparation and feeding of complementary foods are essential to reduce the risk of contamination and the illnesses that it causes.
- The main points to remember for clean and safe preparation of feeds are:
  - Clean hands
  - Clean utensils
  - Safe water and food
  - Safe storage
- *Ask: When is it important to wash your hands?*

▸ **Wait for a few replies and then continue.**

▸ **Organize participants in buzz groups of three and ask them to study COUNSELLING CARD 13. GOOD HYGIENE (CLEANLINESS) PRACTICES PREVENT DISEASE, and the section in the *Guidance on the use of counselling cards* on KEY PRACTICES AND DISCUSSION POINTS for that Counselling card, and to mention the hygiene practices they observe. Ask various groups to share their observations**

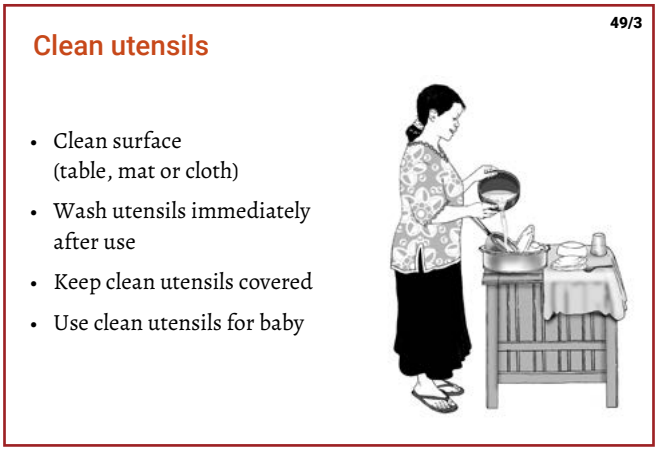
▸ **Show Slide 49/2 – Clean hands and make the points that follow, summarizing the observations of the participants:**



- Always wash your hands:
  - after using the toilet, after cleaning the baby's bottom, after disposing of children's stools, and after washing nappies and soiled cloths
  - after handling foods that may be contaminated, for example, raw meat and poultry products
  - after touching animals or animal faeces
  - before preparing or serving food
  - before eating, and before feeding children.
- However, it is not necessary to wash hands before every breastfeed if there is no other reason to wash them.

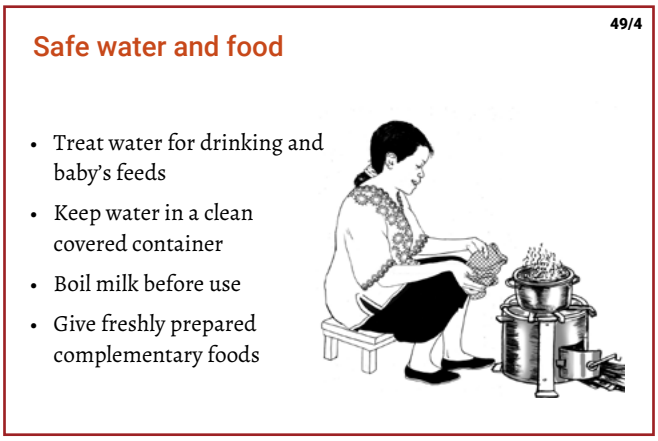
- ¤ It is important to wash your hands thoroughly:
  - with soap or ash
  - with plenty of clean running or poured water
  - front, back, between the fingers and under the nails.
- ¤ Let your hands dry in the air or dry them with a clean cloth. It is best not to dry them on your clothing or a shared towel.

► Show **Slide 49/3 – Clean utensils** and make the points that follow:



- ¤ You need to keep both the utensils that you use, and the surface on which you prepare feeds, as clean as possible.
- ¤ Use a clean table or mat that you can clean each time you use it.
- ¤ Wash utensils with cold water immediately after use, to remove milk before it dries on, and then wash with hot water and soap.
- ¤ If you can, use a soft brush to reach all the corners.
- ¤ Keep utensils covered, to keep off insects and dust until you use them.
- ¤ Use a clean spoon to feed a baby complementary foods. Use a clean cup to give a baby milk or fluids.
- ¤ If a caregiver wants to put some of the baby's food into their mouth to check the taste or temperature, they should use a different spoon from the baby.

► Show **Slide 49/4 – Safe water and food** and make the points that follow:



- ¤ Safe water and food are especially important for babies.
- ¤ *Ask: How can water be made safer for feeding babies?*

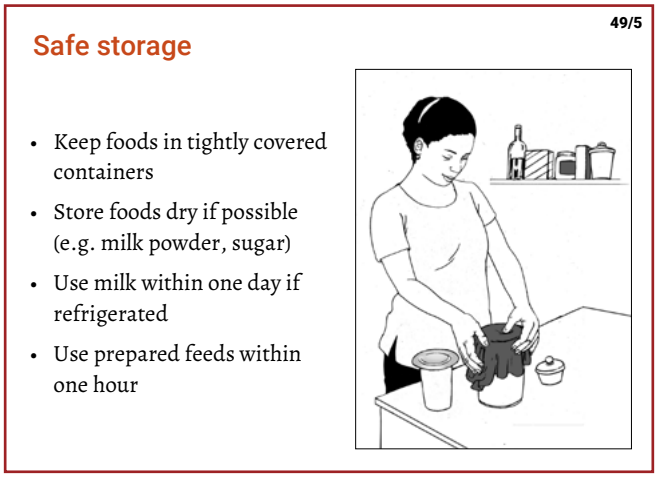
► Wait for a few replies and then continue.

- Bring the water to a rolling boil before use. This will kill most harmful microorganisms. A rolling boil is when the surface of the water is moving vigorously. It only has to "roll" for a second or two.
- Put the boiled water in a clean, covered, container, and allow to cool.
- The best kind of container has a narrow top, and a tap through which the water comes out.
- This prevents people from dipping cups and hands into the water, which can make it not safe.
- If the water has been stored for more than 48 hours, it is better to use it for something else, for example cooking, or to give it to older children to drink.
- Now we will talk about safe food.
- *Ask: How can food and milk be made safer for babies?*

▸ **Wait for a few replies and then continue.**

- Fresh cow's milk or other animal's milk to be used for a baby also needs to be briefly boiled, to kill harmful bacteria.
- Boiling also makes the milk more digestible. The milk and water can be boiled together.
- Milk sold in the shops may already have been heat-treated in various ways, such as pasteurization, ultra-high temperature (UHT) or sterilization. These treatments kill the harmful microorganisms, and help the milk to keep longer if it is not opened.
- It can be used without boiling if it is used immediately on opening. After it is open, it will only keep as long as fresh milk.
- If it has been open more than an hour, it will need to be boiled before giving it to a baby.
- Some families keep water cool in a pottery jar, which allows evaporation of water from the surface. This method is not safe for milk.
- If a caregiver is giving complementary foods, they should prepare them freshly each time they feed the baby, especially if they are semi-liquid.

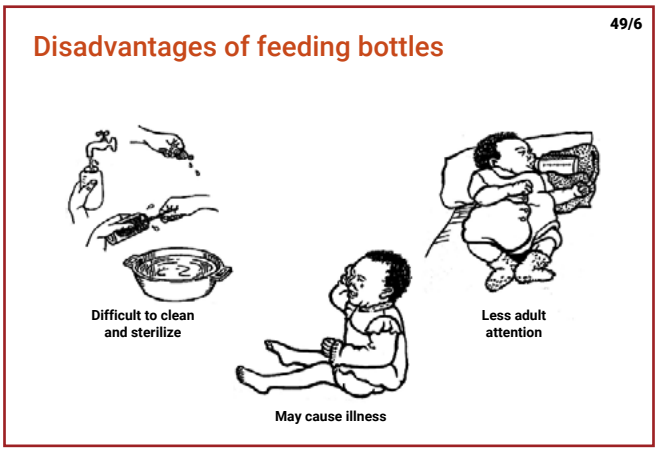
▸ **Show Slide 49/5 – Safe storage and make the points that follow:**



- Food should be kept tightly covered, to stop insects and dirt getting into it.
- Food can be kept longer when it is in a dry form, such as milk powder, sugar, bread and biscuits, than when it is in liquid or semi-liquid form.
- Fresh fruits and vegetables keep for several days if they are covered, especially if they have thick peel, like bananas.
- Fresh milk can be kept in a clean, covered container at room temperature for a few hours. Exactly how long depends on the condition of the milk when bought, and what the room temperature is.
- However, for an infant, milk must be boiled and then used within an hour of boiling.

- If a caregiver does not have a refrigerator, they must make feeds freshly each time. When a feed has been prepared with formula or dried milk, it should be used within an hour, like fresh milk.
- If a baby does not finish the feed, the caregiver should give it to an older child or use it in cooking.
- Some families keep water hot in a thermos flask. This is safe for water. But it is not safe to keep warm milk or formula milk in a thermos flask.
- Bacteria grow when milk is kept warm.
- Discuss with the mother or other caregiver how the household routine works – whether the mother cooks once or twice a day, whether she can prepare feeds many times a day, how often she goes to the market and what facilities she has for storage. Help her to find ways of preparing the baby's food in a clean and safe way.

▸ Show **Slide 49/6 – Disadvantages of feeding bottles** and make the points that follow:



- You will remember that we talked about the advantages of cup-feeding.
- Bottles are difficult to clean and easily contaminated with harmful bacteria, particularly if milk is left in a bottle for a long time. Bottles and contaminated milk can make babies ill with diarrhoea.
- A bottle may be propped for a baby to feed themself, or given to a young sibling to feed the baby, so the baby has less adult attention and social contact.
- If a mother decides to use a feeding bottle, help her to do it in a way that ensures good contact with the baby, holding the baby close and making eye contact.
- Mothers need to know how to clean cups and bottles.

Cleaning a cup

- A cup does not need to be boiled, in the way that a bottle does.
- To clean a cup, wash it and scrub it in hot soapy water each time it is used.
- If possible, dip the cup into boiling water, or pour boiling water over it just before use, but this is not essential.
- An open, smooth-surfaced cup is easiest to clean.
- Avoid tight spouts, lids or rough surfaces where milk could stick and allow bacteria to grow.

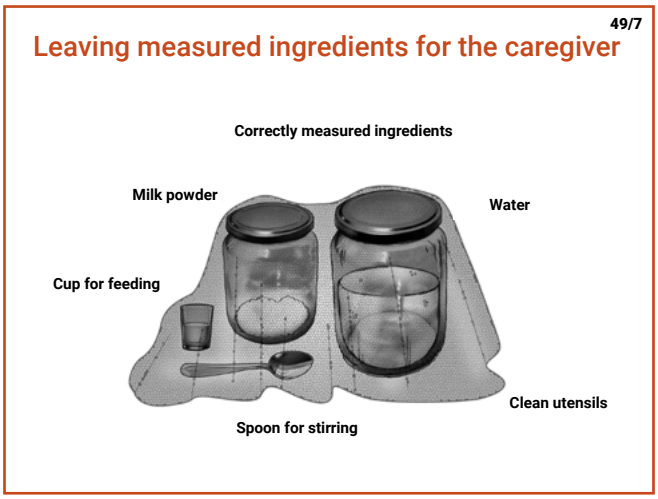
Cleaning feeding bottles and teats

- Bottles and teats are more difficult to clean than cups and you should discourage their use. However, you need to know how to clean them in case a caregiver insists on using them.
- A bottle and teat need to be rinsed immediately after use with cold water, and then scrubbed inside with a bottle brush and hot soapy water.
- At least once a day they should be sterilized.
- *Ask: What are ways of sterilizing used locally?*

► Wait for a few replies and then continue.

- Ways of sterilizing washed bottles may include:
  - Boiling – the bottle needs to be completely covered in water. The water needs to be boiling, with the surface actively rolling, for at least 10 minutes.
  - Soaking in a diluted bleach solution for at least 30 minutes (these should be diluted according to the instructions on the label).
- Remember that bleach is not good for a baby. If this method of sterilization is used, the bottle needs to be rinsed with previously boiled water before adding the milk, to ensure no bleach remains.
- Teats need to be turned inside out and scrubbed using salt or abrasive. They should then be boiled or soaked as above to sterilize.

► Show **Slide 49/7 – Leaving measured ingredients for the caregiver** and make the points that follow:



- A baby may be cared for by someone other than the mother for all or part of the time.
- A mother may feel it is safer to do as much of the preparation as possible herself, especially if the caregiver is young or inexperienced, or has difficulty measuring.
- This picture shows what a mother has to prepare if she is going to leave feeds ready for a caregiver.
- She cannot mix up a feed, because it will not be safe to feed the baby after an hour. She will have to leave the ingredients for the carer to mix.
- The mother still needs to leave clean utensils. She will have to boil and measure the water and measure the milk powder. She needs to cover them all and leave them in a cool, safe place, away from animals and insects.
- The mother must teach the caregiver to mix the ingredients just before they give the feed, and to feed it from a cup.

III. Summarize the session 3 minutes

- Ask participants whether they have any questions, and try to answer them.
- Make these points:
  - In this session, we discussed safe and clean preparation of replacement milk and complementary feeds.
  - Health workers need to discuss these with mothers.

In your *Participant's manual* on page 380 there are the FIVE KEYS TO SAFER FOOD. You can read these at another time.

- Explain that a summary of this session can be found on pages 373–380 of the *Participant's manual*.

FIVE KEYS TO SAFER FOOD

Keep clean

- Wash your hands before handling food and often during food preparation.
- Wash your hands after going to the toilet, changing the baby or contact with animals.
- Wash very clean all surfaces and equipment used for food preparation or serving.
- Protect kitchen areas and food from insects, pests and other animals.

Separate raw and cooked foods

- Separate raw meat, poultry and seafood from other foods.
- Use separate equipment and utensils, such as knives and cutting boards, for handling raw foods.
- Store foods in covered containers, to avoid contact between raw and prepared foods.

Cook thoroughly

- Cook food thoroughly, especially meat, poultry, eggs and seafood.
- Bring foods like soups and stews to boiling point. For meat and poultry, make sure juices are clear not pink.
- Reheat cooked food thoroughly. Bring to the boil or heat until too hot to touch. Stir while reheating.

Keep food at safe temperatures

- Do not leave cooked food at room temperature for more than 2 hours.
- Do not store food too long, even in a refrigerator.
- Do not thaw frozen food at room temperature.
- Food for infants and young children should ideally be freshly prepared and not stored at all after cooking.

Use safe water and raw materials

- Use safe water or treat it to make it safe.
- Choose fresh and wholesome foods.
- Use pasteurized milk.
- Wash fruits and vegetables in safe water, especially if eaten raw.
- Do not use food beyond its expiry date.

Adapted from WHO Food Safety Programme. Five keys to safer food. Geneva: World Health Organization; 2001 (WHO/SDE/PHE/FOS/01.1; http://apps.who.int/iris/bitstream/10665/66735/1/WHO_SDE_PHE_FOS_01.1.pdf).

Notes

SESSION 50

Feeding during illness and recovery

Objectives

After completing this session, participants will able to:

- explain why children need to continue to eat during illness
- describe appropriate feeding during illness and recovery
- counsel families about young child feeding during and after illness
- list the Key message from this session

Session outline . . . . . 45 minutes

Participants are all together for a lecture presentation by one trainer.

I. Introduce the session, present **Slide 50/1** . . . . . 3 minutes
II. Explain why children need to continue to eat during illness (**Slides 50/2** and **50/3**) . . . . . 10 minutes
III. Describe appropriate feeding during illness (**Slide 50/4**, EXERCISE 50.A) . . . . . 15 minutes
IV. Describe appropriate feeding during recovery (**Slides 50/5** and **50/6**) . . . . . 10 minutes
V. Outline counselling about feeding during and after illness . . . . . 5 minutes
VI. Summarize the session . . . . . 2 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides.
- Study the **Slides 50/1** to **50/6** and the text that goes with them, so that you are able to present them.
- You need a flipchart and markers.
- You needs copies of EXERCISE 50.A. SUGGESTIONS FOR FEEDING DURING ILLNESS, one copy per group
- Write the Key message from this session on a flipchart page. Keep it covered until later in the session:
  - KEY MESSAGE 10: ENCOURAGE THE CHILD TO DRINK AND EAT DURING ILLNESS, AND PROVIDE EXTRA FOOD AFTER ILLNESS TO HELP THEM RECOVER QUICKLY
- You need:
  - the flipchart list of RESPONSIVE FEEDING PRACTICES from Session 48
  - a flipchart of all the Key messages from earlier sessions
  - For SECTION II, COUNSELLING CARD 22. FEEDING THE SICK CHILD OVER 6 MONTHS OF AGE, and the *Guidance on the use of counselling cards*.

As you follow the text, remember:

► indicates an instruction to you, the trainer.

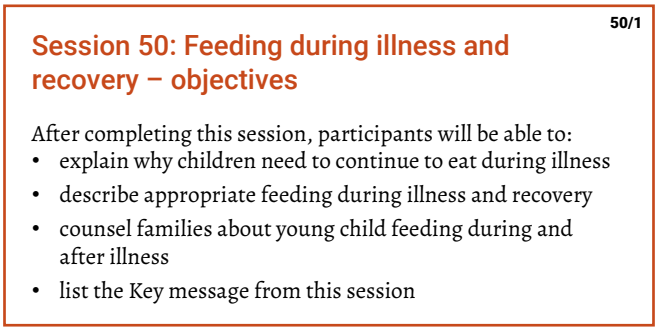
¤ indicates what you say to participants.

I. Introduce the session — 3 minutes

▸ **Make these points:**

- Some of the children you see for feeding counselling may be ill or recovering from an illness.
- Children who are ill may lose weight because they have little appetite, or their families may believe that ill children cannot tolerate much food.
- If a child is ill frequently, they may become malnourished and therefore at higher risk of more illness. Children recover more quickly from illness and lose less weight if they are helped to feed when they are ill.
- Children who are fed well when healthy are less likely to falter in growth from an illness and more likely to recover more quickly. They are better protected.
- Breastfed children are protected from many illnesses. Special care needs to be given to those who are not breastfed and who do not have this protection.

▸ **Show Slide 50/1 – Session 50 – objectives and read out the objectives:**



II. Explain why children need to continue to eat during illness — 10 minutes

- *Ask: How do families in your community feed a young child during illness? Do they use special foods? Give different amounts of food?*

▸ **Write participants' replies on the flipchart. Refer to their responses as you make these points:**

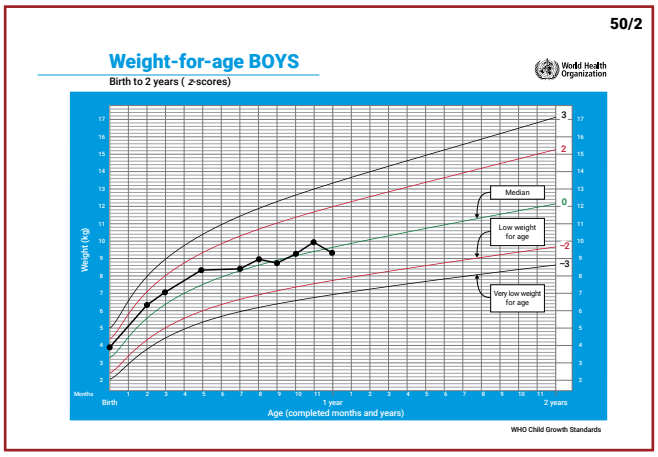
- Some families may feed the young child in a different way during illness.
- They may:
  - think food will harm a sick child and so give less food, or none at all
  - give only thin, watery foods with little nutritional value
  - give special foods believed to help the child recover from the illness
  - offer more high-quality foods
  - encourage the child to eat more.
- A child who is ill may have little interest in eating.
- *Ask: Why might a young child feed less during illness?*

▸ **Write participants' replies on the flipchart. Refer to their responses as you make these points:**

¤ A child may eat less during illness because:

- the child does not feel hungry and is weak and lethargic
- the child is vomiting, or their mouth or throat is sore
- the child has a respiratory infection, which makes eating and suckling more difficult
- caregivers withhold food, thinking that this is best during illness
- there are no suitable foods available in the household
- the child is hard to feed and the caregiver is not patient
- someone advises the mother to stop feeding/breastfeeding.

▸ **Show Slide 50/2 – Weight chart of an ill child and make the points that follow:**



¤ This is the growth chart of John who is 12 months old.

¤ *Ask: What do you think of the growth chart?*

▸ **Wait for a few replies and then continue.**

¤ John grew well for the first 5 months, then his growth started to falter. He was ill and lost weight.

¤ He recovered some weight but then became ill again and lost more. After each illness, he did not get back to his previous growth curve and is heading towards being malnourished.

¤ During infections, the child needs more energy and nutrients to fight the infection.

¤ If they do not get extra food, their fat and muscle tissue are used as fuel. This is why they lose weight, look thin and stop growing.

▸ **Show Slide 50/3 – KEY MESSAGE 10: FEEDING DURING AND AFTER ILLNESS and read it out:**

¤ The goal in feeding a child during and after illness is to help them to return to the growth they had before they were ill.

- Form buzz groups of three participants to examine COUNSELLING CARD 22: FEEDING THE SICK CHILD OVER 6 MONTHS OF AGE and the section in the *Guidance on the use of counselling cards* on KEY PRACTICES AND DISCUSSION POINTS for the Counselling card. They should discuss the card, in order to share the results of their discussion with the large group.
- After the group discussion, ask one group to present the results of the discussion; ask other groups to add any additional points.

III. Describe appropriate feeding during illness — 15 minutes

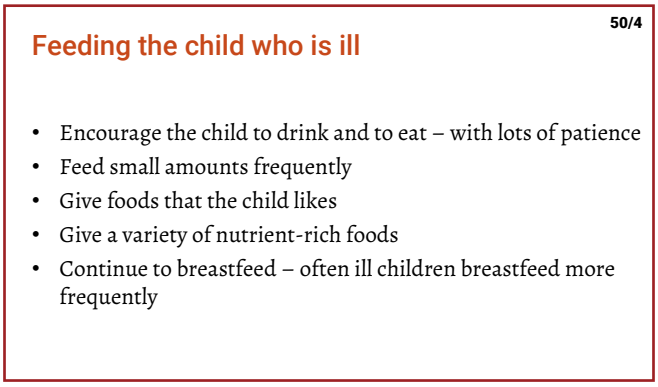
- Make the following points:
  - First, let us look at feeding during illness.
  - Sick children often need extra drinks and food during illness – for example if they have fever or diarrhoea. A sick child may prefer breastfeeding to eating other foods. Do not withhold food from a sick child.
- Ask participants to open their manuals to page 384 and find EXERCISE 50.A. Divide the illnesses between the groups. Ask participants, in their small group, to write a suggestion[1] or a piece of information for the condition that they could offer the caregiver – not a command. Allow 10 minutes for this exercise.

EXERCISE 50.A SUGGESTIONS FOR FEEDING DURING ILLNESS

Illness/condition	Information/suggestion – *possible replies*
Child's mouth or throat is sore	*Sour fruits, very sweet foods or spicy foods may irritate the mouth.* *Could you give soft or smooth foods?* *It might help to drink through a straw.*
Child has a blocked nose	*It often helps to clear the nose before feeding.* *Could you try to feed slowly, as this would give time to breathe?*
Child has fever	*Extra fluids/breastfeeds are good during a fever.* *Have you tried frequent small amounts of food?*
Child has chest infection or cough	*What about sitting the child upright and slowly giving small amounts?*
Child has diarrhoea	*Continuing to give some foods during diarrhoea helps the child to avoid losing weight.* *Extra fluids/breastfeeds are important.* *Some families give bananas, mashed fruits, soft rice and porridge during diarrhoea.* *Would you like to try this?* *If diarrhoea is severe, give oral rehydration solution (ORS).*
Child is vomiting	*Could you give frequent fluids/breastfeeds in small amounts?*
Child is sleepy	*Could you watch for times the child is alert and feed then?*

[1] The suggestion does not need to be one of the Key messages.

- **Bring the participants back to the large group. Say the first condition on the list and ask one group for one suggestion. Ask whether others groups have more suggestions. Continue through the list. Watch for participants who are writing down the additional suggestions, and allow time for this as needed.**
- **Show Slide 50/4 – Feeding the child who is ill and make the points that follow:**

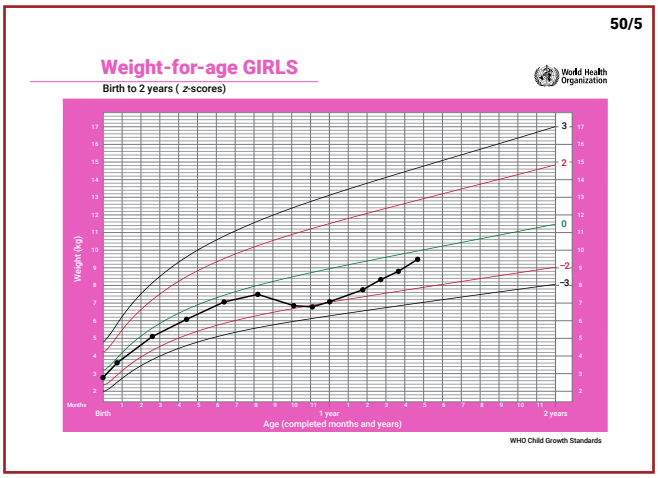


- When you talk with caregivers about feeding during illness, include this information as relevant to the situation.
- If the child is ill, they may need extra encouragement to drink and to eat. Offer drinks and foods with lots of patience and encouragement.
- Have a person that the child likes to help with feeding.
- Make the child comfortable before feeding – wash, rinse out their mouth, and position them comfortably.
- Offer smaller amounts of food than usual but give food more frequently during the day. Suggest that the caregiver looks for signs that the child might accept some food whenever possible, for example, if they have just woken up or if the child's fever is down.
- Give foods that the child likes to eat. Give as much variety as possible.
- Feed the child nutrient-rich complementary foods if they will eat them. Offer the child foods of a thick consistency, as well as the thinner foods that the child may prefer when ill. Semi-liquid foods or smoother foods may help if the child has a sore throat or sore mouth, or vomits with coughing.
- Encourage the child to take extra fluids.
- Increase the amount of breastfeeding. Breastfeeding will provide fluid, nutrients and protective factors to help combat infection as well as comfort. Small frequent breastfeeds may be easier for the child to manage.

- **Make these points:**
  - Sometimes a child, who is difficult to feed may be suffering from a physical illness.
  - *Ask: What are signs of illness that require early treatment?*
- **Write participants' responses on the flipchart**
  - Signs to watch for and for the need to seek early treatment include:
    - the child is sick, not feeding and refusing drinks
    - repeated vomiting
    - very frequent loose watery stools
    - marked thirst, dry lips, no tears, dehydration
    - blood in the stools
    - fast or difficult breathing
    - the child is very sleepy, difficult to wake
    - the child is not getting better from any illness or home care
    - weight loss that is not corrected by attention to feeding practices.
  - If it is not part of your job to treat an ill child, you need to know where to refer a child for treatment.

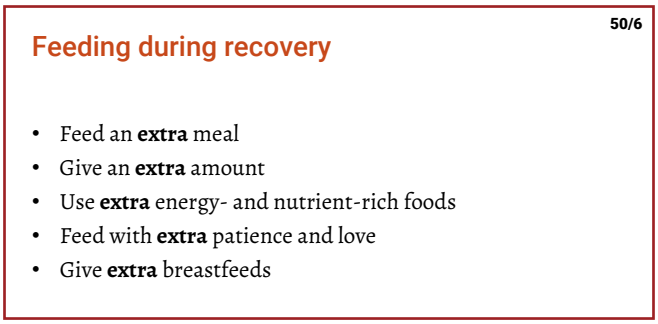
IV. Describe appropriate feeding during recovery 10 minutes

- **Make these points:**
  - A child's appetite may be poor during illness. Even with encouragement to eat, the child may not eat well. The child's appetite usually increases after the illness, so it important to continue to give extra attention to feeding after the illness. This is a good time for families to give extra food so that lost weight is quickly regained. This allows "catch-up" growth.
  - Young children need extra food until they have regained all their lost weight and are growing at a healthy rate.
- **Show Slide 50/5 – Weight chart: recovery and ask the question:**



  - *Ask: What can you tell from this weight chart?*
- **Wait for a few replies and then continue.**
  - This child grew well until about 9 months old. Then she lost weight, perhaps due to illness. However, continuing to feed during the illness and during recovery meant the child had "catch-up growth". She is now growing along the line she had before illness.
  - The child recovering from an illness needs good mixed foods to replace the nutrients such as iron and vitamin A that they lost from their body stores.
  - *Ask: What are some of the ways families may give a child extra food during recovery?*
- **Wait for a few replies and then continue.**

▸ Show **Slide 50/6 – Feeding during recovery** and ask a participant to read out the points:



- ¤ The child's appetite usually increases after the illness, so it is important to continue to give extra attention to feeding after the illness.
- ¤ This is a good time for families to give extra food, so that lost weight is quickly regained. This allows "catch-up" growth.
- ¤ Young children need extra food until they have regained all their lost weight and are growing at a healthy rate.
  - Feed more frequently, give an **extra meal** or nutritious food between meals.
  - Give an **extra amount** at each meal if the child's appetite is good.
  - Use foods that are **extra rich** in energy and nutrients, such as animal products, fruits and margarine or oil.
  - Encourage the child to eat, using **extra patience and love**.
  - Continue to breastfeed and give **extra breastfeeds** if the child is not eating.

V. Outline counselling about feeding during and after illness — 5 minutes

▸ Make these points:

- ¤ When you are talking with the family of a sick child, first find out what they do already. Many families know a lot about feeding sick children. They know what foods their child likes and how to encourage their child to eat.
- ¤ *Ask: How can you find out what children are eating and drinking?*

▸ Wait for a few responses and then continue.

- ¤ You can use your LISTENING AND LEARNING SKILLS to find out what the child is eating and drinking during the illness. The REFERENCE TOOL: FOOD INTAKE – 6 UP TO 24 MONTHS can help you to gather information on feeding practices during illness. Use this reference tool as described in Session 47, before giving more attention to the feeding during illness and recovery.
- ¤ The main information you need is about:
  - breastfeeding
  - whether the child has taken any other foods or fluids
  - different types of foods.
- ¤ Then ask:
  - *Were the foods you gave the child thinner or thicker than usual?*
  - about feeding techniques
  - *During this illness, has the child's feeding changed? If yes, how?*
  - *Can you tell me whether your child's feeding has changed during this illness?*
- ¤ *Ask: What can you say to families about helpful practices they are using?*

▸ Wait for a few responses, and then continue.

- ¤ You can praise and encourage helpful practices the family are using.

- Ask: *What type of information can you give to families when their child is ill?*

Wait for a few responses, and then continue.

- Limit the information you give to what is relevant at this time. Families may be overtired and stressed if their child is ill. It may be difficult for them to take in large amounts of information.
- Discuss what foods the child can eat and drink. If the child can only eat small amounts, suggest foods that can be prepared easily and are both nutrient rich and easy for the child to eat.
- A child who is ill or malnourished may not respond to their caregiver and the caregiver may find it difficult to continue giving care without response. Show that you understand that it can be difficult to feed an ill child. Praise the caregiver for continuing to try the various feeding techniques.
- After the child is past an acute stage of the illness, you can talk in more detail with the caregiver about how the child eats.

VI. Summarize the session — 2 minutes

Ask participants whether they have any questions, and try to answer them.

Make these points:

- In this session, we discussed the importance of adequate feeding during illness and recovery, and practised counselling families in this situation.

Point to the flipchart page with the Key message from this session:

- KEY MESSAGE 10: ENCOURAGE THE CHILD TO DRINK AND EAT DURING ILLNESS, AND PROVIDE EXTRA FOOD AFTER ILLNESS TO HELP THEM RECOVER QUICKLY

Point to the flipchart with the 10 Key messages listed. Explain to participants that the list of Key messages can be found on page xiv of the *Participant's manual*.

Explain that a summary of this session can be found on pages 383–387 of the *Participant's manual*.

Reference tool: Food intake – 6 up to 24 months

Feeding practice	Ideal feeding practice	Key messages to help counsel mothers
Growth appropriate?		*Look at the shape of the growth curve of the child: is the child growing?*
Child received breast milk?	Yes	Breastfeeding for 2 years or longer helps a child to develop and grow strong and healthy
How many meals of a thick consistency did the child eat yesterday? (use Food consistency pictures as needed)	3 meals	Foods that are thick enough to stay on the spoon give more energy to the child
Child ate an animal-source food yesterday (meat/fish/offal/bird/eggs)?	Animal-source foods should be eaten daily	Animal-source foods are especially good for children, to help them grow strong and lively
Child ate a dairy product yesterday?	Try to give dairy products daily	Animal-source foods are especially good for children, to help them grow strong and lively
Child ate pulses, nuts or seeds yesterday?	If meat is not eaten, pulses or nuts should be eaten daily, with an iron enhancer such as a vitamin-C-rich food	Peas, beans, lentils, nuts and seeds are good for children
Child ate a dark-green or yellow vegetable or yellow fruit yesterday?	A dark-green or yellow vegetable or yellow fruit should be eaten daily	Dark-green leaves and yellow-coloured fruits and vegetables help the child to have healthy eyes and fewer infections
Child ate sufficient number of meals and snacks yesterday, for their age?	Child 6–8 months: 2–3 meals plus 1–2 snacks if hungry Child 9–24 months: 3–4 meals plus 1–2 snacks if hungry	A growing child needs 2–4 meals a day, plus 1–2 snacks if hungry: give a variety of foods
Quantity of food eaten at main meal yesterday appropriate for child's age?	Child 6–8 months: gradually increased to approx. ½ cup at each meal Child 9–11 months: approx. ½ cup at each meal Child 12–24 months: approx. ¾–1 cup at each meal	A growing child needs increasing amounts of food
Caregiver assisted the child at mealtimes?	Yes, assists with learning to eat	A young child needs to learn to eat: encourage and give help … with lots of patience
Child took any vitamin or mineral supplements?	Vitamin and mineral supplements may be needed if child's needs are not met by food intake	*Explain how to use vitamin and mineral supplements if they are needed*
Child ill or recovering from an illness?	Continue to eat and drink during illness and recovery	Encourage the child to drink and eat during illness, and provide extra food after illness to help them recover quickly

Notes

SESSION 51

Checking understanding and arranging follow-up 1

Objectives

After completing this session, participants will be able to:

- demonstrate how to ensure that a caregiver understands information provided, by using checking questions
- arrange referral or follow-up of a child

Session outline . . . . . 15 minutes

Participants are all together for a lecture presentation by one trainer.

I. Introduce the session, present **Slide 51/1**. . . . . 2 minutes
II. Demonstrate two skills for checking understanding and arranging follow-up (DEMONSTRATION 51.A) . . . 10 minutes
III. Summarize the session . . . . . 3 minutes

Preparation

- Refer to the Introduction for guidance on giving a demonstration.
- Prepare two flipcharts: one with the LISTENING AND LEARNING SKILLS and one with the SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT. Have a blank flipchart ready to list the two new skills we will be discussing in this session.
- Make sure you have **Slide 51/1** ready. Alternatively, as there is only one slide in this session, you might prefer to read aloud the objectives on **Slide 51/1** without projecting them onto the screen.
- Study the instructions for DEMONSTRATION 51.A, so that you are clear about the ideas they illustrate, and you know what to do. Ask participants to be prepared to read the parts of the mother and the health workers in the demonstration.

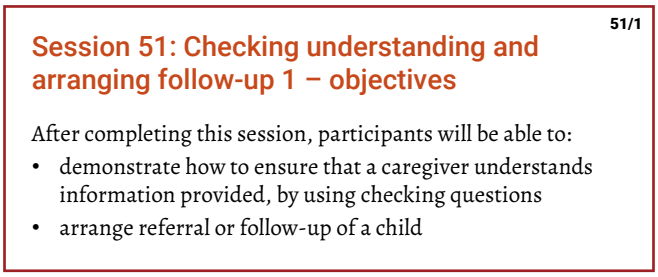
As you follow the text, remember:

▶ indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

I. Introduce the session — 2 minutes

- Show **Slide 51/1 – Session 51 – objectives** and read out the objectives:



- **Make these introductory points:**
  - In this session, you will learn two further skills to help support caregivers: checking understanding and arranging follow-up.

II. Demonstrate two skills for checking understanding and arranging follow-up — 10 minutes

Checking understanding

- **Put up on the wall two lists: one of the LISTENING AND LEARNING SKILLS and another of the SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT. Then put up a blank flipchart and on this write CHECKING UNDERSTANDING.**
- **Make these points:**
  - We have already practised the counselling skills of LISTENING AND LEARNING and BUILDING CONFIDENCE AND GIVING SUPPORT. However, you need to discuss the suggestions you make with a caregiver, so they can decide on a course of action. Your suggestion does not automatically become what a caregiver will do.
  - Often you need to check a caregiver understands a practice or action they plan to carry out. For example, if you have talked about feeding frequently, you may need to check the understanding of the term "frequently".
  - It is not enough to ask a caregiver whether they understand, because they may not realize that they understood incorrectly.
  - Ask open questions to find out whether further explanation is needed. Avoid asking closed questions, because they suggest the answer and can be answered with a simple "yes" or "no". They do not tell you whether a caregiver really understands.
  - "Checking understanding" also helps to summarize what you have talked about.
  - We will now see a demonstration of the need for using the skill of checking understanding. The demonstration involves a mother and health worker coming to the end of a discussion about feeding a 12-month-old baby.
- **Ask the two participants whom you have prepared to give DEMONSTRATION 51.A. The trainer briefly discusses what the participants have observed after each section.**

DEMONSTRATION 51.A CHECKING UNDERSTANDING

Health worker: *Now, (name), have you understood everything that I've told you?*
Mother: *Yes, ma'am.*

Health worker: *You don't have any questions?*
Mother: *No, ma'am.*

Comment: What did you observe?
This mother would need to be very determined to say that she had questions for this health worker. Let us hear this again, with the health worker using good checking questions.

Health worker: *Now, (name), we talked about many things today, so let's check everything is clear. What foods do you think you will give (name) tomorrow?*
Mother: *I will make his porridge thick.*

Health worker: *Thick porridge helps him to grow. Are there any other foods you could give, maybe from what the family is eating?*
Mother: *Oh yes. I could mash some of the rice and lentils we are having and I could give him some fruit, to help his body to use the iron in the food.*

Health worker: *Those are good foods to give your child to help him to grow. How many times a day will you give food to (name)?*
Mother: *I will give him something to eat five times a day. I will give him thick porridge in the morning and evening, and in the middle of the day, I will give him the food we are having. I will give him some fruit or bread in between.*

Health worker: *You have chosen well. Children who are 1 year old need to eat often. Would you come back to see me in 2 weeks to see how the feeding is going?*
Mother: *Yes, OK.*

Comment: What did you observe this time?

This time the health worker checked the mother's understanding and found that the mother knew what to do. She also asked the mother to come back for follow-up.

If you get an unclear response, ask another checking question. Praise the mother for correct understanding, or clarify any information as necessary.

Arranging follow-up or referral

- Write ARRANGE FOLLOW-UP OR REFERRAL on the flipchart below CHECKING UNDERSTANDING.
- Make these points:
  - All children should receive visits to check their general health and feeding. If a child has a difficulty that you are unable to help with, you may need to refer them for more specialized care.
  - Follow-up is especially important if there has been any difficulty with feeding. Ask the caregiver to visit the health facility in 5 days for follow-up.
  - This follow-up includes checking what foods are used and how they are given; checking how breastfeeding is going; and checking the child's weight, length, health, general development and care.
  - The follow-up visits also give an opportunity to praise and reinforce practices, thus building the caregiver's confidence; to offer relevant information; and to discuss suggestions as needed.
  - It is especially important for children with special difficulties, for example children whose mothers are living with HIV, to receive regular follow-up from health workers. These children are at special risk. In addition, it is important to check how the mother is coping with her own health and difficulties.

III. Summarize the session 3 minutes

- Ask participants whether they have any questions, and try to answer them.
- Explain that a summary of this session can be found on page 389 of the *Participant's manual*.

Notes

SESSION 52

Food demonstration

Objectives

After completing this session, participants will be able to:

- prepare a plate of food suitable for an infant or young child
- explain why they have chosen these foods
- conduct a food demonstration with a caregiver

Session outline . . . . . 60 minutes

Participants work in groups of 8–10 with two trainers.

I.	Introduce the session, present **Slide 52/1**	2 minutes
II.	How to help a mother learn to prepare a suitable meal (DEMONSTRATION 52.A)	20 minutes
III.	Prepare a plate of food	15 minutes
IV.	Discuss the meals prepared (EXERCISE 52.A)	20 minutes
V.	Summarize the session	3 minutes

Preparation

- Refer to the Introduction for guidance on giving a demonstration and facilitating group work.
- Make sure that **Slide 52/1** is ready. Alternatively, as there is only one slide in this session, you might prefer to read aloud the objectives without projecting them onto the screen.
- EXERCISE 52.A PREPARING A YOUNG CHILD'S MEAL – have one copy for each group.
- Display the list of COUNSELLING SKILLS and the Key messages from previous sessions.
- To prepare the plate of food, you need:
  - A room in which you can bring food
  - A table for each group to work at
  - A variety of common foods (cooked if needed) that young children would eat, enough to make a child size bowlful for each group, from the kitchen at the course facilities or elsewhere. Include some inappropriate food, if possible. Do not divide the food for the groups. Cover the food until you are ready to use it
  - One plate, knife, fork and eating spoon for each group
  - A local measure that holds 250 mL, as used in Session 47, marked at ½ and ¾ full. Do not distribute this until after the plate of food is prepared by the group
  - Facilities for washing hands before and after preparing food
  - Waste container and materials for cleaning up afterwards.
- Ask one participant and one trainer to assist you in DEMONSTRATION 52.A. Choose names for the people in the story. Adapt foods in the story as needed.
- You will need a small amount of food and a set of equipment similar to the "plate of food" exercise above for DEMONSTRATION 52.A. Adapt the text to suit the food you have available.

As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

I. Introduce the session — 2 minutes

► Show **Slide 52/1 – Session 52 – objectives** and read out the objectives:

52/1

Session 52: Food demonstration – objectives

After completing this session, participants will be able to:
- prepare a plate of food suitable for a young child
- explain why they have chosen these foods
- conduct a food demonstration with a caregiver

¤ This session helps you to teach a mother or caregiver to prepare age-appropriate food for their child.

II. How to help a mother learn to prepare a suitable meal — 20 minutes

¤ *Ask: In your experience, what is the best way to teach a mother a new skill or behaviour? For example, teaching a mother to prepare a new food recipe?*

► Wait for a few replies and then continue.

¤ To teach a new skill or behaviour, you could:

- **tell** the mother how to do it – this is good, but the mother might not understand all you say or remember it
- ask the mother to **watch** while you talk and prepare the food – this is better, because the mother is seeing and hearing together
- help the mother to actually **prepare the food herself** – this is the BEST method, because the mother is doing the activity, so will understand more.

¤ **How** you assist the mother to learn is important. Your counselling can also be used when helping a mother to learn a new skill (*point to the list of* COUNSELLING SKILLS).

¤ You can use your skills to:

- use open questions to find out whether the mother understands
- avoid words that sound judging or critical
- praise the mother
- explain things in a simple and suitable way, to help her understand.

¤ Today we will see a demonstration of helping a mother to learn in a supportive way. Listen for supportive ways of giving information.

► Ask the participant and the trainer whom you prepared to give DEMONSTRATION 52.A. They should both stand at the same side of the table, facing the rest of the group. A small selection of food and the equipment listed is on the table or beside it. Have the food and equipment clean and covered with a clean cloth.

- **Introduce the role-play by making the following points:**
- (Mother's name) has talked to the health worker a few days ago about her 10-month-old baby. (Child's name) grew well for the first 6 months but his weight gain has slowed down since then. The health worker gathered information by observation, listening and learning.
- The health worker discussed (child's name's) feeding and praised good practices. The health worker gave some information on two Key messages and offered some suggestions on putting two new practices into place – to offer food frequently and to offer a larger amount each time.
- Today the health worker has called to the home of (mother's name) to help her learn more about foods and amounts to offer (child's name). The health worker asked (mother's name) to keep some of the food from the family meal.

DEMONSTRATION 52.A SUPPORTIVE TEACHING

Health worker: *Good morning (mother's name). How are you and (child's name) today?*
Mother: *We are well, thank you.*

Health worker: *A few days ago, we talked about feeding (child's name) and you decided you would try to offer (child's name) some food more often. How is that going?*
Mother: *It is good. One time he had about a half of a banana. Another time he had a piece of bread with some butter on it.*

Health worker: *Those sound like good snacks. Now, we want to talk about how much food to give for his main meal.*
Mother: *Yes, I'm not sure how much to give.*

Health worker: *It can be hard. What sort of bowl or cup do you feed him from?*
Mother: *We usually use this bowl.* (shows a bowl – about 250 mL size)[1]

Health worker: *How full do you fill the bowl for his meal?.*
Mother: *Oh, about a third.*

Health worker: *(Child's name) is growing very fast at this age, so he needs increasing amounts of food.*
Mother: *What foods should I use?*

Health worker: *You have some of the food here from the family today. Let us see.* (uncovers food)
First we need to wash our hands.
Mother: *Yes, I have some water here.* (washes hands with soap and dries them on a clean cloth)

Health worker: *Now, what could you start with for the meal?*
Mother: *I guess we would start with some rice.* (puts in 2 large spoonfuls)

Health worker: *Yes, the rice would almost fill half of the bowl. Animal-source foods are good for children – is there some you could add to the bowl?*
Mother: *I kept a few pieces of fish from our meal.* (puts in 1 large spoonful)

Health worker: *Fish is a good food for (child's name). A little animal-source food each day helps him to grow well.*
Mother: *Does he need some vegetables too?*

Health worker: *Yes, dark-green or yellow vegetables help (child's name) to have healthy eyes and fewer infections. What vegetables could you add?*
Mother: *Some spinach?* (puts in some)

Health worker: *Spinach would be very nutritious. Some would fill half the bowl.*
Mother: *Oh, that isn't hard to do. I could do that each day. Two spoons of rice, a spoon of an animal-source food and some dark-green or yellow vegetable so the bowl is half full.*

Health worker: *Yes, you are able to do it. Now, what about his morning meal?*
Mother: *I can give some porridge, with milk and a little sugar.*

Health worker: *That's right. How much will you put in the bowl?*
Mother: *Until it is at least half full.*

[1] If a different size cup or bowl is used, adjust the text accordingly. If a smaller cup is used, it will need to be a full cup. If a larger cup is used, it may only need to be less than half full.

Health worker:	*Yes. So, we've talked about his morning meal, and the main meal with the family. (Child's name) needs three to four meals each day. So what else could you give?*
Mother:	*Well, he would have some banana or some bread like I said before.*
Health worker:	*Those are healthy foods to give between meals. (Child's name) needs at least half a bowlful of food three to four times a day as well.*
Mother:	*Oh, I don't know what else to give him.*
Health worker:	*Your family has a meal in the middle of the day. What do you eat in the evening?*
Mother:	*Usually there is a pot of soup with some beans and vegetables in it. Could I give him that?*
Health worker:	*Thick foods help him to grow better than thin foods such as soup. Could you take out a few spoons of the beans and vegetables and mash them for (child's name). And maybe soak some bread in the soup?*
Mother:	*Yes, I could do that easily enough.*
Health worker:	*So, how much will you put in (child's name) bowl for each meal?*
Mother:	*I will fill it half full.*
Health worker:	*Very good. And how often each day will you give him some food?*
Mother:	*I will give half a bowlful of food three to four times a day. If he is hungry, I will give some extra food between meals.*
Health worker:	*Exactly. You know how to feed (child's name) well. Will you bring (child's name) back to the health centre in 2 weeks, so we can look at his weight?*
Mother:	*Yes, I will. With all this food, I know he will grow very well.*

- *Ask: What did you observe about how the health worker taught this mother?*

▶ **Wait for a few replies, which should include the following points:**

- The health worker let the mother prepare the food.
- The health worker explained points carefully.
- The health worker used the Key messages so the information was familiar.
- The health worker used counselling skills:
  - LISTENING AND LEARNING SKILLS: open questions, empathy and no judging words
  - SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT: gave praise, did not criticize mistakes, and used simple language.
- The health worker offered information and suggestions rather than giving commands.
- The health worker checked the mother's understanding and arranged follow-up.

▶ **Explain any points that the participants did not mention.**

- *Ask: How will this mother manage with preparing food for her child?*

▶ **Wait for a few replies.**

- This mother probably will be able to prepare foods well.
- *Ask: How did the counsellor use counselling skills to assist the mother to learn?*

▶ **Wait for answers and then fill in gaps with the key information below:**

- Remember to use the counselling skills when you teach a mother. This supportive teaching can help to build her confidence, as well as making it easier for her to learn.
- Whenever possible, let the mother prepare the food herself, with the support of the health worker, until she is confident and competent. Watching a health worker prepare foods is not enough, particularly if there is a problem with the child's weight gain or feeding.
- The health worker in our demonstration could also stay and observe **how** the mother feeds the child.
- *Ask: What practices would the health worker look for when the child was being fed?*

▶ **Wait for a few replies and then continue.**

- The health worker would be looking for techniques such as:
  - assist children to eat, being sensitive to their cues or signals
  - feed slowly and patiently, encourage but do not force
  - talk to children during feeding, with eye-to-eye contact.
- We discussed these responsive feeding practices in Session 48.

III. Prepare a plate of food — 15 minutes

- Each group will now prepare a bowl or plate of food suitable for the age of child they are assigned: 6½ months old, 8 months old, 10 months old, 15 months old.
- Give your child a name and describe the family setting, for example that they live in the town, or have many children in the family.

▶ **Assign an age to each group. Add other ages as needed for more groups.**

▶ **Give these directions:**

- A selection of foods is provided. Each group will choose suitable foods, and decide on the amount and consistency to make up the meal. You are a mother with a large family to feed – do not take more food than you need for the one child. Also, keep in mind what foods local mothers give to young children.
- You are a busy mother. Do this task quickly.
- Be prepared afterwards to say why your group chose those particular foods and whether there are any additional foods you would include that are not available here.
- Decide on one or two Key messages you would give if you were preparing this food in a demonstration for mothers to explain the importance of adequate complementary feeding.
- Choose only one or two Key messages that are relevant to the child for whom you are preparing the meal.

▶ **Trainers observe their group and assist as needed.**

- First, the group should discuss the foods and agree on choices rather than taking spoonfuls of all of the different foods and then deciding what they will use.
- Allow 10 minutes to choose and prepare the meal.
- Keep to the time; a mother would do this very quickly.

IV. Discuss the meals prepared — 20 minutes

- **Gather all the groups together with their finished plates of food. Distribute EXERCISE 52.A PREPARING A YOUNG CHILD'S MEAL to each group.**
- **Ask each group to score their own meal using the worksheet. Allow 2 minutes for the group to fill in the worksheet.**
- **Ask each group in turn to explain their meal:**
  - why they chose those foods
  - why they prepared it in the way they did (mashed finely, chopped, etc.)
  - how thick the consistency is (for a young child) – test with a spoon
  - any additional foods they would include that are not available
  - the one or two Key messages they would use in a demonstration for mothers
  - why they gave that amount.
- **Except for the group with the baby aged 6½ months,[1] give the group the 250 mL container to measure the amount of food they prepared for their child.**
  - They are not allowed to "test" the size of the meal during preparation.
  - They must wait until they have finished to see whether they have judged correctly.
  - See box AMOUNTS OF FOOD TO OFFER (below in the *Trainer's guide*).
  - Is it the correct amount for a child of that age?
  - How many meals of this size does a child of this age need each day?
  - *Ask the whole group: Were all the recommendations contained in the meal? Are there any suggestions you could give this group?*
- **Repeat so each group has the opportunity to explain and discuss their meal.**

AMOUNTS OF FOOD TO OFFER

Age	Texture	Frequency	Amount of food an average child will usually eat at each meal[2]
6–8 months	Start with thick porridge, well-mashed foods Continue with mashed family foods	2–3 meals per day plus frequent breastfeeds Depending on the child's appetite, 1–2 snacks may be offered	Start with 2–3 tablespoonfuls per feed increasing gradually to ½ of a 250 mL cup
9–11 months	Finely chopped or mashed foods, and foods that baby can pick up	3–4 meals plus breastfeeds Depending on the child's appetite, 1–2 snacks may be offered	½ of a 250 mL cup/bowl
12–23 months	Family foods, chopped or mashed if necessary	3–4 meals plus breastfeeds Depending on the child's appetite, 1–2 snacks may be offered	¾ to one 250 mL cup/bowl
If the baby is not breastfed, give in addition: 1–2 cups of milk per day, and 1–2 extra meals per day.			

[1] The baby of 6½ months would have 2–3 spoonfuls.
[2] Adapt the chart to use a suitable local cup/bowl to show the amount. The amounts assume an energy density of 0.8–1.0 kcal/g.

¤ Turn to page 393–395 in your *Participant's manual*. There is a guide for planning and conducting a group demonstration in your health facility and examples of a clear recipe format. You can refer to this guide when planning a demonstration in your health facility (This is on page 664–666 of the *Trainer's guide*).

Exercise 52.A Preparing a young child's meal

Group:

Task	Achieved	Comments
Mixture of foods:		
Staple		
Animal-source food		
Bean/pulse **plus** vitamin C fruit or vegetable		
Dark-green vegetable or yellow-coloured fruit or vegetable		
Consistency		
Amount		
Prepared in a clean and safe manner		

Key messages:

1.

2.

V. Summarize the session 3 minutes

- Ask participants whether they have any questions, and try to answer them.
- Make these points:
  - In this session, we discussed helping a mother to learn feeding and care practices.
  - To be effective, teaching should be supportive, using counselling skills.
  - In addition to watching a demonstration, mothers may need to practise new skills under the gentle supervision of the counsellor, until they are competent and confident.
  - Food demonstrations can be carried out individually or in groups in the community. A group demonstration reaches more families and can help to reinforce Key messages on feeding.

PLANNING GUIDE FOR A GROUP DEMONSTRATION OF THE PREPARATION OF YOUNG CHILDREN'S FOOD

Gather the equipment and materials

- Cooked food for the preparation
- Plates and utensils for the preparation
- Utensils for mothers and infants to taste the preparation
- Table on which to prepare the food
- Facilities for washing hands

Review the objectives of the demonstration

1. Teach mothers how to prepare a simple and nutritious food for young children, using local ingredients (to learn through doing).
2. Demonstrate to mothers the appropriate consistency (thick) for these foods.
3. Demonstrate the taste and acceptability of the food preparations for mothers and young children.

Decide the Key messages and which Counselling cards to use (if necessary)

Select 1–3 Key messages to give to mothers (see KEY MESSAGES on page xvi)
Follow each message with a checking question (a question that you cannot answer with a simple "yes" or "no")

For example:

1. KEY MESSAGE 3: FOODS THAT ARE THICK ENOUGH TO STAY ON THE SPOON GIVE MORE ENERGY TO THE CHILD
   Checking question: What should the consistency of foods be for a small child?
   (*Answer:* thick, so the food stays in the spoon)
2. KEY MESSAGE 4: ANIMAL-SOURCE FOODS ARE ESPECIALLY GOOD FOR CHILDREN, TO HELP THEM GROW STRONG AND LIVELY
   Checking question: What animal-source food could you give your child in the next 2 days?
   (*Answer:* meats, fish, egg, milk, cheese – these are special foods for the child)
3. KEY MESSAGE 9: A YOUNG CHILD NEEDS TO LEARN TO EAT: ENCOURAGE AND GIVE HELP ... WITH LOTS OF PATIENCE
   Checking question: How should you feed a child learning to eat?
   (*Answer*: with patience and encouragement)

Give the participatory demonstration

- Thank the mothers for coming.
- Present the recipe that will be prepared.
- Hold up each of the ingredients. Mention any ingredients that can be easily substituted, for example oil for butter, powdered milk or tinned milk (unsweetened) for fresh milk, or cooking water or boiled water if no milk is available.
- Invite at least two mothers to prepare the food. If possible, have enough ingredients to have two or three pairs of mothers to participate in the preparation, each pair working with their own plate of ingredients and utensils.
- Talk the mothers through each step of the preparation, for example:
  - Wash hands
  - Mashing a potato or _____
  - Adding the correct quantity of fish or egg, etc.
  - Adding the correct quantity of milk or water
- Point out the consistency of the preparation as the mothers are making it, and demonstrate with a spoon when they are finished.
- Reinforce the use of local inexpensive and nutritious ingredients, especially using foods from the family pot.
- Ask the mothers whether they would have difficulty in obtaining any of the ingredients (suggest alternatives).
- Ask the mothers whether they could prepare the food in their household.

Offer food preparations to taste

- Invite the mothers who prepared the food to taste it in front of the rest and give their opinion (use clean spoons).
- Invite all the mothers to taste the preparation and to give it to their small children (who are at least 6 months old). Use a clean spoon for each child.
- Use this time to stress the Key messages you decided to use when planning the demonstration.

Ask checking questions

- *What are the foods used in this recipe?* Wait for responses.
- Then the health worker reads out the list of the foods again.
- Ask the mothers when they think they can prepare this food for their young child (e.g. tomorrow).
- You may repeat the Key messages and checking questions again.

Conclude the demonstration

- Thank the mothers for coming and participating.
- Ask the mothers to share their new knowledge of preparing this food with a neighbour who has small children.
- Invite mothers to visit the health facility for nutrition counselling and growth checks.

Recipes for food demonstration[1,2] – fill in the food and the amount needed

Recipe 1

Family food for a 10-month-old child's main course (about ½ cupful – a cup/bowl that holds 250 mL)

Staple:_____

Meat or fish or beans:_____

If using beans or egg instead of meat, include a source of vitamin C to help iron absorption: _____

Dark-green or yellow vegetable: _____

Milk or hot boiled water or soup water if milk is not available: 1 tablespoon (large spoon)

Wash hands and use clean surface, utensils and plates.

Take the cooked foods and mash them together.

Add the oil or margarine and mix well.

Check the consistency of the mashed food with a spoon – it should stay easily on the spoon without dripping off.

Add the milk or water to the mashed foods and mix well. Only add a small amount of milk or water to make the right consistency.

Recipe 2

Family food for a 15-month-old child's main course (a full cup)

Staple:_____

Meat or fish or beans:_____

If using beans or egg instead of meat, include a source of vitamin C to help iron absorption: _____

Dark-green or yellow vegetable: _____

Oil or margarine: 1 teaspoon (small spoon)

Wash hands and use clean surface, plates and utensils.

Take the cooked foods and cut them into small pieces or slightly mash them together (depending on the child's age).

Add the oil or margarine and mix well.

[1] The amounts indicated are recommended if the energy content of the meals is 0.8 to 1.0 kcal/g. These amounts should be adjusted if the foods are diluted.
[2] If there is a need to increase the amounts of food for each meal, instruct the participants to make the change in their recipes.

Counselling skills

Listening and learning skills

1. Use helpful non-verbal communication
2. Ask open questions
3. Use responses and gestures that show interest
4. Reflect back what the mother/caregiver says
5. Empathize – show that you understand how the mother/caregiver feels
6. Avoid using words that sound judging

Skills for building confidence and giving support

1. Accept what a mother/caregiver thinks and feels
2. Recognize and praise what a mother/caregiver and baby are doing right
3. Give practical help
4. Give a little, relevant information
5. Use simple language
6. Make one or two suggestions, not commands

Notes

Notes (contd)

SESSION 53

Clinical practice session 5: Gathering information on complementary feeding practices 1

Objectives

After completing this session, participants will be able to:

- demonstrate how to gather information about complementary feeding using counselling skills and the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS
- build a picture of local feeding practices

Session outline . . . . . 120 minutes

Participants are together as a class led by one trainer, to prepare for the session, and to discuss it afterwards.

Participants work in small groups of 3–4, each with one trainer, or in pairs, for the clinical practice session in a ward or clinic.

I. Prepare the participants . . . . . 5 minutes
II. Conduct the clinical practice . . . . . 100 minutes
III. Discuss the findings as a whole group . . . . . 12 minutes
IV. Summarize the session . . . . . 3 minutes

Preparation

- Make sure you know where the clinical practice will be held and what times you are expected there. Visit the wards or clinics if you have not done so before. Introduce yourself to the staff members in charge, and make sure that they are prepared for the session (see *Director's guide*).
- Study the instructions on the following pages, and ask all trainers who will lead groups to study the instructions also.
- Make sure that two copies of the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS and two copies of the COUNSELLING SKILLS CHECKLIST are available for each participant.
- Make sure there are copies of the CLINICAL PRACTICE DISCUSSION checklist for each trainer.
- Make sure that one set of the FOOD CONSISTENCY PICTURES is available for each participant.
- Each group needs a typical bowl that a young child would use.
- Have ready COUNSELLING CARD 16: START COMPLEMENTARY FEEDING WHEN THE BABY REACHES 6 MONTHS, COUNSELLING CARD 17: FOOD VARIETY, COUNSELLING CARD 18: COMPLEMENTARY FEEDING FROM 6 UP TO 9 MONTHS, COUNSELLING CARD 19: COMPLEMENTARY FEEDING FROM 9 UP TO 12 MONTHS and COUNSELLING CARD 20: COMPLEMENTARY FEEDING FROM 12 UP TO 24 MONTHS, and the *Guidance on the use of counselling cards*.

As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

I. Prepare the participants 5 minutes

- **One trainer leads a preparatory session with all participants and the other trainers together.**
- **If you have to travel to another facility for the clinical practice session, hold the preparatory session in the classroom before you leave. If necessary, this can take place on the evening or the morning before the clinical session.**
- **Explain the following to the participants:**
  - You are going to practise using your counselling skills and using the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS.
- **Explain where participants will go: explain where the groups will go to, and what kinds of mothers or caregivers they will be working with during this clinical practice.**
- **Explain what participants should take with them.**
  - Take with you:
    - One copy of the REFERENCE TOOL: FOOD INTAKE – 6 UP TO 24 MONTHS
    - Two copies of the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS
    - Two copies of the COUNSELLING SKILLS CHECKLIST
    - A set of the FOOD CONSISTENCY PICTURES
    - A common bowl used to feed a young child – one between each pair of participants
    - One set of Counselling cards, and the *Guidance on the use of counselling cards*
    - Pencil and paper to make notes
  - You do not need to take anything else – no books, manuals or handbags.
- **Explain how participants will work:**
  - You will work in your groups of 3–4 and each group will have one trainer.
  - One participant talks with the mother or caregiver, filling in the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS at the same time.
  - Talk with caregivers of children aged 6 up to 24 months.
  - The others in the group observe and fill in the COUNSELLING SKILLS CHECKLIST.
  - If you meet a child who is ill or has a major feeding difficulty, encourage the caregiver to bring the child to the local health centre.
  - Do not offer suggestions for treatment of an ill child.
- **Explain what participants should do when they talk to a mother or caregiver:**
  - Introduce yourself to the mother or caregiver and ask permission to talk with them. Introduce the others in your group and explain you are interested in learning about feeding young children in general.
  - You may wish to say you are on a course.
  - Try to find a chair or stool to sit on, so you are at the same level as the caregiver.
  - Ask to see the growth chart of the child and, if it is available, observe the trend in the child's growth. If the child does not have a growth chart, ask for their weight and length and check them for nutritional status against the reference growth chart.
  - Practise as many of the counselling skills as possible as you gather information from the mother using the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS.
  - Listen to what the caregiver is saying and try not to ask a question if you have already been told the information.
  - Fill out the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS as you listen and learn from the caregiver.

- ¤ Use the information you have gathered and then:
  - try to praise two things that are going well
  - offer the caregiver two or three pieces of relevant information, using the Counselling card for the age group of the child you see
  - offer two or three suggestions that are useful at this time.
- ¤ Be careful not to give advice. You are just practising your skills of gathering information.
- ¤ If the caregiver has any questions about feeding their child, encourage them to discuss them with their health worker at the health facility.
- ¤ The participants that are observing can place a tick mark on the COUNSELLING SKILLS CHECKLIST for every skill that they observe their partner practising. Remember to observe what the "counsellor" is doing, rather than thinking about what you would say if you were talking to the caregiver. The observers do not ask the caregiver any questions.
- ¤ When you have finished talking with a caregiver, thank them and move away.
- ¤ Briefly, discuss with the group and your trainer what you did and what you learnt, and clarify any questions you may have about conducting the exercise.
- ¤ Discuss what practices you praised, what feeding problems you noticed, information and suggestions that you offered, and counselling skills used.
- ¤ Find another caregiver and repeat the exercise with another participant doing the counselling.

► **Encourage participants to notice feeding practices, such as:**

- whether children eat any food or have any drinks while waiting
- whether children are given a bottle or soother/pacifier while waiting
- general interaction between caregivers and children
- any posters or other information on feeding in the area.

- ¤ Use the CLINICAL PRACTICE DISCUSSION checklist to guide you as you give feedback to the participants.

II. Conduct the clinical practice — 100 minutes

These notes are for the trainers. Trainers should read them to ensure that they know what to do. There is no need to read these notes to the participants.

► **Take your group to the working area and introduce your group to the person in charge. Listen to any directions that this contact person gives. This may include suitable areas to use, as well as children and caregivers that it is better not to talk to.**

► **Conduct a demonstration interview using the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS for the participants to observe. Invite a caregiver with a young child between the ages of 6 months and 2 years to participate in this interview.**

► **Remind the participants to try and find caregivers of children over 6 months of age.**

- ¤ If you cannot find any more children over 6 months of age, you can take a feeding history from caregivers with children under 6 months of age, using the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS from Session 15.

► **About 10 minutes before the end of the time, remind the groups to start finishing up.**

III. Discuss the findings as a whole group — 12 minutes

- **Return to the whole class group. Discuss what the participants learnt from listening to the mothers and from the completed JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS.**
  - Ask: *What did you observe in general looking around the health centre?*
- **Wait for a few replies. Prompt if needed – posters, leaflets, food for sale, children with food/bottles/soothers?**
  - Look at the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS that you filled in.
    - What practices are caregivers doing that you could praise and encourage?
    - What areas need improvement?
- **Ask participants to summarize their findings, using the form for EXERCISE 53.A. Give them a few minutes to complete this exercise.**
- **Explain to the participants:**
  - Now we are going to look at the feeding practices of the caregivers you talked with and compare them with the recommendations or Key messages we discussed in earlier sessions. As each recommendation is read out, report whether the caregivers you met followed this recommendation.
  - As well as gathering information on the practices of the individual caregivers, this summary will give us information generally about practices in the community. This information helps you to know which are the practices that you need to pay most attention to in your work. It also helps you to learn about differences in practice between caregivers in your community.
  - Now look at the summary of practices for the whole group. What do you see?
  - What practices are caregivers doing that you could praise and encourage?
  - What areas need improvement?
  - What were the practices that you found and were they what you expected to find?
  - Do caregivers in your area have similar practices, or do you see many differences between caregivers' practices?
  - What does this mean to you as health workers in your practice?
- **Make the points that are relevant to the summary table.**
- **Several patterns may exist in the summary table. They may include:**
  - Many practices occur that you can praise and encourage; many practices occur that you would like to change; there may be a mixture of practices within one recommendation.
  - These patterns may be quite clear and indicate which practices you need to pay most attention to in your work.
  - Or, there may be little pattern (for example, numbers may be spread across the boxes). This spread may indicate that there are differences between caregivers in your area and that you may need more assessment to identify practices to focus on.
  - *Ask: Did you use skills to gather information from the caregivers? What are three skills of listening and learning that are useful in this activity?*
- **Wait for a few responses. Point to the flipchart page on the wall listing the skills and comment on the skills the participants mentioned.**

IV. Summarize the session — 3 minutes

- Ask participants whether they have any questions, and try to answer them.
- Explain that a summary of this session can be found on pages 399–405 of the *Participant's manual*.

Exercise 53.A Summary of groups' Job aids: Food intake – 6 up to 24 months

Job aid: Food intake – 6 up to 24 months

Child's name:

Date of birth: **Age of child at visit:**

Feeding practice	Yes / number where relevant	Key message given
Growth appropriate?		
Child received breast milk?		
How many meals of a thick consistency did the child eat yesterday? (use Food consistency pictures as needed)		
Child ate an animal-source food yesterday (meat/fish/offal/bird/eggs)?		
Child ate a dairy product yesterday?		
Child ate pulses, nuts or seeds yesterday?		
Child ate a dark-green or yellow vegetable or yellow fruit yesterday?		
Child ate sufficient number of meals and snacks yesterday, for their age?		
Quantity of food eaten at main meal yesterday appropriate for child's age?		
Caregiver assisted the child at mealtimes?		
Child took any vitamin or mineral supplements?		
Child ill or recovering from an illness?		

CLINICAL PRACTICE DISCUSSION CHECKLIST

Practical skills are best developed by introducing and demonstrating the skills, observing participants as they practise the skills, and giving feedback to participants on how well they performed. Feedback should include praising participants for things done well, and giving gentle suggestions for how to overcome difficulties. Use the checklist below to help guide your feedback discussions.

Questions to ask after each participant completes their turn practising (either in the clinic or using counselling stories)

To the participant who practised:

- What did you do well?
- What difficulties did you have?
- What would you do differently in the future?

To the participants who observed:

- What did the participant do well?
- What difficulties did you observe?

LISTENING AND LEARNING SKILLS (give feedback on the use of these skills in all practical sessions)[1]

- Which LISTENING AND LEARNING SKILLS did you use?
- Was the mother willing to talk?
- Did the mother ask any questions? How did you respond?
- Did you empathize with the mother? Give an example.

SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT (give feedback on the use of these skills during clinical practice sessions after Session 10)[1]

- Which SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT were used?
  (check especially for praise and for two relevant suggestions)
- Which skills were most difficult to use?
- What was the mother's response to your suggestions?

KEY MESSAGES FOR COMPLEMENTARY FEEDING (give feedback on the use of these skills in Sessions 53 and 54 [Clinical practice sessions 5 and 6])[2]

- Which messages for complementary feeding did you use? (check especially for "only a few relevant messages")
- What was the mother's response to your suggestions?

General questions to ask at the end of each clinical practice session (in the clinic or using counselling stories)

- What special difficulties or situations helped you to learn?
- What was the most interesting thing that you learnt from this clinical practice session?

[1] See list of skills at the end of the session.
[2] See list of KEY MESSAGES FOR COMPLEMENTARY FEEDING on page xiv of the *Participant's manual* and page xvi of the *Trainer's guide*.

Reference tool: Food intake – 6 up to 24 months

Feeding practice	Ideal feeding practice	Key messages to help counsel mothers
Growth appropriate?		*Look at the shape of the growth curve of the child: is the child growing?*
Child received breast milk?	Yes	Breastfeeding for 2 years or longer helps a child to develop and grow strong and healthy
How many meals of a thick consistency did the child eat yesterday? (use Food consistency pictures as needed)	3 meals	Foods that are thick enough to stay on the spoon give more energy to the child
Child ate an animal-source food yesterday (meat/fish/offal/bird/eggs)?	Animal-source foods should be eaten daily	Animal-source foods are especially good for children, to help them grow strong and lively
Child ate a dairy product yesterday?	Try to give dairy products daily	Animal-source foods are especially good for children, to help them grow strong and lively
Child ate pulses, nuts or seeds yesterday?	If meat is not eaten, pulses or nuts should be eaten daily, with an iron enhancer such as a vitamin-C-rich food	Peas, beans, lentils, nuts and seeds are good for children
Child ate a dark-green or yellow vegetable or yellow fruit yesterday?	A dark-green or yellow vegetable or yellow fruit should be eaten daily	Dark-green leaves and yellow-coloured fruits and vegetables help the child to have healthy eyes and fewer infections
Child ate sufficient number of meals and snacks yesterday, for their age?	Child 6–8 months: 2–3 meals plus 1–2 snacks if hungry Child 9–24 months: 3–4 meals plus 1–2 snacks if hungry	A growing child needs 2–4 meals a day, plus 1–2 snacks if hungry: give a variety of foods
Quantity of food eaten at main meal yesterday appropriate for child's age?	Child 6–8 months: gradually increased to approx. ½ cup at each meal Child 9–11 months: approx. ½ cup at each meal Child 12–24 months: approx. ¾–1 cup at each meal	A growing child needs increasing amounts of food
Caregiver assisted the child at mealtimes?	Yes, assists with learning to eat	A young child needs to learn to eat: encourage and give help … with lots of patience
Child took any vitamin or mineral supplements?	Vitamin and mineral supplements may be needed if child's needs are not met by food intake	*Explain how to use vitamin and mineral supplements if they are needed*
Child ill or recovering from an illness?	Continue to eat and drink during illness and recovery	Encourage the child to drink and eat during illness, and provide extra food after illness to help them recover quickly

Enter a ✓ in the Yes column if the practice is in place.

Enter your initials if a message is given (see REFERENCE TOOL: FOOD INTAKE – 6 UP TO 24 MONTHS for the message).

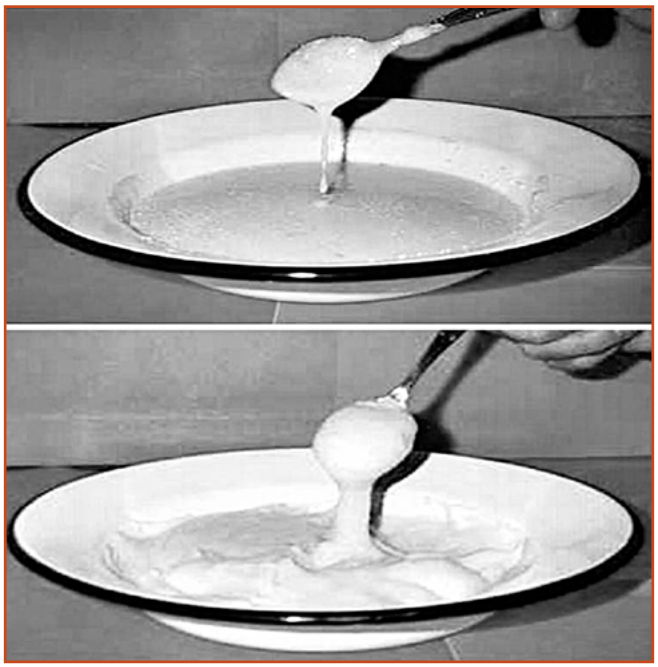
JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS

Child's name:

Date of birth: **Age of child at visit:**

Feeding practice	Yes / number where relevant	Key message given
Growth appropriate?		
Child received breast milk?		
How many meals of a thick consistency did the child eat yesterday? (use FOOD CONSISTENCY PICTURES as needed)		
Child ate an animal-source food yesterday (meat/fish/offal/bird/eggs)?		
Child ate a dairy product yesterday?		
Child ate pulses, nuts or seeds yesterday?		
Child ate a dark-green or yellow vegetable or yellow fruit yesterday?		
Child ate sufficient number of meals and snacks yesterday, for their age?		
Quantity of food eaten at main meal yesterday appropriate for child's age?		
Caregiver assisted the child at mealtimes?		
Child took any vitamin or mineral supplements?		
Child ill or recovering from an illness?		

Food consistency pictures



Counselling skills checklist

Name of counsellor:

Name of observer:

Date of visit:

(✓ for Yes and X for No)

Did the counsellor:

Use Listening and learning skills:

☐ Keep the head level with mother/parent/caregiver?

☐ Pay attention (eye contact)?

☐ Remove barriers (tables and notes)?

☐ Take time? Allow the mother/caregiver time to talk?

☐ Use appropriate touch?

☐ Ask open questions?

☐ Use responses and gestures that showed interest?

☐ Reflect back what the mother/caregiver said?

☐ Empathize – showing that he or she understood how the mother/caregiver feels?

☐ Avoid using words that sound judging?

Use Skills for building confidence and giving support:

☐ Accept what the mother/caregiver thinks and feels?

☐ Recognize and praise what the mother/caregiver and baby are doing right?

☐ Give practical help?

☐ Give a little, relevant information?

☐ Use simple language?

☐ Make one or two suggestions, not commands?

Notes

Notes

SESSION 54

Clinical practice session 6: Gathering information on complementary feeding practices 2

Objectives

After completing this session, participants will be able to:

- demonstrate how to gather information about complementary feeding using counselling skills and the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS
- provide information about complementary feeding and continuing breastfeeding to a caregiver of a child aged 6 up to 24 months

Session outline . . . . . 120 minutes

Participants are together as a class led by one trainer, to prepare for the session, and to discuss it afterwards.

Participants work in small groups of 3–4, each with one trainer, or in pairs, for the clinical practice session in a ward or clinic

I. Prepare the participants . . . . . 5 minutes
II. Conduct the clinical practice . . . . . 100 minutes
III. Discuss the findings as a whole group . . . . . 12 minutes
IV. Summarize the session . . . . . 3 minutes

Preparation

- Make sure you know where the clinical practice will be held and what times you are expected there. Visit the wards or clinics if you have not done so before. Introduce yourself to the staff members in charge, and make sure that they are prepared for the session (see *Director's guide*).
- Study the instructions on the following pages, and ask all trainers who will lead groups to study the instructions also.
- Make sure that two copies of the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS and two copies of the COUNSELLING SKILLS CHECKLIST are available for each participant.
- Make sure there are copies of the CLINICAL PRACTICE DISCUSSION CHECKLIST for each trainer.
- Make sure that one set of the FOOD CONSISTENCY PICTURES is available for each participant.
- Each group needs a typical bowl that a young child would use.
- Have ready COUNSELLING CARD 16: START COMPLEMENTARY FEEDING WHEN THE BABY REACHES 6 MONTHS, COUNSELLING CARD 17: FOOD VARIETY, COUNSELLING CARD 18: COMPLEMENTARY FEEDING FROM 6 UP TO 9 MONTHS, COUNSELLING CARD 19: COMPLEMENTARY FEEDING FROM 9 UP TO 12 MONTHS and COUNSELLING CARD 20: COMPLEMENTARY FEEDING FROM 12 UP TO 24 MONTHS, and the *Guidance on the use of counselling cards*.

As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

I. Prepare the participants 5 minutes

- **One trainer leads a preparatory session with all participants and the other trainers together.**
- **If you have to travel to another facility for the clinical practice session, hold the preparatory session in the classroom before you leave. If necessary, this can take place on the evening or the morning before the clinical session.**
- **Explain the following to the participants:**
  - You are going to practise using your counselling skills and the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS.
- **Explain where participants will go: explain where the groups will go to, and what kinds of mothers or caregivers they will be working with during this clinical practice.**
- **Explain what participants should take with them.**
  - Take with you:
    - One copy of the REFERENCE TOOL: FOOD INTAKE – 6 UP TO 24 MONTHS
    - Two copies of the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS
    - Two copies of the COUNSELLING SKILLS CHECKLIST
    - A set of the FOOD CONSISTENCY PICTURES
    - A common bowl used to feed a young child – one between each pair of participants
    - One set of Counselling cards, and the *Guidance on the use of counselling cards*
    - Pencil and paper to make notes
  - You do not need to take anything else – no books, manuals or handbags.
- **Explain how participants will work:**
  - You will work in your groups of 3–4 and each group will have one trainer.
  - One participant talks with the mother or caregiver, filling in the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS at the same time.
  - Talk with caregivers of children aged 6 up to 24 months.
  - The others in the group observe and fill in the COUNSELLING SKILLS CHECKLIST.
  - If you meet a child who is ill or has a major feeding difficulty, encourage the caregiver to bring the child to the local health centre.
  - Do not offer suggestions for treatment of an ill child.
- **Explain what participants should do when they talk to a mother or caregiver:**
  - Introduce yourself to the mother or caregiver and ask permission to talk with them. Introduce the others in your group and explain you are interested in learning about feeding young children in general.
  - You may wish to say you are on a course.
  - Try to find a chair or stool to sit on, so you are at the same level as the caregiver.
  - Ask to see the growth chart of the child and, if it is available, observe the trend in the child's growth. If the child does not have a growth chart, ask for their weight and length and check them for nutritional status against the reference growth chart.
  - Practise as many of the counselling skills as possible as you gather information from the mother using the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS.
  - Listen to what the caregiver is saying and try not to ask a question if you have already been told the information.
  - Fill out the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS as you listen and learn from the caregiver.

- Use the information you have gathered and then:
  - try to praise two things that are going well
  - offer the caregiver two or three pieces of relevant information, using the counselling card for the age group of the child you see
  - offer two or three suggestions that are useful at this time.
- Be careful not to give a lot of advice. You are just practising your skills of gathering information.
- Answer any questions the caregiver may ask as best as you can. Ask your trainer for assistance if necessary.
- The participants that are observing can place a tick mark on the COUNSELLING SKILLS CHECKLIST for every skill that they observe their partner practising. Remember to observe what the "counsellor" is doing, rather than thinking about what you would say if you were talking to the caregiver. The observers do not ask the caregiver any questions.
- When you have finished talking with a caregiver, thank them and move away.
- Briefly, discuss with the group and your trainer what you did and what you learnt, and clarify any questions you may have about conducting the exercise.
- Discuss what practices you praised, what feeding problems you noticed, information and suggestions that you offered, and counselling skills used.
- Find another caregiver and repeat the exercise with another participant doing the counselling.

▶ **Encourage participants to notice feeding practices, such as:**

- whether children eat any food or have any drinks while waiting
- whether children are given a bottle or soother/pacifier while waiting
- general interaction between caregivers and children
- any posters or other information on feeding in the area.

▶ **Use the CLINICAL PRACTICE DISCUSSION CHECKLIST to guide you as you give feedback to the participants.**

II. Conduct the clinical practice — 100 minutes

These notes are for the trainers. Trainers should read them to ensure that they know what to do. There is no need to read these notes to the participants.

▶ **Take your group to the working area and introduce your group to the person in charge. Listen to any directions that this contact person gives. This may include suitable areas to use as well as children and mothers not to talk with.**

▶ **Remind the participants to try and find caregivers of children over 6 months of age.**

- If you cannot find any more children over 6 months of age, you can take a feeding history from caregivers with children under 6 months of age, using the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS from Session 15.

▶ **About 10 minutes before the end of the time, remind the groups to start finishing up.**

III. Discuss the findings as a whole group — 12 minutes

- **Return to the whole class group. Discuss what the participants learnt from listening to the mothers and from the completed JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS.**
  - *Ask: What did you observe in general looking around the health centre?*
- **Wait for a few replies. Prompt if needed – posters, leaflets, food for sale, children with food/bottles/soothers?**
  - Look at the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS that you filled in.
    - What practices are mothers doing that you could praise and encourage?
    - What areas need improvement?
    - Give some examples of suggestions you made to mothers about complementary feeding practices.
    - Would these suggestions be easy to carry out?

IV. Summarize the session — 3 minutes

- **Ask participants whether they have any questions, and try to answer them.**
- **Explain that a summary of this session can be found on pages 407–412 of the *Participant's manual*.**

CLINICAL PRACTICE DISCUSSION CHECKLIST

Practical skills are best developed by introducing and demonstrating the skills, observing participants as they practise the skills, and giving feedback to participants on how well they performed. Feedback should include praising participants for things done well, and giving gentle suggestions for how to overcome difficulties. Use the checklist below to help guide your feedback discussions.

Questions to ask after each participant completes their turn practising (either in the clinic or using counselling stories)

To the participant who practised:

- What did you do well?
- What difficulties did you have?
- What would you do differently in the future?

To the participants who observed:

- What did the participant do well?
- What difficulties did you observe?

LISTENING AND LEARNING SKILLS (give feedback on the use of these skills in all practical sessions)[1]

- Which LISTENING AND LEARNING SKILLS did you use?
- Was the mother willing to talk?
- Did the mother ask any questions? How did you respond?
- Did you empathize with the mother? Give an example.

SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT (give feedback on the use of these skills during clinical practice sessions after Session 10)[1]

- Which SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT were used?
  (check especially for praise and for two relevant suggestions)
- Which skills were most difficult to use?
- What was the mother's response to your suggestions?

KEY MESSAGES FOR COMPLEMENTARY FEEDING (give feedback on the use of these skills in Sessions 53 and 54 [Clinical practice sessions 5 and 6])[2]

- Which messages for complementary feeding did you use? (check especially for "only a few relevant messages")
- What was the mother's response to your suggestions?

General questions to ask at the end of each clinical practice session (in the clinic or using counselling stories)

- What special difficulties or situations helped you to learn?
- What was the most interesting thing that you learnt from this clinical practice session?

[1] See list of skills at the end of the session.
[2] See list of KEY MESSAGES FOR COMPLEMENTARY FEEDING on page xiv of the *Participant's manual* and page xvi of the *Trainer's guide*.

Reference tool: Food intake – 6 up to 24 months

Feeding practice	Ideal feeding practice	Key messages to help counsel mothers
Growth appropriate?		*Look at the shape of the growth curve of the child: is the child growing?*
Child received breast milk?	Yes	Breastfeeding for 2 years or longer helps a child to develop and grow strong and healthy
How many meals of a thick consistency did the child eat yesterday? (use Food consistency pictures as needed)	3 meals	Foods that are thick enough to stay on the spoon give more energy to the child
Child ate an animal-source food yesterday (meat/fish/offal/bird/eggs)?	Animal-source foods should be eaten daily	Animal-source foods are especially good for children, to help them grow strong and lively
Child ate a dairy product yesterday?	Try to give dairy products daily	Animal-source foods are especially good for children, to help them grow strong and lively
Child ate pulses, nuts or seeds yesterday?	If meat is not eaten, pulses or nuts should be eaten daily, with an iron enhancer such as a vitamin-C-rich food	Peas, beans, lentils, nuts and seeds are good for children
Child ate a dark-green or yellow vegetable or yellow fruit yesterday?	A dark-green or yellow vegetable or yellow fruit should be eaten daily	Dark-green leaves and yellow-coloured fruits and vegetables help the child to have healthy eyes and fewer infections
Child ate sufficient number of meals and snacks yesterday, for their age?	Child 6–8 months: 2–3 meals plus 1–2 snacks if hungry Child 9–24 months: 3–4 meals plus 1–2 snacks if hungry	A growing child needs 2–4 meals a day, plus 1–2 snacks if hungry: give a variety of foods
Quantity of food eaten at main meal yesterday appropriate for child's age?	Child 6–8 months: gradually increased to approx. ½ cup at each meal Child 9–11 months: approx. ½ cup at each meal Child 12–24 months: approx. ¾–1 cup at each meal	A growing child needs increasing amounts of food
Caregiver assisted the child at mealtimes?	Yes, assists with learning to eat	A young child needs to learn to eat: encourage and give help … with lots of patience
Child took any vitamin or mineral supplements?	Vitamin and mineral supplements may be needed if child's needs are not met by food intake	*Explain how to use vitamin and mineral supplements if they are needed*
Child ill or recovering from an illness?	Continue to eat and drink during illness and recovery	Encourage the child to drink and eat during illness, and provide extra food after illness to help them recover quickly

Enter ✓ in the Yes column if the practice is in place.

Enter your initials if a message is given (see REFERENCE TOOL: FOOD INTAKE – 6 UP TO 24 MONTHS for the message).

JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS

Child's name:

Date of birth: **Age of child at visit:**

Feeding practice	Yes / number where relevant	Key message given
Growth appropriate?		
Child received breast milk?		
How many meals of a thick consistency did the child eat yesterday? (use FOOD CONSISTENCY PICTURES as needed)		
Child ate an animal-source food yesterday (meat/fish/offal/bird/eggs)?		
Child ate a dairy product yesterday?		
Child ate pulses, nuts or seeds yesterday?		
Child ate a dark-green or yellow vegetable or yellow fruit yesterday?		
Child ate sufficient number of meals and snacks yesterday, for their age?		
Quantity of food eaten at main meal yesterday appropriate for child's age?		
Caregiver assisted the child at mealtimes?		
Child took any vitamin or mineral supplements?		
Child ill or recovering from an illness?		

Food consistency pictures

COUNSELLING SKILLS CHECKLIST

Name of counsellor:

Name of observer:

Date of visit:

(✓ for Yes and X for No)

Did the counsellor:

Use LISTENING AND LEARNING SKILLS:

- ☐ Keep the head level with mother/parent/caregiver?
- ☐ Pay attention (eye contact)?
- ☐ Remove barriers (tables and notes)?
- ☐ Take time? Allow the mother/caregiver time to talk?
- ☐ Use appropriate touch?
- ☐ Ask open questions?
- ☐ Use responses and gestures that showed interest?
- ☐ Reflect back what the mother/caregiver said?
- ☐ Empathize – showing that he or she understood how the mother/caregiver feels?
- ☐ Avoid using words that sound judging?

Use SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT:

- ☐ Accept what the mother/caregiver thinks and feels?
- ☐ Recognize and praise what the mother/caregiver and baby are doing right?
- ☐ Give practical help?
- ☐ Give a little, relevant information?
- ☐ Use simple language?
- ☐ Make one or two suggestions, not commands?

Notes

SESSION 55

Feeding during illness and feeding low-birth-weight babies

Objectives

After completing this session, participants will be able to:

- explain why children need to continue to eat during illness
- describe appropriate feeding during illness and recovery
- describe feeding of low-birth-weight babies
- estimate the volume of milk to offer to a low-birth-weight baby
- list the Key message from this session

Session outline . . . . . 45 minutes

Participants are all together for a lecture presentation by one trainer.

I. Introduce the session, present **Slide 55/1** . . . . . 3 minutes
II. Explain why children need to continue to eat during illness **(Slides 55/2** and **55/3)** . . . . . 10 minutes
III. Describe appropriate feeding during illness and recovery (**Slides 55/4** and **55/5**) . . . . . 10 minutes
IV. Discuss feeding of low-birth-weight babies (**Slide 55/6**) . . . . . 20 minutes
V. Summarize the session . . . . . 2 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides.
- Study the **Slides 55/1** to **55/6** and the text that goes with them, so that you are able to present them.
- You need a flipchart and markers.
- Write the Key message for this session on a flipchart page. Keep it covered until later in the session.
  - KEY MESSAGE 10: ENCOURAGE THE CHILD TO DRINK AND EAT DURING ILLNESS, AND PROVIDE EXTRA FOOD AFTER ILLNESS TO HELP THEM RECOVER QUICKLY.
- You need:
  - the flipchart list of RESPONSIVE FEEDING TECHNIQUES from Session 48.
  - a flipchart of all the Key messages from earlier sessions.
  - to find out what percentage of babies are low birth weight in your area.
  - have ready COUNSELLING CARD 4: BREASTFEEDING POSITIONS for Section IV, COUNSELLING CARD 22: FEEDING THE SICK CHILD OVER 6 MONTHS OF AGE, for Section II, COUNSELLING CARD 23: FEEDING A LOW-BIRTH-WEIGHT BABY, for Section IV, and the *Guidance on the use of counselling cards*.
- Read the **Further information** sections, so that you are familiar with the ideas that they contain, so that you can answer participants' questions.

As you follow the text, remember:

- ▸ indicates an instruction to you, the trainer.
  - ¤ indicates what you say to participants.

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the session — 3 minutes

- ▸ Make these points:
  - ¤ Some of the children you see for feeding counselling may be ill or recovering from an illness.
  - ¤ Children who are ill may lose weight because they have little appetite or their families may believe that ill children cannot tolerate much food.
  - ¤ If a child is ill frequently, they may become malnourished and therefore at higher risk of more illness. Children recover more quickly from illness and lose less weight if they are helped to feed when they are ill.
  - ¤ Children who are fed well when healthy are less likely to falter in growth from an illness and more likely to recover more quickly. They are better protected.
  - ¤ Breastfed children are protected from many illnesses. Special care needs to be given to those who are not breastfed and who do not have this protection.
- ▸ Show **Slide 55/1 – Session 55 – objectives** and read out the objectives:

55/1

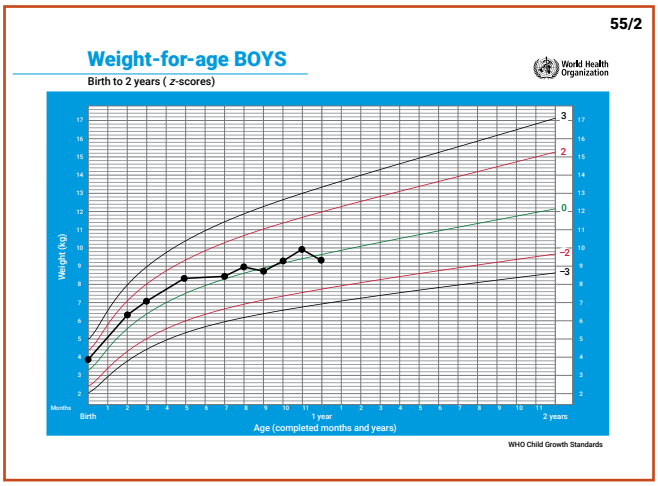
Session 55: Feeding during illness and feeding low-birth-weight babies – objectives

After completing this session, participants will be able to:
- explain why children need to continue to eat during illness
- describe appropriate feeding during illness and recovery
- describe feeding of low-birth-weight babies
- estimate the volume of milk to offer to a low-birth-weight baby
- list the Key message from this session

II. Explain why children need to continue to eat during illness — 10 minutes

- ¤ *Ask: Why might a young child feed less during illness?*
- ▸ Write participants' replies on the flipchart. Refer to their responses as you make these points:
  - ¤ A child may eat less during illness because:
    - the child does not feel hungry and is weak and lethargic
    - the child is vomiting, or their mouth or throat is sore
    - the child has a respiratory infection, which makes eating and suckling more difficult
    - caregivers withhold food, thinking that this is best during illness
    - there are no suitable foods available in the household
    - the child is hard to feed and the caregiver is not patient
    - someone advises the mother to stop feeding/breastfeeding.

▶ Show **Slide 55/2 – Weight chart of ill child** and make the points that follow:



- This is the growth chart of John who is 12 months old.
- *Ask: What do you think of the growth chart?*

▶ Wait for a few replies and then continue.

- John grew well for the first 5 months, then his growth started to falter. He was ill and lost weight.
- He recovered some weight but then became ill again and lost more. After each illness, he did not get back to his previous growth curve and is heading towards being malnourished.
- During infections, children need more energy and nutrients to fight the infection.
- If they do not get extra food, their fat and muscle tissue are used as fuel. This is why they lose weight, look thin and stop growing.

▶ Show **Slide 55/3 – KEY MESSAGE 10: FEEDING DURING AND AFTER ILLNESS** and read it out:

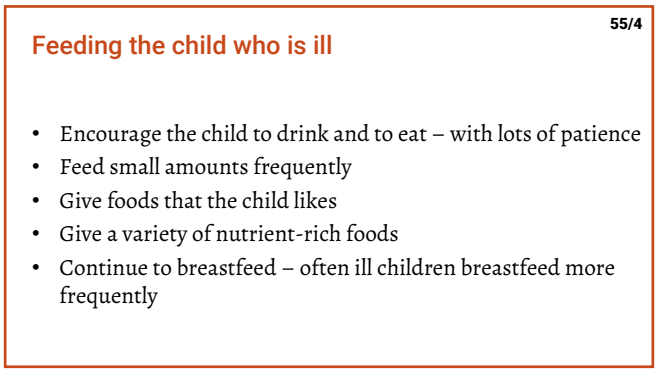
- The goal in feeding a child during and after illness is to help them to return to the growth they had before they were ill.

▶ Form buzz groups of three participants to examine COUNSELLING CARD 22: FEEDING THE SICK CHILD OVER 6 MONTHS OF AGE and the section in the *Guidance on the use of counselling cards* on KEY PRACTICES AND DISCUSSION POINTS for that Counselling card. They should discuss the card, in order to share the results of their discussion with the large group.

- After the group discussion, ask one group to present the results of the discussion; ask other groups to add any additional points.

III. Describe appropriate feeding during illness and recovery — 10 minutes

▶ Show **Slide 55/4 – Feeding the child who is ill** and ask a participant to read out the points:



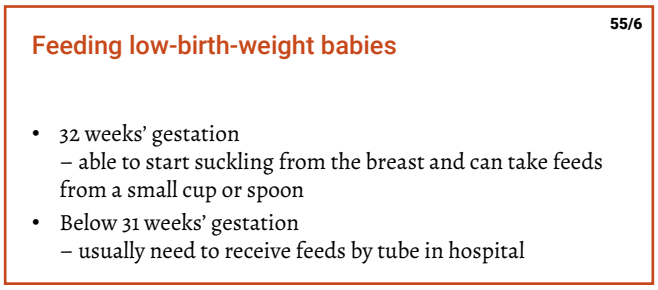
▶ Show **Slide 55/5 – Feeding during recovery** and ask a participant to read out the points:

- A child's appetite may be poor during illness. Even with encouragement to eat, the child may not eat well. The child's appetite usually increases after the illness, so it is important to continue to give extra attention to feeding after the illness. This is a good time for families to give extra food, so that lost weight is quickly regained. This allows "catch-up" growth.
- Young children need extra food until they have regained all their lost weight and are growing at a healthy rate.

IV. Discuss feeding of low-birth-weight babies — 20 minutes

- **Ask participants to define the following terms:**
  - Low birth weight
  - Preterm or premature
  - Small for gestational age
- **Record participants' responses on a flipchart. Correct any incorrect information.**
  - *Ask: What does the term low birth weight mean?*
- **Wait for a few replies and then continue.**
  - The term **low birth weight baby** includes any baby with a birth weight of less than 2500 g (up to and including 2499 g), regardless of gestational age. This includes babies who are **preterm**, that is, born before 37 weeks of gestation, or they may be born at term but small for **gestational age**.
  - *Ask: How many babies are low birth weight in this country?*
  - In many countries, 15–20% of all babies are low birth weight.
  - *Ask: How many babies are low-birth-weight in this country?*
- **Wait for a few replies and then continue.**
  - In this country, ...% of all babies are low birth weight.
  - *Ask: Why is it important for low-birth-weight babies to get breast milk?*
  - Low-birth-weight babies, whether they are term or preterm, are at particular risk of infection, and they need breast milk more than larger babies. Yet they are given artificial feeds more often than larger babies.
  - *Ask: Why is it sometimes difficult for low-birth-weight babies to breastfeed exclusively?*
- **Wait for a few replies and then continue. (Participants may give answers such as: low-birth-weight babies are not able to suckle strongly at the breast; they need more of some nutrients than breast milk can provide; it can be difficult for mothers to express enough breast milk.)**
  - Many low-birth-weight babies can breastfeed without difficulty. Babies born at term who are small for date usually suckle effectively. They are often very hungry and need to breastfeed more often than larger babies, so that their growth can catch up.
  - Babies who are born preterm may have difficulty suckling effectively at first. But they can be fed on breast milk by tube or cup, and helped to establish full breastfeeding later. Breastfeeding is easier for these babies than bottle feeding.
  - Mothers of low-birth-weight babies need skilled help to express their milk and to cup-feed.
  - *Ask: When should a mother with a low-birth-weight baby start to express her milk?*
- **Wait for a few replies and then continue.**
  - It is important to start expressing on the first day, within 6 hours after delivery if possible. This helps to start the flow of breast milk, in the same way that suckling soon after delivery helps breast milk to "come in".
  - If a mother can express just a few millilitres of colostrum, it is valuable for her baby.
  - *Ask: At what age can low-birth-weight babies suckle from the breast?*
- **Wait for a few replies and then continue by displaying the next slide.**

▸ Show **Slide 55/6 – Feeding low-birth-weight babies** and make the points that follow:



- ¤ Babies of about 32 weeks' gestational age or more are able to start suckling on the breast.
- ¤ Babies below 30 weeks usually need to receive their feeds by a tube in hospital.
- ¤ Let the mother put her baby to her breast as soon as they are well enough. They may only root for the nipple and lick it at first, or may suckle a little. Continue giving expressed breast milk by cup, to make sure the baby gets all that they need.
- ¤ When a low-birth-weight baby starts to suckle effectively, they may pause during feeds quite often and for quite long periods. For example, they may take 4–5 sucks and then pause for up to 4 or 5 minutes.
- ¤ It is important not to take the baby off the breast too quickly. Leave them on the breast so that they can suckle again when they are ready.
- ¤ The baby can continue for up to an hour if necessary. Offer a cup feed after the breastfeed.
- ¤ Make sure that the baby suckles in a good position. Good attachment may make effective suckling possible at an earlier stage.

▸ Ask participants to pair up (groups of two) and examine COUNSELLING CARD 4: BREASTFEEDING POSITIONS and COUNSELLING CARD 23: FEEDING A LOW-BIRTH-WEIGHT BABY, and the sections in the *Guidance on the use of counselling cards* on KEY PRACTICES AND DISCUSSION POINTS for those Counselling cards. Participants demonstrate to each other the positions that are suitable for a mother to hold her low-birth-weight baby.

▸ After the activity in pairs, bring all participants together. Ask one pair to present the results of their discussion and other participants to add any additional comment.

▸ Review together the best positions for a mother to hold her low-birth-weight baby at the breast

- ¤ The best positions for a mother to hold her low-birth-weight baby at the breast are:
  - across her body, holding the baby with the arm on the opposite side to the breast
  - the underarm position.

▸ Ask participants to turn to page 82 or 194 of their *Participant's manual* and the *Guidance on the use of counselling cards*, to remind themselves of these positions. Continue with these points:

- ¤ Low-birth-weight babies need to be followed up regularly to make sure that they are getting all the breast milk that they need.
- ¤ Low-birth-weight babies of mothers who are living with HIV and who are replacement feeding are at higher risk of complications and should also be followed up regularly, to make sure they are growing. Encourage mothers to feed the replacement milk to their babies by cup.

▸ Ask participants to turn to page 417 of their *Participant's manual* and find the box AMOUNT OF MILK TO GIVE TO LOW-BIRTH-WEIGHT BABIES WHO CANNOT BREASTFEED. Ask participants to look at this in their own time.

AMOUNT OF MILK TO GIVE TO LOW-BIRTH-WEIGHT BABIES WHO CANNOT BREASTFEED

What milk to give

- Choice 1: expressed breast milk (if possible from the baby's mother, or from a donor); this may be pasteurized or heat-treated according to local policy
- Choice 2: formula milk made up according to the instructions and World Health Organization (WHO) guidelines

Amount of milk to give to babies who weigh less than 2.5 kg (low birth weight)

- Start with 60 mL/kg body weight per day
- Increase the total volume by 20 mL/kg per day, until the baby is taking a total of 180 mL/kg per day
- Divide the total into 8–12 feeds, to feed every 2–3 hours
- Continue until the baby weighs 1800 g or more, and is fully breastfeeding

Check the baby's 24-hour intake

The size of individual feeds may vary

V. Summarize the session 2 minutes

Ask participants whether they have any questions, and try to answer them.

- **Make these points:**
  - In this session, we discussed the importance of adequate feeding during illness and recovery.
  - We also discussed feeding of low-birth-weight babies.
- **Point to the flipchart page with the Key message:**
  - KEY MESSAGE 10: ENCOURAGE THE CHILD TO DRINK AND EAT DURING ILLNESS, AND PROVIDE EXTRA FOOD AFTER ILLNESS TO HELP THEM RECOVER QUICKLY
- **Point to the flipchart with the 10 Key messages for complementary feeding listed. Explain to participants that they can find this list on page xiv of their *Participant's manual*.**
- **Explain that a summary of this session can be found on pages 415–417 of the *Participant's manual*.**

Further information

Low-birth-weight babies

Whenever possible, low-birth-weight babies should be under the care of a health worker with specialist training. However, this information may help you if specialist care is not easily available.

Time of first oral feed

If oral feeding is possible as soon as a baby is born, the first feed should be given within the first 2 hours, and every 2–3 hours thereafter to prevent hypoglycaemia (low blood sugar).

Until the mother has put the baby to her breast and there is evidence the baby is receiving colostrum, give feeds of donated breast milk, if available. If breast milk is not available, give glucose water or formula. Glucose water is not necessary for well, term babies who are not at risk of hypoglycaemia.

Cup feeds

Cup feeds give a baby valuable experience of taking food by mouth, and the pleasure of taste. They stimulate the baby's digestion. Many babies show signs of wanting to take things into their mouths at this stage, yet they are not able to suckle effectively at the breast.

Weight as a guide to feeding method

Gestational age is a better guide to a baby's feeding ability than weight. However, it is not always possible to know gestational age. Many babies start to take milk from the breast when they weigh about 1300–1500 g. Many can breastfeed fully when they weigh about 1600–1800 g or less.

Development of coordinated suckling

Babies can already swallow and suck long before 32 weeks' gestation. From about 32 weeks, many babies can suckle from the breast, and some can breastfeed fully from this age, but they may have difficulty in coordinating suckling, swallowing and breathing. They need to pause during a breastfeed to breathe. They can suckle effectively for a short time, but they often cannot suckle long enough to take all the breast milk that they need. By about 36 weeks, most babies can coordinate suckling and breathing, and they can take all that they need by breastfeeding. However, a baby may feed well sometimes but tire and feed poorly at other times. If a baby suckles poorly, offer a cup feed after the breastfeed. If they are hungry, they will take milk form the cup. If the baby has had enough, they will not take milk from the cup.

Skin-to-skin contact and kangaroo mother care

Skin-to-skin contact between a mother (or father) and baby has been found to help both bonding and breastfeeding, probably because it stimulates the secretion of prolactin and oxytocin.

If a baby is too sick to move, contact can be between the mother's hand and the baby's body. If a baby is well enough, let their mother hold them next to her body. Usually the best place is between her breasts, inside her clothes. This is called **kangaroo mother care**. It has the following advantages:

- the warmth of the mother's body keeps her baby warm; the baby does not get cold, and does not use up extra energy to keep warm; there is less need for incubators
- the baby's heart works better, and the baby breathes more regularly
- the baby cries less and sleeps better
- it is easier to establish breastfeeding.

Additional information on the subject can be found in the following references:

- WHO recommendations on interventions to improve preterm birth outcomes. Geneva: World Health Organization; 2015 (http://apps.who.int/iris/bitstream/10665/183037/1/9789241508988_eng.pdf).
- Guidelines on optimal feeding of low birth-weight infants in low- and middle-income countries. Geneva: World Health Organization; 2011 (https://apps.who.int/iris/bitstream/handle/10665/85670/9789241548366_eng.pdf).

Notes

Notes (contd)

MODULE 6

Growth assessment

SESSION 56

Introducing child growth assessment

Objectives

After completing this session, participants will be able to:

- start a GROWTH RECORD for a child and select pages to use at a given visit
- determine a child's age on the visit day
- identify the correct charts to use (age and sex) on a given visit, and where these charts are in the GROWTH RECORD

Session outline . . . . . 100 minutes

Participants are all together for a lecture presentation by one trainer, followed by an individual written exercise.

I. Introduce the session, present **Slide 56/1** . . . . . 5 minutes
II. Present **Slides 56/2** to **56/7** and "Grace Madu" example . . . . . 35 minutes
III. Individual written exercise and discussion (EXERCISE 56.A) . . . . . 25 minutes
IV. Individual work on continuing case studies (EXERCISES 56.B and 56.C) . . . . . 25 minutes
V. Summarize the session . . . . . 10 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides and facilitating written exercises.
- Study the **Slides 56/1** to **56/7** and the text that goes with them, so that you are able to present them.
- Each participant should have a BOY'S GROWTH RECORD, a GIRL'S GROWTH RECORD and a CHILD AGE CALCULATOR.
- You need to be familiar with the contents of the CHILD GROWTH RECORD and how to use the CHILD AGE CALCULATOR.

As you follow the text, remember:

► **indicates an instruction to you, the trainer.**

¤ indicates what you say to participants.

I. Introduce the session — 5 minutes

► Show **Slide 56/1 – Session 56 – objectives** and read out the objectives:

> 56/1
>
> **Session 56: Introducing child growth assessment – objectives**
>
> After completing this session, participants will be able to:
> - start a GROWTH RECORD for a child and select pages to use at a given visit
> - determine a child's age on the visit day
> - identify the correct charts to use (age and sex) on a given visit, and where these charts are in the GROWTH RECORD

II. Present **Slides 56/2 to 56/7** and "Grace Madu" example — 35 minutes

► Make these points:

- ¤ We are going to see a series of slides that will help us become familiar with the CHILD GROWTH RECORD and the CHILD AGE CALCULATOR, and how to gather the basic information and take the measurements needed to assess how well a child is growing.

► Show **Slide 56/2 – Child growth assessment 1** and make the points that follow:

> 56/2
>
> **Child growth assessment 1**
>
> - Basic growth assessment involves measuring a child's weight and length/height
> - Measurements are then compared to growth standards
> - Why? To determine whether the child is growing normally or has a growth problem or trend towards a problem
> - Steps: measure, plot, interpret, take action to address or prevent growth problems
> - Correct measurement, plotting and interpretation is essential to identify problems correctly

- ¤ Basic growth assessment involves measuring a child's weight and length or height,[1] and comparing these measurements to growth standards.
- ¤ The purpose is to determine whether a child is growing "normally" or has a growth problem or trend towards a growth problem that should be addressed.
- ¤ The steps involve measuring weight, length and height; plotting these measurements on growth charts; and interpreting growth indicators.
- ¤ Correct measurement, plotting and interpretation are essential for identification of growth problems.

[1] There are other growth measures (e.g. head circumference), but these are not covered in this course. The length of children aged less than 2 years is measured lying down, while standing height is measured for children aged 2 years or older. Throughout the training programme, the term length/height is used to indicate that the age-appropriate measurement for linear growth should be used.

► Show **Slide 56/3 – Child growth assessment 2** and make the points that follow:

56/3

Child growth assessment 2

- If there is a growth problem, determine the causes
- Take action to address the causes of poor growth; without appropriate action, programmes are ineffective in improving child health
- In extreme poverty or emergencies, growth assessment aims to identify children who need urgent intervention, (therapeutic or supplementary feeding), to prevent death
- In health-facility settings, children with severe forms of undernutrition should be referred for specialized care
- Obese children need medical assessment and specialized management; non-severe problems can be managed through counselling, including age-appropriate advice on feeding and physical activity

- If a child has a growth problem, or a trend towards one, the health-care provider should talk with the mother or other caregiver,[1] to determine the causes.
- It is then critically important to take action to address the causes of poor growth. Growth assessments that are not supported by appropriate response programmes are not effective in improving child health.
- In circumstances such as extreme poverty or emergencies, growth assessment aims to identify children who need urgent intervention, such as therapeutic or supplementary feeding, to prevent death.
- In health-facility settings, children with severe forms of undernutrition should be referred for specialized care.
- Children with obesity should be referred for medical assessment and specialized management if these services are available. Non-severe problems can be managed through counselling, including age-appropriate advice on feeding and physical activity.

► Show **Slide 56/4 – The CHILD GROWTH RECORD** and make the points that follow:

56/4

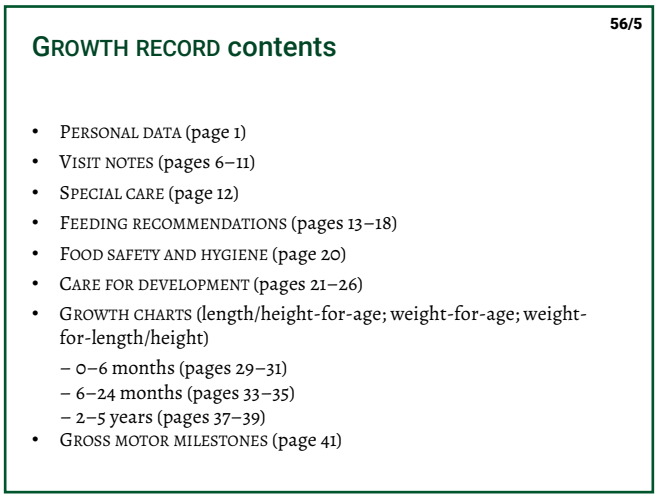
The CHILD GROWTH RECORD

- Contains all of the charts needed to record and assess the growth of a child from birth up to 5 years of age
- A different GROWTH RECORD is needed for boys and girls because boys and girls have different weights and lengths from birth

- A CHILD GROWTH RECORD is a booklet that contains all of the charts needed to record and assess the growth of a child from birth up to 5 years of age.
- It also contains recommendations on child feeding and care, and is a useful reference for parents, other caregivers and health-care providers.
- A different GROWTH RECORD is needed for boys and girls because boys and girls have different weights and lengths from birth.
- A GROWTH RECORD should be started for each child and kept by the mother.

[1] In this course, the word "mother" is often used to refer to the child's primary caregiver. It is understood that the primary caregiver may be another person, such as the father, grandmother or another relative or guardian.

► Show **Slide 56/5 – GROWTH RECORD contents** and make the points that follow:

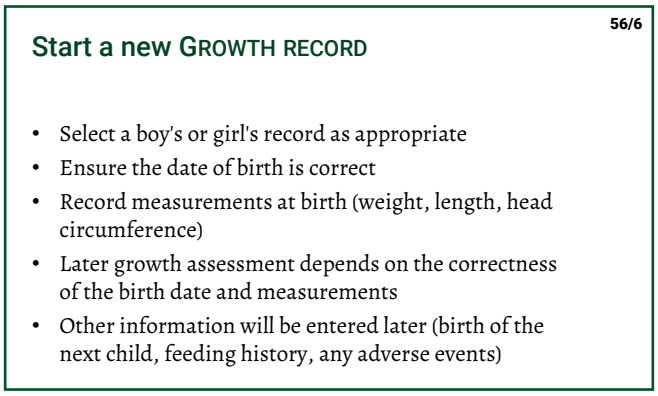


► **Ask participants to study each section of the CHILD GROWTH RECORD, to identify the different sections listed on the slide. Review the contents of each section with the participants and respond to any questions they may have.**

- PERSONAL DATA (page 1): more detailed information is given in the next slide.
- Under VISIT NOTES (pages 6–11), record visit dates, age, reasons for clinic visits, measurements, information that will help explain any problems that may be observed during the assessment, and observations on the physical status of the child, for example if a child looks:
  - wasted[1] (too thin)
  - lean (fleshed out, no noticeable fat)
  - normal (rounded contours, no noticeable excess fat)
  - heavy (sturdy, mostly muscular, not lean or thin)
  - overweight[1] (noticeable fat)
  - obese[1] (excess fat).
- The reference sections of the GROWTH RECORD (SPECIAL CARE, FEEDING RECOMMENDATIONS, FOOD SAFETY AND HYGIENE, and CARE FOR DEVELOPMENT) are handy references for parents and health-care providers.
- We will not use the BMI (body mass index) charts in this course, although they are included in the GROWTH RECORD.
- Take note that in the 0–6 months charts (pages 29–31), the first 3 months are plotted in weeks (and 13 weeks make 3 months exactly).

[1] You will learn more technical definitions for these terms later in the course.

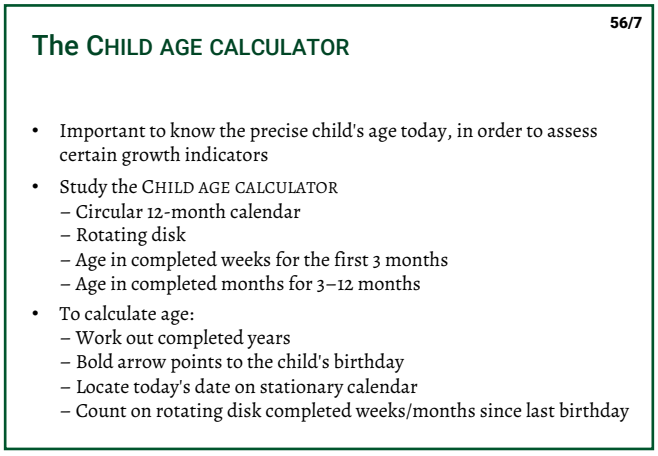
▸ Show **Slide 56/6 – Start a new GROWTH RECORD** and make the points that follow:



▸ **Ask participants to turn to page 1 of the GROWTH RECORD (PERSONAL DATA), and make the following points about starting a new CHILD GROWTH RECORD:**

- Verify the child's sex and select the correct GROWTH RECORD for a boy or girl.
- Ideally, the GROWTH RECORD is started for each child at birth, in order to enter correct information on the date of birth, gestational age, birth weight, length and head circumference.
- Correct birth information is necessary for correct growth assessment later, as it affects age calculation and the interpretation of growth trends.
- The date of birth of the next younger sibling is entered later, if and when the mother gives birth to the next child.
- Similarly, information on feeding and any adverse events will be entered later, as and when the relevant events happen.
- Where the exact date of birth is unknown, a local events calendar could be used to establish the child's likely date of birth.

▸ Show **Slide 56/7 – The CHILD AGE CALCULATOR** and make the points that follow:



▸ **Ask participants to take out the CHILD AGE CALCULATOR, and make the following points:**

- It is important to know the precise age of the child, in order to assess certain growth indicators.
- The World Health Organization (WHO) CHILD AGE CALCULATOR is a rotating disk mounted on a calendar and is used to calculate a child's age in completed weeks or months in the first year of life. Instructions are given on the back of the calculator and on page 424 of your *Participant's manual*.
- Determine the child's date of birth. This date should already be recorded in the GROWTH RECORD on page 1 (PERSONAL DATA) or, if the exact date of birth is unknown, use a local events calendar to establish the likely date of birth.
- Determine and note down the number of full years the child has completed, e.g. ask the mother how many birthdays have been celebrated if this is a local custom. (Note: simply subtracting the year of birth from the current year will be accurate only if the child has already had a birthday this year.)

- If the child is one or more years old, you will turn the disk to calculate the number of additional months completed.
- If the child is less than 1 year old, you will use the disk to count the number of weeks (in the first 3 months) or months (from 3 to 11 months) completed since birth.
- Turn the disk until the bold arrow points to the child's birthday (month and day) on the stationary circular calendar.
- Locate today's date on the stationary calendar and count on the rotating disk how many months (or weeks if less than 3 months old) the child has completed since birth or the last birthday.

Instructions for use of the Child age calculator

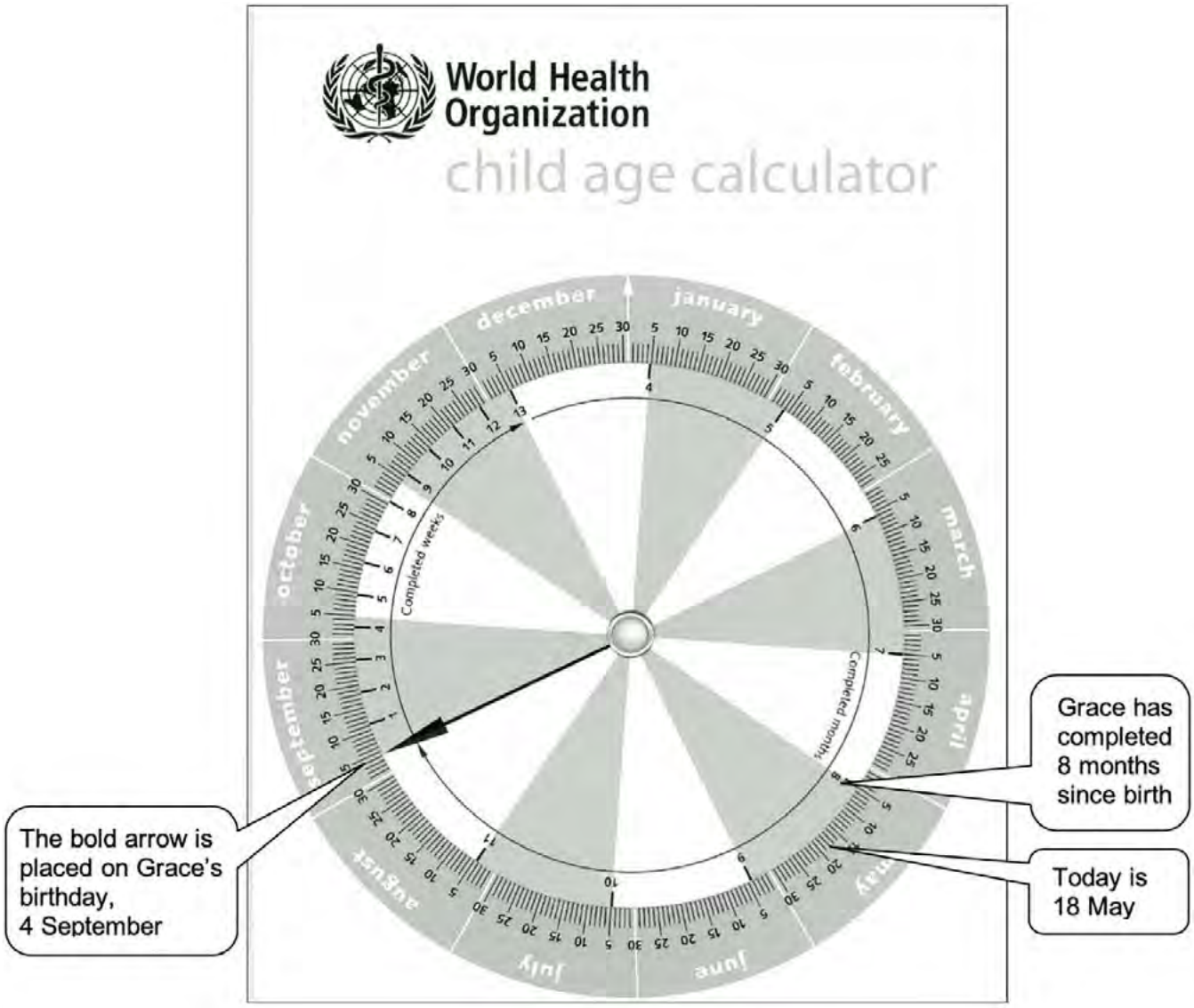
1. Determine the child's date of birth. This date should already be recorded in the Growth record on page 1 (Personal data).
2. Determine and note down the number of full years the child has completed, e.g. ask the mother how many birthdays have been celebrated if this is a local custom. (Note: simply subtracting the year of birth from the current year will be accurate only if the child has already had a birthday this year.)
   - If the child is one or more years old, you will turn the disk to calculate the number of additional months completed.
   - If the child is less than 1 year old, you will use the disk to count the number of weeks (in the first 3 months) or months (from 3 to 11 months) completed since birth.
3. Turn the disk until the bold arrow points to the child's birthday (month and day) on the stationary circular calendar.
4. Locate today's date on the stationary calendar and count on the rotating disk how many months (or weeks if less than 3 months old) the child has completed since birth or the last birthday.
5. Record the child's age today in the Visit notes of the Growth record. Use abbreviations agreed upon for year, month and week.
   - If the child is more than 1 year old, record completed years and months, for example, "1 yr 6 mo", "2 yr 3 mo". If no months have been completed beyond the child's birthday, record as "1 yr 0 mo", "2 yr 0 mo", etc.
   - If the child is between 3 months and 1 year old, record completed months, for example, "4 mo", "11 mo".
   - If the child is less than 3 months old, record completed weeks, for example, "9 wk".[1] Notice that 13 weeks = 3 months.
   - If the child was born on 29 February, place the bold arrow on 28 February.

► **Ask participants to study the example of Grace Madu on page 425 of their *Participant's manual* and discuss any issues before they proceed to do the individual written exercises on the next page.**

[1] If a country uses different growth charts that count months rather than weeks from birth, it will not be necessary to record weeks.

Example

Grace Madu is seen at a clinic on 18 May 2020. Her mother has brought her for immunization. Grace's date of birth is already recorded on the PERSONAL DATA page of her GIRL'S GROWTH RECORD as 4 September 2019. She has not yet completed 1 year since birth.



¤ Now please turn to page 426 of your *Participant's manual* and do the written EXERCISE 56.A.

III. Individual written exercise and discussion — 25 minutes

Exercise 56.A Determining a child's age today and selecting growth charts to use in the Growth record

In this exercise, you will determine the age of several children using the WHO Child age calculator. Then you will determine which growth charts in the Growth record should be used during the child's growth assessment.

Answer the questions about each case described in your *Participant's manual*, pages 426–427:

1. On 30 June 2020, Mrs Ismail brings her son Salaam to the health centre because he has ear pain. The Personal data page in Salaam's Boy's growth record says that he was born on 12 September 2018.

What is Salaam's age today (30 June 2020), as it should be recorded in the Visit notes (page 6) of the Boy's growth record?

After weighing and measuring Salaam and recording his weight and length in the Visit notes, which three growth charts from the Growth record should the health-care provider use for Salaam's growth assessment?

Title of growth chart:	Page number:
1.	
2.	
3.	

2. On 19 April 2020, a girl named Ruby is seen at the health centre for a well-child visit. Ruby's grandmother says that Ruby's Girl's growth record has been lost. She says that Ruby will celebrate her first birthday soon, on the first day of May. The health-care provider begins a new Girl's growth record for Ruby by completing the Personal data page.

What is Ruby's date of birth, as it should be recorded on the Personal data page?

What is Ruby's age today (19 April 2020), as it should be recorded on the Visit notes page?

After weighing and measuring Ruby and recording her weight and length in the VISIT NOTES, which three growth charts should the health-care provider use?

Title of growth chart:	Page number:
1.	
2.	
3.	

3. On 20 August 2020, a baby boy named Ivan is brought to the health centre for immunization. The boy's birth record says that he was born on 26 May 2020. The health-care provider begins a BOY'S GROWTH RECORD for Ivan, by completing the PERSONAL DATA page. He then turns to the VISIT NOTES page to record Ivan's age today.

What is Ivan's age today (20 August 2020), as it should be recorded on the VISIT NOTES page?

After weighing and measuring Ivan and recording his weight and length in the VISIT NOTES, which three growth charts should the health-care provider use?

Title of growth chart:	Page number:
1.	
2.	
3.	

- **Ask participants whether they have any questions about the exercise, and try to answer them.**
- **Then explain to them what to do next:**
  - We will use the two GROWTH RECORDS to follow a little girl called Nalah and a boy called Toman.
  - In the next 20 minutes, you will start a GROWTH RECORD for each of them with the information given on page 428 of your *Participant's manual*.

IV. Individual work on continuing case studies — 25 minutes

EXERCISE 56.B CONTINUING CASE STUDIES – NALAH AND TOMAN

In this exercise, you will begin a GROWTH RECORD for a girl named Nalah and one for a boy named Toman. You will continue to follow the growth of Nalah and Toman throughout this course. You have been given a GIRL'S GROWTH RECORD and a BOY'S GROWTH RECORD to use in this and other exercises about Nalah and Toman.

Read the information about each child on page 428 of your *Participant's manual* and follow the instructions given.

Nalah

Nalah Parab was born on 7 February 2020. She was a single, term birth (38 weeks of pregnancy). According to her birth record, her weight was 2.9 kg and length was 49 cm. Her head circumference was not measured.

Nalah's parents are Hamid and Shira Parab. Their address is at 40 Rim Road. Nalah is the first and only child born to her mother. She is breastfed, but she has also been taking some water since she was 3 weeks old. There have been no unusual adverse events in her life so far.

The date of Nalah's visit to the health centre is 25 March 2020. Her mother has brought her for immunization.

Instructions:

1. Complete the PERSONAL DATA page of the GIRL'S GROWTH RECORD for Nalah. (You may make up a record number.)
2. In the VISIT NOTES section of the GIRL'S GROWTH RECORD, record Nalah's date of birth. On the first row, enter the date of Nalah's visit, her age today, and the reason for her visit.
3. List below the titles and page numbers of the three growth charts that the health-care provider should use during Nalah's growth assessment.

Title of growth chart:	Page number:
1.	
2.	
3.	

Toman

Toman Baruni comes to the health centre with his mother, Salwa Baruni, on 15 August 2020 for a well-child visit. Mrs Baruni thinks that it must be time for Toman to have another immunization, but she has lost his GROWTH RECORD, so she is not sure. She says that his last visit to the health centre was at 6 months, and he had received all of his immunizations at that point.

In order to start a new BOY'S GROWTH RECORD, the health-care provider asks Mrs Baruni about Toman's birth. Mrs Baruni says that Toman was born on 10 July 2019. He was a single, term birth and weighed 3.5 kg. She does not remember his length or head circumference.

Mrs Baruni was sick at Toman's birth, and Toman was given infant formula milk by the nurses for 3 days in the hospital. After leaving the hospital, Mrs Baruni breastfed Toman, but she stopped after 3 months.

Toman is Mrs Baruni's second child. He lives with her at 100 Centre Street, Apartment 22. Mrs Baruni's first child was born of a different husband and lives with him. Toman has no younger siblings. Mrs Baruni is separated from Shaka Baruni, but Toman spends weekends with his father. Mrs Baruni does not think that the separation has been traumatic for Toman.

Instructions:

1. Complete the PERSONAL DATA page of the BOY'S GROWTH RECORD for Toman. (You may make up a record number.)
2. Above the VISIT NOTES section of the BOY'S GROWTH RECORD, record Toman's date of birth for easy reference. On the first row, enter the date of Toman's visit, his age today, and the reason for his visit.
3. List below the titles and page numbers of the three growth charts that the health-care provider should use during Toman's growth assessment.

Title of growth chart:	Page number:
1.	
2.	
3.	

¤ When you have finished this exercise, review your answers with a facilitator.

► Ask participants to do EXERCISE 56.C (page 429 of *Participant's manual*) as homework.

Exercise 56.C Continuing case studies – Nalah and Toman: homework

In Exercise 56.B, you began a Girl's growth record for Nalah and a Boy's growth record for Toman. In this exercise, you will enter additional information from a series of visits by each child on the Visit notes page, and determine the age at each visit.

Nalah

On the Visit notes page of Nalah's Girl's growth record, you have already recorded some information from her visit of 25 March 2020, when she was 6 weeks old. Open her Growth record to the Visit notes.

1. Nalah's weight at 6 weeks was 3.5 kg and her length was 51.3 cm. Record her weight and length at 6 weeks on the Visit notes page.
2. The following is information from four subsequent visits by Nalah. Enter this information on the Visit notes page. Determine Nalah's age at each visit and enter that as well.

Date of visit	Weight	Length/height	Reason for visit
20 April 2020	4.2 kg	54.8 cm	Immunization
22 May 2020	4.3 kg	54.8 cm	Diarrhoea
26 June 2020	4.8 kg	56.2 cm	Immunization
15 August 2020	5.4 kg	58.1 cm	Well-baby visit

Toman

On the Visit notes page of Toman's Boy's growth record, you have already recorded some information from his visit of 15 August 2020, when he was 1 year and 1 month old. Open his Growth record to the Visit notes.

1. Toman's weight at 1 year and 1 month old was 11.9 kg and his length was 79.0 cm. Record his weight and length at this age on the Visit notes page.
2. The following is information from three subsequent visits by Toman. Enter this information on the Visit notes page. Determine Toman's age at each visit and enter that as well.

Date of visit	Weight	Length/height	Reason for visit
15 December 2020	13.5 kg	84.5 cm	Well-child visit
16 March 2021	15.0 kg	87.0 cm	Ear pain
12 July 2021	16.8 kg	90.9 cm	Well-child visit
15 August 2020	5.4 kg	58.1 cm	Well-baby visit

When you have finished this exercise, review your answers with a facilitator.

► Answer sheets are provided at the end of this session (page 715–718).

V. Summarize the session 10 minutes

- **Make the following points:**
  - You started CHILD GROWTH RECORDS for Nalah and Toman today. As homework, use the information given in EXERCISE 56.C pages 429–430 to calculate their ages at different visits and enter the details in the VISIT NOTES pages of their respective growth records.
  - Important: this information will be used later to assess growth, so if there are any errors in what you enter here, you will not be able to assess their growth correctly.
- **Ask participants whether they have any questions, and try to answer them.**
- **Explain that a summary of this session can be found on pages 421–430 of the *Participant's manual*.**

Answer sheets

EXERCISE 56.A DETERMINING A CHILD'S AGE TODAY AND SELECTING GROWTH CHARTS TO USE IN THE GROWTH RECORD

1. Salaam's age today: 1 year 9 months

   The growth charts to be used for Salaam are:

   - Length-for-age, Boys, 6 months to 2 years, on page 33
   - Weight-for-age, Boys, 6 months to 2 years, on page 34
   - Weight-for-length, Boys, Birth to 2 years, on page 35

2. Ruby's date of birth: 1 May 2019

   Ruby's age today: 11 months

   The growth charts to be used for Ruby are:

   - Length-for-age, Girls, 6 months to 2 years, on page 33
   - Weight-for-age, Girls, 6 months to 2 years, on page 34
   - Weight-for-length, Girls, Birth to 2 years, on page 35

3. Ivan's age today: 12 weeks

   The growth charts to be used for Ivan are:

   - Length-for-age, Boys, Birth to 6 months, on page 29
   - Weight-for-age, Boys, Birth to 6 months, on page 30
   - Weight-for-length, Boys, Birth to 6 months, on page 31

Exercise 56.B Continuing case studies – Nalah and Toman

Nalah

Note that only minimal information about feeding is recorded on the Personal data page. More details of the child's feeding history may be recorded in the Visit notes. There is no need to write "still breastfeeding" for Nalah on the Personal data page; leave the line after "Age at termination of breastfeeding" blank until termination occurs. Also leave the line for "Adverse events" blank unless some event has occurred; do not write "none", as something may happen later.

1. Nalah's Personal data page should look something such as the following:

Personal Data

Child's name Nalah Parab ☑ Girl ☐ *If a boy, must use a Boy's Growth Record*

Identification/Record number _____

Parents' names Hamid and Shira Parab

Address 40 Rim Road

Birth information:

Date of birth 7-2-2020

Gestational age at birth 38 wk Single/multiple birth? Single

Measurements at birth:

Weight 2.9 kg Length 49 cm Head circumference _____

Birth rank 1st

Date of birth of next younger sibling (born to mother)_____

Feeding:

Age at introduction of any foods or fluids 3wk (water) *More details of feeding history may be recorded in Visit Notes*

Age at termination of breastfeeding _____

Adverse events (dates):

(such as death of parent, death of sibling age <5 years) _____

2. Nalah's Visit notes (first row) should appear as follows:

Date of birth: 7-2-2020

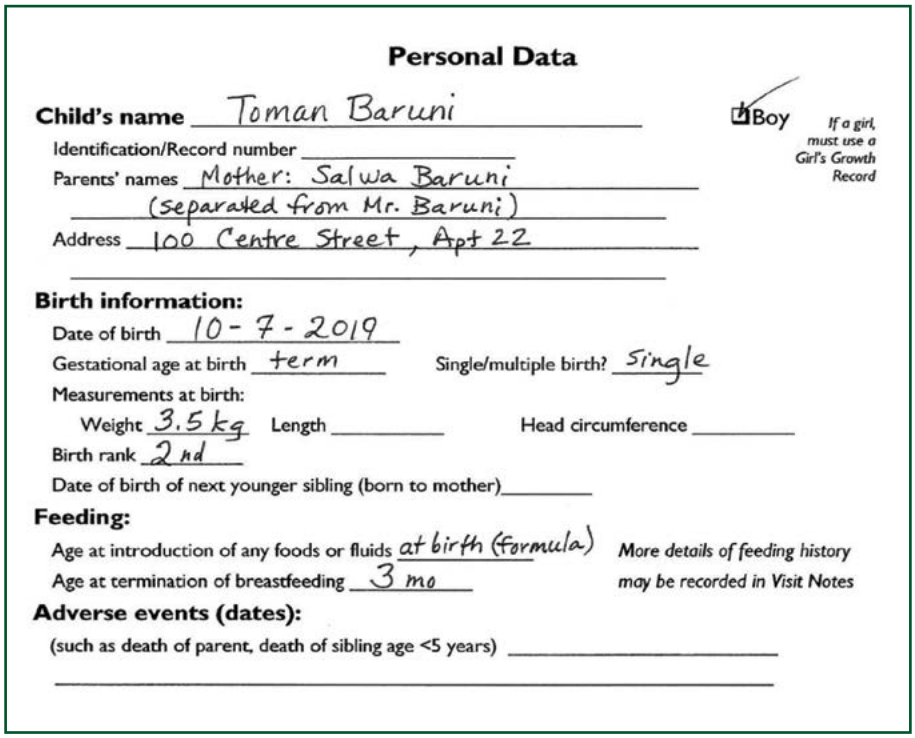
Visit Notes

Date of visit	Age today (Completed years/months or weeks)	Measurements (Record below; then plot on charts)			Reason for visit, observations, recommendations
		Weight (kg)	Length/ Height (cm)	BMI*	
25-3-2020	6 wk				immunization

3. The health-care provider should use the following growth charts for Nalah at this visit:
   - Length-for-age, Girls, Birth to 6 months, page 29
   - Weight-for-age, Girls, Birth to 6 months, page 30
   - Weight-for-length, Girls, Birth to 6 months, page 31

Toman

1. Toman's PERSONAL DATA page should look something such as the following:



Personal Data

Child's name Toman Baruni ☑ Boy ☐ Girl — *If a girl, must use a Girl's Growth Record*

Identification/Record number _____

Parents' names Mother: Salwa Baruni (separated from Mr. Baruni)

Address 100 Centre Street, Apt 22

Birth information:

Date of birth 10-7-2019

Gestational age at birth term Single/multiple birth? Single

Measurements at birth:

Weight 3.5 kg Length _____ Head circumference _____

Birth rank 2nd

Date of birth of next younger sibling (born to mother)_____

Feeding:

Age at introduction of any foods or fluids at birth (formula)

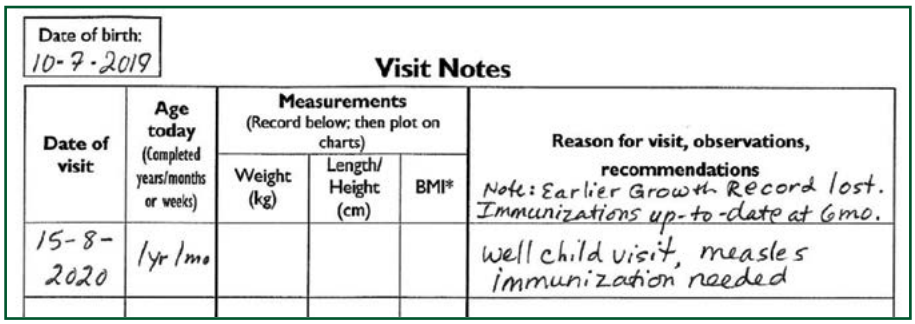
Age at termination of breastfeeding 3 mo

More details of feeding history may be recorded in Visit Notes

Adverse events (dates):

(such as death of parent, death of sibling age <5 years) _____

2. Toman's VISIT NOTES (first row) should appear as follows:



Date of birth: 10-7-2019

Visit Notes

Date of visit	Age today (Completed years/months or weeks)	Measurements (Record below; then plot on charts)			Reason for visit, observations, recommendations
		Weight (kg)	Length/ Height (cm)	BMI*	Note: Earlier Growth Record lost. Immunizations up-to-date at 6mo.
15-8-2020	1yr 1mo				well child visit, measles immunization needed

3. The health-care provider should use the following growth charts for Toman at this visit:
   - Length-for-age, Boys, 6 months to 2 years, page 33
   - Weight-for-age, Boys, 6 months to 2 years, page 34
   - Weight-for-length, Boys, Birth to 2 years, page 35

Exercise 56.C Continuing case studies – Nalah and Toman: homework

Nalah

Nalah's Visit notes page should appear as follows (ignore the BMI values).

Date of birth: 7-2-2020

Visit Notes

Date	Age today (Completed years/months or weeks)	Measurements (Record below; then plot on charts) Weight (kg)	Length/ Height (cm)	BMI*	Reason for visit, observations, recommendations
25-3-2020	6 wk	3.5	51.3	13.5	immunization
20-4-2020	10 wk	4.2	54.8	14	immunization
22-5-2020	3 mo	4.3	54.8	14	diarrhoea
26-6-2020	4 mo	4.8	56.2	15	immunization
15-8-2020	6 mo	5.4	58.1	16	well-baby visit

* BMI (body mass index) = weight in kilograms divided by length or height in meters squared (kg/m²)

Other information (e.g. drug or food allergies, chronic conditions):

Toman

Toman's Visit notes page should appear as follows (ignore the BMI values).

Date of birth: 10-7-2019

Visit Notes

Date	Age today (Completed years/months or weeks)	Measurements (Record below; then plot on charts) Weight (kg)	Length/ Height (cm)	BMI*	Reason for visit, observations, recommendations Note: Earlier Growth Record Lost - Immunizations up-to-date at 6 mo
15-8-2020	1yr 1mo	11.9	79.0	19	well-child visit, measles immunization needed
15-12-2020	1yr 5mo	13.5	84.5	19	well-child visit
16-3-2021	1yr 8mo	15.0	87.0	20	ear pain
12-7-2021	2yr 0mo	16.8	90.9	20	well-child visit

* BMI (body mass index) = weight in kilograms divided by length or height in meters squared (kg/m²)

Other information (e.g. drug or food allergies, chronic conditions):

Notes

Notes (contd)

SESSION 57

Measuring weight, length and height

Objectives

After completing this session, participants will be able to:

- use the available weighing and measuring equipment
- weigh a child
- measure a child's length
- measure a child's height

Session outline . . . . . 60 minutes

Participants are all together for a practical demonstration led by one trainer, followed by participants' practice with all trainers and then some video excerpts.

I. Introduce the session, present **Slide 57/1** . . . . . 3 minutes
II. Practical demonstrations of using equipment (DEMONSTRATIONS 57.A–57.C) . . . . . 30 minutes
III. Participants' practice . . . . . 25 minutes
IV. Summarize the session . . . . . 2 minutes

Preparation

- Refer to the Introduction for guidance on giving a demonstration.
- Work in advance with the weight and length/height measuring equipment provided for the course and be sure you will be able instruct the participants in how to use it.
- Make sure you have **Slide 57/1** ready. Alternatively, as there is only one slide, you might prefer to read aloud the objectives without projecting them onto the screen.
- You will demonstrate how to use the taring scale and a height/length board. The following equipment is needed in the classroom for the demonstrations:
  - a taring scale (if available)
  - a length/height board set up to measure height
  - a length/height board set up to measure length
  - paper towels or soft cloth to cover the length/height board
  - a large doll is very helpful.
- The JOB AID: WEIGHING AND MEASURING A CHILD is a useful reference.

As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

I. Introduce the session 3 minutes

► Show **Slide 57/1 – Session 57 – objectives** and read out the objectives:

57/1

Session 57: Measuring weight, length and height – objectives

After completing this session, participants will be able to:
- use the available weighing and measuring equipment
- weigh a child
- measure a child's length
- measure a child's height

► **The descriptions below of how to demonstrate and the key points to mention are very detailed. It is not expected that you will follow this description word for word. Instead, read it carefully a few times before the demonstration, to remind yourself of the important steps and key points to make. Your co-facilitator can help to make sure that all the points are mentioned. Refer to the JOB AID: WEIGHING AND MEASURING A CHILD, for illustrations of the measurement procedures you will describe.**

► Make these points:

- After the practical demonstrations in this session, you will be able to use the anthropometry equipment available for this training to weigh a child, to measure length and to measure height.

II. Practical demonstrations of using equipment 30 minutes

DEMONSTRATION 57.A USE OF MEASURING EQUIPMENT: TARING SCALE

► Before starting the demonstration, present the following information:

- It is recommended to weigh children using a scale with the following features:
  - solidly built and durable
  - electronic (digital reading)
  - measures up to 150 kg
  - measures to a precision of 0.1 kg (100 g)
  - allows tared weighing.
- "Tared weighing" means that the scale can be reset to zero ("tared") with the person just weighed still on it. Thus, a mother can stand on the scale, be weighed, and the scale tared. While remaining on the scale, if the mother is given her child to hold, the child's weight alone appears on the scale. Tared weighing has two clear advantages:
  - there is no need to subtract weights to determine the child's weight alone (reducing the risk of error).
  - the child is likely to remain calm when held in their mother's arms for weighing.
- There are many types of scales currently in use. The UNISCALE (made by the United Nations Children's Fund [UNICEF]) has the recommended features listed above and is used in this course to demonstrate weighing techniques.
- It is powered by a lithium battery that lasts for one million measurement sessions. The scale has a solar on-switch, so it requires adequate lighting to function. Footprints may be marked on the scale to show where a person should stand. How to weigh a child using the UNISCALE or a similar model is described in the following sections.
- A taring scale is easy to use and reliable. However, there are other types of scales that may be reliable, for example, an electronic baby scale, or a paediatric beam balance that has been calibrated. Children who can stand alone can be weighed standing on a scale. Otherwise, the mother can be weighed alone; then the mother and child can be weighed together and the mother's weight subtracted to determine the child's weight.
- Bathroom scales are not recommended, as they tend to be unreliable. Hanging scales are also not reliable when weighing agitated babies.

► **Ask a participant to be the "mother" for this demonstration. For the demonstration, prepare a "baby" that will weigh over 2 kg, such as 2–3 handbags or a bag holding several water bottles or books. Then, as you demonstrate use of the taring scale, mention the key points below.**

- Place the scale on a flat, hard surface. The solar panel should be in good light.
- Mention that the mother would undress the baby.
- To turn on the scale, cover the solar panel for a second (literally one second). Wait until the number 0.0 appears.
- Ask the mother to remove her shoes. Then ask her to step on the scale and stand still. Ask her to remain on the scale even after her weight appears, until you have finished weighing the baby.
- After the mother's weight is displayed, tare the scale by covering the solar panel for only a second and then waiting for the number 0.0 to appear along with a figure of a mother and baby.
- Gently hand the "baby" to the mother. In a moment, the "baby's" weight will appear.
  - **Note:** If the scale takes a long time to show 0.0 or a weight, it may not have enough light. Reposition the scale so that the solar panel is under the most direct light available.
  - **Note:** If a mother is very heavy (such as more than 100 kg) and the baby is light (such as less than 2.5 kg), the baby's weight may not register on the scale. In such cases, have a lighter person hold the baby on the scale.

Demonstration 57.B Use of measuring equipment: length board

► **Before starting the demonstration, present the following information:**

- The equipment needed to measure length is a length board (sometimes called an infantometer), which should be placed on a flat, stable surface such as a table. To measure height, use a height board (sometimes called a stadiometer) mounted at a right angle between a level floor and against a straight, vertical surface such as a wall or pillar.
- A good length or height board should be made of smooth, moisture-resistant (varnished or polished) wood. The horizontal and vertical pieces should be firmly joined at right angles. A movable piece serves as the footboard when measuring length, or the headboard when measuring height. Unless there is a digital counter, a measuring tape should be fixed firmly in a groove along the length of the board, so that moving parts do not scrape it and rub off the markings. Care of the length and height boards is described in a later session.

► **If the length/height board requires assembling, begin by demonstrating how to assemble and disassemble the board. Then as you demonstrate use of the length board, mention the key points below. It is most helpful if you have a large doll for this demonstration.**

- Place the length board on a sturdy surface, such as a table or the floor. Cover the length board with a cloth or paper towel.
- Stand on the side where you can see the measuring tape and move the footboard.
- Explain to the mother that she will need to place the baby on the length board herself and then help to hold the baby's head in place while you take the measurement. Show her where to stand when placing the baby down. Also show her where to place the baby's head (against the fixed headboard).
- When the mother is ready, ask her to lay the child on their back with their head against the headboard, compressing the hair.
- Quickly position the head so that the child's eyes are looking straight up (an imaginary vertical line from the ear canal to the lower border of the eye socket is perpendicular to the board). The person assisting should stand behind the headboard and hold the head in this position (see illustration in the Job aid: Weighing and measuring a child).
- Speed is important.
- Check that the child lies straight along the board and does not change position. The shoulders should touch the board, and the spine should not be arched.

- Hold down the child's legs with one hand and move the footboard with the other. You will have best control if you hold the child's legs at the knees (with one finger between the knees) and gently press them down.
- While holding the knees, move the footboard against the soles of the child's feet. The soles should be flat against the footboard, toes pointing upwards. If the child bends the toes or arches the foot and prevents the footboard from touching the soles, scratch the soles slightly and slide in the footboard quickly when the child straightens their toes.
- Read the measurement and record the child's length in centimetres to the last completed 0.1 cm (1 mm). This is the last line that you can actually see.
  - **Note:** If the child is extremely agitated and both legs cannot be held in position, measure with one leg in position.
  - **Note:** It is not possible to straighten the knees of neonates to the same degree as older children. Their knees are fragile and could be injured easily, so apply minimum pressure.
- Remember that if the child whose length you measured is aged 2 years or more, subtract 0.7 cm from the length and record the result as height in the VISIT NOTES.

DEMONSTRATION 57.C USE OF MEASURING EQUIPMENT: HEIGHT BOARD

▶ **Demonstrate use of the height board and mention the key points below. It is also helpful if you have a large doll for this demonstration, or even a stick. Then, as you demonstrate use of the height board, mention the key points below.**

- Place the height board with its back against the wall, so that it sits flat on the floor and cannot tip backward.
- Place yourself to the right of the height board, kneeling down so that your head is at the level of the child's head.
- Position the "child" (doll) on the baseboard with the back of the head, shoulder blades, buttocks, calves and heels touching the vertical board.

▶ **Ask the person assisting to kneel down, hold the child's knees and feet in place, and focus the child's attention and soothe the child as needed.**

- Position the child's head and hold the chin in place with your left hand. Push gently on the tummy to help the child stand to full height.
- With your right hand, bring down the headboard to rest on the top of the head. These positions are illustrated the JOB AID: WEIGHING AND MEASURING A CHILD.
- Read and record the measurement to the last completed 0.1 cm. This is the last line that you can actually see.

III. Participants' practice — 25 minutes

- **Explain to participants that they need to prepare the mother and child for weighing and measuring length or height.**
  - Begin by explaining to the mother the reasons for measuring the child, for example, to see how the child is growing, how the child is recovering from a previous illness, or how the child is responding to changes that have been made in their feeding or care.
  - The following are practical points to remember as you prepare mothers and their children for the different measurements:
  - If the child is less than 2 years old or is unable to stand, you will do tared weighing.
  - If the child is 2 years or older, you will weigh the child alone if they will stand still.
  - Undress the child. Explain that the child needs to remove their outer clothing in order to obtain an accurate weight. A wet diaper, or shoes and jeans, can weigh more than 0.5 kg. Babies should be weighed naked; wrap them in a blanket to keep them warm until weighing. Older children should remove all but minimal clothing, such as their underclothes.
  - **Note:** If the child has braids or hair ornaments that will interfere with length/height measurements, remove them before weighing, to avoid delay between the measurements. Especially with young children whose length will be measured, it is important to move quickly and confidently from the scale to the length board, to avoid upsetting the child.
  - Depending on a child's age and ability to stand, measure the child's length or height. A child's length is measured lying down (recumbent). Height is measured standing upright.
  - If a child is less than 2 years old, measure recumbent length.
  - If the child is aged 2 years or older and able to stand, measure standing height.
  - In general, standing height is about 0.7 cm less than recumbent length. This difference was taken into account in developing the World Health Organization (*WHO*) *child growth standards* used to make the charts in the Growth record. Therefore, it is important to adjust the measurements if length is taken instead of height, and vice versa.
  - If a child aged under 2 years will not lie down for measurement of length, measure standing height and add 0.7 cm to convert it to length.
  - If a child aged 2 years or older cannot stand, measure recumbent length and subtract 0.7 cm to convert it to height.
- **Now ask participants to study the Job aid: Weighing and measuring a child, which summarizes how to take the measurements.**
- **Then give them time to practise handling the equipment.**

IV. Summarize the session — 2 minutes

- **Make the following points:**
  - In Session 68, you will have the chance to measure real children.
- **Ask participants whether they have any further questions, and try to answer them.**
- **Explain that a summary of this session can be found on pages 431–437 of the *Participant's manual*.**

Job aid: Weighing and measuring a child

Weighing a child using a taring scale

Be sure that the scale is placed on a flat, hard, even surface. There must be enough light to operate the solar-powered scale.

Explain all procedures to the mother and enlist her help. Babies should be weighed naked; wrap them in a blanket or other covering until weighing. Older children should be weighed with minimal clothing. If it is socially unacceptable to undress the child, remove as much clothing as possible.

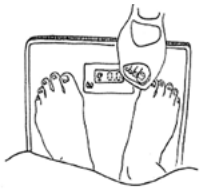
If the child is less than 2 years old, do tared weighing.

To turn on the scale, cover the solar panel for a second. When the number 0.0 appears, the scale is ready.

The mother will remove her shoes and step on the scale to be weighed first alone. Have someone else hold the undressed baby wrapped in a blanket.

Ask the mother to stand in the middle of the scale, feet slightly apart (on the footprints, if marked), and to remain still. The mother's clothing must not cover the display or the solar panel. Remind her to stay on the scale, even after her weight appears, until the baby has been weighed in her arms.

With the mother still on the scale and her weight displayed, tare the scale by covering the solar panel for a second. The scale is tared when it displays a figure of a mother and baby and the number 0.0.



Hand the undressed baby to the mother and ask her to remain still.

The baby's weight will appear on the display (shown to the nearest 0.1 kg). Record this weight.

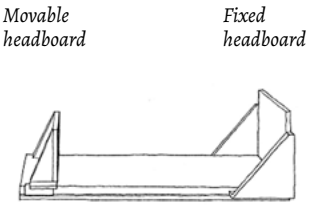
Note: If a mother is very heavy (e.g. more than 100 kg) and the baby's weight is relatively low (e.g. less than 2.5 kg), the baby's weight may not register on the scale. In such cases, have a lighter person hold the baby on the scale.

If the child is 2 years or older and will stand still, weigh the child alone. If the child jumps on the scale or will not stand still, use the tared weighing procedure instead.

Ask the mother to help the child remove shoes and outer clothing. Talk with the child about the need to stand still.

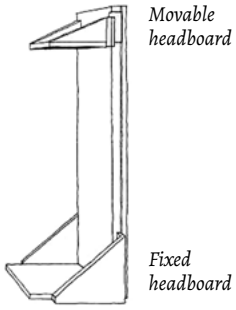
- To turn on the scale, cover the solar panel for a second. When the number 0.0 appears, the scale is ready.
- Ask the child to stand in the middle of the scale, feet slightly apart (on the footprints, if marked), and to remain still until the weight appears on the display.
- Record the child's weight to the nearest 0.1 kg.

Measuring length or height



Depending on a child's age and ability to stand, measure the child's length or height.

- **If a child is less than 2 years old**, measure the child's length lying down (recumbent) using a length board, which should be placed on a flat, stable surface such as a table.
- **If the child is aged 2 years or older**, measure standing height unless the child is unable to stand. Use a height board mounted at a right angle between a level floor and against a straight, vertical surface such as a wall or pillar.



Standing height is about 0.7 cm less than recumbent length. This difference was taken into account in developing the *WHO child growth standards*. Therefore, it is important to adjust the measurements if length is taken instead of height, and vice versa.

- If a child less than 2 years old will not lie down for measurement of length, measure standing height and add **0.7cm** to convert it to length.
- If a child aged 2 years or older cannot stand, measure recumbent length and **subtract 0.7 cm** to convert it to height.

Preparing to measure length or height

Be prepared to measure length/height immediately after weighing, while the child's clothes are off. Before weighing:

- remove the child's shoes and socks
- undo braids and remove hair ornaments if they will interfere with the measurement of length/height.

If a baby is weighed naked, a dry diaper can be put back on to avoid getting wet while measuring length.

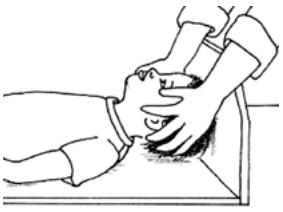
If the room is cool and there is any delay, keep the child warm in a blanket until length/height can be measured.

Explain all procedures to the mother and enlist her help.

Measuring length

Cover the length board with a thin cloth or soft paper for hygiene and for the baby's comfort.

Explain to the mother that she will need to place the baby on the length board herself and then help to hold the baby's head in place while you take the measurement. Show her where to stand when placing the baby down, i.e. opposite you, on the side of the length board away from the tape. Also show her where to place the baby's head (against the fixed headboard) so that she can move quickly and surely without distressing the baby.

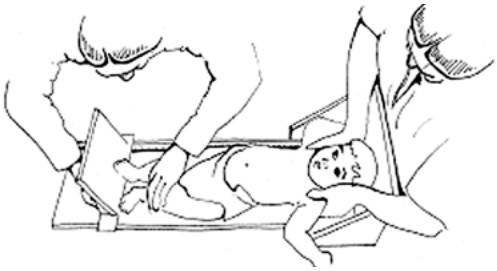


- Ask her to lay the child on their back with their head against the fixed headboard, compressing the hair.
- Quickly position the head so that an imaginary vertical line from the ear canal to the lower border of the eye socket is perpendicular to the board. (The child's eyes should be looking straight up.) Ask the mother to move behind the headboard and hold the head in this position.

Speed is important. Standing on the side of the length board where you can see the measuring tape and move the footboard:

- Check that the child lies straight along the board and does not change position. The shoulders should touch the board, and the spine should not be arched. Ask the mother to inform you if the child arches the back or moves out of position.
- Hold down the child's legs with one hand and move the footboard with the other. Apply gentle pressure to the knees to straighten the legs as far as they can go without causing injury. Note: it is not possible to straighten the knees of newborn babies to the same degree as older children. Their knees are fragile and could be injured easily, so apply minimum pressure.
- If a child is extremely agitated and both legs cannot be held in position, measure with one leg in position.
- While holding the knees, pull the footboard against the child's feet. The soles of the feet should be flat against the footboard, toes pointing upwards. If the child bends their toes and prevents the footboard from touching the soles, scratch the soles slightly and slide in the footboard quickly when the child straightens their toes.

- Read the measurement and record the child's length in centimetres to the last completed 0.1 cm in the VISIT NOTES of the GROWTH RECORD. This is the last line that you can actually see (0.1 cm = 1 mm).



Remember: If the child whose length you measured is 2 years old or more, subtract 0.7 cm from the length and record the result as height in the VISIT NOTES.

Measuring standing height

Ensure that the height board is on level ground. Check that shoes, socks and hair ornaments have been removed.

Working with the mother, and kneeling in order to get down to the level of the child:

- Help the child to stand on the baseboard with their feet slightly apart. The back of the head, shoulder blades, buttocks, calves and heels should all touch the vertical board.
- Ask the mother to hold the child's knees and ankles to help keep their legs straight and feet flat, with the heels and calves touching the vertical board. Ask her to focus the child's attention, soothe the child as needed, and inform you if the child moves out of position.
- Position the child's head so that a horizontal line from the ear canal to the lower border of the eye socket runs parallel to the base board. To keep the head in this position, hold the bridge between your thumb and forefinger over the child's chin.
- If necessary, push gently on the tummy to help the child stand to full height.
- Still keeping the head in position, use your other hand to pull down the headboard to rest firmly on top of the head and compress the hair.
- Read the measurement and record the child's height in centimetres to the last completed 0.1 cm in the VISIT NOTES of the GROWTH RECORD. This is the last line that you can actually see (0.1 cm = 1 mm).

Remember: If the child whose height you measured is less than 2 years old, add 0.7 cm to the height and record the result as length in the VISIT NOTES.

Notes

Notes (contd)

SESSION 58

Measuring: it's not so easy

Objectives

After completing this session, participants will be able to:

- identify common errors in measuring weight, length and height

Session outline . . . . . 30 minutes

Participants are all together for a slide presentation and demonstration by one trainer.

I. Introduce the session, present **Slide 58/1** . . . . . 3 minutes
II. Present **Slides 58/2** to **58/29** and comment on the errors or good points observed . . . . . 24 minutes
III. Conclude the session with a summary of key messages on measuring. . . . . 3 minutes

Preparation

- Refer to the Introduction for guidance on giving a demonstration.
- Study the **slides 58/1** to **58/29** and the text that goes with them, so that you are able to present them.

As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

I. Introduce the session — 3 minutes

► Show **Slide 58/1 – Session 58 – objectives** and read out the objectives:

58/1

Session 58: Measuring: it's not so easy – objectives

After completing this session, participants will be able to:

- identify common errors in measuring weight, length and height

II. Present Slides 58/2 to 58/29 and comment on the errors or good points observed
24 minutes

Slide show – assessing measuring techniques

- **Immediately after Session 57, show the PowerPoint presentation titled MEASURING: IT'S NOT SO EASY and discuss each slide. When you show each slide, ask the participants what they can observe about the position of the measurer or assistant or the position of the child. Slides show some good points of technique and some mistakes. Comments are provided next about each slide. There may be other valid comments too.**

Measuring height

Slide 58/2: The child is held in position at the knees and tummy. The measurer is in a good position.

Slide 58/3: The measurer on the right is leaning over to read the tape. The assistant should be over to the left, so that the measurer can take position in front of the child.

Slide 58/4: The measurer is well down on the level of the child. She should hold the head board at its top centre. She should hold the child's head; it should not be the assistant. The assistant should be over to the left of the board, so that the measurer can be in front of the tape to read it.

Slide 58/5: The assistant should be down. The measurer should be holding the child's head, not the assistant. The measurer should hold the board at its top centre. The assistant should check the feet and hold the knees. The child seems to be leaning toward the assistant, with the weight not balanced equally on both feet.

Slide 58/6: Good position of the child's head. The measurer is holding the headboard correctly.

Measuring length

Slide 58/7: The diaper interferes with straightening of the legs. The assistant is holding one shoulder, instead of holding both sides of the head, so the baby's torso is twisted.

Slide 58/8: The feet are flat on the board. The child is wearing a lot of clothes.

Slide 58/9: The feet are not flat.

Slide 58/10: The measurement is being taken with one leg only. The head is held in a good position. It is important to be certain the torso is straight.

Slide 58/11: The head is held in a good position, with the knees controlled well. This is a difficult child measured well.

Slide 58/12: Going into position – most children get upset at this point when the mother is laying them down, so the measurer should be closer and ready to move quickly. The board should be closer to the edge of the table.

Slide 58/13: The knees are held in a good position by the measurer. The child's torso is straight. The assistant is holding the child's head in a good position by holding her hands over the child's ears with her thumbs on the shoulders. The feet do not look flat yet; the measurer should be working the footboard.

Slide 58/14: Good position of the knees and feet. The measurer bends close to check the feet and read the tape accurately. The assistant is in a good position.

Slide 58/15: Poor head position. It is dangerous to have a toy in the mouth.

Slide 58/16: The torso is not straight. A person other than the measurer is holding the knees. (Too many helpers often do more harm than good.) The measurer could see the child's body position better if the child was undressed.

Slide 58/17: We cannot see this child's feet!

Slide 58/18: The child is in a good position, as we can see without clothes. The knees are held well and the legs and torso are straight. (There are too many helpers around the head.)

Slide 58/19: A cooperative child!

Slide 58/20: The measurer took the feet out of the clothes so he could see them. The measurer is holding the knees and footboard correctly. The assistant is holding the head correctly. It would be better if the child were undressed.

Slide 58/21: The child's body is very crooked. The head is not in position. The assistant should be standing behind the headboard.

Slide 58/22: The child is in a good position. The torso is straight and the measurer and assistant are in a good position.

Slide 58/23: The assistant should stand at the head of the child – no one is holding or checking the head. The measurer should hold the footboard by its centre support.

Slide 58/24: Clothes make it difficult to see the knees. The feet are not yet flat against the footboard with the toes pointing up. The mother should be on the opposite side, so that the measurer has more space. The assistant seems to have good control of the head.

Measuring weight

Slide 58/25: The scale gives an error message when the robe swings, covering and uncovering the solar panel.

Slide 58/26: Notice the person on the left is holding back the robe, to keep it out of the way.

Slide 58/27: Too many clothes! Jeans, diaper, shirt can weigh a kilogram and more!

Slide 58/28: The child is undressed so that this weight measurement will be accurate.

Slide 58/29: The child is standing nicely on the centre of the scale. The clothes were not removed.

III. Conclude the session with a summary of key messages on measuring 3 minutes

- **When you have finished the slide show, take a moment to conclude the session. Ask participants whether they have any questions about how to weigh and measure children, and try to answer them.**
- **Reinforce the following important points from the module:**
  - Four pieces of information are essential for growth assessment: age, sex, weight and length or height. If any of these is incorrect, the growth assessment will be incomplete or inaccurate.
  - For correct age assessment, use any available written records or make a local events calendar to help determine children's ages as precisely as possible. The local events calendar has to be updated regularly.
  - Equipment needs to be in good working order and to be calibrated regularly.
  - Measuring children requires specific skills, speed and confidence. With practice, everyone can improve their measuring skills.
- **Ask participants whether they have any questions, and try to answer them.**
- **Explain that a summary of this session can be found on page 439 of the *Participant's manual*.**
- **Ask participants whether they have any questions on EXERCISE 56.C on Nalah and Toman, which was set for homework (see answers at the end of your *Trainer's guide* for Session 56). Try to answer them.**
  - You will continue using the information you have recorded on Nalah and Toman to plot their growth. If your answers to EXERCISES 56.B and 56.C are incorrect, it will not be possible to plot their growth correctly.

Notes

SESSION 59

Plotting points for growth indicators

Objectives

After completing this session, participants will be able to:

- identify axes on growth-indicator charts
- plot single points for height-for-age, weight-for-age and weight-for-height charts

Session outline . . . . . 60 minutes

Participants are all together for a lecture presentation by one trainer, followed by an oral drill and an individual written exercise with all trainers.

I. Introduce the session, present **Slide 59/1** . . . . . 2 minutes
II. Present **Slides 59/2** to **59/6** and conduct SHORT-ANSWER EXERCISES 59.A–59.C . . . . . 15 minutes
III. Conduct an oral drill using **Slides 59/7** to **59/12** . . . . . 5 minutes
IV. Individual written work on continuing case studies (EXERCISE 59.A) . . . . . 36 minutes
V. Summarize the session . . . . . 2 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides and facilitating written exercises.
- Study the **Slides 59/1** to **59/12** and the text that goes with them, so that you are able to present them.

As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

I. Introduce the session — 2 minutes

► Show **Slide 59/1 – Session 59 – objectives** and read out the objectives:

59/1

Session 59: Plotting points for growth indicators – objectives

After completing this session, participants will be able to:

- identify axes on growth-indicator charts
- plot single points on height-for-age, weight-for-age and weight-for-height charts

II. Present **Slides 59/2** to **59/6** and conduct SHORT-ANSWER EXERCISES 59.A–C 15 minutes

► **Make these points:**

- We will start with very basic steps in plotting points, for example, identifying what the horizontal and vertical axes of a graph stand for, and then we will have a drill to see whether things that should be obvious are, in fact, obvious.

► **Show Slide 59/2 – Plot points for growth indicators and make the points that follow:**

59/2

Plot points for growth indicators

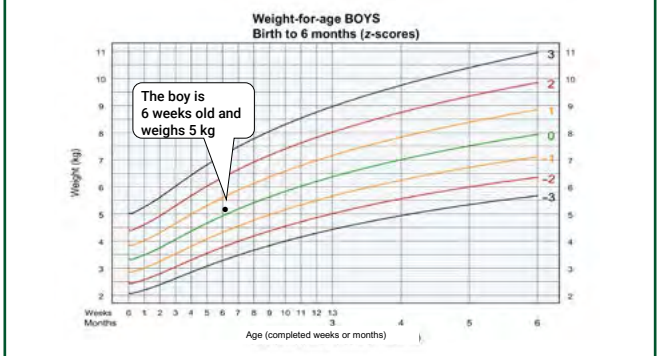
- Select charts in the GROWTH RECORD, based on the child's age at this visit
- Is the child growing normally?
- Note the plotting convention in this course
- The *x*-axis (horizontal)
- The *y*-axis (vertical)
- Plotted point

- Growth indicators are used to assess growth, considering together a child's age and measurements.
- The purpose is to determine whether a child is growing "normally" or has a growth problem or a trend towards a growth problem that should be addressed.
- In order to plot points, one needs to understand certain terms related to graphs and the plotting convention that applies in this course:

► **Show Slide 59/3 – Plotted weight-for-age point and make the points that follow:**

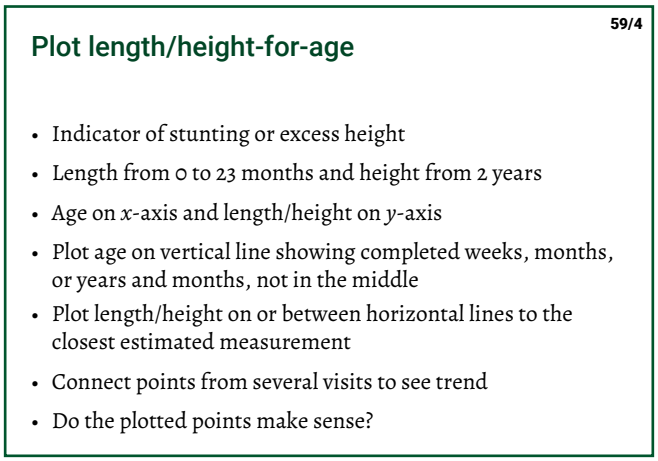
59/3

Example: plotted weight-for-age point



- On this graph, age (in completed weeks or months) is on the *x*-axis and weight in kilograms is on the *y*-axis. The horizontal lines represent increments of 0.1 kg (100 g). A point has been plotted for an infant boy who is 6 weeks old and weighs 5 kg.
- ***x*-axis** – the horizontal reference line is at the bottom of the graph. In the GROWTH RECORD graphs, some *x*-axes show age and some show length/height. Plot points on vertical lines corresponding to completed age (in weeks, months, or years and months), or to length or height rounded to the nearest whole centimetre.
- ***y*-axis** – the vertical reference is line at the far left of the graph. In the GROWTH RECORD graphs, the *y*-axes show length/height or weight. Plot points on or between horizontal lines corresponding to length/height or weight as precisely as possible.
- **Plotted point** – the point on a graph where a line extended from a measurement on the *x*-axis (e.g. age) intersects with a line extended from a measurement on the *y*-axis (e.g. weight).

▸ Show **Slide 59/4 – Plot length/height-for-age** and make the points that follow:

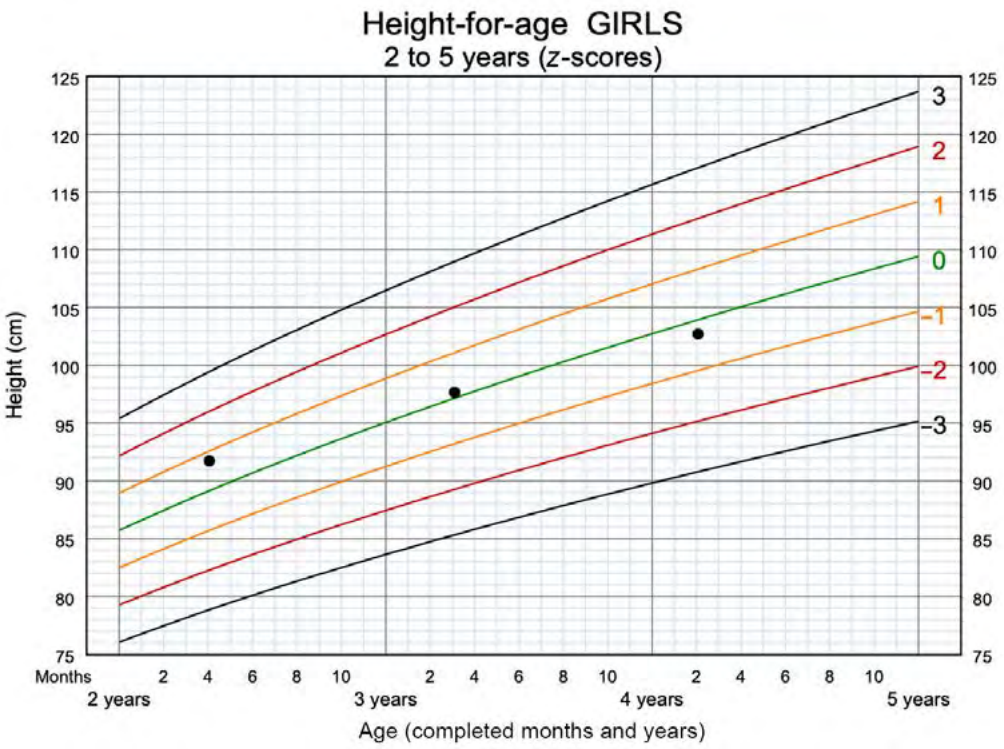


- Length/height-for-age reflects attained growth in length or height at the child's age, at a given visit. This indicator can help identify children who are stunted (short for their age) owing to prolonged undernutrition or repeated illness. Children who are tall for their age can also be identified, but tallness is rarely a problem unless it is excessive and may reflect uncommon endocrine disorders.
- Charts for length-for-age for younger age groups (birth to 6 months, and 6 months to 2 years) are given on pages 29 and 33 of the Growth record. A chart for height-for-age (for children aged 2–5 years) is given on page 37. In each of these charts, the *x*-axis shows age, and the *y*-axis shows length or height in centimetres. Age is plotted in completed weeks from birth until age 3 months; in completed months from 3 to 12 months; and then in completed years and months.
- To plot length/height-for-age, plot completed weeks, months, or years and months on a vertical line (not between vertical lines). For example, if a child is 5½ months old, the point will be plotted on the line for 5 months (not between the lines for 5 and 6 months).
- Plot length or height on or between the horizontal lines as precisely as possible. For example, if the measurement is 60.5 cm, plot the point midway between the horizontal lines 60 and 61 cm.
- When points are plotted for two or more visits, connect adjacent points with a straight line, to better observe the trend.
- Judge whether a plotted point seems sensible, and, if necessary, re-measure the child. For example, a baby's length should not be shorter than at the previous visit. If it is, one of the measurements was wrong.
- Please do the Short-answer exercise 59.A on page 443 of your *Participant's manual*.

SHORT-ANSWER EXERCISE 59.A

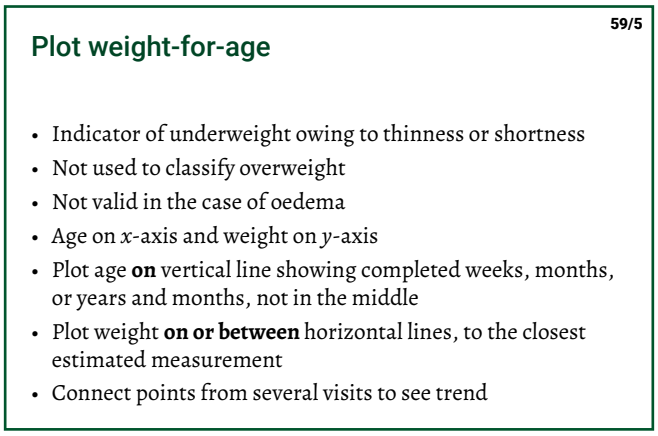
Example: Anna

The following graph shows Anna's height-for-age at three visits. The horizontal lines represent 1 cm increments. At the first visit, Anna was 2 years and 4 months of age and was 92 cm in height.



1. Connect the plotted points on the growth chart above for Anna.
2. Fill in the blanks in the sentences below to describe the meaning of the points plotted.
   a. At her second visit, Anna was _____ in height at age ____ years and ____ months.
   b. At her third visit, Anna was _____ in height at age ____ years and _____ months.

▶ Show **Slide 59/5 – Plot weight-for-age** and make the points that follow:

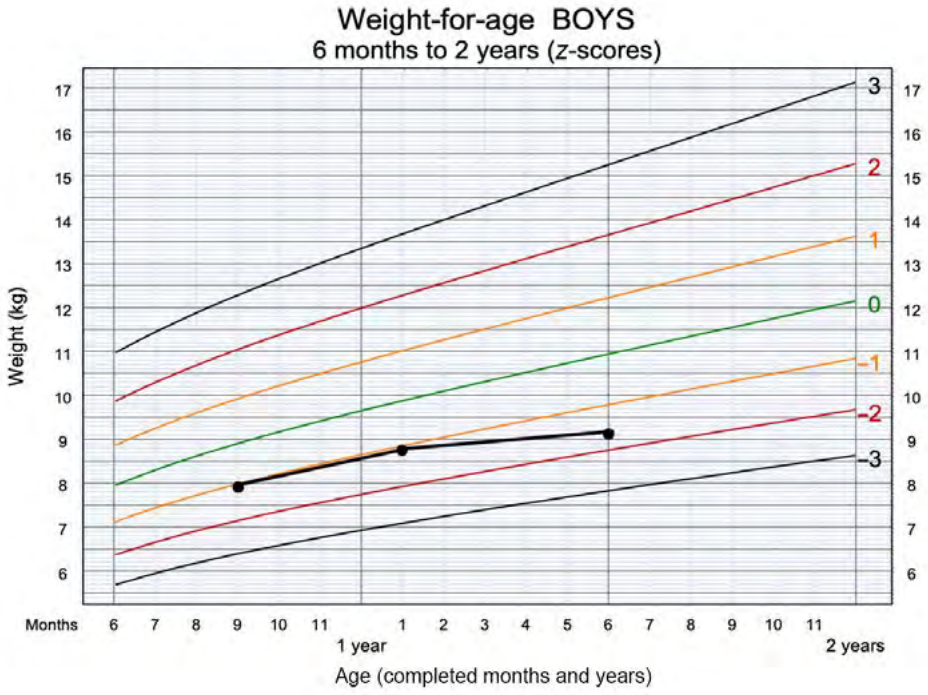


- Weight-for-age reflects body weight relative to the child's age on a given day. This indicator is used to assess whether a child is underweight or severely underweight, but it is not used to classify a child as overweight or obese. Because weight is relatively easily measured, this indicator is commonly used, but it cannot be relied upon in situations where the child's age cannot be accurately determined, such as refugee situations. It is important to note also that a child may be underweight either because of short length/height (stunting), or because of thinness, or both.
- **Note:** If a child has **oedema of both feet**, fluid retention increases the child's weight, masking what may actually be very low weight. Plot this child's weight-for-age and weight-for-length/height, but mark clearly on the growth charts (close to the plotted point) that the child has oedema. Such a child is automatically considered severely undernourished and should be referred for specialized care.
- Weight-for-age charts for three age groups are given on pages 30, 34 and 38 of the GROWTH RECORD. On each of these charts, the *x*-axis shows age, and the *y*-axis shows weight in kilograms. Age is plotted in completed weeks from birth until age 3 months; in completed months from 3 to 11 months; and then in completed years and months.
- To plot weight-for-age, plot completed weeks, months, or years and months on a vertical line (not between vertical lines).
- Plot weight on a horizontal line or in the space between lines, to show weight measurement to 0.1 kg, e.g. 7.8 kg.
- When points are plotted for two or more visits, connect adjacent points with a straight line, to better observe trends.
- Please do SHORT-ANSWER EXERCISE 59.B on page 444 of your *Participant's manual*.

SHORT-ANSWER EXERCISE 59.B

Example: Amahl

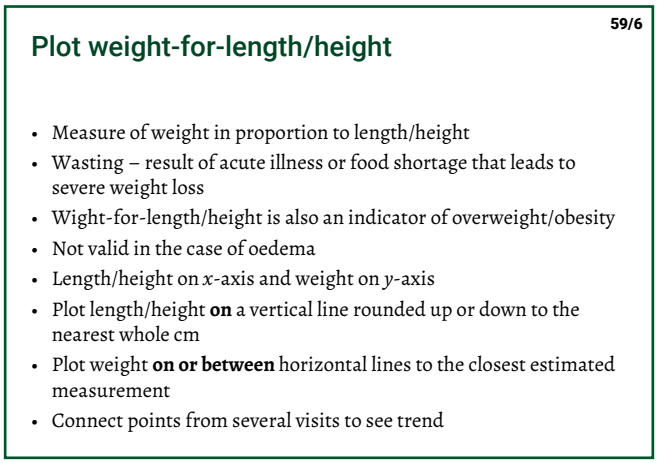
The following graph shows weight-for-age at three visits of a boy named Amahl. The horizontal lines represent 0.1 kg (100 g) increments.



Refer to Amahl's weight-for-age chart above to answer the following questions:

1. How much did Amahl weigh at age 9 months?
2. How old was Amahl at the visit when he weighed a little less than 9 kg?
3. What was Amahl's age and weight at the last visit shown?
4. Plot a point for Amahl's next visit, when he is age 1 year and 11 months and weighs 11.2 kg. Draw a line to connect this visit to the previous one.

▶ Show **Slide 59/6 – Plot weight-for-length/height** and make the points that follow:



- Weight-for-length/height reflects body weight in proportion to attained growth in length or height. This indicator is especially useful in situations where children's ages are unknown (e.g. refugee situations). Weight-for-length/height charts help to identify children with low weight-for-height who may be wasted or severely wasted. Wasting is usually caused by a recent illness or food shortage that causes acute and severe weight loss, although chronic undernutrition or illness can also cause this condition. These charts also help to identify children with high weight-for-length/height who may be at risk of becoming overweight or obese.
- Charts for weight-for-length are given on pages 31 and 35 of the GROWTH RECORD. The chart for infants from birth to 6 months (page 31) is an enlargement of part of the chart for children from birth to 2 years (page 35); the enlargement is provided to allow more room for plotting and detecting small changes in the growth of infants. A chart for weight-for-height (for children age 2–5 years) is given on page 39. In these charts, the *x*-axis shows length or height in centimetres, and the *y*-axis shows weight in kilograms.
- To plot weight-for-length/height:
  - Plot length or height on a vertical line (e.g. 75 cm, 78 cm). It will be necessary to round the measurement to the nearest whole centimetre (i.e. round down 0.1 to 0.4 and round up 0.5 to 0.9), and follow the line up from the x-axis to wherever it intersects with the the weight measurement.
  - Plot weight as precisely as possible, given the spacing of lines on the chart.
- When points are plotted for two or more visits, connect adjacent points with a straight line, to better observe the trend.
- Please do SHORT-ANSWER EXERCISE 59.C on page 445 of your *Participant's manual*.

SHORT-ANSWER EXERCISE 59.C

Example: Tran

This chart shows Tran's weight-for-height at two visits. The horizontal lines represent 0.5 kg (500 g) increments, while the vertical lines represent 1 cm increments. At the first visit, Tran is 2 years and 2 months old. He is 85 cm in height and weighs 13 kg.

Refer to Tran's weight-for-height chart above to answer the following questions:

1. How tall is Tran at the second visit shown on the graph?
2. How much does Tran weigh at the second visit?
3. Plot the point for Tran's next visit, when he is 112 cm tall and weighs 19 kg. Connect the plotted point to the point for the previous visit.

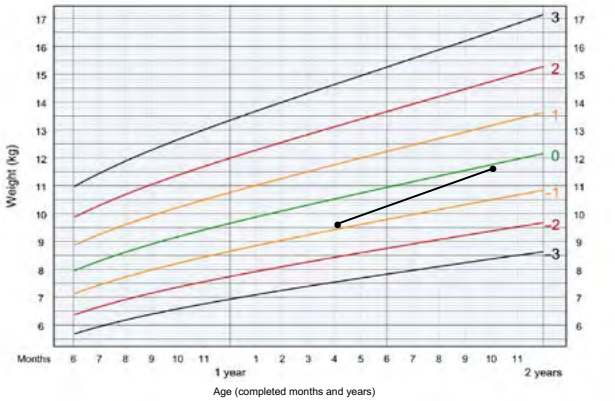
► Answer sheets for the short-answer exercises are provided at the end of this session (pages 746–747).

III. Conduct an oral drill using **Slides 59/7** to **59/12** 5 minutes

- **The purpose of this drill is for participants to practise reading points on the growth charts.**
- **You will project the growth charts, and participants will take turns reading the points. For example, a participant will say, "This girl weighed ___ kg at age ___ months" or "This boy had a length of ____ cm and weighed ___ kg". If the participant hesitates, point to the graph and ask questions to prompt a response, such as, "Looking here at the ages along the *x*-axis, how old was the child at this visit?".**
- **A few of the slides (Slides 59/10 to 59/12) illustrate possible mistakes in measurement. If participants notice these mistakes, congratulate them. If they do not notice, ask questions such as, "What seems unusual about this growth chart?", "Do you think there could have been a mistake?", "What type of mistake?".**
- **Participants have not yet learnt to interpret the plotted points in terms of the growth curves or definitions of growth problems, so do not try to identify growth problems or interpret the child's growth pattern during this drill. Participants should focus simply on reading the points correctly and identifying possible measurement mistakes.**
- **Points on the slides should be read as follows:**
  - **Slide 59/7**: At age 1 year and 4 months, this boy weighed about 9.5 kg. At age 1 year and 10 months, this boy weighed 11.5 kg.
  - **Slide 59/8**: At age 2 years and 7 months, this boy was 94 cm in height. At age 3 years and 8 months, this boy was 103 cm in height.
  - **Slide 59/9**: At the first visit, this girl was 65 cm in length and weighed 9 kg. At the second visit, this girl was about 82 cm in length and weighed about 12.7 kg. (It is necessary to estimate where the second point is located between the lines.)
  - **Slide 59/10**: The growth chart suggests that this boy was 61 cm in length at age 10 weeks and 60 cm in length at age 3 months. That would mean he got shorter! One of the length measurements may have been inaccurate. Possibly the baby was measured with bent knees at age 3 months. Another possibility is that the measurements were correct, but one of them was graphed incorrectly. It would be a good idea to check the measurements recorded in the VISIT NOTES of this child's GROWTH RECORD.
  - **Slide 59/11**: This growth chart shows that the girl weighed 3 kg at birth and 5.5 kg at 3 weeks old. This is a very unlikely weight gain from birth to 3 weeks. It is possible that there was a mistake in reading or recording the weight, or in graphing the child's age, at the second visit. Perhaps the child was actually 3 months old instead of 3 weeks old at the second visit. It would be a good idea to check the VISIT NOTES.
  - **Slide 59/12**: According to the graph, this boy weighed 10 kg at 9 months and 7 kg at 1 year 3 months, showing a loss of 3 kg. This is a dramatic change in weight-for-age. Either there was a mistake in measuring or recording the child's weight or age, or this child is dying.

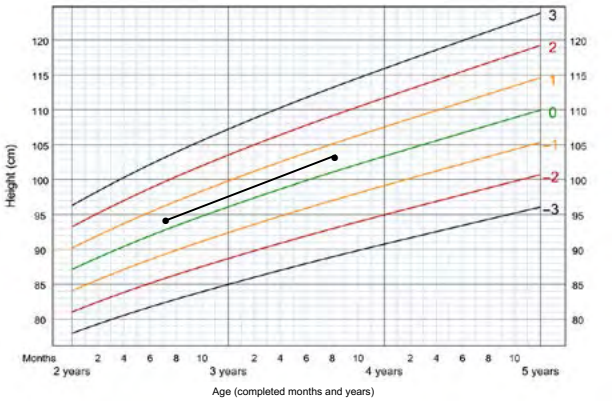
59/7

Weight-for-age BOYS
6 months to 2 years (*z*-scores)



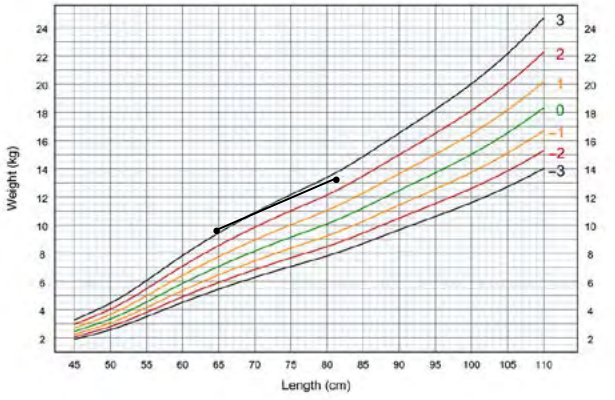
59/8

Height-for-age BOYS
2 to 5 years (*z*-scores)



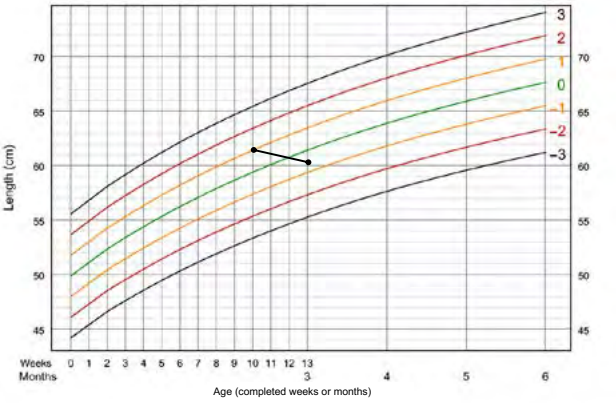
59/9

Weight-for-length GIRLS
Birth to 2 years (*z*-scores)



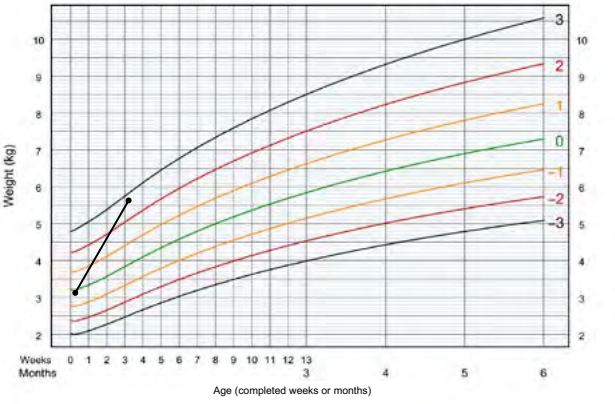
59/10

Length-for-age BOYS
Birth to 6 months (*z*-scores)



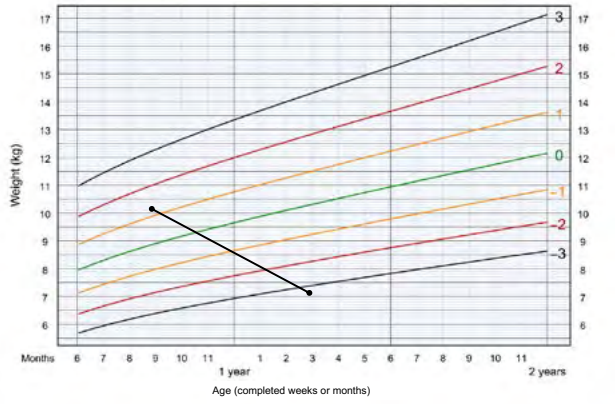
59/11

Weight-for-age GIRLS
Birth to 6 months (*z*-scores)



59/12

Weight-for-age BOYS
6 months to 2 years (*z*-scores)



IV. Individual written work on continuing case studies — 36 minutes

Exercise 59.A Continuing case studies – Nalah and Toman

In Session 56, you began a Girl's growth record for Nalah and a Boy's growth record for Toman. Get out these Growth records. In this exercise, you will plot these children's measurements on the appropriate growth charts in each booklet.

Nalah

On the Personal data page of Nalah's Girl's growth record, you have recorded her birth weight as 2.9 kg and her length as 49 cm. Look at the Visit notes in Nalah's Girl's growth record. You have recorded information from four clinic visits there, including her age, weight and length at each visit.

Find the three growth charts that are suitable for Nalah's age group in the Girl's growth record.

Use the information from Nalah's Personal data page and Visit notes, to plot points on each growth chart. Plot and connect points for all five points available for Nalah on each growth chart.

If you have difficulties, talk with a facilitator at any time.

Toman

Look at the Visit notes page of Toman's Boy's growth record. You have recorded information from four visits there, including his age, weight and length at each visit.

Find the three growth charts that are suitable for Toman's age group in the Boy's growth record.

Use the information from Toman's Visit notes, to plot points on each growth chart. Plot and connect points for all four visits on each growth chart.

When you have finished this exercise, review your answers with a facilitator.

- **Answer sheets are provided at the end of this session (pages 748–751).**

V. Summarize the session — 2 minutes

- **Ask participants whether they have any questions, and try to answer them.**
- **Explain that a summary of this session can be found on page 441–446 of the *Participant's manual*.**

Answer sheets

Short-answer exercise 59.A

Anna

1. The dots on the graph should be connected.

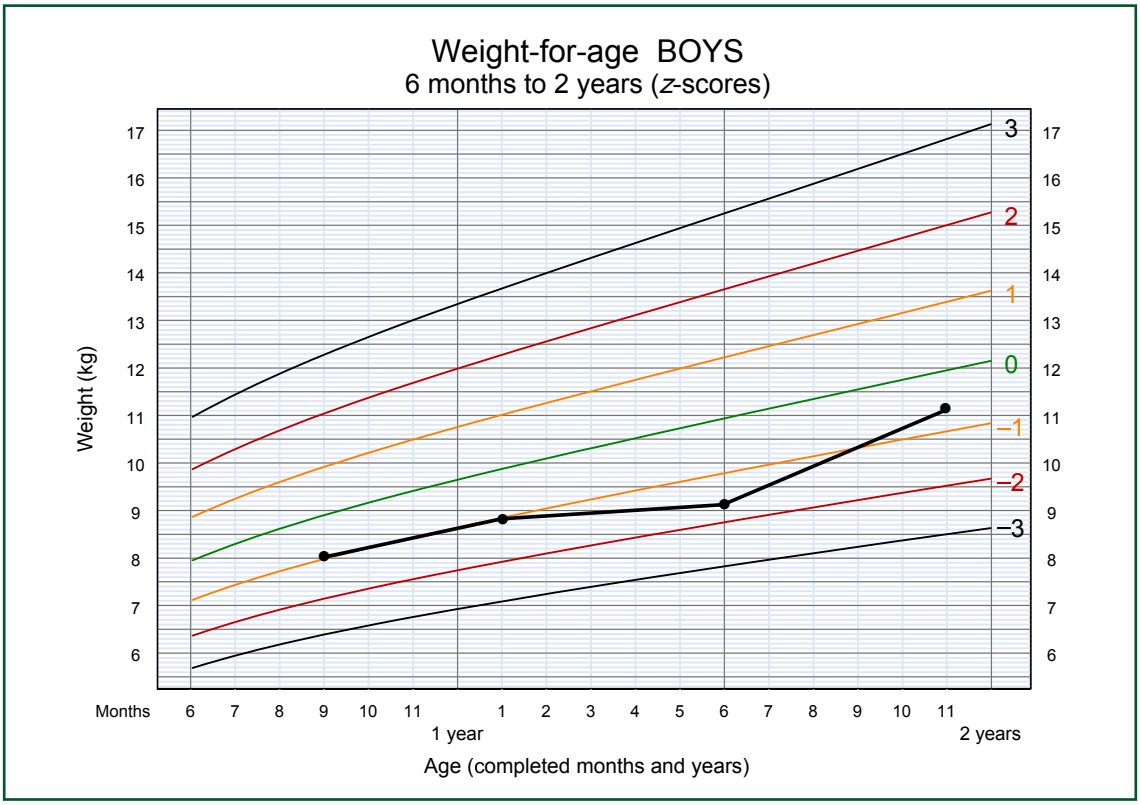
2a. 98 cm at 3 years and 3 months

2b. 103 cm at 4 years and 2 months

Short-answer exercise 59.B

Amahl

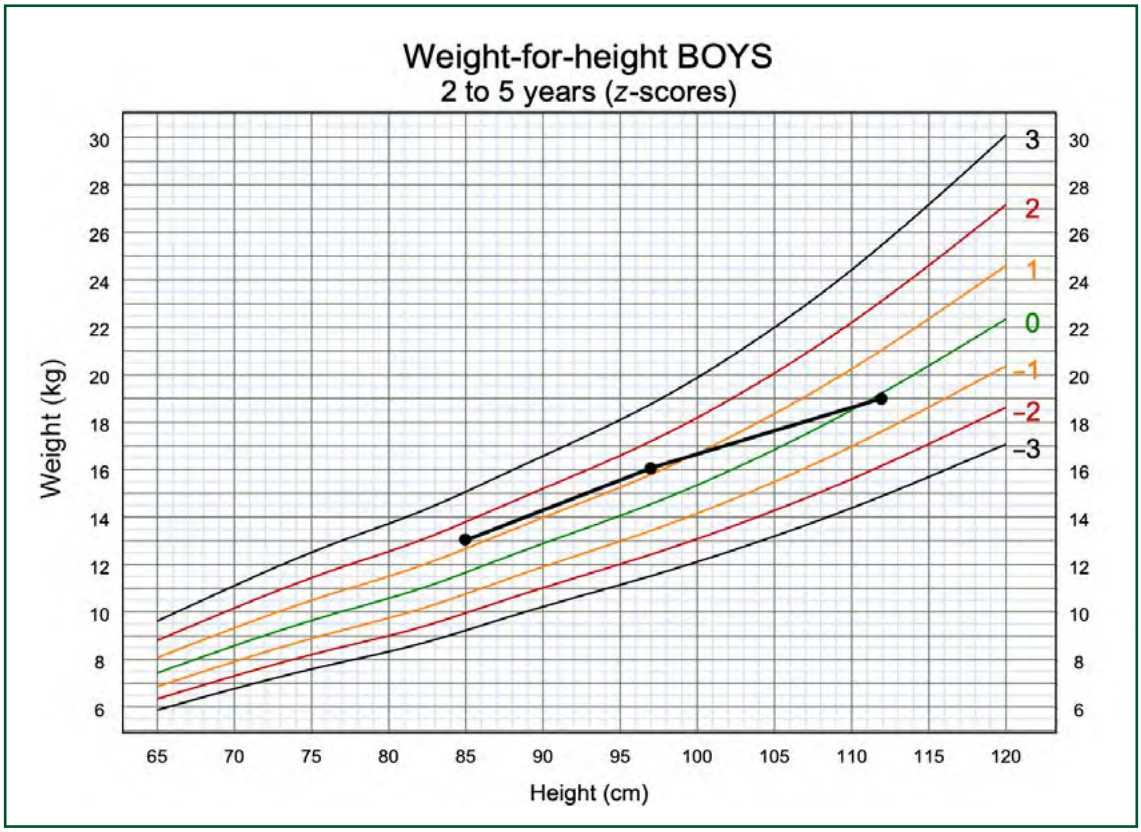
1. 8 kg
2. 1 year and 1 month
3. 1 year and 6 months, 9.1 or 9.2 kg
4. Completed graph for Amahl:



SHORT-ANSWER EXERCISE 59.C

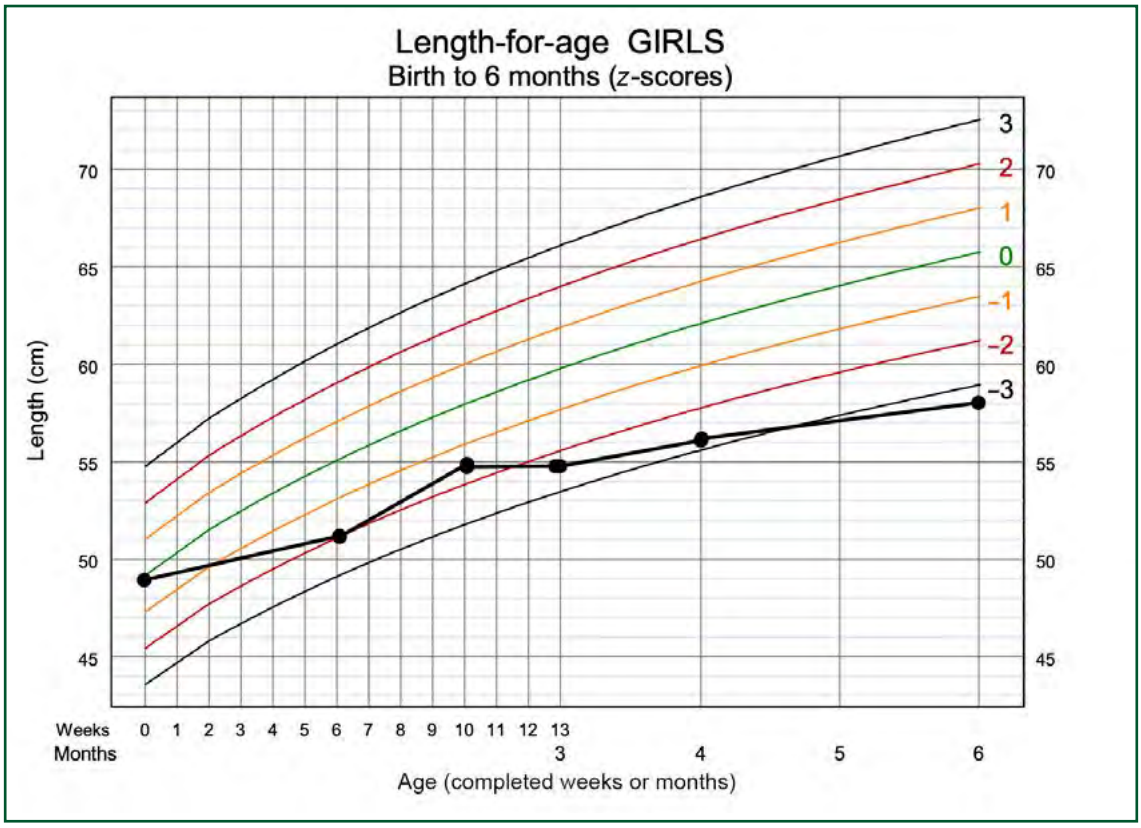
Tran

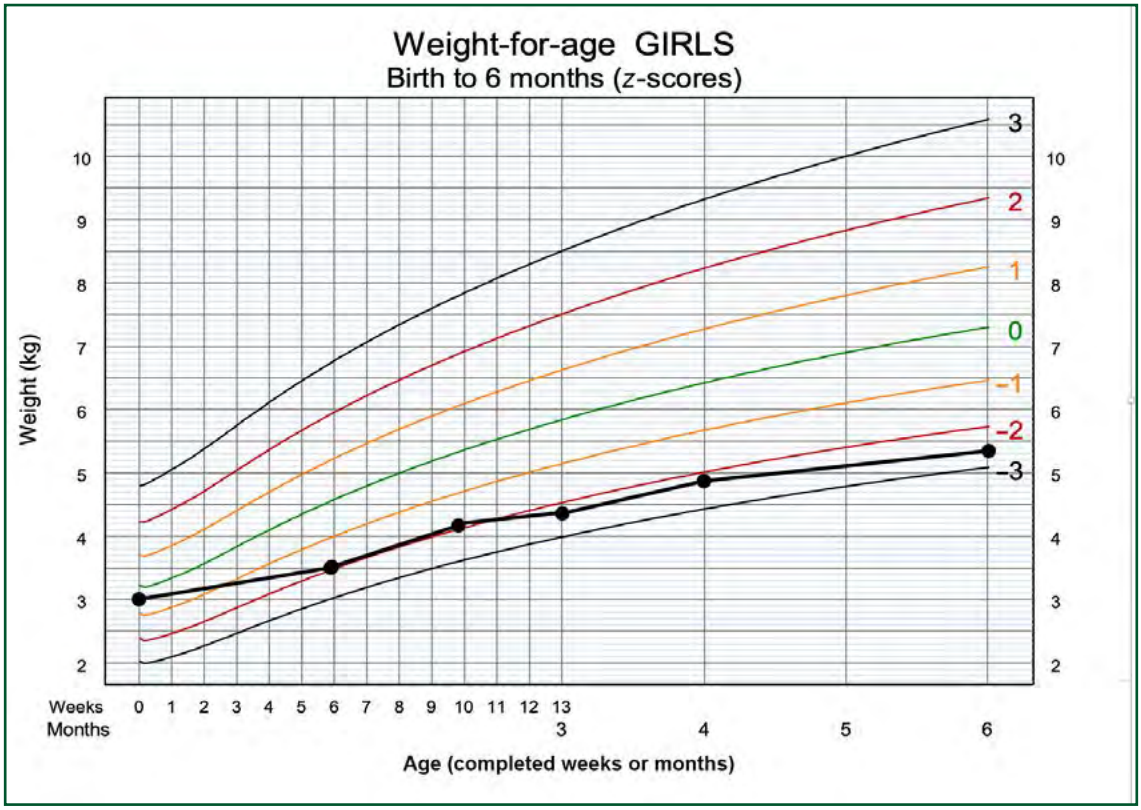
1. about 97 cm
2. 16 kg
3. Completed graph for Tran:

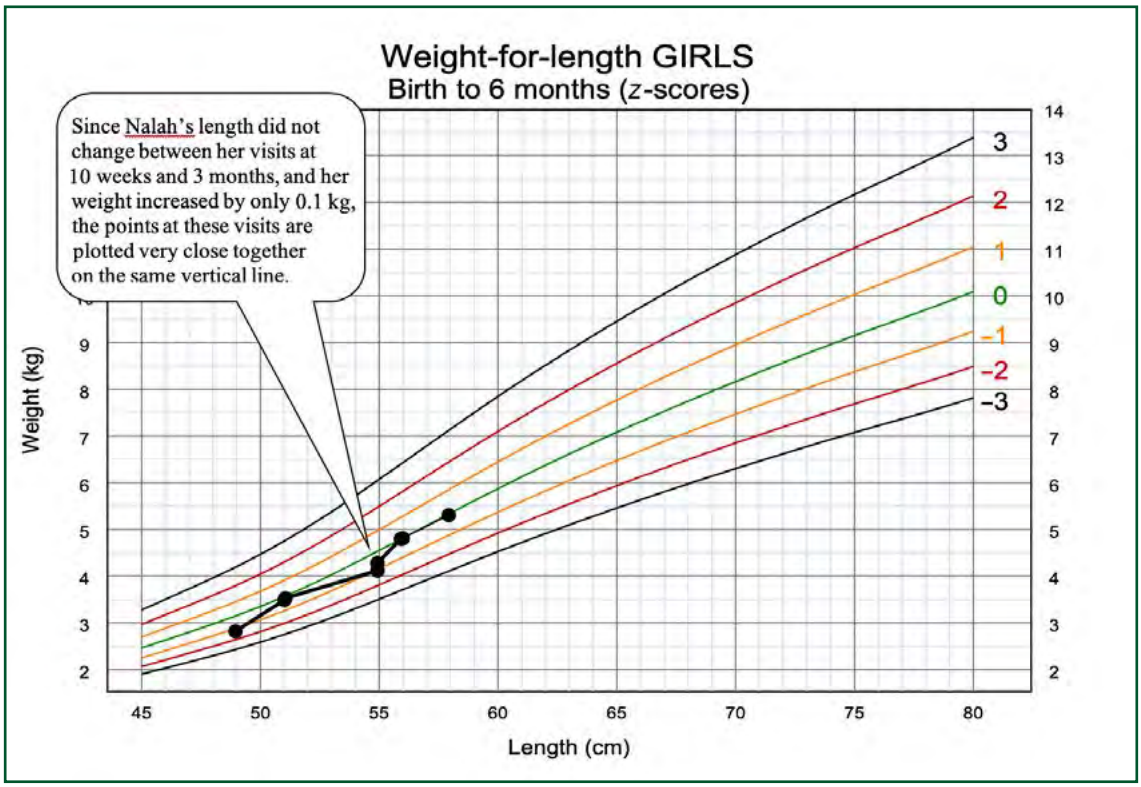


Exercise 59.A Continuing case studies – Nalah and Toman

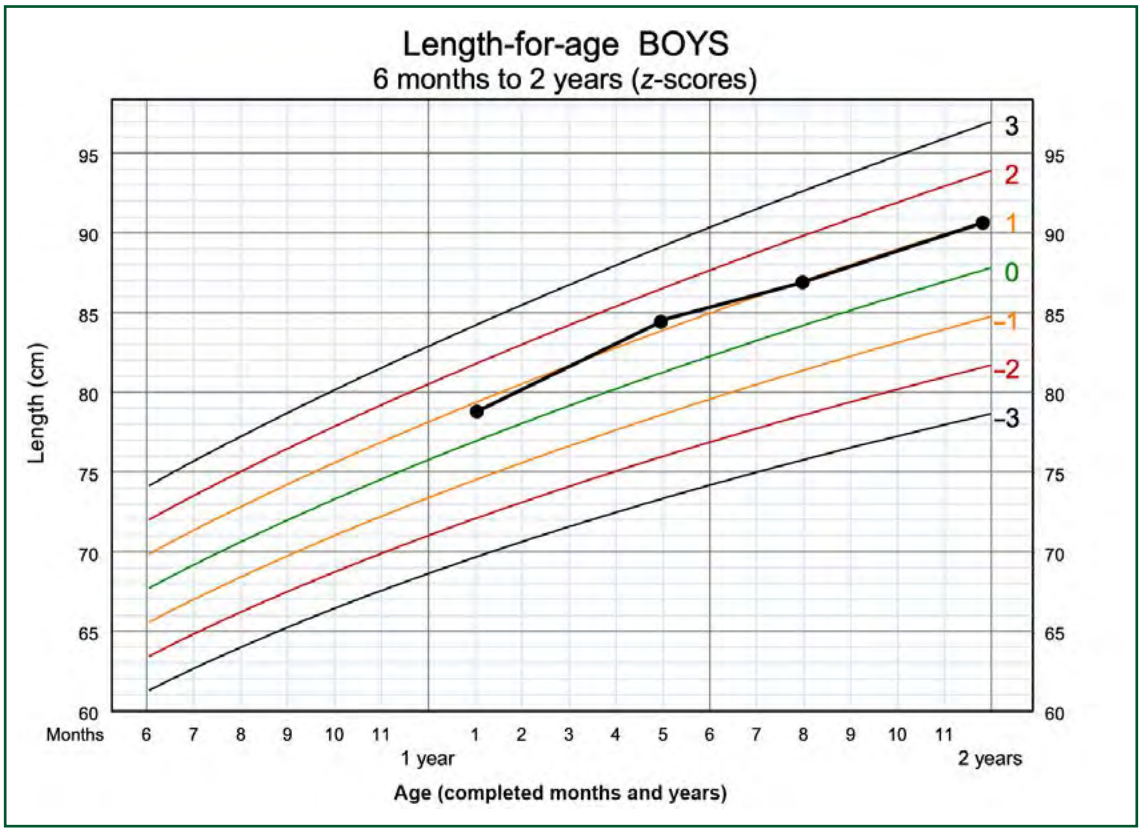
Nalah's plotted growth trends

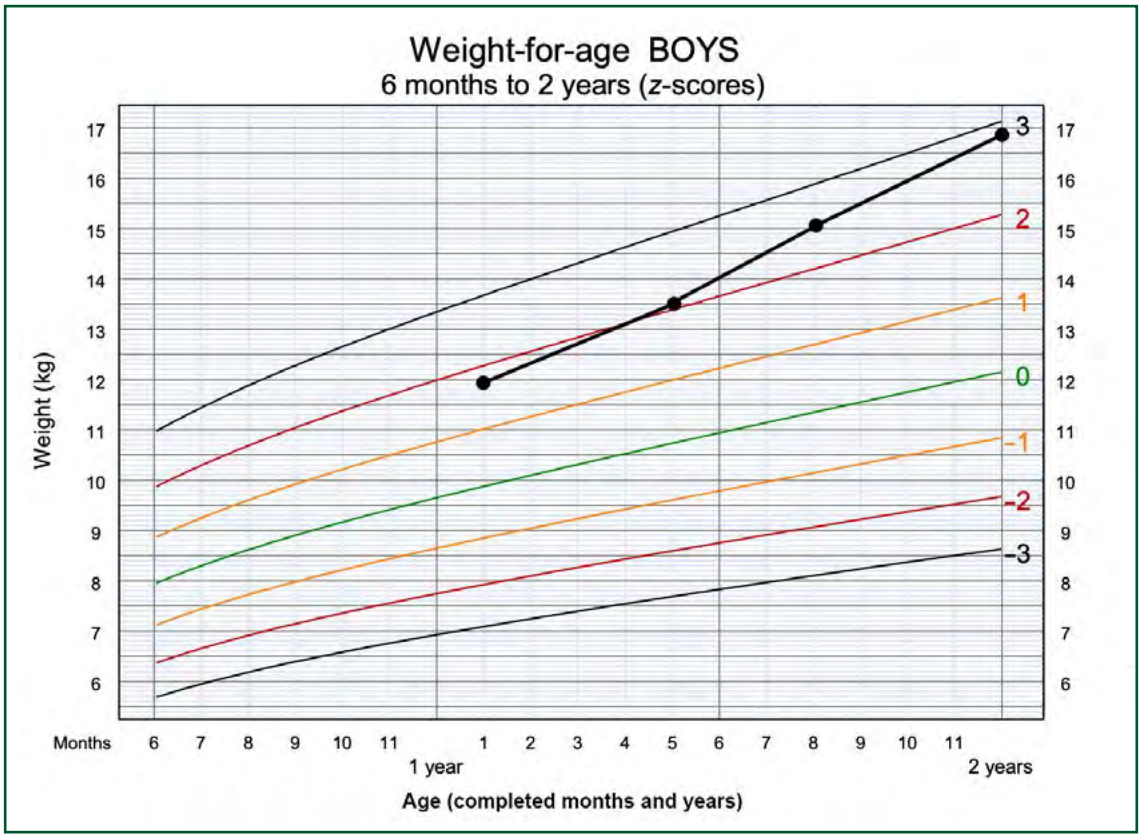


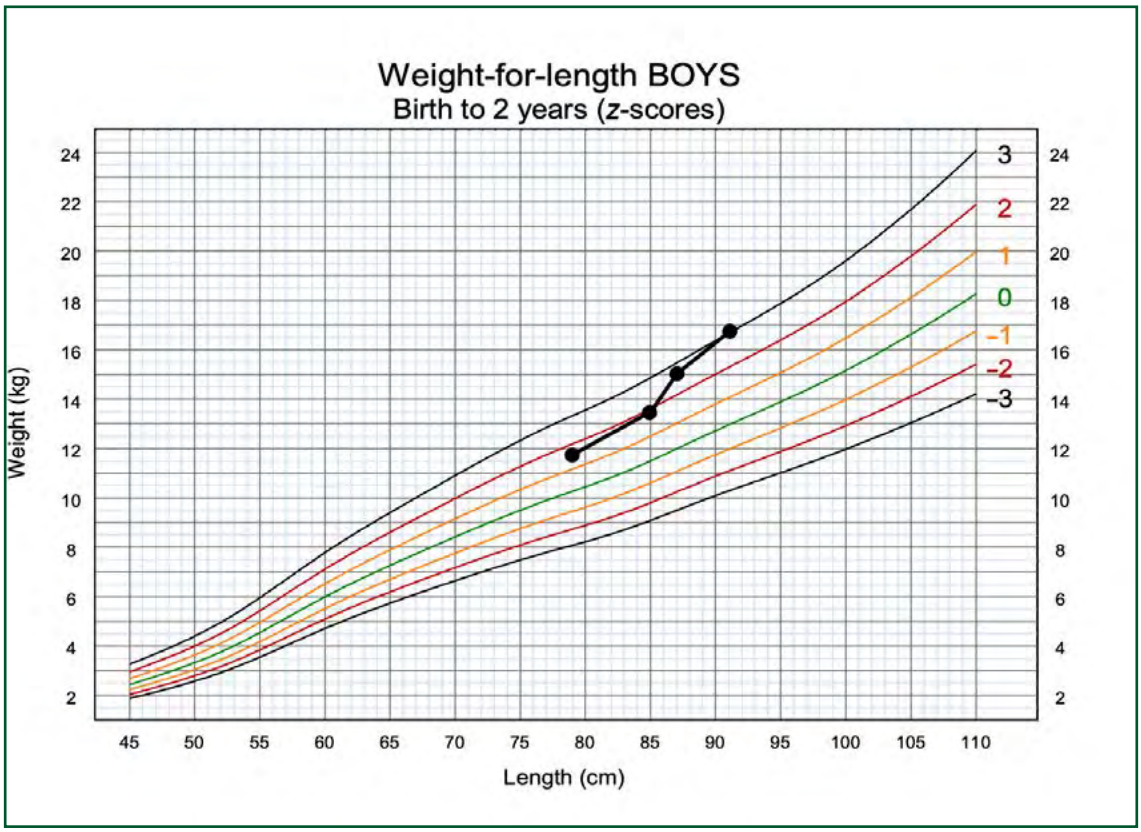



Weight-for-length GIRLS
Birth to 6 months (z-scores)
Since Nalah's length did not change between her visits at 10 weeks and 3 months, and her weight increased by only 0.1 kg, the points at these visits are plotted very close together on the same vertical line.
Weight (kg)
Length (cm)
3
2
1
0
-1
-2
-3
45
50
55
60
65
70
75
80
2
3
4
5
6
7
8
9
10
11
12
13
14

Toman's plotted growth trends






Weight-for-length BOYS
Birth to 2 years (z-scores)
Weight (kg)
Length (cm)
3
2
1
0
-1
-2
-3
24
22
20
18
16
14
12
10
8
6
4
2
45
50
55
60
65
70
75
80
85
90
95
100
105
110

Notes

Notes (contd)

SESSION 60

Interpreting plotted points for growth indicators

Objectives

After completing this session, participants will be able to:

- identify growth problems from plotted points on a single indicator chart
- define a growth problem using several indicator charts and observations

Session outline . . . . . 120 minutes

Participants are all together for a lecture presentation by one trainer, followed by a group discussion.

I. Introduce the session, present **Slide 60/1** . . . . . 2 minutes
II. Present **Slide 60/2** . . . . . 10 minutes
III. Study growth curves and malnutrition classifications in the GROWTH RECORD . . . . . 30 minutes
IV. Study and discuss graphs supplied and photos 9–11 (Training course on child growth assessment: WHO child growth standards. Photo booklet. Geneva: World Health Organization; 2008 (http://www.who.int/childgrowth/training/module_e_photo_booklet.pdf). . . . . 15 minutes
V. Present **Slide 60/4** . . . . . 5 minutes
VI. Study and discuss graphs supplied and photos 12, 1, 2 and 8 from the *Photo booklet* . . . . . 15 minutes
VII. Group discussion of measurements taken in CLINICAL PRACTICE SESSION 7: LISTENING AND LEARNING – MEASURING CHILDREN. . . . . 33 minutes
VIII. Growth assessment of two girls (**Slides 60/5** to **60/8**) . . . . . 8 minutes
IX. Summarize the session . . . . . 2 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides and facilitating group discussion.
- Study the **slides 60/1** to **60/8** and the text that goes with them, so that you are able to present them.
- The participants and you should have Module E (*Photo booklet*) of the *WHO child growth assessment course*.
- In preparation for the discussion on how to interpret several indicators, plot the measurements of children measured in SESSION 68: CLINICAL PRACTICE SESSION 7: LISTENING AND LEARNING – MEASURING CHILDREN, on blank charts of appropriate age and sex. Plot points on the charts for length/height-for-age, weight-for-age and weight-for-length/height.
- Ask three participants to do the same for children they measured and to present following your example. (Participants recorded the measurements of these children on the WORKSHEET: MEASURING WEIGHT, LENGTH AND HEIGHT in Session 68.) If possible, select children with a variety of growth problems.

As you follow the text, remember:

► **indicates an instruction to you, the trainer.**

¤ indicates what you say to participants.

I. Introduce the session — 2 minutes

► Show **Slide 60/1 – Session 60 – objectives** and read out the objectives:

60/1

Session 60: Interpreting plotted points for growth indicators – objectives

After completing this session, participants will be able to:

- identify growth problems from plotted points on a single indicator chart
- define a growth problem using several indicator charts and observations

II. Present Slide 60/2 — 10 minutes

► Make these remarks:

¤ In Session 59, we learnt how to plot points on different indicator graphs. Here we will be looking at what those points mean for single indicators, and for combinations of the indicators.

► Show **Slide 60/2 – Interpret plotted points** and make the points that follow:

60/2

Interpret plotted points for growth indicators

- Growth curves to help you interpret plotted points
- Median and *z*-score (standard deviation = SD) lines
- Positive and negative *z*-scores
- The farther from the median, the more likely that there is a growth problem
- Consider other facts when interpreting points (health condition, parent size, etc.)

► Ask participants to open a GROWTH RECORD to any page with a growth chart

¤ The curved lines printed on the growth charts will help you interpret the plotted points that represent a child's growth status.

¤ The line labelled 0 on each chart represents the **median**, which is, generally speaking, the average.

¤ The other curved lines are ***z*-score lines**, which indicate the distance from the average. The median and the *z*-score lines on each growth chart were derived from measurements of children in the WHO Multicentre Growth Reference Study.

¤ *z*-score lines on the growth charts are numbered positively (1, 2, 3) or negatively (–1, –2, –3).

¤ In general, a plotted point that is far from the median in either direction (for example, close to the 3 or –3 *z*-score line) may represent a growth problem.

¤ To interpret points, consider other factors, such as the growth trend, the health condition of the child and the height of the parents.

¤ Take out a GROWTH RECORD and turn to page 29.

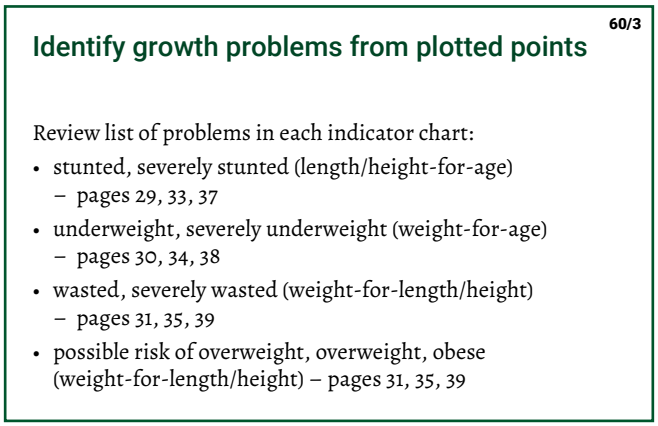
¤ Next to each growth chart in the GROWTH RECORD, there is a list of the growth problems represented by plotted points that are above or below certain *z*-score lines. Read points as follows:

¤ A point between the *z*-score lines –2 and –3 is "below –2."

¤ A point between the *z*-score lines 2 and 3 is "above 2".

III. Study growth curves and malnutrition classifications in the GROWTH RECORD 30 minutes

▸ Show **Slide 60/3 – Identify growth problems** and make the points that follow:



▸ **This is part study, part discussion with the whole group**

- ⌑ Take time now to study the pages in the GROWTH RECORD that present the different indicators and what forms of malnutrition they are used to define.
  - stunted, severely stunted (length/height-for-age) – pages 29, 33, 37
  - underweight, severely underweight (weight-for-age) – pages 30, 34, 38
  - wasted, severely wasted (weight-for-length/height) – pages 31, 35, 39
  - possible risk of overweight, overweight, obese (weight-for-length/height) – pages 31, 35, 39
- ⌑ See the table on page 450 of your *Participant's manual* for a summary of the definitions of growth problems in terms of *z*-scores.
- ⌑ Notice that an indicator is included in a certain definition if it is plotted above or below a particular *z*-score line. If it is plotted exactly on the *z*-score line, it is considered in the less-severe category. For example, weight-for age on the –3 *z*-score line is considered "underweight" as opposed to "severely underweight."

▸ **Give participants time to study the growth conditions classification table on page 450 of their manual before running a drill to check their understanding of the classifications.**

Growth problems

Growth problems chart

Compare the points plotted on the child's growth charts with the *z*-score lines, to determine whether they indicate a growth problem. Measurements in the shaded boxes are in the normal range.

z-score[a]	Growth indicators			
	Length/ height-for-age	Weight-for-age	Weight-for-length/height	BMI-for-age
Above 3	See note 1	See note 2	Obese	Obese
Above 2			Overweight	Overweight
Above 1			Possible risk of overweight (see note 3)	Possible risk of overweight (see note 3)
0 (median)				
Below –1				
Below –2	Stunted (see note 4)	Underweight	Wasted	Wasted
Below –3	Severely stunted (see note 4)	Severely underweight (see note 5)	Severely wasted	Severely wasted

BMI: body mass index.
[a]The *z*-score label in this column refers to a range. For example "above 2" means 2.1 to 3.0; "median" includes –1.1 to 1.0; "below –2" refers to –2.1 to –3.0, etc.

Notes:

1. A child in this range is very tall. Tallness is rarely a problem, unless it is so excessive that it may indicate an endocrine disorder such as a growth-hormone-producing tumour. Refer a child in this range for assessment if you suspect an endocrine disorder (e.g. if parents of normal height have a child who is excessively tall for their age).
2. A child whose weight-for-age falls in this range may have a growth problem, but this is better assessed from weight-for-length/height or BMI-for-age.
3. A plotted point above 1 shows possible risk. A trend towards the 2 *z*-score line shows definite risk.
4. It is possible for a stunted or severely stunted child to become overweight.
5. This is referred to as very low weight in Integrated Management of Childhood Illness training modules; see IMCI in-service training. Geneva: World Health Organization; 1997 (WHO/CHD/97.3.K; https://www.who.int/publications/m/item/WHO-CHD-97.3.K).

► **Run a spontaneous drill of which indicator to use to define different growth/malnutrition conditions; the numbers given are all *z*-scores:**

A child's length-for-age is –2.0, is he stunted or not?	No
A boy's weight-for-height is 1.35, what is his current status?	Possible risk of overweight
This girl has a weight-for-age of 2.9, what is her problem?	Undefined
With height-for-age –2.8 and weight-for-height 2.1, what is this girl's problem?	Stunted and overweight
A child with weight-for-length –3.2 is	Severely wasted
What is the status of a child whose weight-for-age is –1.89?	Undefined
The status of a child with weight-for-height 3.2	Obese

IV. Study and discuss graphs supplied and photos 9–11 from the *Photo booklet* 15 minutes

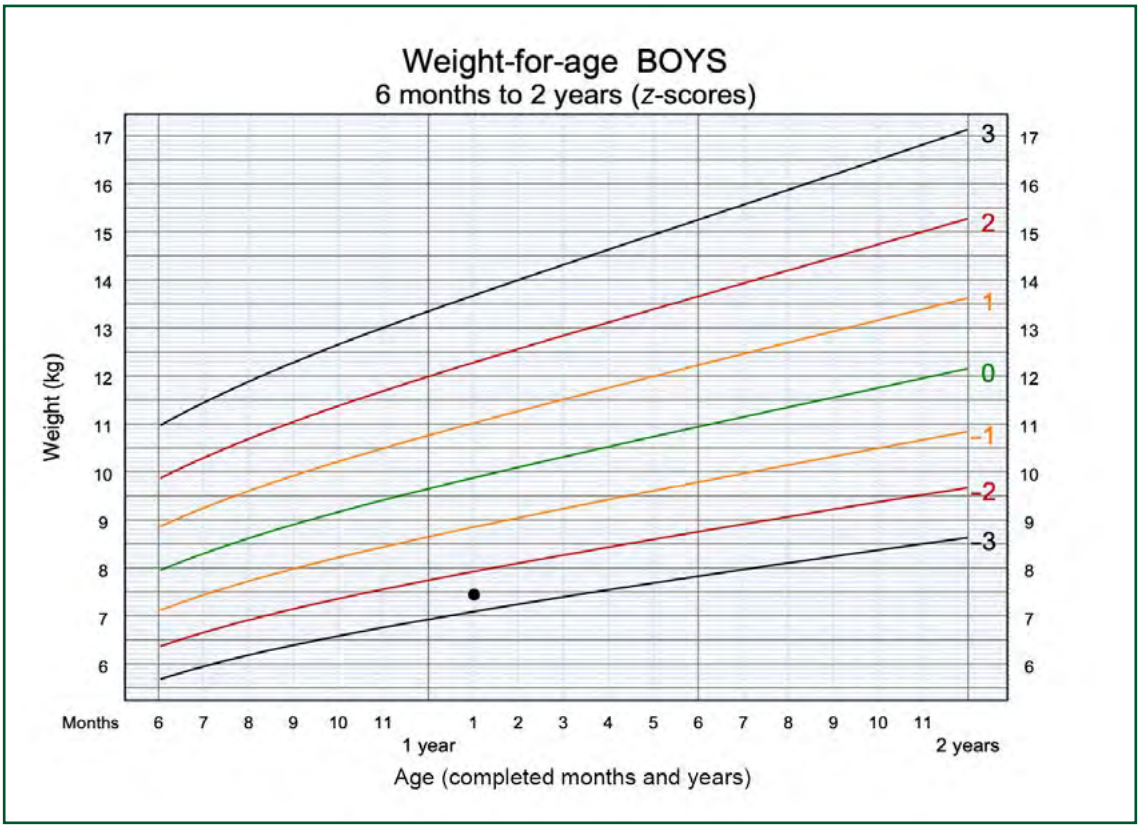
► **This section involves study and discussion with the whole group of the correspondence between the charts provided and photos 9, 10 and 11 in Module E of the *WHO training course on child growth assessment. Photo booklet*.[1]**

- We are now going to look at examples of some of the growth problems described above. The examples are illustrated by selected growth charts and photos to show correspondence between growth indicators and clinical observations.
- Take time now to study the examples in your *Participant's manual* (pages 451–453) and refer as directed to the photos in the *Photo booklet* supplied.

[1] Training course on child growth assessment: WHO child growth standards. Photo booklet. Geneva: World Health Organization; 2008 (http://www.who.int/childgrowth/training/module_e_photo_booklet.pdf).

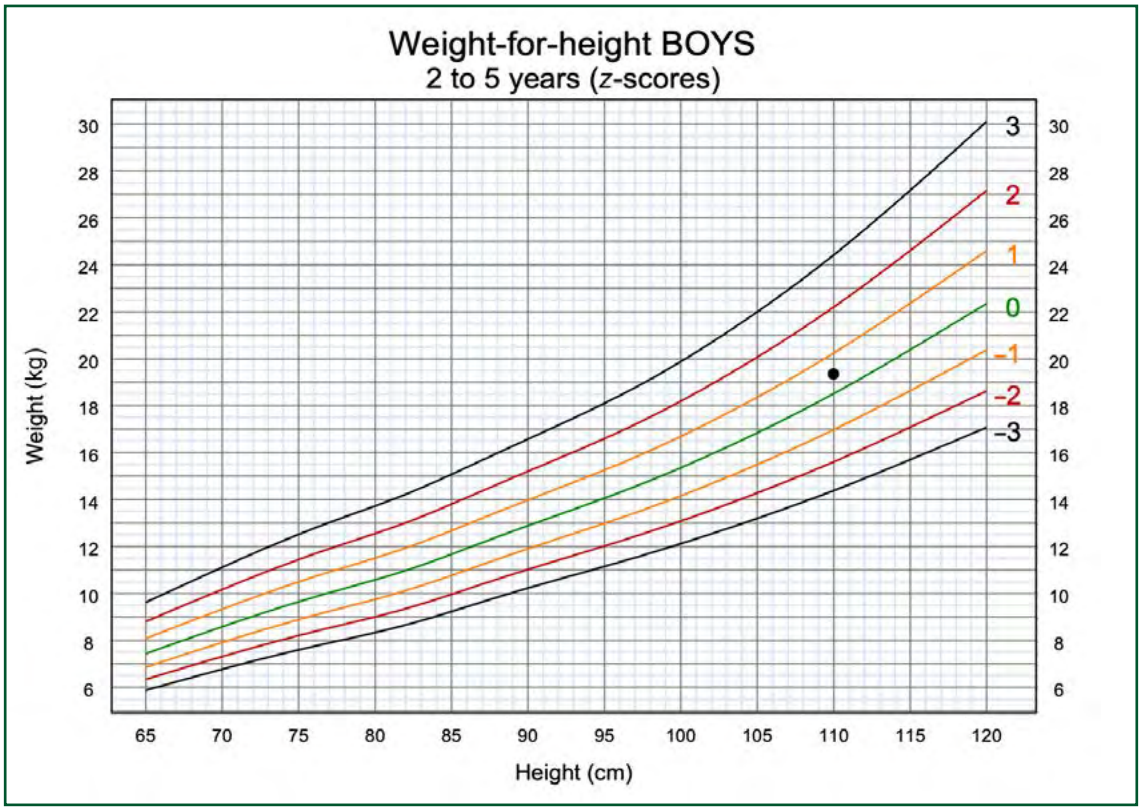
Example: Underweight boy, photo 9

- The following weight-for-age chart is for a boy who is 1 year 1 month old. He weighs 7.5 kg and is 70.3 cm in length. Notice that his weight-for-age is below the –2 *z*-score line, so he is considered underweight. This boy is pictured in photo 9 in the *Photo booklet*. Look at his photo now.



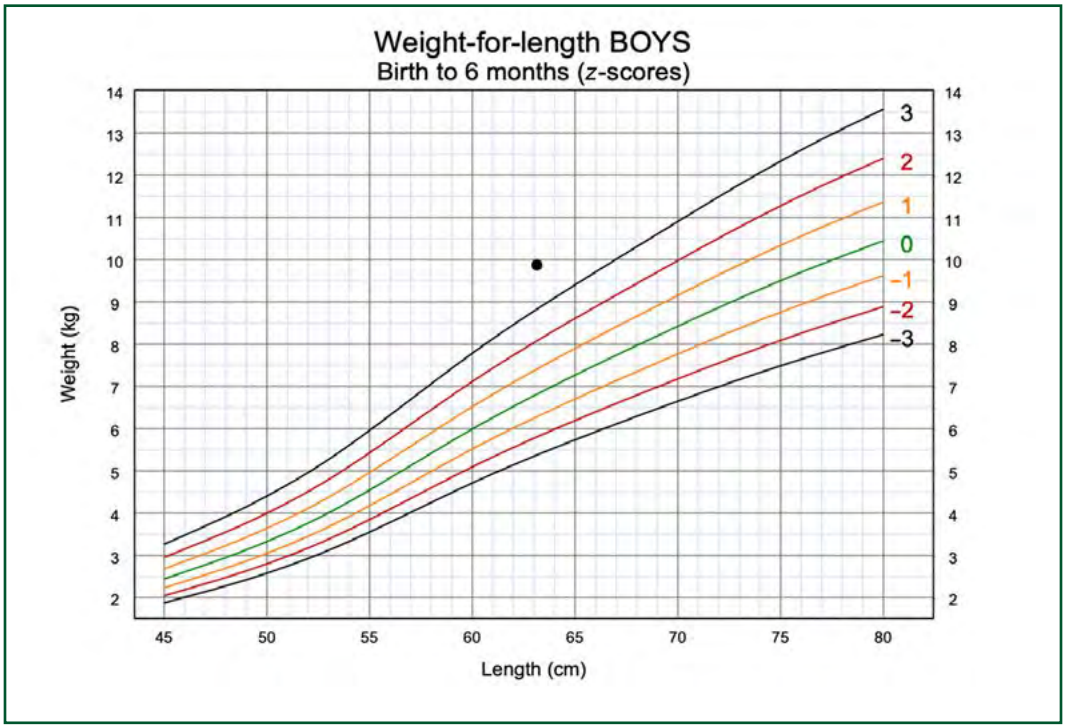
Example: Normal-weight boy, photo 10

- Look at photo 10 of a boy aged 3 years and 11 months. He weighs 19.5 kg and is 109.6 cm tall. His weight-for-age is above the 1 *z*-score line, and his height-for-age is above the 1 *z*-score line (charts not shown). His weight-for-height, shown on the chart below, is in the normal range.



Example: Obese boy, photo 11

- Look at photo 11 of a boy who is 3½ months old. He weighs 10 kg and is 63 cm long. On the length-for-age chart, he is above the median. His weight-for-length chart, shown below, indicates that he is obese. Notice that his weight-for-length is above the 3 *z*-score line.



V. Present Slide 60/4 — 5 minutes

- **Consider all growth charts and clinical observations.**
- Show **Slide 60/4 – Consider all growth charts and observations** and make the points that follow:

Consider all growth charts and observations — 60/4

- Consider all growth charts together: there may be a problem with one but not the others
- Low weight-for-age could be due to wasting or shortness: look at weight-for length/height and length-for-age when there is a problem with weight-for-age
- A stunted child may have a normal weight-for-height, but have low weight-for-age
- Weight-for-length/height is usable even when age is not known
- Looking at the growth charts all together is useful to determine the nature of growth problems

- It is important to consider all of a child's growth charts together, as their growth problem may be evident in one chart but not the others. For example, if a child is underweight according to the weight-for-age chart, you must also consider the child's length-for-age and weight-for-length. Focus more on the weight-for-length/height and the length/height-for-age charts.
- A stunted child may have a normal weight-for-height, but have low weight-for-age owing to shortness.
- Weight-for-length/height is usable even when a child's age is not known.
- Looking at the growth charts all together will help you to determine the nature of growth problems.

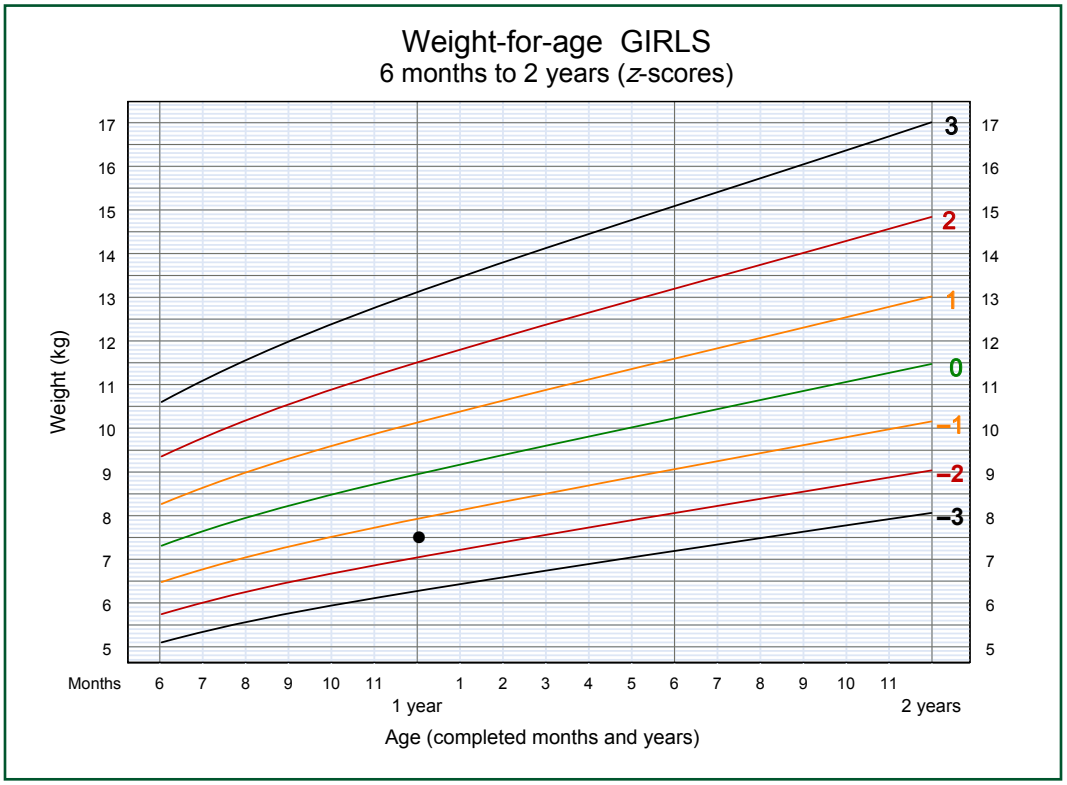
VI. Study and discuss graphs supplied and photos 12, 1, 2 and 8 from the *Photo booklet* 15 minutes

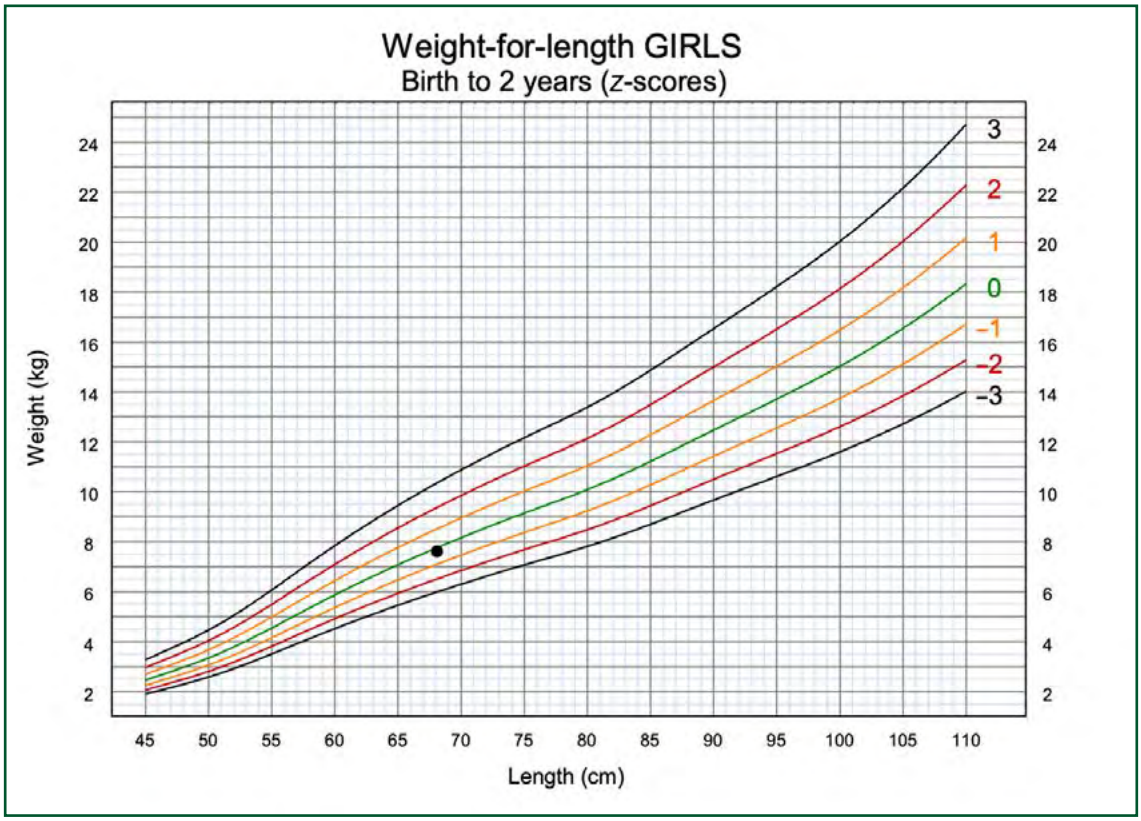
- **This section involves study and discussion with the whole group of the correspondence between the charts provided and photos 12, 1, 2 and 8 in the *Photo booklet*.**

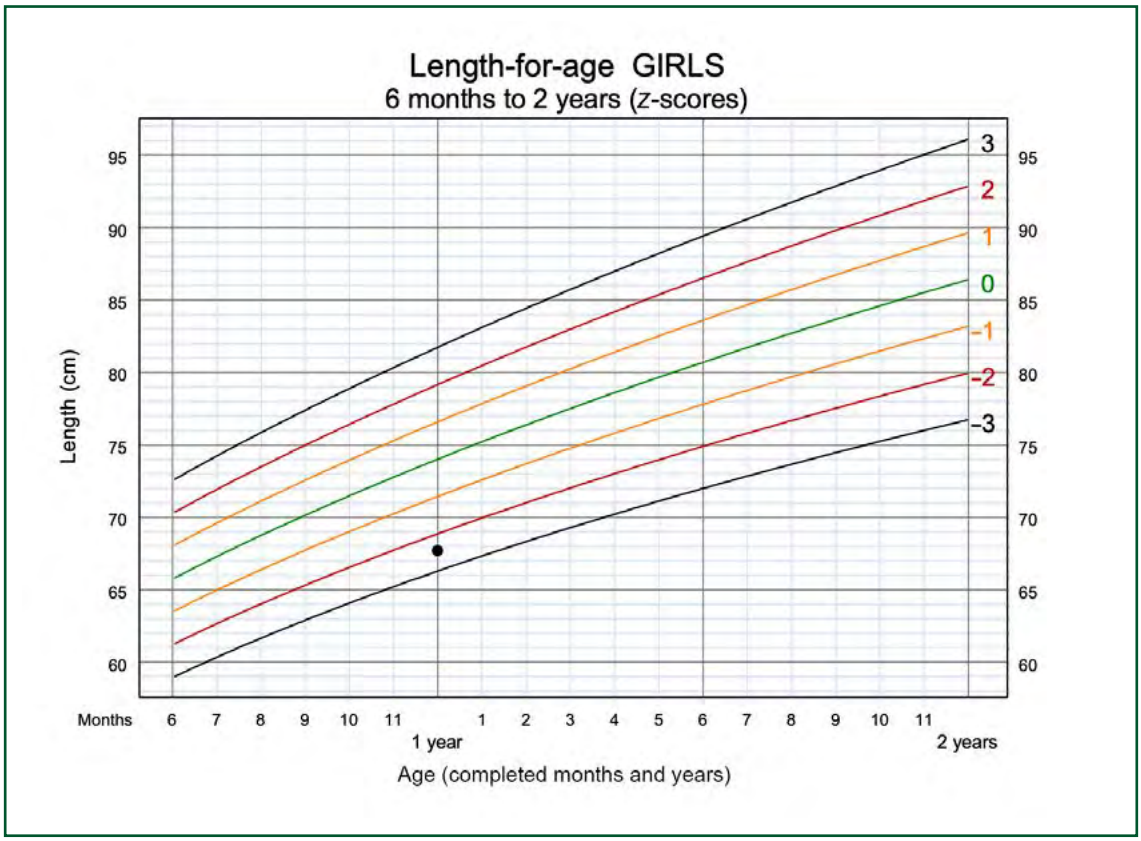
  - Study the examples presented in the *Participant's manual* (pages 454–456) and refer as directed to the corresponding photos in the *Photo booklet*.

Example: Stunting, photo 12

- The girl in photo 12 is aged 1 year 0 months, is 67.8 cm long and weighs 7.6 kg. Her weight-for-age chart is shown below, and her length-for-age and weight-for-length charts are on the next page. Notice that her weight-for-age is low, but still in the normal range. Her weight-for-length is on the median, so she has a completely normal appearance. Her length-for-age is below the −2 *z*-score line, however, showing that she is stunted.




Weight-for-length GIRLS
Birth to 2 years (z-scores)
Weight (kg)
Length (cm)
3
2
1
0
-1
-2
-3


Length-for-age GIRLS
6 months to 2 years (z-scores)
Length (cm)
Months
1 year
2 years
Age (completed months and years)
3
2
1
0
-1
-2
-3

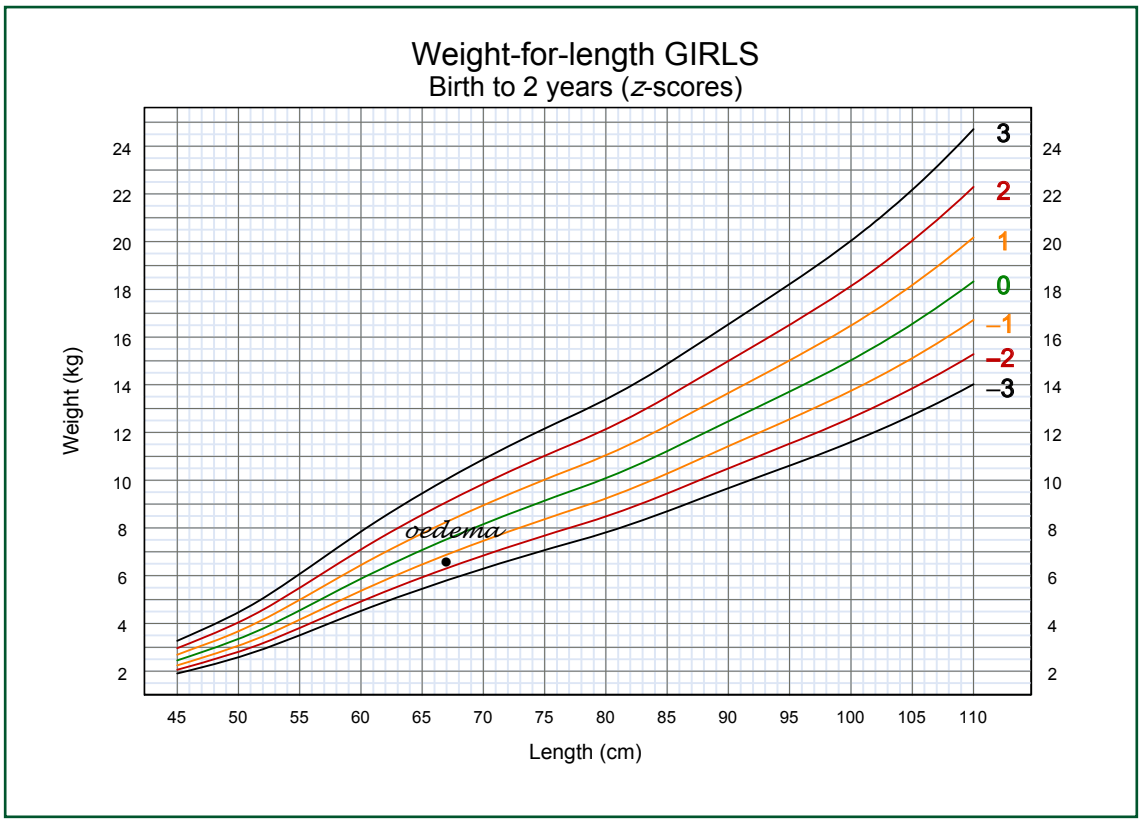
- When interpreting the growth charts, remember to consider your observation of the child's appearance. A child who is below –1 *z*-score in weight-for-length may be fine if they appear lean (fleshed out) rather than wasted (too thin). A child who is above 1 *z*-score in weight-for-length may be fine if they appear heavy (sturdy, mostly muscular) as opposed to having noticeable fat.
- Clinical signs of marasmus and kwashiorkor require special attention. The wasting associated with marasmus (photos 1–3) will be apparent in the child's graphs for weight-for-age and weight-for-length/height. However, the oedema (fluid retention) associated with kwashiorkor (photos 4–8) can hide the fact that a child has very low weight. When you plot the weight of a child who has oedema of both feet, it is important to note on the growth chart that the child has oedema. A child with oedema of both feet is assumed to have a *z*-score below –3 and should be referred for specialized care.

Example: Marasmus, photos 1 and 2

Look at photos 1 and 2, which show a child with marasmus. It is clear that the child needs immediate referral.

Example: Oedema of both feet, photo 8

Look at photo 8, which shows a girl with oedema of both feet. She is aged 1 year and 8 months, weighs 6.5 kg and is 67 cm long. Since she has oedema of both feet, she should be referred. Her weight-for-length is graphed below; it appears to be above the –2 z-score line because her fluid retention masks her low weight.



VII. Group discussion of measurements taken in Clinical practice 7: Listening and learning – measuring children — 33 minutes

- When everyone is ready, announce the group discussion. Lead the discussion of the first child as follows:
- Put up the first chart plotted for a selected child. Show the plotted point on the growth chart as you explain how it was plotted and what it means. For example, say, "I plotted the point on the vertical line for Maria's age and on the horizontal line for her height. This point shows that Maria is 90 cm in height at age 2 years and 3 months".
- Ask participants whether the plotted point shows that the child has any growth problem, and, if so, what that growth problem is. If there is a growth problem, ask participants whether they could have guessed it simply by looking at the child.
- Repeat steps 1 and 2 for each of the relevant growth charts for the child. As you show the plotted points on the other growth charts, discuss what each additional chart reveals. For example, "If you found that a child was stunted but normal weight-for-length, what does this reveal?".
- Ask the participant to present the next child in the same way. Ask questions of participants, as needed to analyse each chart and each child's growth problems.

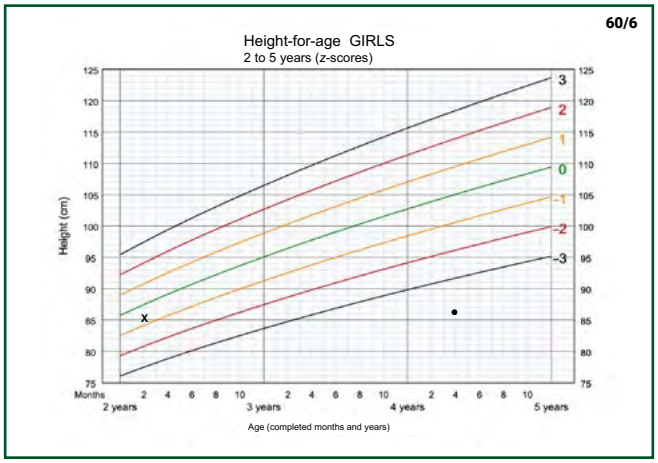
VIII. Growth assessment of two girls — 8 minutes

- After discussing several of the real children measured in Session 68, use **slides 60/5** to **60/8** for the following discussion.
  - These slides show measurements for two girls on the same graphs. One girl is indicated by the mark X and the other by a round point. (*Remind participants that they would never really graph measurements for two children on the same chart; these examples are intended simply for discussion.*)
  - **Slides 60/5** to **60/8** show that two children can have the same measurements and very different *z*-scores. These two girls have the same height and weight. However, they are 2 years apart in age. Their ages make the difference in their *z*-scores and the identification of growth problems.
- Show **Slide 60/5 – Measurements for two girls** and make the point that follows:

	Age	Height	Weight	BMI
Girl X	2 years 2 months	86 cm	12 kg	16.2 kg/m^2
Girl ●	4 years 4 months	86 cm	12 kg	16.2 kg/m^2

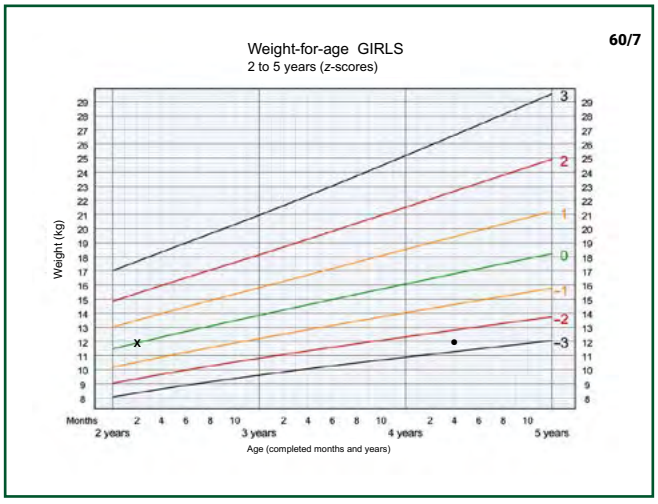
  - The girls' measurements are the same, but their ages are 2 years apart.

▸ Show **Slide 60/6 – Height for age** and make the point that follows:



¤ Girl X is just below the median in height-for-age. Girl ● is well below the –3 *z*-score line (severely stunted).

▸ Show **Slide 60/7 – Weight-for-age** and make the point that follows:



¤ Girl X is on the median in weight-for-age. Girl ● is below the –2 *z*-score line (underweight).

- Show **Slide 60/8 – Weight-for-height** and make the point that follows:

  - ¤ Since the girls have the same weight and height, their points are plotted in the same place on the weight-for-height growth chart. Both girls are above the median in weight-for-height.

- Stress that it is important to look at all of the growth charts for a child. According to one of the charts, girl ● does not seem to have a growth problem, but according to the other two charts, she is severely stunted and underweight.
- These growth charts in this section represent the two little girls shown in photo 13 in the *Photo booklet*. Ask participants to look at photo 13. In the photo, both girls appear healthy and normal in size. Only by charting height and weight with age can one see that the older girl is severely stunted and underweight.
- Ask participants to guess which girl is the older, stunted one. (They are likely to guess wrong.) It is the girl on the right, wearing a dress, who is older.

IX. Summarize the session — 2 minutes

- Ask participants whether they have any questions, and try to answer them.
- Explain that a summary of this session can be found on pages 449–456 of the *Participant's manual*.

Notes

Notes (contd)

Notes (contd)

SESSION 61

Interpreting trends on growth charts

Objectives

After completing this session, participants will be able to:

- interpret trends on growth charts
- determine whether a child is growing normally, has a growth problem or is at risk of a growth problem

Session outline . . . . . 120 minutes

Participants are all together for a lecture presentation by one trainer, followed by a group discussion.

I. Introduce the session, present **Slide 61/1**. . . . . 2 minutes
II. Present **Slides 61/2** to **61/7** . . . . . 45 minutes
III. Group discussion on interpreting growth trends **(Slides 61/8** to **61/13)** . . . . . 15 minutes
IV. Individual written work on continuing case studies (EXERCISE 61.A) . . . . . 55 minutes
V. Summarize the session . . . . . 3 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides and facilitating group discussion.
- Study the **slides 61/1** to **61/13** and the text that goes with them, so that you are able to present them.

As you follow the text, remember:

► **indicates an instruction to you, the trainer.**

¤ indicates what you say to participants.

I. Introduce the session — 2 minutes

► Show **Slide 61/1 – Session 61 – objectives** and read out the objectives:

61/1

Session 61: Interpreting trends on growth charts – objectives

After completing this session, participants will be able to:

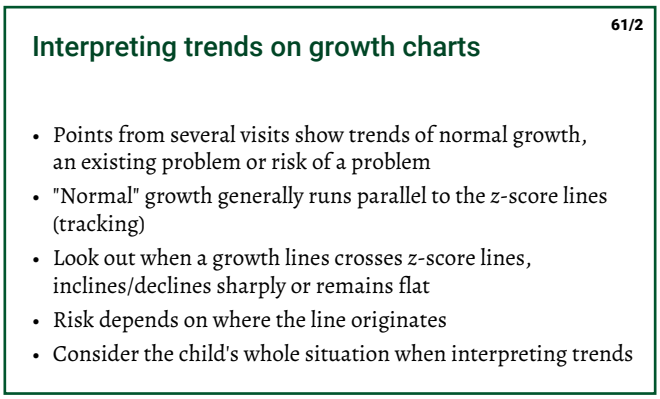
- interpret trends on growth charts
- determine whether a child is growing normally, has a growth problem or is at risk of a growth problem

II. Present **Slides 61/2** to **61/7** 45 minutes

▸ **Make these remarks:**

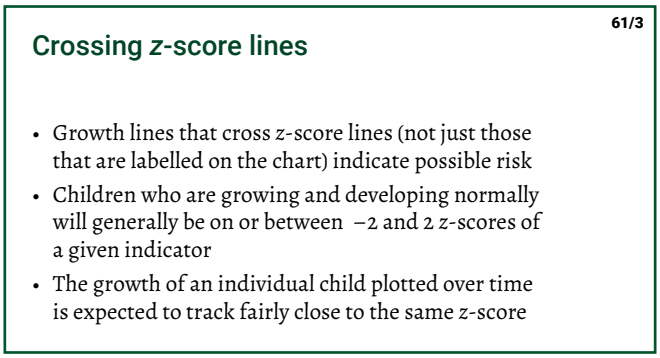
- We saw in a previous session that even if you have just one set of measurements, you can get a good picture of growth status by looking at different indicators.
- Could someone illustrate for us why looking at one indicator may not be enough?
- In this session, we will go further and look at growth trends that we can draw when a child has multiple visits.

▸ **Show Slide 61/2 – Interpreting trends on growth charts and make the points that follow:**



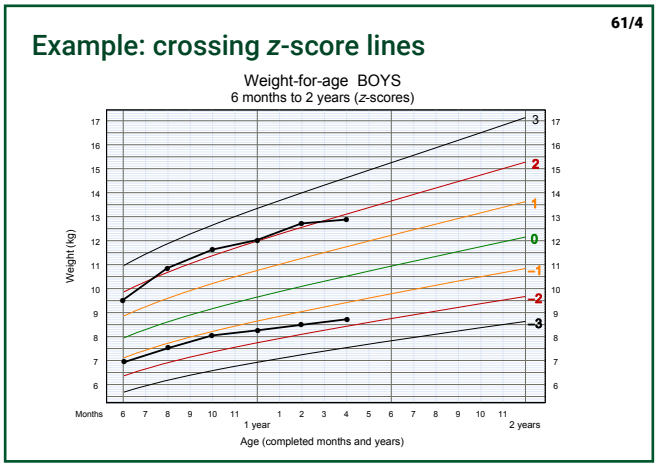
- To identify trends in a child's growth, look at points for growth indicators plotted at a series of visits. Trends may indicate that a child is growing consistently and well, or they may show that a child has a growth problem, or that a child is "at risk" of a problem and should be reassessed soon.
- "Normally" growing children follow trends that are, in general, parallel to the median and *z*-score lines. Most children will grow in a "track", that is, on or between *z*-score lines and roughly parallel to the median; the track may be below or above the median.
- The following situations may indicate a problem or suggest risk:
  - a child's growth line crosses a *z*-score line and keeps going
  - there is a sharp incline or decline in the child's growth line
  - the child's growth line remains flat (stagnant); i.e. there is no gain in weight or length/height.
- Whether the above situations actually represent a problem or risk depends on where the change in the growth trend began and where it is headed. For example, if a child has been ill and lost weight, a rapid gain (shown by a sharp incline on the graph) can be good and indicate "catch-up growth". Similarly, for an overweight child, a slightly declining or flat weight growth trend towards the median may indicate desirable "catch-down". It is very important to consider the child's whole situation when interpreting trends on growth charts.

▸ Show **Slide 61/3 – Crossing *z*-score lines** and make the points that follow:



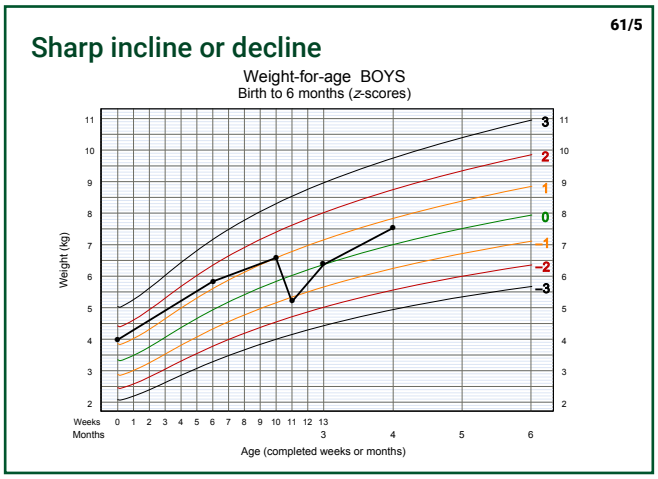
- Growth lines that cross *z*-score lines (not just those that are labelled on the chart) indicate possible risk.
- Children who are growing and developing normally will generally be on or between −2 and 2 *z*-scores of a given indicator.
- The growth of an individual child plotted over time is expected to track fairly close to the same *z*-score.

▸ Show **Slide 61/4 – Example: crossing *z*-score lines** and make the points that follow:



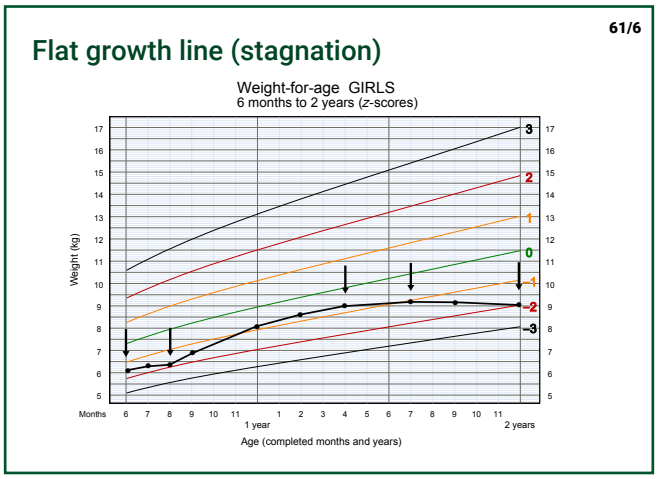
- The figure on the slide presents two theoretical growth lines. In one of the lines, growth generally tracks along the 2 *z*-score line, crossing it from time to time in a pattern that indicates no risk. The other line shows a boy's weight falling away from his expected growth track. Although his growth line remains between −1 and −2 *z*-scores, this child has in fact crossed *z*-scores following a systematic trend that indicates risk.
- A growth line tending towards the median is probably a good change. If it tends away from the median, this probably signals a problem or risk of a problem.
- If the growth line is inclining or declining so that it may cross a *z*-score line soon, consider whether the change may be problematic. In the example graph, if the trend in the lower growth line continues, it will soon cross the cut-off line (−2 *z*-scores) that defines underweight. If a trend towards stunting, overweight or underweight is noticed in time, it may be possible to intervene in good time to prevent a problem.

► Show **Slide 61/5 – Sharp incline or decline** and make the points that follow:



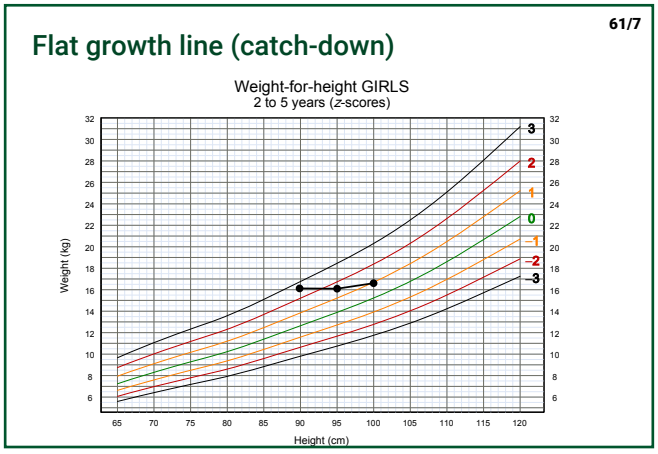
- Any sharp incline or decline in a child's growth line requires attention. If a child has been ill or severely undernourished, a sharp incline is expected during the re-feeding period, as the child experiences "catch-up" growth. Otherwise, a sharp incline is not good, as it may signal a change in feeding practices that will result in overweight.
- If a child has gained weight rapidly, look also at height. If the child grew in weight only, this is a problem. If the child grew in weight and height proportionately, this is probably catch-up growth from previous undernutrition, because of improvement in feeding or recovery from previous infection. In this situation, the weight-for-age and height-for-age charts should show inclines, while the weight-for-height growth line tracks steadily along the *z*-score curves.
- A sharp decline in the growth line of a normal or undernourished child indicates a growth problem to be investigated and remedied.
- Even if a child is overweight, they should not have a sharp decline in the growth line, as losing too much weight rapidly is undesirable. The overweight child should instead maintain their weight while increasing in height; i.e. the child should "grow into their weight".
- In the example on the slide, the weight-for-age chart shows a sharp decline from age 10 to 11 weeks, when the child had diarrhoea and lost 1.3 kg. The chart shows a sharp incline after the episode of diarrhoea, during re-feeding, as he gained back most of the lost weight.

▸ Show **Slide 61/6 – Flat growth line (stagnation)** and make the points that follow:



- A flat growth line, also called stagnation, usually indicates a problem. If a child's weight stays the same over time as their height or age increases, the child most likely has a problem. If height stays the same over time, the child is not growing. The exception is when an overweight or obese child is able to maintain the same weight over time, bringing the child to a healthier weight-for-height.
- If an overweight child is losing weight over time, and the weight loss is reasonable, the child should continue to grow in height. However, if the child experiences no growth in height over time, there is a problem. This problem would be evident as a flat growth line on the height-for-age chart.
- For children in age groups where the growth rate is fast, as shown by steep growth curves (e.g. during the first 6 months of life), even 1 month's stagnation in growth represents a possible problem.
- In the example on the slide, the weight-for-age chart shows a flat growth line (stagnation) from age 6 months to 8 months and again from about 1 year and 4 months to 2 years. These periods of stagnation correspond to times when the child had malaria episodes (indicated by arrows). From 8 months up to 1 year and 4 months, she grew. Owing to periods of stagnation, the child's weight-for-age is about to cross the –2 *z*-score line.

▸ Show **Slide 61/7 – Flat growth line (catch-down)** and make the points that follow:



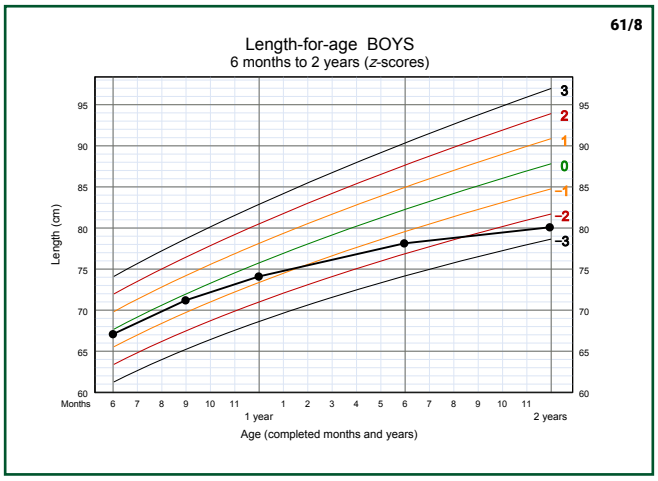
- Unlike the flat line on the previous chart, the flat line on this weight-for-height chart shows a good trend. The child was overweight, but her weight remained about the same while she grew in height. She is no longer overweight.

III. Group discussion on interpreting growth trends — 15 minutes

▸ **Lead a discussion of the growth trends apparent on the charts for each child. Use the questions below to guide the discussion. Possible answers are given below each question.**

¤ **Slides 61/8** to **61/10** show Ben's growth charts with five visits from age 6 to 24 months.

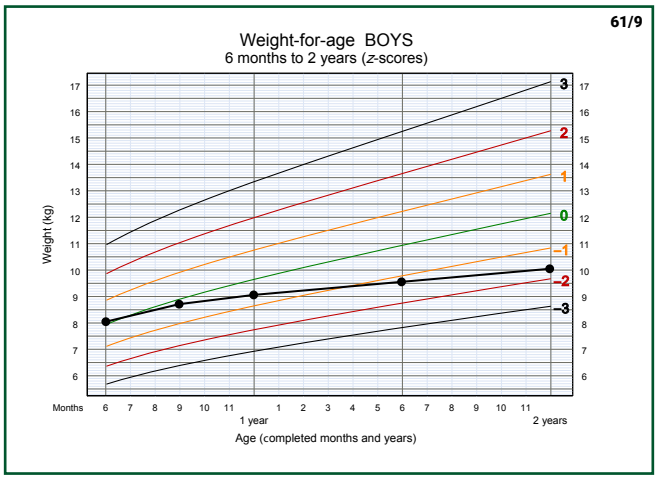
▸ **Show Slide 61/8 – Ben's length for age:**



¤ What trend is shown on Ben's length-for-age chart? Has his growth line crossed any *z*-score lines systematically, and if so, in what direction? Does this chart show a growth problem or trend towards a growth problem?

- Ben's length-for-age was close to the median at age 6 months, but over the next 18 months, his growth line trended systematically downward and crossed the –1 and the –2 *z*-score lines. By age 24 months, he was stunted.

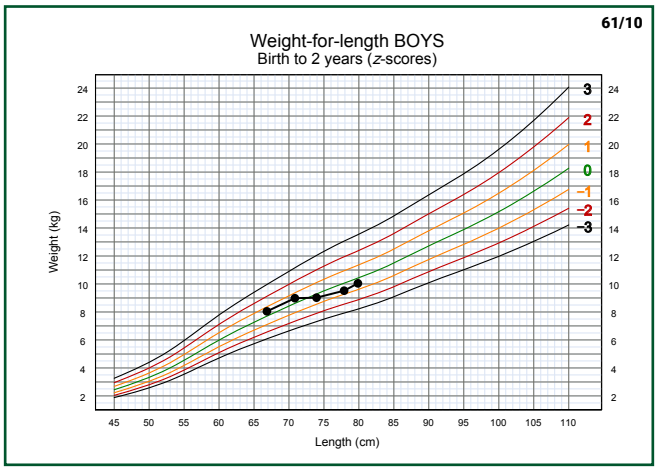
▸ **Show Slide 61/9 – Ben's weight for age:**



¤ What trend is shown on Ben's weight-for-age chart? Has his growth line crossed any *z*-score lines systematically, and if so, in what direction? Does this chart show a growth problem or trend towards a growth problem?

- Ben's weight-for-age was on the median at age 6 months, but over the next 18 months, his growth line trended systematically away from the median, crossed the –1 *z*-score line, and by 2 years was close to the –2 *z*-score line.

▸ Show **Slide 61/10 – Ben's weight for length**:



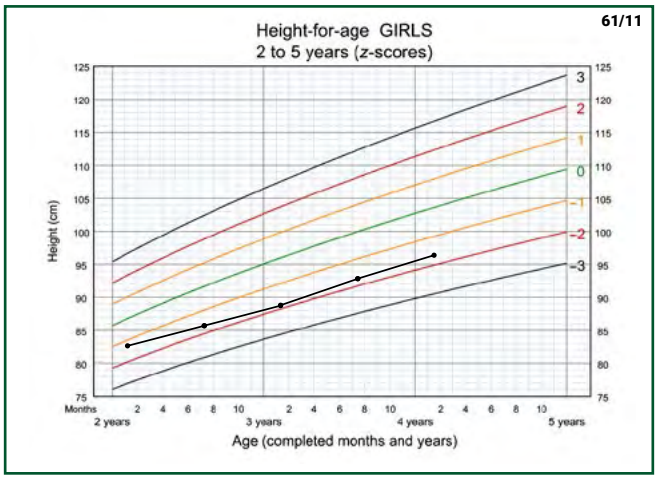
⌑ What trend is shown on Ben's weight-for-length chart? Does this chart show a growth problem or trend towards a growth problem?

- Unlike his weight-for-age and length-for-age, Ben's weight-for-length has stayed close to the median. No problem is evident on the weight-for-length chart.

▸ **Using Ben as an example, stress the importance of looking at trends on all three growth charts. If you only looked at the weight-for-length chart, you might think that Ben was growing well. However, when you look at the weight-for-age and height-for-age charts, problem trends become apparent.**

⌑ **Slides 61/11** to **61/13** show Delia's growth charts with five visits from age 2 to 4 years.

▸ Show **Slide 61/11 – Delia's height for age**:



⌑ What trend is shown on Delia's height-for-age chart? Does this chart show a growth problem or trend towards a growth problem?

- For almost 2 years, Delia's height-for-age has stayed just below the –2 z-score line. She is stunted. The stunting does not seem to be getting any worse.

▸ Show **Slide 61/12 – Delia's weight-for-age**:

¤ What trend is shown on Delia's weight-for-age chart? Does this chart show a growth problem or trend towards a growth problem?

- At age 2 years, Delia's weight-for-age was slightly below the median; then over the next 2 years it climbed to a point slightly above the median. No problem is evident from this chart alone.

▸ Show **Slide 61/13 – Delia's weight for height**:

¤ What trend is shown on Delia's weight-for-height chart? Has her growth line crossed any z-score lines systematically, and, if so, in what direction? Does this chart show a growth problem or trend towards a growth problem?

- Delia's weight-for-height is trending upward. Over a period of 2 years, her growth line has crossed the 1 and 2 z-score lines. She has become overweight. Although her weight is normal for her age, it is high for her stunted height.

▸ **Again, use this example to stress the importance of looking at trends on all of the growth charts.**

¤ If you look only at Delia's weight-for-age, she appears to be growing normally. If you look only at her height-for-age, you might think that she is just a short child tracking along a low z-score but since her stunting is not getting any worse, she is fine. However, if you look at weight-for-length, the growth problem of overweight becomes apparent.

IV. Individual written work on continuing case studies — 55 minutes

Exercise 61.A Continuing case studies – Nalah and Toman

▸ **Ask participants to work individually on the continuing case studies.**

- In Exercise 59.A, you plotted points on the growth charts in Nalah's and Toman's Growth records. In this exercise, you will review the growth charts for Nalah and Toman to identify:
  - each child's growth patterns
  - any current growth problem(s)
  - any growth trend(s) that may become a problem.
- To describe growth problems, use the definitions given on page 450 of Session 60, and next to the growth charts in the Growth record. To describe growth patterns and trends, point out whether the growth line shows an incline or decline, whether it is tracking along or between certain *z*-score lines, whether it has crossed a *z*-score line, etc.

Nalah

Review the growth charts that you completed in Nalah's Girl's growth record. Then write short answers to the questions below:

1. a. Describe the growth trend shown on Nalah's length-for-age chart.

   b. Does Nalah's length-for-age chart show a current growth problem or risk of a problem, and if so, what is it?
2. a. Describe the growth trend shown on Nalah's weight-for-age chart.

   b. Does Nalah's weight-for-age chart show a current growth problem or risk of a problem, and if so, what is it?
3. a. Describe the growth trend shown on Nalah's weight-for-length chart.

   b. Does Nalah's weight-for-length chart show a current growth problem or risk of a problem, and if so, what is it?
4. Summarize Nalah's growth pattern over the first 6 months of life.

Toman

Review the growth charts that you completed in Toman's Boy's growth record. Then write short answers to the questions below:

1. a. Describe the growth trend shown on Toman's length-for-age chart.

   b. Does Toman's length-for-age chart show a current growth problem or risk of a problem, and if so, what is it?
2. a. Describe the growth trend shown on Toman's weight-for-age chart.

   b. Does Toman's weight-for-age chart show a current growth problem or risk of a problem, and if so, what is it?
3. a. Describe the growth trend shown on Toman's weight-for-length chart.

   b. Does Toman's weight-for-length chart show a current growth problem or risk of a problem, and if so, what is it?
4. Briefly summarize Toman's growth pattern from age 1 year and 1 month to age 2 years.

- When you have finished this exercise, review your answers with a facilitator.

▸ **Answer sheets are provided at the end of this session (page 779).**

V. Summarize the session 3 minutes

- **Make these points:**
  - Measurements have to be plotted correctly on the appropriate age and sex charts, as a start to assessing how well a child is growing.
  - With measurements from a single visit, three indicators give a better picture of the child's growth status than one indicator on its own.
  - An assessment of growth trends indicates whether a growth problem is chronic or of recent onset. Changes in growth trend are often linked with events such as illness.
- **Ask participants whether they have any questions, and try to answer them.**
- **Explain that a summary of this session can be found on pages 457–463 of the *Participant's manual*.**

Answer sheet

Exercise 61.A Continuing case studies – Nalah and Toman

Nalah

1. a. Nalah was an average length at birth but has experienced periods of slow growth and stagnation. Her length-for-age has thus dropped from the median at birth to below –3 *z*-scores at 6 months.

   b. At 6 months, Nalah is severely stunted.

2. a. Nalah's weight at birth was just below the median but because of periods of very slow growth (e.g. birth to 6 weeks, 10–13 weeks), followed by inadequate catch-up growth (e.g. at 6–10 weeks and at 3–4 months), her weight-for-age has dropped systematically to below –2 *z*-scores at 6 months.

   b. Nalah is underweight.

3. a. Nalah's weight-for-length has fluctuated between –1 *z*-scores and the median since birth, and at 6 months is tracking along the median.

   b. The weight-for-length chart shows the stagnation in length that occurred when Nalah was 55 cm long but currently it does not indicate a growth problem or risk of a problem.

4. Although Nalah was average length at birth, she became severely stunted by the age of 6 months. Her growth in both length and weight stagnated between the ages of 10 weeks and 13 weeks, perhaps because of the episode of diarrhoea for which she was seen at the end of this period. Her weight has stayed appropriate for her length, so problems are not apparent on the weight-for-length. However, she is severely stunted and underweight according to the length-for-age and weight-for-age charts.

Toman

1. a. Toman's length-for-age has been consistent, staying very close to the 1 *z*-score line.

   b. No problem or risk of a problem is evident on the length-for-age chart.

2. a. Toman's weight is increasing too rapidly in relation to his age. His weight-for-age line has crossed the 2 *z*-score line and continued rising.

   b. The weight-for-age chart shows that Toman is very heavy for his age, but a judgement of whether he has a problem with overweight should be based on his weight-for-height.

3. a. Toman's weight is increasing too rapidly in relation to his length. His weight-for-length has crossed the 2 *z*-score line and reached the 3 *z*-score line.

   b. The weight-for-length chart shows that Toman is overweight and is at risk of becoming obese.

4. Toman has grown normally in length, tracking along the 1 *z*-score line, but his weight has increased too rapidly for his length and his age, as shown on three of the growth charts (weight-for-age, weight-for-length) where his growth lines are near or on the 3 *z*-score line. His is overweight and has a definite trend towards obesity.

Notes

SESSION 62

Growth assessment results and feeding counselling when the child is growing well

Objectives

After completing this session, participants will be able to:

- explain to a mother or caregiver the results of their child's growth assessment
- explain how to deal with a child who has severe growth problems
- gather information on feeding practices using the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS

Session outline . . . . . 50 minutes

Participants are all together for a lecture presentation and demonstration by one trainer.

I.	Introduce the session, present **Slides 62/1** and **62/2**	10 minutes
II.	Inform the caregiver of growth assessment results	2 minutes
III.	Refer children with severe growth problems (**Slide 62/3**)	8 minutes
IV.	Demonstrate gathering information on feeding practices (Demonstration 62.A)	25 minutes
V.	Summarize the session	5 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides and giving a demonstration.
- You need a typical bowl that a young child would use.
- Have ready one set of FOOD CONSISTENCY PICTURES.
- Ask two people to assist with DEMONSTRATION 62.A. Show them the text and forms. Ask them to read it through and to practise. Ask one person to play the health worker and to have ready the FOOD CONSISTENCY PICTURES, a JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS and a bowl, plus the growth chart.
- Have ready COUNSELLING CARD 17: FOOD VARIETY; COUNSELLING CARD 18: COMPLEMENTARY FEEDING FROM 6 UP TO 9 MONTHS; CARD 19: COMPLEMENTARY FEEDING FROM 9 UP TO 12 MONTHS and COUNSELLING CARD 20: COMPLEMENTARY FEEDING FROM 12 UP TO 24 MONTHS, and the *Guidance on the use of counselling cards*.
- Study the **Slides 62/1** to **62/3** and the text that goes with them, so that you are able to present them.
- You need a flipchart and markers.

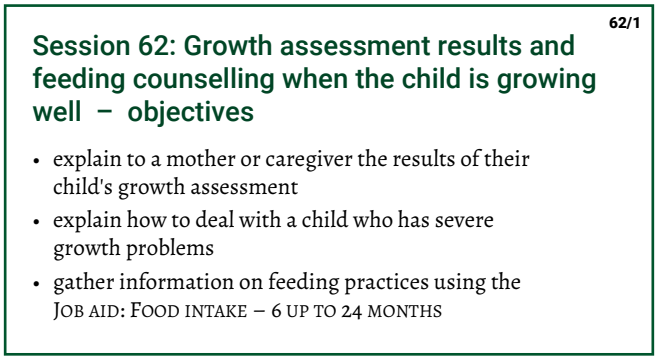
As you follow the text, remember:

► **indicates an instruction to you, the trainer.**

¤ indicates what you say to participants.

I. Introduce the session — 10 minutes

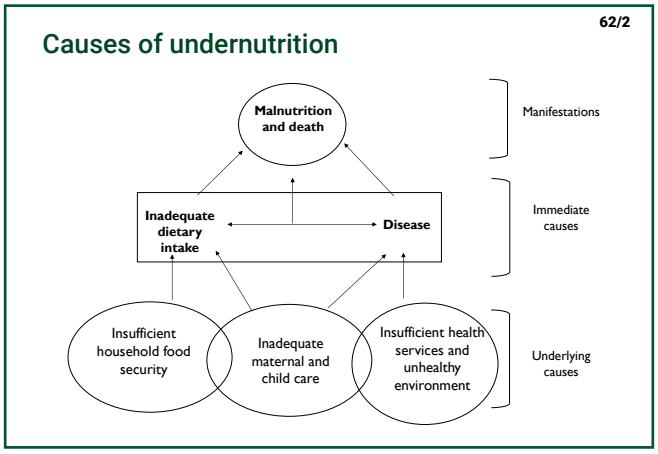
► Show **Slide 62/1 – Session 62 – objectives** and read out the objectives:



► Make these points:

- The mother or caregiver will be very curious to know what you found when you assessed their child's growth, so the first step is to inform them in a clear and sensitive way, using appropriate counselling skills.
- If the child is growing well, the next step is to provide counselling on appropriate feeding for the child's approaching age group, so that the child will continue to grow well. The Job aid: Food intake – 6 up to 24 months is used for this purpose.
- If there is a growth problem, or a trend towards a problem, you will interview the caregiver, to identify possible causes of the problem. A booklet is provided with this course to assist in these interviews; the booklet contains two Job aids:
  - Job aid: Investigating causes of undernutrition
  - Job aid: Investigating causes of overweight
- These two Job aids suggest questions to ask the caregiver, in order to identify causes of problems, and they suggest specific advice related to each possible cause.
- Many social and environmental factors can affect a child's feeding, care and resulting growth. That is why it is very important to determine the most important causes of a problem for a particular child before counselling. For example, if a child is wasted primarily because the family lacks food, it will not be helpful simply to advise the caregiver to feed the child more often. In such a situation, it would be better to guide the family to a source of assistance.

► Show **Slide 62/2 – Causes of undernutrition** and make the following points



- As implied in the diagram, in order to resolve the immediate causes of undernutrition, i.e. inadequate diet and disease, it may be necessary to address causes in the home environment, such as the absence of a responsible adult to care for the child during the day, or poor sanitation or contaminated water. It is not always possible to resolve these causes, but the health-care provider can help the mother to understand them and think of positive actions to take.
- Causes of overweight and obesity are also typically rooted in the environment. For example, a busy family may rely on high-energy convenience foods instead of taking time for leisurely, well-planned meals. Children may not be able to play outdoors safely and thus spend too much inactive time watching television or playing video games. Resolving problems of overweight and obesity will require addressing root environmental causes, as well as immediate dietary causes.
- During the counselling session, it is important to agree on actions to improve the child's growth that are feasible for the mother or caregiver. If too many actions are suggested, they may forget many of them or be discouraged. Suggest the most important and feasible actions (two or three), and encourage the caregiver to bring the child back for follow-up. The follow-up visit will give the caregiver a chance to report success and the health-care provider a chance to give additional advice as needed. Change takes time and the underlying causes of poor growth are unlikely to be resolved in a single counselling session. The need to follow up and monitor the child's feeding, care and growth is critical.

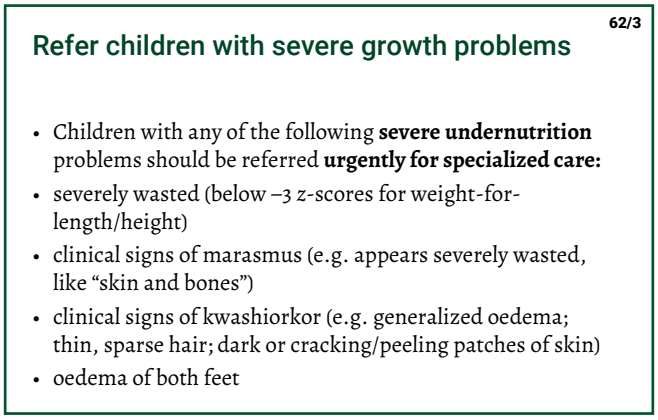
II. Inform the caregiver of growth assessment results — 2 minutes

► Make these points:

- Throughout the growth assessment, the caregiver has seen you recording measurements in the GROWTH RECORD and plotting and connecting points on the growth charts. They are likely to be curious about the results. Explain that you have plotted the points to see whether the child is growing as expected, or whether there is any growth problem. Explain the points and trends on each chart to the caregiver, clearly and simply.
- If a child is growing well, be sure to say so to the mother or caregiver and compliment them. If there are problems, it is still very important to keep the discussion positive. Avoid any suggestion of accusing or judging the caregiver. You want to build their trust and communicate that they can help the child.
- Use clear, non-medical language as much as possible. If you use an unfamiliar word, such as "obese", explain it. For example, you could say, "obese means very heavy for one's height". Words such as "stunted", "wasted" and "obese" are used in the GROWTH RECORD, so be prepared to explain them in simple words.

III. Refer children with severe growth problems — 8 minutes

► Show **Slide 62/3 – Refer children with severe growth problems** and make the following points



- Children with any of the following **severe undernutrition** problems should be **referred urgently for specialized care:**
  - severely wasted (below –3 z-scores for weight-for-length/height)
  - clinical signs of marasmus (e.g. appears severely wasted, like "skin and bones")
  - clinical signs of kwashiorkor (e.g. generalized oedema; thin, sparse hair; dark or cracking/peeling patches of skin)
  - oedema of both feet.
- An undernourished child may have a current illness (such as diarrhoea) or a chronic health problem that could be contributing to undernutrition. If so, treat the contributing illness or problem if you are able to, and explain how to feed a sick child (KEY MESSAGE 10). If you cannot treat, refer the child for appropriate treatment. If you know or suspect that a child has a chronic health problem (such as HIV/AIDS), refer the caregiver and/or child for counselling or testing as appropriate.
- Refer children with obesity (above 3 z-scores for weight-for-length/height) for medical assessment and specialized management if these services are available.
- Whenever you refer a child, explain to the caregiver the reasons for the referral and stress its importance. According to your usual practice, provide a referral form or note for the caregiver to take with them. Also write a note in the GROWTH RECORD in the VISIT NOTES section, and show the caregiver this note. Ensure that they know when and where to take the child. Ask whether they have transportation, and help them to arrange it if necessary. Follow up later, to ensure that the child was taken for the required urgent care or medical assessment.
- Every time you see a mother, try to build her confidence. Praise her for what she and her baby are doing right. Give relevant information, and suggest something appropriate.

IV. Demonstrate gathering information on complementary feeding practices 25 minutes

- **Make these points:**
  - This section addresses how to proceed in counselling a mother or caregiver whose child is growing well. The focus of the dialogue is on complementary feeding and we will use the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS.
  - If you are going to counsel a mother or caregiver whose child is growing well on complementary feeding, you need to find out what the child is eating.
  - This could be quite complicated because children eat different things at different times in a day.
  - In Session 15, you looked at the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS and learnt how to take a feeding history.
  - Now we are going to look at assessing the intake of complementary foods in detail.
- **Make these points:**
  - Gathering information on complementary feeding gives you the opportunity to reinforce feeding practices that support healthy growth and to provide information on how to feed the child in an approaching age range, so that they continue to grow well.
- **Ask participants to turn to page 468 of their *Participant's manual* and find the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS (page 794 in the *Trainer's guide*). Make these points:**
  - A useful way to find out what a child eats is to ask the caregiver what the child ate yesterday. This information can be used to praise the good feeding practices that are there already and to identify any Key messages to help improve practices.
  - The JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS helps you to do this.
  - The caregiver is asked to recall everything the child consumed the previous day. This includes all foods, snacks, drinks, breastfeeds, other liquids and any vitamin or mineral supplements.
  - As you can see, the first column has questions about feeding practices. As you listen to the caregiver, put a tick in the column, to mark if the practice occurred the previous day.
  - You will see that most of the questions in the first column are closed questions. When you use this tool with a caregiver to gather information, you should use your counselling skills, including open questions. We will see how this is used in a demonstration later.
- **Ask participants to refer to the FOOD CONSISTENCY PICTURES on page 470 of their *Participant's manual*. Point out how the pictures are different.**
  - If you ask a caregiver about the consistency of the food – whether it was thin or thick, there might be some confusion about how thick you mean. Therefore, here are pictures to show a thick and a thin consistency.
  - You show the FOOD CONSISTENCY PICTURES to the caregiver and ask which drawing is most like the food they gave to the child.
  - After you have listened to find out what the feeding practices are, you can praise some of the practices you wish to reinforce.
  - After you have taken the history and filled in the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS, you then choose two or three Key messages to give. It is important to listen to the caregiver first, so that you gather all the information on complementary feeding before you decide which Key messages to give to them. There is a column on the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS to indicate which items you discussed in more detail and gave a Key message about.
  - Put your initials at the Key message you gave.
  - *Ask: Why is it important to choose just 2–3 Key messages to give the caregiver?*
- **Wait for a few replies and then continue.**
  - It is important to choose just 2–3 Key messages at a visit, so the caregiver is not overwhelmed.
  - Discuss the Key messages you think are most important at this time and that the caregiver thinks that they can do.

- **Ask participants to turn to page 469 and the REFERENCE TOOL: FOOD INTAKE – 6 UP TO 24 MONTHS. This can be found on page 795 of the *Trainer's guide*. Ask one participant to read the first question on feeding practice, the recommended practice and the Key message, then another participant to read the next practice.**
- **Answer questions as needed about the practices. (Make sure the participants notice the differences between the recording form and the reference form.)**
  - Feeding techniques to assist the child to learn to eat are discussed in Session 48. Feeding the child who is ill is discussed in Session 50.
  - All the Key messages have already been introduced in Module 5 and are listed on page xiv of the *Participant's manual*.
  - On page 467 in your *Participant's manual*, there are instructions on how to use the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS
- **Ask participants to take turns to read out the instructions.**

Instructions for completing the Job aid: Food intake – 6 up to 24 months

1. Greet the mother/caregiver. Explain that you want to talk about the child's feeding.
2. Fill out the child's name, birth date, age in completed months or years and today's date.
3. Ask to see the growth chart and observe the pattern of the growth.
4. Start with:
   (Mother/caregiver name), let us talk about what (child's name) ate yesterday.
5. Continue with:
   As we go through yesterday, tell me all (child's name) ate or drank, meals, other foods, water or breastfeeds.
   What was the first thing you gave (child's name) after he woke up yesterday?
   Did (child's name) eat or drink anything else at that time or breastfeed?
6. If the caregiver mentions a preparation, such as a porridge or stew, ask them for the ingredients in the porridge or stew.
7. Then continue with:
   What was the next food or drink or breastfeed (child's name) had yesterday?
   Did (child's name) eat/drink anything else at that time?
8. Remember to "walk" through yesterday's events with the caregiver, to help them remember all the food/drinks/breastfeeds that the child had.
9. Continue to remind the caregiver you are interested in what the child ate and drank yesterday (caregivers may talk about what the child eats/drinks in general).
10. Clarify any points or ask for further information as needed.
11. Mark on the Job aid: Food intake – 6 up to 24 months the practices that are present. If appropriate, show the caregiver the pictures of thin and thick consistency (for porridge and mixed foods). Ask them which drawing is most like the food they gave the child. Was it thick, did it stay on the spoon and hold a shape on the plate, or was it thin and did it flow off the spoon and not hold its shape on the plate?
12. Praise practices you wish to encourage. Offer two or three Key messages as needed and discuss how the caregiver might use this information.
13. If the child is ill on that day and not eating, give the Key message 10: Encourage the child to drink and eat during illness, and provide extra food after illness to help them recover quickly.
14. See the child another day and use the Job aid: Food intake – 6 up to 24 months when they are eating again.

- ¤ Now we will see this Job aid: Food intake – 6 up to 24 months in use. Follow the demonstration, using the completed Job aid: Food intake – 6 up to 24 months on page 471 of your *Participant's manual* and add your own comments in the second column. Later, you will use a Job aid: Food intake – 6 up to 24 months with mothers in a clinical practice session.
- ¤ In this demonstration, listen for open questions and other Listening and learning skills that we discussed in Session 5.
- ¤ We will review the demonstration and your comments at the end

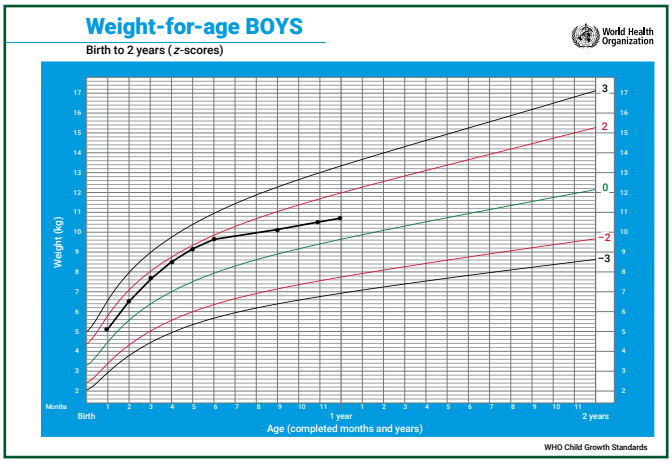
▸ **Ask the two trainers/facilitators whom you prepared to assist. One person is the mother and one is the health worker who fills in the Job aid: Food intake – 6 up to 24 months. The health worker also has the counselling cards that will help them in counselling the mother.**

- ¤ Set the room out with seating with no desk or barrier between the health worker and mother. If the health worker needs a desk to write on, place it to one side (right-hand side if the health worker writes with the right hand). They are already sitting. The health worker has a Job aid: Food intake – 6 up to 24 months, Reference tool: Food intake – 6 up to 24 months, Food consistency pictures and a typical bowl. The mother has a growth chart for the child.

► **Find out the mother's and child's "names", then introduce the demonstration:**

- (Name) is 11 months old. (Mother's name) has brought him to the health centre for immunization. The child was ill at the last visit but has recovered and is growing well again, so the health worker asks (mother's name) to talk to her about how (name) is eating.
- This corresponds to the ASSESS phase you can find in your *Guidance on the use of counselling cards*. Please open your booklet to find the section on INFANT AND YOUNG CHILD FEEDING THREE-STEP COUNSELLING, where you will find STEP 1: ASSESS – ask, listen and observe. Let's now pay attention to the demonstration.

DEMONSTRATION 62.A LEARNING WHAT A CHILD EATS



Health worker: *Thank you for coming today. (Mother's name), the growth charts show that your child is growing well again since I last saw him when he was ill.*
(show growth chart)
Mother: *I am pleased that he is recovering. I was worried that he might still be growing poorly from last time.*

Health worker: *I can see you are anxious about his growth.*
Mother: *Yes. I was wondering if I was feeding him the right sorts of food.*

Health worker: *Perhaps we could go through everything that (child's name) ate or drank yesterday?*
Mother: *Yes, I can tell you about that.*

Health worker: *What was the first thing you gave (child's name) after he woke up yesterday?*
Mother: *First thing, he breastfed. Then about one hour later the baby had a small amount of bread with butter, and several pieces of papaya.*

Health worker: *Breastfeeding, then bread, butter and some pieces of papaya. That is a good start to the day. What was the next food or drink or breastfeed that he had yesterday?*
Mother: *At mid-morning, the baby had some porridge with milk and sugar.*

Health worker: *Which of these drawings is most like the porridge you gave to (child's name)?*
(show FOOD CONSISTENCY PICTURES)
Mother: *Like that thick one* (points to the thick consistency).

Health worker: *A thick porridge helps (child's name) to grow well. After the porridge mid-morning, what was the next food, drink, breastfeed (child's name) had?*
Mother: *Let's see, in the middle of the day, he had soup with vegetables and beans.*

Health worker: *How did the baby eat the vegetables and beans?*
Mother: *I mashed them all together and added the liquid of the soup so he could eat it.*

Health worker: **(show FOOD CONSISTENCY PICTURES)**	*Which picture is most like this food that you fed (child's name) yesterday in the middle of the day?*
Mother:	*This one – the more runny one* (points to the thin consistency).
Health worker:	*Was there anything else that (child's name) had at midday yesterday?*
Mother:	*Oh yes, he had a small glass of fresh orange juice.*
Health worker:	*That is a healthy drink to give to (child's name). After this meal at midday, what was the next thing he ate?*
Mother:	*Let's see, he didn't eat anything more until we all ate our evening meal. He breastfed a few times in the afternoon. In the evening, he ate some rice, a spoonful of mashed greens and some mashed fish.*
Health worker: **(show FOOD CONSISTENCY PICTURES)**	*Breastfeeding will help (child's name) to grow and to stay healthy. It is good that you are still breastfeeding. Which of these pictures looks most like the food the baby ate in the evening?*
Mother:	*This thicker one. I mashed up the foods together and it looked like that.*
Health worker:	*Did (child's name) eat or drink anything more for the evening meal yesterday?*
Mother:	*No, nothing else.*
Health worker:	*After that or during the night, what other foods or drinks did (child's name) have?*
Mother:	*(Child's name) breastfeeds during the night but he had no more foods.*
Health worker: **(show typical bowl)**	*Using this bowl, can you show me about how much food (child's name) ate at his main meal yesterday?*
Mother:	(Points to bowl) *About half of that bowl.*
Health worker:	*Thank you. Who helps (child's name) to eat, or does he eat by himself?*
Mother:	*Oh, yes. (Child's name) needs help. Usually I help him, but sometimes if my mother or sister is there, they will help also.*
Health worker:	*Is (child's name) taking any vitamins or minerals?*
Mother:	*No, not now.*
Health worker:	*Thank you for telling me so much about what (child's name) eats.*

▸ Make the following points:

- Now we will have the "counsellor" going through the ANALYSE step of the counselling process, "thinking out loud" about the information the mother provided. The "counsellor" will review what the mother said and was recorded in the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS, comparing the findings with the age-appropriate feeding recommendations, as included in the REFERENCE TOOL: FOOD INTAKE – 6 UP TO 24 MONTHS.
- As you can see from the example form on page 471 in your *Participant's manual* (page 792 in the *Trainer's guide*), the health worker has gathered information on the foods the child ate the previous day and filled in the second column.
- The "counsellor" will demonstrate the process and may engage you to determine what you have heard.

This part of the process is facilitated by the trainer/facilitator acting as counsellor. They may ask all or some of the questions to the participants, as part of the process of analysis of information provided by the mother.

- Let us go through the questions:
- *Ask: Do the growth curves show appropriate growth?*

▶ **Wait for a few replies and then continue.**

- Yes, however, it is only going upwards very slowly.
- *Ask: Does the child receive breast milk?*

▶ **Wait for a few replies and then continue.**

- Yes, frequently. A practice to praise.
- *Ask: How many meals were of a thick consistency?*

▶ **Wait for a few replies and then continue.**

- Two, the porridge and the evening meal of rice, mashed greens and fish. However, the soup given at lunch time was thin, so this might be something to discuss with the mother.

▶ **The variety of foods eaten is looked at next.**

- *Ask: Did the child eat an animal-source food yesterday?*

▶ **Wait for a few replies and then continue.**

- Yes, fish in the evening.
- *Ask: Did he eat a dairy product?*

▶ **Wait for a few replies and then continue.**

- Yes, there was milk on the porridge.
- *Ask: Did he eat pulses or nuts yesterday?*

▶ **Wait for a few replies and then continue.**

- Yes, beans at midday. And the child had juice with the meal, which helps iron absorption.
- *Ask: Did the child eat a dark-green or yellow-coloured fruit or vegetable yesterday?*

▶ **Wait for a few replies and then continue.**

- Yes, some papaya in the morning, some green vegetables in the evening, maybe some green or yellow vegetables in the pot at midday. If you need to, you can ask for more information about the kinds of vegetables. However, do not ask many questions about details if the answers are not important. In this example, you have learnt by listening that the child had some green vegetables and a yellow fruit so has met the recommendation. You do not need to ask more questions about types of vegetables.
- Then we check the frequency of meals and the amount of food.
- *Ask: How many meals and snacks did the child have?*

▶ **Wait for a few replies and then continue.**

- Three meals and one snack.
- *Ask: Is three meals and one snack adequate for this child aged 11 months?*

▶ **Wait for a few replies and then continue.**

- Yes, it is adequate.
- *Ask: Was the quantity of food eaten at the main meal adequate for the child's age?*

- **Wait for a few replies and then continue.**
  - Yes, the child is 11 months old and received about half of a bowl.
  - *Ask: Does the mother assist with eating?*
- **Wait for a few replies and then continue.**
  - Yes.
  - *Ask: Was the child given any vitamins or mineral supplements?*
- **Wait for a few replies and then continue.**
  - Not at this time. There is no Key message about vitamins or mineral supplements. However, if the child is not eating animal-source foods and is not likely to eat them, he may need an iron supplement.
  - *Ask: Was the child healthy and eating?*
- **Wait for a few replies and then continue.**
  - Yes.
- **Make the following points:**
  - This summary helps you to pick out the practices to praise and specific Key messages to give to this mother. If the mother has not mentioned that the child has received some of the food items or practices listed in the column, then the health worker should ask the mother directly. If an answer is unclear, you can ask for more information.
  - Now the "counsellor" has to ACT; that is the third step of the counselling process. To do that they need to choose which practices to praise and 2–3 Key messages to discuss.
  - *Ask: What practices of this mother could you praise and support to continue?*
- **Wait for a few replies and then continue.**
- **Write the points that participants suggest on the flipchart. Refer to these responses as you make the following points.**
  - This mother had many good practices you could praise and support:
    - continuing breastfeeding
    - frequent meals and snacks
    - variety of foods used including staple, some animal-source foods, fruit and vegetables
    - thick consistency for some meals
    - assistance with eating.
  - *Ask: What are the main points to give relevant information on? What Key message could you give to this mother?*
- **Wait for a few replies and then continue.**

Completed Job aid: Food intake – 6 up to 24 months for Demonstration 62.A

Enter a ✓ in the Yes column if the practice is in place.

Enter your initials if a message is given (see Reference tool: Food intake – 6 up to 24 months for the message).

Job aid: Food intake – 6 up to 24 months

Child's name:

Date of birth: **Age of child at visit:** 11 months

Feeding practice	Yes / number where relevant	Key message given
Growth appropriate?	Slow weight gain	
Child received breast milk?	✓	
How many meals of a thick consistency did the child eat yesterday? (use Food consistency pictures as needed)	2 times: at breakfast and dinner	Yes
Child ate an animal-source food yesterday (meat/fish/offal/bird/eggs)?	✓ fish in the evening	
Child ate a dairy product yesterday?	✓ milk in the porridge	
Child ate pulses, nuts or seeds yesterday?	✓ beans at midday	
Child ate a dark-green or yellow vegetable or yellow fruit yesterday?	✓ papaya at breakfast and greens in the evening	
Child ate sufficient number of meals and snacks yesterday, for their age?	✓ 3 meals and 1 snack	
Quantity of food eaten at main meal yesterday appropriate for child's age?	✓	
Caregiver assisted the child at mealtimes?	✓	
Child took any vitamin or mineral supplements?	—	
Child ill or recovering from an illness?	—	

- After you had praised the practices, you would then discuss:
  - the amount of food in each meal – suggest increasing so that by 12 months the child has a full bowl
  - to make the food a thick consistency at each meal (remember the bean and vegetable meal was thin).

► Ask participants to pay attention to the third part of the process of counselling. This phase will include the use of Counselling cards.

► After the process is over, make the following point:

- For this particular child, the growth curve was only rising very slowly. Therefore, the amount of food at each meal and giving a thick consistency are particularly important suggestions to discuss.
- Gather all the information first and then discuss practices that could be improved with the mother, giving the relevant Key messages.
- The health worker put her initials at the Key messages she discussed.
- You will have an opportunity to practise how to gather information on feeding practices with actual mothers later in the course.

V. Summarize the session 5 minutes

► Make these points:

- In this session, we looked at various ways of gathering information on complementary feeding practices. This included observation, listening, using growth charts and asking questions.
- We also discussed the Job aid: Food intake – 6 up to 24 months, which will be used in Clinical practice session 8.
- If the child is ill on that day and not eating, give the Key message 10: Encourage the child to drink and eat during illness, and provide extra food after illness to help them recover quickly.

► Ask participants whether they have any questions, and try to answer them.

► Explain that a summary of this session can be found on pages 465–471 of the *Participant's manual*.

Enter a ✓ in the Yes column if the practice is in place.

Enter your initials if a message is given (see REFERENCE TOOL: FOOD INTAKE – 6 UP TO 24 MONTHS for the message).

JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS

Child's name:

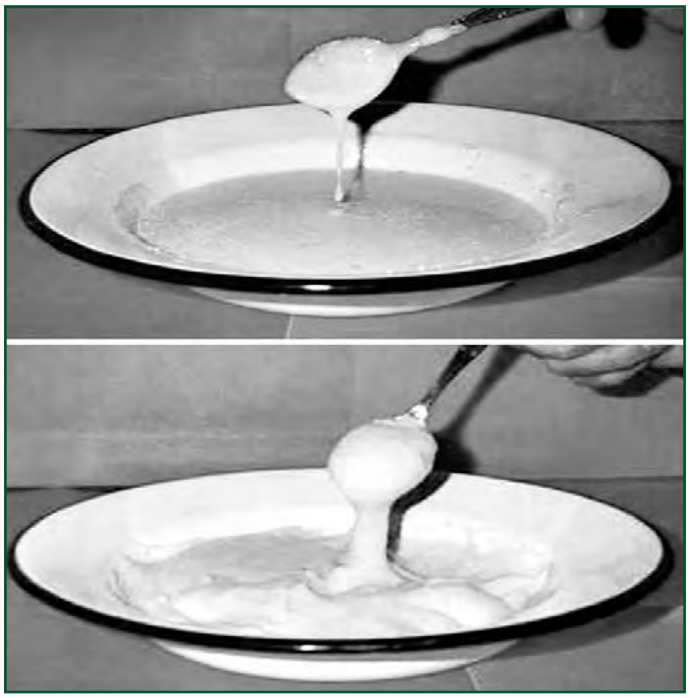
Date of birth: **Age of child at visit:**

Feeding practice	Yes / number where relevant	Key message given
Growth appropriate?		
Child received breast milk?		
How many meals of a thick consistency did the child eat yesterday? (use FOOD CONSISTENCY PICTURES as needed)		
Child ate an animal-source food yesterday (meat/fish/offal/bird/eggs)?		
Child ate a dairy product yesterday?		
Child ate pulses, nuts or seeds yesterday?		
Child ate a dark-green or yellow vegetable or yellow fruit yesterday?		
Child ate sufficient number of meals and snacks yesterday, for their age?		
Quantity of food eaten at main meal yesterday appropriate for child's age?		
Caregiver assisted the child at mealtimes?		
Child took any vitamin or mineral supplements?		
Child ill or recovering from an illness?		

Reference tool: Food intake – 6 up to 24 months

Feeding practice	Ideal feeding practice	Key messages to help counsel mothers
Growth appropriate?		*Look at the shape of the growth curve of the child: is the child growing?*
Child received breast milk?	Yes	Breastfeeding for 2 years or longer helps a child to develop and grow strong and healthy
How many meals of a thick consistency did the child eat yesterday? (use Food consistency pictures as needed)	3 meals	Foods that are thick enough to stay on the spoon give more energy to the child
Child ate an animal-source food yesterday (meat/fish/offal/bird/eggs)?	Animal-source foods should be eaten daily	Animal-source foods are especially good for children, to help them grow strong and lively
Child ate a dairy product yesterday?	Try to give dairy products daily	Animal-source foods are especially good for children, to help them grow strong and lively
Child ate pulses, nuts or seeds yesterday?	If meat is not eaten, pulses or nuts should be eaten daily, with an iron enhancer such as a vitamin-C-rich food	Peas, beans, lentils, nuts and seeds are good for children
Child ate a dark-green or yellow vegetable or yellow fruit yesterday?	A dark-green or yellow vegetable or yellow fruit should be eaten daily	Dark-green leaves and yellow-coloured fruits and vegetables help the child to have healthy eyes and fewer infections
Child ate sufficient number of meals and snacks yesterday, for their age?	Child 6–8 months: 2–3 meals plus 1–2 snacks if hungry Child 9–24 months: 3–4 meals plus 1–2 snacks if hungry	A growing child needs 2–4 meals a day, plus 1–2 snacks if hungry: give a variety of foods
Quantity of food eaten at main meal yesterday appropriate for child's age?	Child 6–8 months: gradually increased to approx. ½ cup at each meal Child 9–11 months: approx. ½ cup at each meal Child 12–24 months: approx. ¾–1 cup at each meal	A growing child needs increasing amounts of food
Caregiver assisted the child at mealtimes?	Yes, assists with learning to eat	A young child needs to learn to eat: encourage and give help … with lots of patience
Child took any vitamin or mineral supplements?	Vitamin and mineral supplements may be needed if child's needs are not met by food intake	*Explain how to use vitamin and mineral supplements if they are needed*
Child ill or recovering from an illness?	Continue to eat and drink during illness and recovery	Encourage the child to drink and eat during illness, and provide extra food after illness to help them recover quickly

Food consistency pictures



Notes

Notes (contd)

Notes (contd)

SESSION 63

Investigating causes of undernutrition

Objectives

After completing this session participants will be able to:

- explain when to investigate causes of undernutrition
- identify the key sections of the JOB AID: INVESTIGATING CAUSES OF UNDERNUTRITION
- explain how to use the Job aid
- identify the eight steps involved in investigating causes and counselling for undernutrition

Session outline . . . . . 60 minutes

Participants are all together for a lecture presentation by one trainer, followed by a demonstration, and group discussion with all trainers.

I. Introduce the session, present **Slide 63/1** . . . . . 2 minutes
II. Present **Slides 63/2** to **63/6** . . . . . 26 minutes
III. Investigating causes of Nalah's undernutrition (DEMONSTRATION 63.A) . . . . . 15 minutes
IV. Discussion: possible causes of Nalah's undernutrition . . . . . 15 minutes
V. Summarize the session . . . . . 2 minutes

Preparation

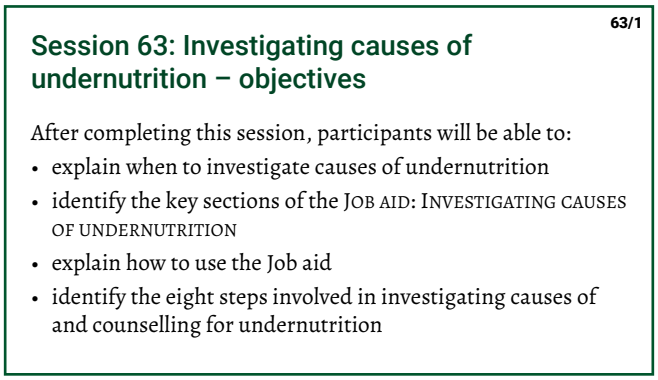
- Refer to the Introduction for guidance on giving a presentation with slides, giving a demonstration and facilitating group discussion.
- Study the **Slides 63/1** to **63/6** and the text that goes with them, so that you are able to present them.
- Ask two people to assist with DEMONSTRATION 63.A. Show them the text and ask them to read it through.
- You need a flipchart and markers.
- You need tape or other means of fixing the page to the wall or board.

As you follow the text, remember:

- ▸ **indicates an instruction to you, the trainer.**
- ¤ indicates what you say to participants.

I. Introduce the session — 2 minutes

► Show **Slide 63/1 – Session 63 – objectives** and read out the objectives:

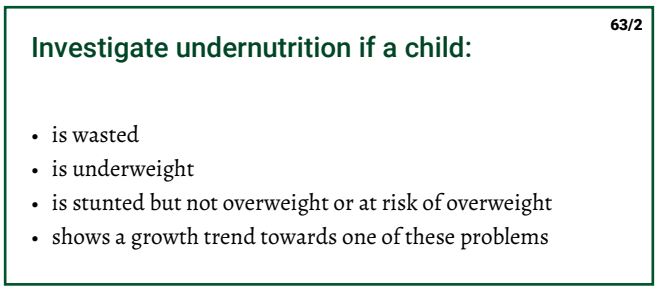


II. Present **Slides 63/2** to **63/6** — 26 minutes

► Make these points:

- When growth assessment reveals a problem of undernutrition, your focus in the counselling session will be to find out from the mother or caregiver what the likely underlying causes are. Recall the conceptual framework on the causes of malnutrition as you discuss with the caregiver what might be the immediate or underlying causes.

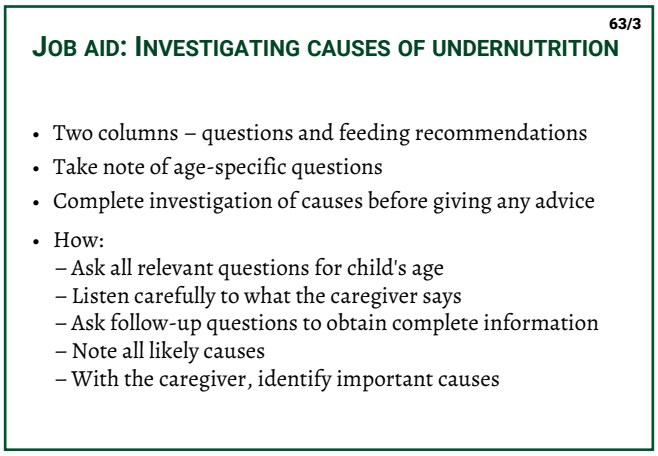
► Show **Slide 63/2 – Investigate undernutrition** if a child: and make the following points:



► Make these points:

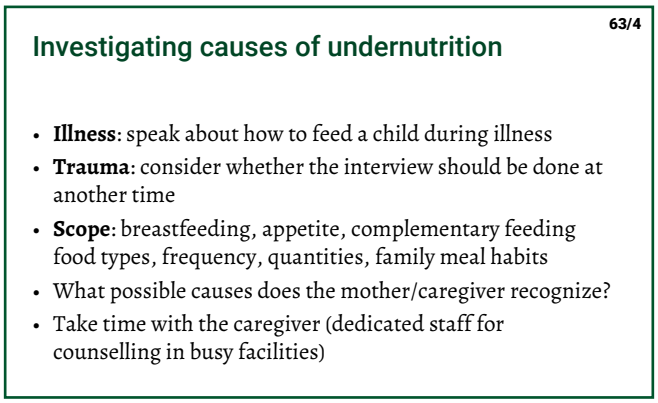
- It is important to investigate the causes of the problem before counselling the mother or caregiver.
- This investigation should be carried out for any child who:
  - Is wasted (below –2 z-scores for weight-for-length/height)
  - is underweight (below –2 z-scores for weight-for-age)
  - is stunted (below –2 z-scores for length/height-for-age) and not overweight or at risk of overweight
  - shows a growth trend towards one of these problems.

▸ Show **Slide 63/3 – Job aid: Investigating causes of undernutrition** and make the following points:



- Use the Job aid: Investigating causes of undernutrition provided with this course. The left-hand side of this Job aid lists questions to ask the caregiver. The right-hand side lists advice to be given, depending on the caregiver's answers. Some pages of the Job aid are used only for children in a specific age group, while others apply to all children.
- To use the Job aid, first ask all of the relevant questions about causes. Give advice only after the investigation of causes is complete, so that you can tailor your advice to the most important causes.
- To investigate causes of undernutrition:
  - ask all the relevant questions for the child's age
  - listen carefully to the caregiver's answers.
  - ask follow-up questions as needed, to get complete information to understand the causes of the child's undernutrition.
  - note causes that are applicable for the child.
- If there are many applicable causes, try to identify the most important ones. Ask the caregiver for their opinion about which causes are most important. You may comment on causes as they are discovered, but give advice only when the investigation of causes is complete.

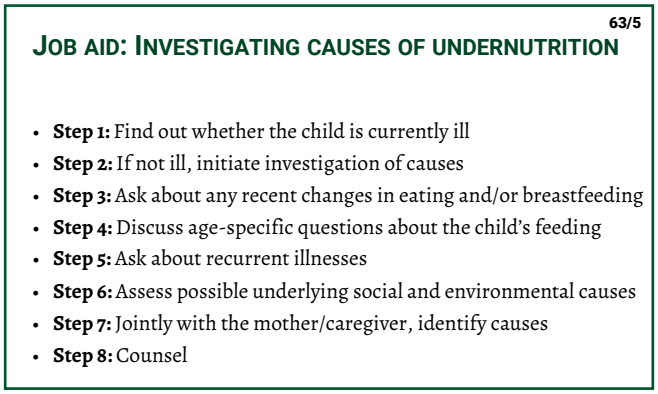
▸ Show **Slide 63/4 – Investigating causes of undernutrition** and make the following points:



- If the child is currently ill or has a chronic disease that could be a cause of undernutrition, treat the child (or refer the child for treatment) rather than completing the entire interview about causes. Also advise the caregiver how to feed the child during illness, using the feeding recommendations for the child's age group in the Growth record. When the child returns for follow-up, you can investigate other possible reasons for the undernutrition.

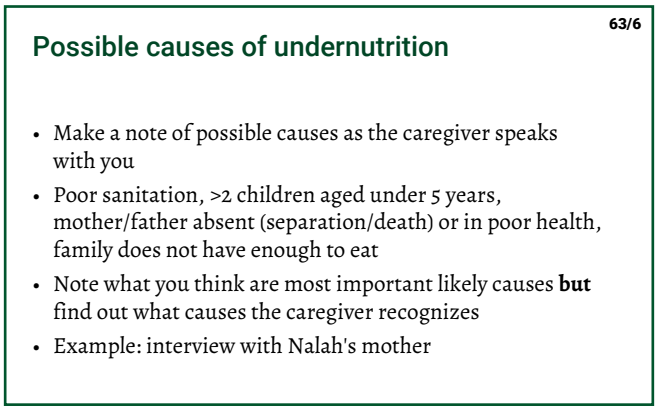
- If the child has experienced a trauma (such as death in the family or a change in caregiver), this may be a contributing factor to a decrease in food intake. In this type of situation, assess whether it would be better to wait to conduct the interview at a later time.
- Questions in the interview are related to breastfeeding, the child's appetite, the types and variety of foods given, the frequency of feeding, family mealtime habits, illnesses, recent trauma, and social and environmental factors that may contribute to undernutrition. The interview also includes a question to ask the caregiver directly what they think the causes may be.
- The interview requires taking time with the caregiver, but taking this time is critical, in order to identify the most relevant and helpful advice. In a busy health facility, it may be necessary to assign specific health-care providers to the tasks of interviewing and counselling mothers and caregivers.

▸ Show **Slide 63/5 – Job aid: Investigating causes of undernutrition** and make the following points:



- Here is a summary of the steps to follow when investigating causes of undernutrition. We will go through the Job aid page by page and step by step:
- **Top page:** The questions for investigating causes are **age specific for Steps 1–4.** The relevant page references are summarized on the top page, to help you go directly to the relevant pages for the child's age, e.g. for age 1–2 years, refer to pages 6 and 7:
  - **Step 1:** Find out whether the child is currently ill
  - **Step 2:** If not ill, initiate investigation of causes
  - **Step 3:** Ask about any recent changes in eating and/or breastfeeding)
  - **Step 4:** Discuss age-specific questions about the child's feeding
- **Steps 5–8 apply to children of all ages** and are presented on pages 10 and 11:
  - **Step 5:** Ask about recurrent illnesses
  - **Step 6:** Assess possible underlying social and environmental causes
  - **Step 7:** Jointly with the mother/caregiver, identify causes
  - **Step 8:** Counsel (page 11 and refer back to appropriate age-group pages)
- Take time now to study the Job aid: Investigating causes of undernutrition. Focus on the questions listed on the left-hand side. Remember that you will ask all of the relevant questions for the child's age, listen to the mother's or caregiver's replies, and determine the most important causes of undernutrition before giving advice.

▸ Show **Slide 63/6 – Possible causes of undernutrition** and make the following points:



- While interviewing the caregiver, you may note several possible causes of undernutrition, for example, feeding practices that differ from the recommendations for the child's age. You may also note sanitation problems that could cause illnesses leading to undernutrition. In addition, you may note social and environmental factors that could affect the child's feeding and care. Some examples follow.
- If three or more children under 5 years of age live in the household, the child is at risk of undernutrition and neglect. The risk is decreased if there are two or more people who share responsibilities for child feeding and care.
- If there is no mother or no father present in the household (e.g. owing to family separation or death), or if one parent is not involved in the child's care, the child's risk of undernutrition and neglect is increased.
- If the mother or father is not in good health, the child's risk is increased.
- If the caregiver states that there is not usually enough food to feed the family, they are facing serious obstacles and need food assistance as well as advice.
- When there are several possible causes of undernutrition, it is helpful to focus on the main causes that can be changed. After asking the questions in the interview, ask the caregiver's opinion of the causes, so that you know which causes they recognize. Then summarize what you see as the main causes. The next exercise includes an example of an interview with the mother of an undernourished child.

III. Investigating causes of Nalah's undernutrition — 15 minutes

▸ **For this demonstration, ask two participants to act out a script of an interview with Nalah's mother.**

▸ **Explain that the scripted interview follows the JOB AID: INVESTIGATING THE CAUSES OF UNDERNUTRITION. The steps are labelled in the script. Preview the script as follows:**

- Step 1 is covered in the background information and at the beginning of the interview, when the nurse explains the nutritional problem to Mrs Parab.
- (The nurse locates the pages in the Job aid for a baby aged 6 months to 1 year.)
- In Step 2, the nurse asks permission to interview the mother about causes of the problem.
- Since Nalah is not ill, the nurse will do Step 3 of the Job aid (asking about breastfeeding).
- Then the nurse will go to Step 4 and ask questions about feeding from that page.
- The nurse will then ask the questions intended for children of all ages (Steps 5 and 6).
- This script will end with Step 7, identifying likely causes of undernutrition. The next session will deal with counselling to address these causes.

Demonstration 63.A Investigating causes of undernutrition

Script 1: Dialogue with Nalah's mother about the causes of undernutrition

- Ask participants to follow along in the script (pages 475–477 in their *Participant's manual*) and mentally compare the mother's answers about feeding to the recommended practices for Nalah's age group, to identify possible causes of her undernutrition, and to notice which Listening and learning skills the nurse applies.
- Give to the group the following background information:
  - Nalah is now 6 months old and has visited the health centre five times since her birth. Nalah is the only child at home, living with her mother and father. Both parents are in good health; neither is known to be HIV positive. Her growth has been charted in the Girl's growth record. Because Nalah is below the –2 *z*-score line in both length-for-age and weight-for-age, the nurse will counsel the mother, Mrs Parab, about growth and feeding. Before giving any advice, the nurse will interview Mrs Parab about Nalah's feeding and the home situation, in order to find out possible causes of her undernutrition.

Step 1: Nalah is not currently ill and has no known chronic disease.

Nurse:	*Thank you for bringing Nalah back again, Mrs Parab. Now that we have measured and weighed her, let's take a minute to talk, shall we?*
Mrs Parab:	*Of course.*
Nurse:	(Showing the Growth charts) *As you can see from her length chart, Nalah was an average length at birth and she could have grown along this green line if all was going well. But we can see that she is a lot shorter than an average girl of 6 months. Her weight also is a lot lower than the average. Since her growth in both weight and length have slowed down together, she does not look too thin. But we want her to grow longer and to gain weight.*
Mrs Parab:	*What should we do?*

Step 2: The nurse begins at page 4 of the Job aid, since Nalah is 6 months old.

Nurse:	*Well, since Nalah has not been ill, I think we should focus on her feeding. Do you mind if I ask you some questions so that we can better understand the reasons why her growth has slowed down?*
Mrs Parab:	*That would be fine.*

Step 3:

Nurse:	*Alright then, has Nalah been breastfeeding less or eating less than usual?*
Mrs Parab:	*Maybe less, because it's hard to breastfeed when I have to go to work. Sometimes I have to leave her with my neighbour.*

Step 4:

Nurse:	*So you are still breastfeeding?*
Mrs Parab:	*Yes, when I can.*
Nurse:	*That's good. How many times is that during a day and a night?*
Mrs Parab:	*When I have Nalah with me at work, I breastfeed about four or five times from morning until night. If she stays with my neighbour, I can only breastfeed twice, once in the morning and once at night.*
Nurse:	*Do you have any difficulty with breastfeeding itself? Is Nalah attaching well to the breast and emptying the breasts whenever she breastfeeds?*
Mrs Parab:	*Well, I have never thought about that. I was told that I should feed her from both breasts, so sometimes I switch to the other breast before the first is empty.*
Nurse:	*That is something we can look at together in a moment. Do you give Nalah any other fluids besides breast milk?*
Mrs Parab:	*I sometimes have given her water, and I leave her some milk when she stays with my neighbour.*
Nurse:	*What kind of milk?*
Mrs Parab:	*I buy it at the shop. It's cow's milk from a tin.*
Nurse:	*Do you add any water to it?*
Mrs Parab:	*No, because it already looks thin to me.*
Nurse:	*How many times does the neighbour give her the milk?*
Mrs Parab:	*Twice, I think.*
Nurse:	*And how does she feed Nalah the milk?*
Mrs Parab:	*In a cup.*
Nurse:	*That is good. Do you or the neighbour give Nalah any semi-solid or solid foods?*
Mrs Parab:	*My neighbour gives her some porridge if she seems hungry after the milk.*
Nurse:	*How often is that?*
Mrs Parab:	*Not more than once a day.*
Nurse:	*How does the neighbour feed Nalah the porridge?*
Mrs Parab:	*With a spoon.*
Nurse:	*Have you offered Nalah any porridge at home?*
Mrs Parab:	*Not yet.*

Step 5:

Nurse:	*Let me just ask you a few more questions about Nalah's health and your home.Is Nalah often tired, or sick with diarrhoea, cough, or fever?*
Mrs Parab:	*Nalah does not seem strong to me. She sometimes has a runny nose, and she likes to be held. She does not move around a lot but lies still.*

Step 6:

Nurse:	*Tell me about where you live. Do you have a latrine or toilet?*
Mrs Parab:	*No, we live in a poor area. There is a common latrine for many houses.*
Nurse:	*Where do you get water?*
Mrs Parab:	*We get water from a tap in the yard, and once a week I buy water in large cans.*
Nurse:	*Do you boil or treat your water?*
Mrs Parab:	*I boil the drinking water, but not the water for washing dishes.*
Nurse:	*It is very good that you boil the water for drinking. How is water stored in your home?*
Mrs Parab:	*I just keep it in the same cans that we buy it in.*
Nurse:	*How many people are living at home now?*
Mrs Parab:	*Just me, my husband and Nalah.*
Nurse:	*And how is your health?*
Mrs Parab:	*We are fine, although I am very tired, I must admit.*
Nurse:	*Does Mr Parab help with Nalah?*
Mrs Parab:	*He is out looking for construction work most days, but he helps a bit.*
Nurse:	*Do you have enough food to feed the family?*
Mrs Parab:	*We have enough to manage.*

Step 7:

Nurse:	*What do you think is the most important reason for Nalah's small size and tiredness?*
Mrs Parab:	*Well, I thought she looked small but I did not know why. Maybe she needs more food. I wish that I could stay home and breastfeed more...*
Nurse:	*Yes, that would be good if you can do it. From what you have said, it seems to me that Nalah may be growing slowly for a number of reasons, but most probably because she is not getting enough food. Please put her to the breast for a feed so we can see whether she attaches well, and let's speak more about the emptying of the breasts.*

IV. Discussion: possible causes of Nalah's undernutrition — 15 minutes

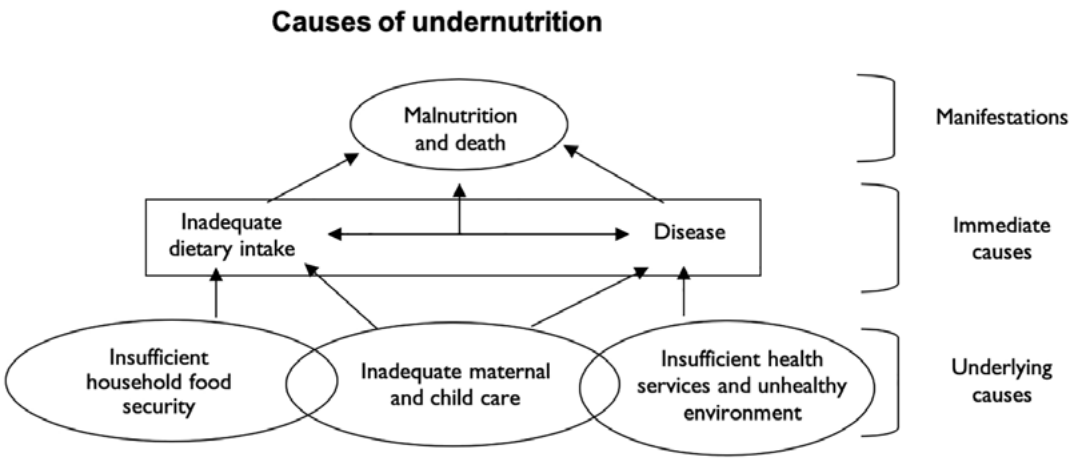
- Lead the discussion on possible causes of Nalah's undernutrition
- List these causes on the flipchart or blackboard. Focus on causes rather than possible solutions or advice to give the mother. Solutions and advice will be the focus of the next exercise.
- Recall the LISTENING AND LEARNING SKILLS and ask participants to mention which ones the nurse used in her dialogue with Mrs Parab (helpful non-verbal communication, open questions, responses and gestures that show interest, reflecting back what the mother says, empathizing, and avoiding judging words).
- There might be other questions that participants feel should have been asked (e.g. when was porridge started and why?). However, in a health facility where many other mothers and children may be waiting to be seen, the health worker will be trying to keep the interview brief, so this is not an exhaustive investigation.
- Wrap up the discussion by classifying all the causes listed as one of the three main causes of undernutrition discussed in Session 62 and shown in the figure on page 477 of the *Participant's manual* and page 807 of the *Trainer's guide*: insufficient household food security; inadequate maternal and child care; and insufficient health services and unhealthy environment.

V. Summarize the session 2 minutes

- Ask participants whether they have any questions, and try to answer them.
- Explain that a summary of this session can be found on pages 473–477 of the *Participant's manual*.

LISTENING AND LEARNING SKILLS

1. Use helpful non-verbal communication
2. Ask open questions
3. Use responses and gestures that show interest
4. Reflect back what the mother/caregiver says
5. Empathize – show that you understand how the mother/caregiver feels
6. Avoid using words that sound judging



Notes

Notes (contd)

SESSION 64

Counselling a mother or caregiver whose child has undernutrition

Objectives

After completing this, session participants will be able to:

- involve the mother or caregiver in identifying possible causes of undernutrition
- find age-appropriate advice for the problem identified
- set goals for improving the growth of an undernourished child
- provide examples of checking questions to use when counselling

Session outline . . . . . 40 minutes

Participants are all together for a lecture presentation by one trainer, followed by a demonstration, and group discussion with all trainers.

I. Introduce the session, present **Slide 64/1** . . . . . 2 minutes
II. Present **Slides 64/2** and **64/3** . . . . . 14 minutes
III. Counselling Nalah's mother (DEMONSTRATION 64.A) . . . . . 10 minutes
IV. Discussion . . . . . 12 minutes
V. Summarize the session . . . . . 2 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides, giving a demonstration and facilitating group discussion.
- Study the **Slides 64/1** to **64/3** and the text that goes with them, so that you are able to present them.
- Ask two people to assist with DEMONSTRATION 64.A. Show them the text and ask them to read it through.
- You need a flipchart and markers.
- You need tape or other means of fixing the page to the wall or board.

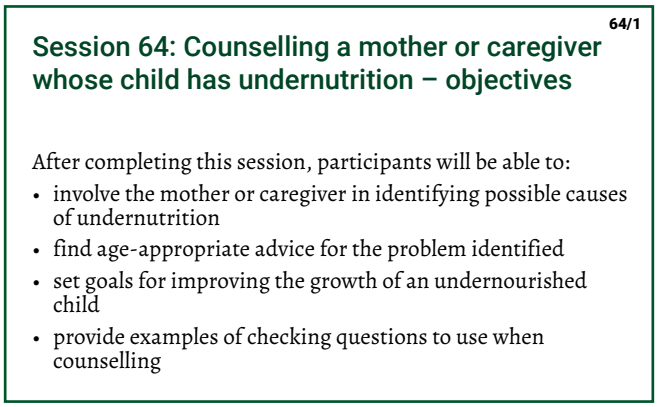
As you follow the text, remember:

► **indicates an instruction to you, the trainer.**

¤ indicates what you say to participants.

I. Introduce the session — 2 minutes

► Show **Slide 64/1 – Session 64 – objectives** and read out the objectives:

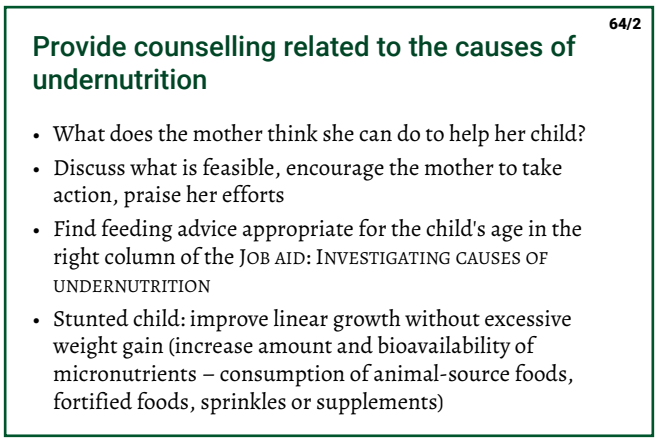


II. Present **Slides 64/2** and 64/3 — 14 minutes

► Make the following remarks

- In the previous session, we, as health workers, identified possible causes of Nalah's undernutrition, but what does the mother think? It is important to find out whether she recognizes the problem in the same way and then to find out what she can do to improve her child's growth. The goal set for improving the child's growth is jointly set by the mother or caregiver and the health worker.

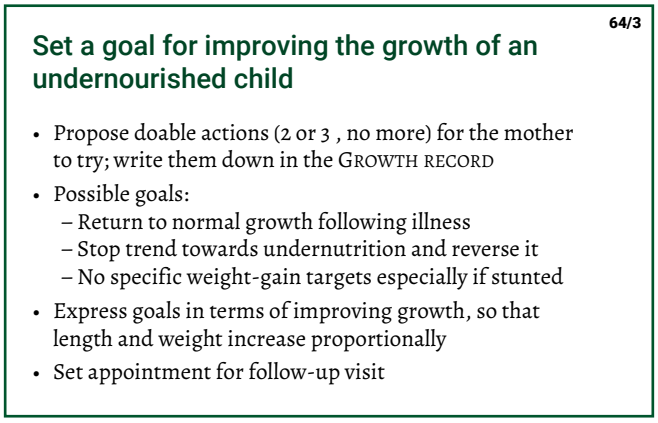
► Show **Slide 64/2 – Provide counselling related to the causes of undernutrition** and make the following points:



- During the first part of the interview with the mother or other caregiver, you summarized the possible causes of the child's undernutrition and determined which causes seemed most applicable and important. Next, focusing on the main causes that the mother or caregiver recognizes as important, ask them: "What do you think that you can do to help the child, given these causes?".
- Then discuss what is feasible to do and who can provide help and support. Acknowledge any difficulties in the mother's situation. Encourage the caregiver to take action.
- Specific advice related to feeding is given on the right-hand side of the Job aid: Investigating causes of undernutrition, next to the related questions. If you noted that a feeding practice differs from what is recommended, explain the recommended practice. Also commend the caregiver if they are following some of the recommendations.
- If there are many causes of undernutrition, there may be much applicable advice, but the caregiver will only be able to remember a limited number of actions to take. Limit your advice to two or three actions that are most important and feasible.

- A **stunted child** whose weight-for-length/height is within normal range needs a diet that will improve their growth in length/height, without excessive weight gain that could result in overweight or obesity. Rather than increasing their energy intake, a strategy for such children is to improve the amount and bioavailability of micronutrients in their diet, by increasing their consumption of animal-source foods. Animal-source foods are high in micronutrients, and many minerals are better absorbed from meat than they are from plant-derived foods.[1] Among vegetarian populations, or where access to a micronutrient-adequate diet is limited, strategies to improve micronutrient intake include using fortified foods and sprinkles or providing micronutrient supplements.

► Show **Slide 64/3 – Set a goal for improving the growth of an undernourished child** and make the following points:



- Since improvement in the child's growth may take some time, and the rate of improvement cannot be predicted, set goals for a few (two or three) actions that the caregiver can take towards improving the child's growth. Suggest actions that can be taken within a few weeks. You can praise and encourage the caregiver when they are accomplished. Make notes (e.g. in the GROWTH RECORD) of the underlying causes of undernutrition for discussion at follow-up visits, when goals may be set for additional actions to take.
- If the cause of the child's undernutrition is a recent illness, the goal is to return the child to their previous, normal growth line, in a reasonable amount of time, such as 3 months.
- If there are other causes of the child's undernutrition, the first goal is to stop the trend towards undernutrition and eventually reverse the trend. Stress that the caregiver can help to achieve these goals by following the recommendations discussed.
- Avoid setting any specific target for weight gain, especially for a stunted child. If the stunted child gains weight without increasing in length, they may become overweight. Express goals in terms of improving growth, so that the length and weight increase appropriately in relation to one another.
- At the end of the discussion with the mother or other caregiver, it is important to set a reasonable time for the child's next visit and to set a general goal for improved growth. The next visit may be at the time that an immunization is required, or at another convenient time.

[1] Allen LH, Gillespie SR. What works? A review of the efficacy and effectiveness of nutrition interventions., Manila: Asian Development Bank; 2001 (https://www.adb.org/sites/default/files/publication/27916/what-works-nutrition-interventions.pdf).

III. Counselling Nalah's mother — 10 minutes

► For this demonstration, ask two participants to act out a script of an interview with Nalah's mother.

Demonstration 64.A Counselling Nalah's mother

- Now we will continue listening to the conversation between Nalah's mother and the nurse. The three main actions suggested are indicated by numbers to the left of the script.
- Follow the conversation on page 480–481 of your *Participant's manual*.

Script 2: Conclusion of counselling session with Nalah's mother

Nurse: *Nalah's breast attachment is very good. Well done. Now, whenever you breastfeed, leave her to empty each breast so that she gets the hindmilk, which has more fat than the foremilk. Let's talk now about how frequently you can feed her. You said that you would like to stay home and breastfeed more. Is there any way that you could do that?*

Mrs Parab: *If my husband could get more work, I could stay home and breastfeed more.*

Nurse: ① *That would be helpful to Nalah if you can do it. Let's talk about some more ways to help Nalah. Let's look in the* Growth record *for the feeding recommendations for her age.* (The nurse opens the Growth record to pages 16–17, to show the recommendations to Mrs Parab.)
Since Nalah is now 6 months old, we need to follow the recommendations for infants who are 6 months to 1 year of age. You see that the first recommendation is to breastfeed as often as Nalah wants. Even if you cannot breastfeed more during the day, you could do it at night.
Nalah also needs a good soft staple food now that she is 6 months old. What kind of porridge is she eating at your neighbour's home?

Mrs Parab: *The porridge is made of maize meal.*

Nurse: ② *That is a fine staple food. You need to feed Nalah thick porridge 2–3 times each day, about 2–3 tablespoons* (shows amount with her hands or a spoon); *if she is already taking more than this, do not reduce the amount.*

Mrs Parab: *Should I give her any other foods?*

Nurse: ③ *Yes, but start just one new food at a time to be sure that she can tolerate it. For example, you can start giving some mashed fruit, such as banana. Let's look at the list of some appropriate foods on page 15 of Nalah's* Growth record.
The porridge will give Nalah energy, but she needs a variety of other foods for their nutrients to help her grow. Just remember to introduce them one at a time.

Mrs Parab: *But I don't have all of these foods. Foods such as chicken and butter are too expensive.*

Nurse: *You don't have to give those. Let's talk about what you do have. What animal-source foods can you give her?*

Mrs Parab: *I can get eggs, and sometimes fish or a bit of meat.*

Nurse: *That will do very well. Can you get leafy green and yellow-coloured vegetables and fruit?*

Mrs Parab: *Yes. For vegetables I can get pumpkin and chard. And banana and papaya for fruit.*

Nurse: *And do you have oil or fat that you could add a little to her food?*

Mrs Parab: *I have oil, but I think it causes constipation in babies.*

Nurse: *Oil should not cause constipation, but what it will do is to increase the energy in Nalah's food.*

Mrs Parab: *That all seems like too much food.*

Nurse: *Well, you will not give all of these foods every day. Remember, at first you will only give a small amount two or three times each day. And you will only introduce one new food every 3–4 days. Please tell me why you should introduce new foods one at a time.*

Mrs Parab: *To be sure that the new food does not make her sick.*

Nurse: *That's right.*

Mrs Parab: *What about breastfeeding? How long should I breastfeed?*

Nurse:	*Keep breastfeeding as often as Nalah wants to, day and night for 2 years or more.*
Mrs Parab:	*I hope that I can do that.*
Nurse:	*I think that if you feed Nalah the way that we have discussed, she will be better nourished and more lively. The food will help her grow and develop more. Now, to review, please tell me how you will feed Nalah for the next month.*
(checking question)	
Mrs Parab:	*I will try to breastfeed more often.*
Nurse:	*Good. What else?*
Mrs Parab:	*I will give her porridge.*
Nurse:	*OK. That's good. How much porridge and how often?*
Mrs Parab:	*About this much* (shows with hands) *two or three times a day.*
Nurse:	*Very good. And what other foods will you start giving, one at a time?*
Mrs Parab:	*Mashed banana, papaya, pumpkin.*
Nurse:	*What food will you give that comes from an animal?*
Mrs Parab:	*Eggs, most likely.*
Nurse:	*All of these foods will help Nalah grow. If you can feed her as we have agreed for 1 month, there should be a change in her health. Do you think that you could bring Nalah back next month?*
Mrs Parab:	*Yes, I can bring her back.*
Nurse:	*Good. We will weigh and measure her again. When she is getting enough food, you will see her being more active instead of lying still. We should also see her growing in length and weight. So, next month we will speak about her feeding needs at 7–8 months, and maybe also look for ways to prevent problems like the runny nose that you mentioned.*
Mrs Parab:	*Okay, I will bring her back in one month.*
Nurse:	*That's great. Let me write the date for that visit in her book. Of course, if Nalah gets sick or if you have any problems or questions, you can come sooner. I look forward to seeing you again.*
Mrs Parab:	*Thank you.*

IV. Discussion — 12 minutes

- **Recall the SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT and ask participants to mention briefly which ones the nurse used in her dialogue with Mrs Parab.**
- **List these on the flipchart or blackboard.**
- **Make these points:**
  - This script covered Step 8 of the JOB AID: INVESTIGATING CAUSES OF UNDERNUTRITION. The nurse counselled Mrs Parab using relevant advice from the right-hand side of the Job aid, as well as feeding recommendations for the age group 6 months to 1 year from the GROWTH RECORD.

V. Summarize the session — 2 minutes

- **Ask participants whether they have any questions, and try to answer them.**
- **Explain that a summary of this session can be found on pages 479–481 of the *Participant's manual*.**

SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT

1. Accept what a mother/caregiver thinks and feels
2. Recognize and praise what a mother/caregiver and baby are doing right
3. Give practical help
4. Give a little, relevant information
5. Use simple language
6. Make one or two suggestions, not commands

Notes

SESSION 65

Investigating causes and counselling a mother or caregiver whose child is overweight

Objectives

After completing this session, participants will be able to:

- explain when to investigate causes of overweight
- identify the key sections of the JOB AID: INVESTIGATING CAUSES OF OVERWEIGHT
- identify the five steps involved in investigating causes of and counselling for overweight
- involve the mother in identifying possible causes of overweight
- set goals for improving the growth of a child who is overweight

Session outline . . . . . 60 minutes

Participants are all together for a lecture presentation by one trainer, followed by a demonstration and group discussion with all trainers.

I.	Introduce the session, present **Slide 65/1**	2 minutes
II.	Present **Slides 65/2** to **65/4**	10 minutes
III.	Investigating causes of Toman's overweight (DEMONSTRATION 65.A)	10 minutes
IV.	Discussion: possible causes of Toman's overweight	15 minutes
V.	Present **Slides 65/5** and **65/6**	10 minutes
VI.	Counselling Toman's mother about causes of overweight (DEMONSTRATION 65.B)	6 minutes
VII.	Discussion	5 minutes
VIII.	Summarize the session	2 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides, giving a demonstration and facilitating group discussion.
- Study the **Slides 65/1** to **65/6 a**nd the text that goes with them, so that you are able to present them.
- Ask two people each to assist with DEMONSTRATIONS 65.A and 65.B. Show them the texts and ask them to read them through.
- You need a flipchart and markers.
- You need tape or other means of fixing the page to the wall or board.

As you follow the text, remember:

► **indicates an instruction to you, the trainer.**

¤ indicates what you say to participants.

I. Introduce the session — 2 minutes

► Show **Slide 65/1 – Session 65 – objectives** and read out the objectives:

65/1

Session 65: Investigating causes and counselling a mother or caregiver whose child is overweight – objectives

After completing this session, participants will be able to:

- explain when to investigate causes of overweight
- identify the key sections of the JOB AID: INVESTIGATING CAUSES OF UNDERNUTRITION
- identify the five steps involved in investigating causes of and counselling for overweight
- involve the mother in identifying possible causes of overweight
- set goals for improving the growth of a child who is overweight

II. Present Slides 65/2 to 65/4 — 10 minutes

► Show **Slide 65/2 – Investigate causes of overweight if a child:** and make the following points:

65/2

Investigate causes of overweight if a child:

- is overweight (above 2 *z*-scores weight-for-length/height)
- shows a growth trend towards overweight
- is stunted and overweight or at risk of overweight
- is obese (where there is no referral system for the specialized management of obesity)

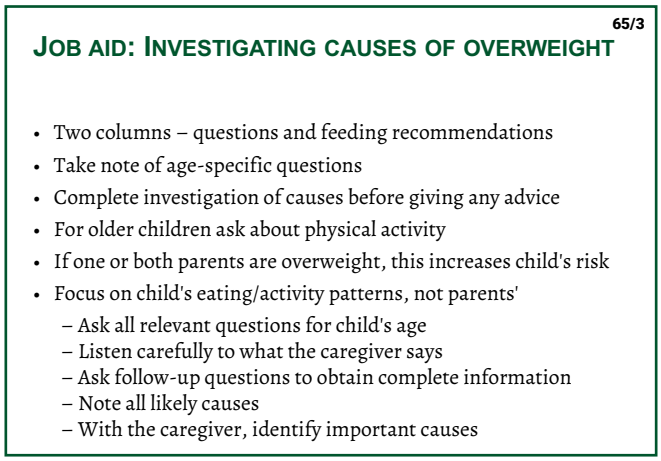
¤ As with problems of undernutrition, it is important to investigate the causes of overweight before giving advice to the mother or caregiver. Investigate the causes by interviewing the caregiver of any child who:

- is overweight (above 2 *z*-scores for weight-for-length/height)
- has a growth trend towards overweight (above 1 *z*-scores for weight-for-length/height, with a trend towards the 2 *z*-score line).

¤ A **stunted** child can be overweight or obese.

¤ **Note:** Obese children (above 3 *z*-scores) need referral for medical assessment and specialized management. If there is a referral system for obese children, refer them. If not, interview the mother or caregiver about causes and counsel them as you would for a child who is overweight.

▶ Show **Slide 65/3 – Job aid: Investigating causes of overweight** and make the following points:



- Use the Job aid: Investigating causes of overweight provided with this course. The left-hand side of this job aid lists questions to ask the caregiver. The right-hand side lists advice to be given, depending on the caregiver's answers. Some questions in the Job aid are used only for children in a specific age group, while others apply to all children.
- To use the Job aid, first ask all of the relevant questions about causes. Give advice only after the investigation of causes is complete, so that you can tailor your advice to the most important causes.
- To investigate the causes of overweight:
  - ask all the relevant questions for the child's age
  - listen carefully to the caregiver's answers
  - ask follow-up questions as needed, to get complete information to understand the causes of the child's overweight
  - note causes that are applicable for the child.
- To identify the causes of overweight, you will ask the caregiver questions about the child's diet and frequency of feeding/eating. For older children, also ask about leisure activities (such as hours spent watching television) and their level of physical activity. Take care to ask these questions in a sensitive way that will not offend the caregiver or imply that they are at fault. If a child is being fed too much or too often, ask follow-up questions to determine why. Particularly in late infancy (age 6–12 months), a child may be overfed by parents who are anxious to keep up the child's weight. Knowing the reasons for overfeeding will help you express your advice in the most relevant way.
- You may need to be particularly sensitive if the mother herself appears to be overweight. If one parent is obese, the child has a 40% probability of being overweight; if both parents are obese, the probability that the child will be overweight goes up to 70%. Although children do have a genetic tendency towards leanness or overweight, the causes of overweight are primarily factors such as family eating patterns and environment (for example, poor dietary habits, high consumption of energy-dense foods, and little physical activity). If parents have poor eating and activity habits, the child is likely to learn the same habits. During the interview about causes of overweight, focus on the child's eating and activity patterns rather than the parents'. However, realize that the parents may need to change some of their habits, in order to address the causes of the child's overweight.
- When there are several possible causes, it is helpful to focus on the main ones that can be changed. After asking the questions in the interview, ask the caregiver's opinion of the main causes of overweight, so that you know which causes they recognize. Then summarize what you see as the main causes.

► Show **Slide 65/4 – JOB AID: INVESTIGATING CAUSES OF OVERWEIGHT** and make the following points

65/4

JOB AID: INVESTIGATING CAUSES OF OVERWEIGHT

- **Step 1:** Initiate investigation of causes
- **Step 2:** Discuss age-specific questions about the child's feeding
- **Step 3:** Ask about physical activity (children aged over 6 months)
- **Step 4:** Jointly with the caregiver, identify causes
- **Step 5:** Counsel

- Take time now to study the JOB AID: INVESTIGATING CAUSES OF OVERWEIGHT. Focus on the questions listed on the left-hand side. Remember that you will ask all of the relevant questions for the child's age, listen to the mother's or caregiver's replies, and determine the most important causes of overweight before giving advice.
- Here is a summary of the steps to follow when investigating causes of overweight:
  - **Step 1:** Initiate investigation of causes
  - **Step 2:** Discuss age-specific questions about the child's feeding
  - **Step 3:** Ask about physical activity (*only for children aged over 6 months*)
  - **Step 4:** Jointly with the caregiver, identify causes
  - **Step 5:** Counsel

III. Investigating causes of Toman's overweight — 10 minutes

► For this demonstration, ask two participants to act out a script of an interview with Toman's mother.

► Explain that the scripted interview follows the JOB AID: INVESTIGATING CAUSES OF UNDERNUTRITION. The steps are labelled in the script. Preview the script as follows:

- **Step 1:** First the nurse will explain the nutritional problem and the purpose of the interview to Mrs Baruni.
- **Step 2:** Since Toman is exactly 2 years old, the nurse will start with the questions for a baby from 6 months to 2 years, to establish how Toman has been fed up to this point.
- **Step 3:** The nurse will ask about physical activity.
- This script will end with **Step 4**, identifying likely causes of overweight. The next demonstration will deal with counselling to address these causes.

DEMONSTRATION 65.A INVESTIGATING CAUSES OF OVERWEIGHT

SCRIPT 3: DIALOGUE WITH TOMAN'S MOTHER ABOUT THE CAUSES OF OVERWEIGHT

► Ask participants to follow along in the script (pages 485–486 in their *Participant's manual*) and mentally compare the mother's answers about feeding to the recommended practices for Toman's age group, to identify possible causes of his overweight, and to notice which LISTENING AND LEARNING SKILLS the nurse applies.

► Give to the group the following background information:

- Toman is now 2 years old. He is the only child at home living with his mother. Mr and Mrs Baruni are separated, and Toman spends weekends with his father. Both parents are in good health; neither is known to be HIV positive. Mrs Baruni does not appear to be overweight.
- Toman's growth has been charted in the BOY'S GROWTH RECORD. Because he is above the 2 *z*-score line in weight-for-height, the nurse is going to counsel his mother, Mrs Baruni, about growth and feeding. Before giving any advice, the nurse will interview Mrs Baruni about Toman's feeding and the home situation, in order to find out the possible causes of his overweight.

Step 1: Toman is not currently ill and has no known chronic diseases.

Nurse:	*Let's look together at Toman's* GROWTH RECORD. *Looking at his length-for-age, we see that he is a nice height, a bit taller than average for boys his age.* *The other charts show that Toman is quite heavy for his height. What do you think? Would you agree that Toman is overweight?*
Mrs Baruni:	*I don't know. I think that he is a big, healthy boy. I never thought he was really overweight. Is this a problem?*
Nurse:	*It will be a problem if he continues gaining weight so fast. We need to slow down his weight gain until his height catches up. Do you mind if I ask you some questions about Toman's eating and his physical activity? Then we can both understand why he seems to be gaining weight faster than expected.*
Mrs Baruni:	*Alright.*

Step 2:

Nurse:	*Is Toman breastfed?*
Mrs Baruni:	*No, I stopped breastfeeding him when he was 3 months old.*
Nurse:	*Is he fed any milk formula or other milk?*
Mrs Baruni:	*He drinks lots of milk. He loves milk.*
Nurse:	*About how much milk does he drink each day?*
Mrs Baruni:	*Oh, probably a litre. He has a glass in the morning, then at about 10:00, and also with snacks. I also give him a bottle to help him go to sleep without crying at night.*
Nurse:	*How is the milk prepared? Is anything added to sweeten or thicken it?*
Mrs Baruni:	*Usually it's just fresh milk from a packet, but sometimes I warm it and add a bit of sugar or chocolate powder.*
Nurse:	*How many meals does he eat each day?*
Mrs Baruni:	*Three.*
Nurse:	*OK. About how much does he eat at each meal?*
Mrs Baruni:	*A small bowl full.*
Nurse:	*What type of bread does Toman eat?*
Mrs Baruni:	*He likes regular sliced bread, toast and sweet breads.*
Nurse:	*Does he eat cakes or other sweets?*
Mrs Baruni	*Well, he eats sweets like cookies and cake when he stays with his father and his father's mother over the weekend. My mother-in-law likes to bake and feed Toman sweets. She is a bit heavy herself.*
Nurse:	*Does Toman drink soft drinks?*
Mrs Baruni	*Yes, sometimes.*
Nurse:	*How often?*
Mrs Baruni	*At my mother-in-law's house he has soft drinks with his meals. I give him juice instead.*
Nurse:	*What about spreads on bread? Does Toman eat a lot of butter, margarine or sweet spreads on his bread?*
Mrs Baruni	*Oh yes, he loves chocolate and hazelnut spread.*
Nurse:	*Does he eat high-energy snacks like chips?*
Mrs Baruni	*No, I don't think so.*
Nurse:	*What about fried foods, such as deep-fried breads or meats, or French fries?*
Mrs Baruni	*I don't usually fry foods. I may add some oil when I cook, but not much.*
Nurse:	*Does he eat fatty meat?*
Mrs Baruni	*He likes meat, but I don't know whether the meat is fatty.*

Nurse:	*You said that Toman eats three meals each day. Does he also have snacks?*
Mrs Baruni	*Well, he eats breakfast, a snack around 10:00, lunch, a snack after his nap, then dinner, and finally his bottle of milk before bed. So I guess he eats about six times each day.*
Nurse:	*Do you think that Toman eats too much at meals?*
Mrs Baruni	*No, not really.*
Nurse:	*Besides the planned snacks, does Toman eat between meals?*
Mrs Baruni	*I don't think so, but I don't really know what happens at his grandmother's house.*
Nurse:	*Do you and Toman sit down at a table to eat?*
Mrs Baruni	*We try, but sometimes we may sit in front of the television to eat.*

Step 3:

Nurse:	*How many physically inactive hours does Toman spend each day, for example, watching the television?*
Mrs Baruni	*When he's at home with the babysitter while I am at work, he watches a lot of television.*
Nurse:	*How often is that?*
Mrs Baruni	*Five days each week while I am working.*
Nurse:	*When he is at his father's, what kind of meals does he have?*
Mrs Baruni	*Oh, at his father's he is sure to have fast foods. That's why they usually eat at his grandmother's.*
Nurse:	*Does Toman have many opportunities for active physical play?*
Mrs Baruni	*He really doesn't. The babysitter stays indoors with him.*

Step 4:

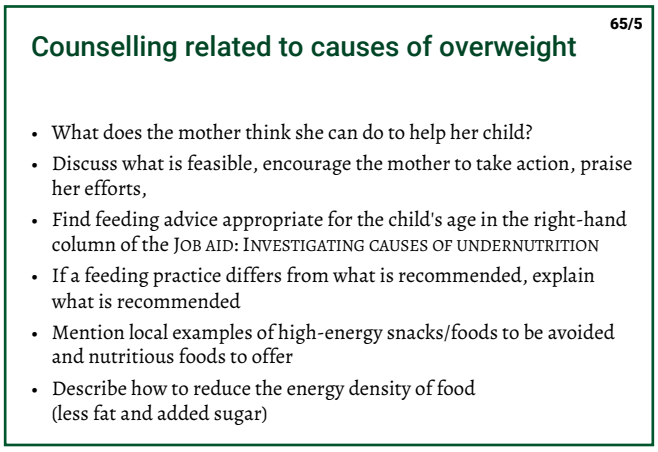
Nurse:	*What do you think could be the main reasons that Toman is overweight?*
Mrs Baruni	*You know, I think he's just a big boy like his father. He seems healthy to me, but maybe he needs to play outside and run around more.*
Nurse:	*I agree. From what you have told me, Toman's weight could be caused by a number of things, including lack of activity and food choices.*

IV. Discussion: possible causes of Toman's overweight — 15 minutes

- **Lead the discussion on possible causes of Toman's overweight**
- **After the interview, lead a discussion of the probable causes of Toman's overweight. Prepare the flipchart or blackboard with the following main headings: FOOD, CARE and ENVIRONMENT. As each participant gives a probable cause of Toman's overweight, ask them which main heading the cause will fall under. List the cause under the appropriate heading. Focus on causes rather than possible solutions or advice to give the mother. Solutions and advice will be the focus of the next demonstration.**
- **Recall the LISTENING AND LEARNING SKILLS and ask participants to mention which ones the nurse used in her dialogue with Mrs Baruni.**

V. Present Slides 65/5 and 65/6 — 10 minutes

- **Show Slide 65/5 – Counselling related to the causes of overweight** and make the following points



- During the first part of the interview with the mother or other caregiver, you found out about the possible causes of the child's overweight and asked which causes seemed most important. Next, focusing on the main causes that the mother or caregiver recognizes as important, ask: "What do you think that you can do to help the child, given these causes?".
- Then discuss with them what is feasible to do and who can provide help and support. Acknowledge their situation and encourage them to take action.
- Specific advice related to feeding and physical activity is given on the right-hand side of the JOB AID: INVESTIGATING CAUSES OF UNDERNUTRITION, next to the related questions. If you noted that a feeding practice differs from what is recommended, explain the recommended practice. Also commend the caregiver if they are following some of the recommendations.
- In your recommendations, include local examples of high-energy snacks to avoid and nutritious foods to provide. Describe specifically how to prepare foods using less fat and sugar. Also discuss feasible ways for the child to participate in active physical play. Encourage parents to find ways to increase the child's activity and reduce anxiety, insecurity or boredom, which are feelings that may lead to overeating.
- Also encourage parents to adopt a healthy lifestyle, including healthy eating habits, physical activity and positive interaction at family meals. The best way to influence children to have healthy lifestyles is for the parents to model the desired behaviours.

► Show **Slide 65/6 – Set a goal for improving the growth of an overweight child** and make the following points

65/6

Set a goal for improving the growth of an overweight child

- Propose doable actions (two or three, no more) for the mother to try, write them down in the GROWTH RECORD
- Do not recommend weight loss
- The goal is to slow down weight gain with continued growth in height, to normalize weight-for-height
- Express goals in terms of improving growth, so that length and weight increase proportionally
- Set an appointment for a follow-up visit

- Set goals for a few (two or three) actions that the caregiver can take towards improving the child's growth. These actions can be reviewed at the next visit. Encourage and praise the caregiver when the actions are accomplished. Make notes (e.g. in the GROWTH RECORD) of the underlying causes of overweight, for discussion at follow-up visits, when goals may be set for additional actions to take.
- It is not recommended for an overweight child to try to lose weight, but instead they should decrease their rate of weight gain while growing in height.
- Because one cannot predict the child's rate of growth, it is not possible to set a specific weight target for a certain time. Instead, discuss the importance of slowing the child's weight gain so that they eventually reach a more normal weight-for-height.
- At the end of the discussion with the mother or other caregiver, it is important to set a reasonable time for the child's next visit and to set a general goal for improved growth. The next visit may be at the time that an immunization is required or at another convenient time.

VI. Script 4: Counselling Toman's mother about causes of overweight 6 minutes

► For this demonstration, ask two participants to act out a script of an interview with Toman's mother.

DEMONSTRATION 65.B COUNSELLING TOMAN'S MOTHER

- The script we are going to read next covers Step 5 of the JOB AID: INVESTIGATING CAUSES OF OVERWEIGHT. The "nurse" will counsel Mrs Baruni, using relevant advice from the right-hand side of the Job aid. The three main actions suggested are indicated by numbers to the left of the script.
- Follow the convesation on pages 487–488 of your *Participant's manual*.

Script 4: Conclusion of counselling session with Toman's mother

Nurse: ① *Your idea of taking Toman outside to play more is a good one. It will help him to have more physical activity. Can you ask the babysitter to take him outside to play?*

Mrs Baruni: *Yes, I will ask her to do that.*

Nurse: *On the weekends, is it possible that Toman's father would take him outside to a playground or to play ball?*

Mrs Baruni: *I can explain to him that Toman is getting fat and ask him to do that. But I really do not have much control over what he does or eats with his father and grandmother. If I make a suggestion to her, she resents it.*

Nurse: ② *I understand. Then let's discuss first what you can do in your own home. I suggest that you stop adding sugar or sweetened chocolate to Toman's milk. If you sweeten it, it is more fattening. Also, he is likely to drink more than he needs because it tastes so good.*

Mrs Baruni: *He will not like the milk as much if I don't sweeten it.*

Nurse: ③ *That is alright. He doesn't need so much milk as you are giving him. Half a litre each day is plenty. And if he is thirsty before bed, give him milk or water in a cup, not a bottle. He will drink more than he needs from a bottle, and it is bad for his teeth to fall asleep with a bottle.*

Mrs Baruni: *I will never get him to sleep then.*

Nurse: *It's alright to let him cry a bit as he falls asleep. He needs to be able to fall asleep without a bottle. It may help to rock him and sing to him. Besides, if he has been outside to play, he may be very tired and have no problem falling asleep.*

Mrs Baruni: *I had not thought of that.*

Nurse: *From what you have told me, there are more feeding changes that would be helpful, but for now let's focus on getting him out to play, reducing sugar in his diet, and decreasing the amount of milk given daily. How do you feel about trying these three things?*

Mrs Baruni: *I am willing to try, but his grandmother will give him all the sweet foods he wants!*

Nurse: *I understand the difficulty. Can you discuss the situation with your husband? Maybe he can help.*

Mrs Baruni: *Not easily, but I could write a letter, or perhaps you could write a note or call him?*

Nurse: *That is a good idea. I will call him. Please give me his phone number.*

Mrs Baruni: *Yes, he may listen to you more than me.*

Nurse (checking question): *I will call him. If you make the feeding changes that we have agreed on, and if your husband and mother-in-law make some changes as well, it will be very good for Toman, especially if he also gets more physical activity. Now, just to review, let me ask you how you will reduce the amount of sugar that Toman is taking.*

Mrs Baruni: *I will stop adding the sugar and chocolate to his milk.*

Nurse: *And how will you reduce the total amount of milk that Toman drinks each day to about half a litre?*

Mrs Baruni: *I will try to stop giving him the bottle at night.*

Nurse: *And how will you increase his activity?*

Mrs Baruni: *I will instruct the babysitter to take him outside to play.*

Nurse: *That sounds great. We could weigh and measure Toman again in about 3 months to see his progress. Could you come back in 3 months?*

Mrs Baruni: *Yes, I will do that.*

Nurse: *Very well. At that time, we will speak about more ways to improve Toman's health. Let me write the date for his next visit in his* Growth record.

Mrs Baruni: *Could you tell me what Toman's father says after you speak with him?*

Nurse: *Of course! I will give you a call.*

Mrs Baruni: *Thank you.*

► Recall the Skills for building confidence and giving support and ask participants to mention which ones the nurse used in her dialogue with Mrs Baruni.

VIII. Summarize the session 2 minutes

- **Ask participants whether they have any questions, and try to answer them.**
  - We will now go directly to Session 66 and discuss how to check understanding and arrange follow-up based on the dialogues with Mrs Parab (Sessions 63 and 64) and Mrs Baruni (this session).

Counselling skills

Listening and learning skills

1. Use helpful non-verbal communication
2. Ask open questions
3. Use responses and gestures that show interest
4. Reflect back what the mother/caregiver says
5. Empathize – show that you understand how the mother/caregiver feels
6. Avoid using words that sound judging

Skills for building confidence and giving support

1. Accept what a mother/caregiver thinks and feels
2. Recognize and praise what a mother/caregiver and baby are doing right
3. Give practical help
4. Give a little, relevant information
5. Use simple language
6. Make one or two suggestions, not commands

Notes

Notes (contd)

Notes (contd)

SESSION 66

Checking understanding and arranging follow-up 2

Objectives

After completing this session, participants will be able to:

- demonstrate how to ensure that a caregiver understands information provided, by using checking questions
- arrange referral or follow-up of a child

Session outline . . . . . 30 minutes

Participants are all together for a demonstration led by one trainer.

I. Introduce the session, present **Slide 66/1** . . . . . 5 minutes
II. Review the dialogues with Mrs Parab and Mrs Baruni . . . . . 10 minutes
III. Demonstrate how to check understanding – oral drill (**Slides 66/2** to **66/17**) . . . . . 13 minutes
IV. Summarize the session . . . . . 2 minutes

Preparation

- Refer to the Introduction for guidance on how to give a demonstration.
- Make sure you have **Slides 66/1** to **66/17** ready.
- Prepare to conduct the oral drill. You may ask some participants to conduct parts of the drill after your demonstration of how it is done. In a drill, participants answer questions spontaneously, without preparation. A drill is intended to be a lively exercise that involves everyone in the group. It is a way to practise a skill quickly and repeatedly, so that it becomes easier, almost automatic. Participants take turns responding, in order around the table. If one participant hesitates, simply move on to the next participant.

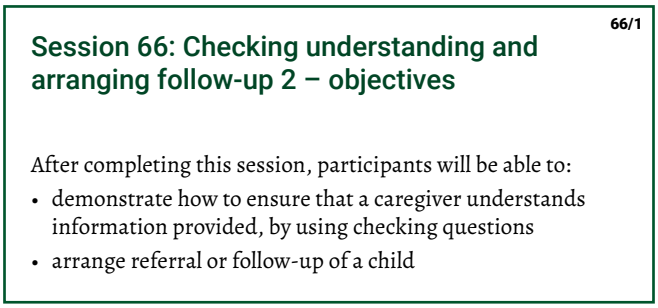
As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

I. Introduce the session — 5 minutes

► Show **Slide 66/1 – Session 66 – objectives** and read out the objectives:



► Make these introductory points:

- In this session we will review two further skills to help support caregivers: checking understanding and arranging follow-up.
- We have already practised the counselling skills of LISTENING AND LEARNING, and BUILDING CONFIDENCE AND GIVING SUPPORT. The dialogue with the caregiver includes suggestions to help them decide on a course of action. Your suggestion does not automatically become what a caregiver will do.
- In addition, you need to check that a caregiver understands a practice or action they plan to carry out. For example, if you have talked about feeding frequently, you may need to check their understanding of the term "frequently".
- It is not enough to ask a caregiver whether they understand, and what they understand, because they may not realize that they understood incorrectly.
- Ask open questions to find out whether further explanation is needed. Avoid asking closed questions, because they suggest the answer and can be answered with a simple "yes" or "no" that does not tell you whether a caregiver really understands.
- "Checking understanding" also helps to summarize what you have talked about.

II. Review the dialogues with Mrs Parab and Mrs Baruni — 10 minutes

► Review the counselling session with Nalah's mother (see Session 64 Script 2):

- Let's review the dialogue between the Nurse and Nalah's mother (Script 2) on pages 480–481 of your *Participant's manual*. Did the nurse ask Mrs Parab any checking questions?
- One checking question is identified in the script. Please identify other checking questions that the nurse asked. (There are five more:
  - *Now, to review, please tell me how you will feed Nalah for the next month.*
  - *What else?*
  - *How much porridge and how often?*
  - *And what other foods will you start giving, one at a time?*
  - *What food will you give that comes from an animal?*)
- Did the nurse adequately tailor the advice to Mrs Parab's situation?
- Please note that the last step in the counselling session was to thank the mother and agree on when to bring the child back to see her progress.

- **Review the counselling session with Toman's mother (Session 65 Script 4):**
  - Let's review the dialogue between the nurse and Toman's mother (Script 4) on pages 487–488 of your *Participant's manual*.
  - One checking question is identified in the script. Please identify two more checking questions that the nurse asked.
    - *(Now just to review, let me ask, how will you reduce the amount of sugar that Toman is taking?*
    - *And how will you increase his activity?)*
  - Did the nurse adequately tailor the advice to Mrs Baruni's situation?
  - The last step in the counselling session was to agree on when to bring the child back to see his progress.

III. Demonstrate how to check understanding – oral drill — 13 minutes

- **Make these points:**
  - We will now run a drill to practise formulating checking questions. These are open-ended rather than "yes" or "no" questions. The subject matter in this drill is child feeding recommendations, but checking questions may be used in any type of counselling.
  - Slides with recommendations are going to be projected and you will each be called upon to formulate a checking question to see whether the mother has understood that recommendation. If your question is closed, the person conducting the drill will respond with a "yes" or a "no", and then the next person in line will be called to formulate a proper checking question.
  - We will move through the drill rapidly – the idea is to form a habit of spontaneously asking open-ended questions as part of your counselling skills.
  - Several checking questions may apply to the recommendations that will be presented.

Oral drill – checking understanding

66/2

Give your child only breast milk from birth to 6 months of age

How old should your child be before you start giving any other food or fluids besides breast milk?

66/3

Breastfeed as often as your child wants, at least 8 times in 24 hours

How often should you breastfeed?

66/4

Breastfeed whenever your child shows signs of hunger, such as fussing, sucking their fingers or moving their lips

How will you know when your child is hungry?

66/5

Now that your baby is 6 months old, start giving 2–3 tablespoons of thick porridge or well-mashed foods 2–3 times a day

What food will you start giving your baby now? How often will you give it? How much will you give?

66/6

Feed your child a staple food, such as rice or wheat cereal

What staple foods will you give your child?

66/7

You need to give your child some animal-source foods, such as meat, chicken, fish, eggs, milk, cheese, yogurt and curds

What foods will you give that come from animal sources?

66/8

Peas and beans are another good source of protein

Besides animal and milk foods, what is another good source of protein for your child?

66/9

Also give a variety of other foods, such as leafy green and yellow-coloured vegetables and fruits

What leafy green vegetables will you give? What yellow vegetables will you give? What fruits will you give?

66/10

At 9–11 months of age, give your baby 3–4 meals per day plus 1–2 snacks

How many meals and snacks does your baby need at age 9 months?

66/11

At each meal, your baby (age 9 months) needs about ½ cup of finely chopped or mashed foods

How much food should you give at each meal?

66/12

Feed your child from their own plate or bowl so you will know when they have eaten their entire serving

Why is it important to feed your child from their own plate or bowl?

66/13

Patiently help your baby eat; talk to them, look into their eyes and encourage them

When you feed your child, how will you keep them interested?

66/14

Now that your child is 2 years old, they should eat family foods at three meals each day

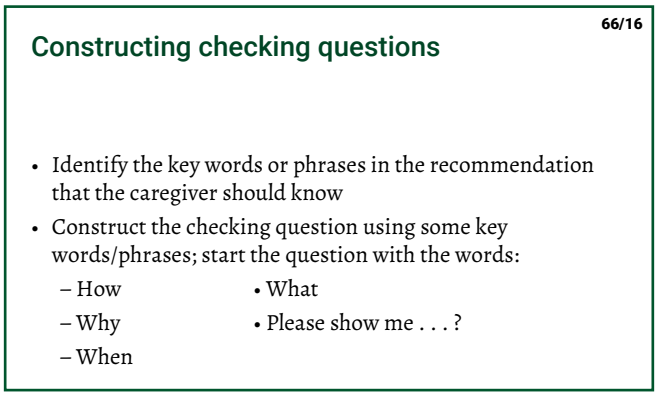
How many family meals should your child have each day?

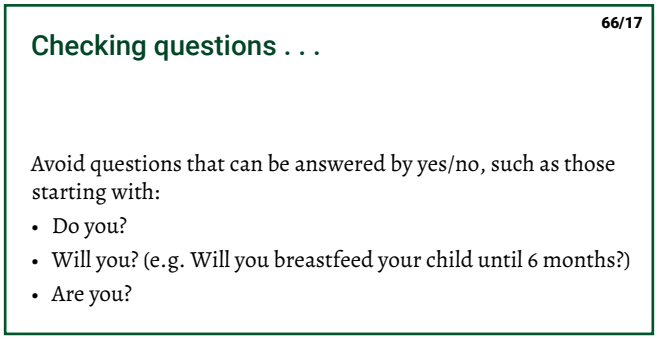
66/15

Twice daily between meals, give nutritious snacks such as yogurt or fruit

How many snacks will you give? What are some nutritious snacks that you can give?

► Show **Slides 66/16** and **66/17** and read them through with the participants:





Arranging follow-up or referral

► Make these points:

- All children should receive visits to check that their general health and feeding. If a child has a difficulty that you are unable to help with, you may need to refer them for more specialized care.
- Follow-up is especially important if there has been any difficulty with feeding. Ask the caregiver to visit the health facility in 5 days, or longer if appropriate, for follow-up.
- This follow-up includes checking what foods are used and how they are given; checking how breastfeeding is going; and checking the child's weight, health, general development and care.
- The follow-up visits also give an opportunity to praise and reinforce practices, thus building the mother's confidence; to offer relevant information; and to discuss suggestions as needed.
- It is especially important for children with special difficulties, for example children whose mothers are living with HIV, to receive regular follow-up from health workers. These children are at special risk. In addition, it is important to follow-up how the mother is coping with her own health and difficulties.
- *Ask: Mrs Parab was asked to return in 1 month, while Mrs Baruni was asked to return in 3 months. What explains the difference in the follow-up dates of those two children?*

► Give the participants time to consider and discuss:

► The difference is determined by how soon it is possible to detect a difference in growth. Nalah, at age 6 months, should be growing rapidly, so it is possible to see an improvement in her growth status and activity levels within as little as 1 month if she receives appropriate feeding and care. Toman, who is overweight, needs to "decrease the rate of weight gain while growing in height" and this requires a longer time (at least 3 months) before a change in weight relative to height becomes measurable.

► Other points include the different family circumstances and how many people need to change care and feeding practices that affect the children's growth.

IV. Summarize the session 2 minutes

- Ask participants whether they have any questions, and try to answer them.
- Explain that a summary of this session can be found on page 491 of the *Participant's manual*.

Notes

SESSION 67

Gathering information and counselling on complementary feeding practices and growth: role-plays

Objectives

After completing this session, participants will be able to gather information and provide counselling on complementary feeding practices and growth, by:

- demonstrating appropriate use of counselling skills
- investigating causes of growth problems
- providing appropriate counselling on the identified problem
- setting a target for growth to be reviewed at a follow-up visit
- using the JOB AID: INVESTIGATING CAUSES OF UNDERNUTRITION and JOB AID: INVESTIGATING CAUSES OF OVERWEIGHT
- using the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS

Session outline . . . . . 60 minutes

Participants are all together for the introduction by one trainer, followed by small-group work with all trainers.

I. Introduce the session, present **Slide 67/1** . . . . . 2 minutes
II. Practise gathering information using the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS, the JOB AID: INVESTIGATING CAUSES OF UNDERNUTRITION and the JOB AID: INVESTIGATING CAUSES OF OVERWEIGHT (EXERCISE 67.A) . . . 55 minutes
III. Summarize the session . . . . . 3 minutes

Preparation

- Refer to the Introduction for guidance on facilitating group work.
- Make sure you have **Slide 67/1** ready. Alternatively, as there is only one slide in this session, you might prefer to read aloud the objectives on **Slide 67/1** without projecting them onto the screen.
- Prepare the room, so that the participants can break out into groups of three.
- Ask each participant to have their GROWTH RECORD (boy's and girl's), the JOB AID: INVESTIGATING CAUSES OF UNDERNUTRITION, the JOB AID: INVESTIGATING CAUSES OF OVERWEIGHT, the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS, a pen/pencil and a notebook.
- Before they break out into groups, inform the participants that this is a preparation for the next day's Clinical practice session, when they will meet real-life situations that they have to understand quickly and counsel appropriately.
- Have ready COUNSELLING CARD 17: FOOD VARIETY, COUNSELLING CARD 18: COMPLEMENTARY FEEDING FROM 6 UP TO 9 MONTHS, COUNSELLING CARD 19: COMPLEMENTARY FEEDING FROM 9 UP TO 12 MONTHS and COUNSELLING CARD 20: COMPLEMENTARY FEEDING FROM 12 UP TO 24 MONTHS, and the *Guidance on the use of counselling cards*.

As you follow the text, remember:

- ► indicates an instruction to you, the trainer.
- ¤ indicates what you say to participants.

I. Introduce the session — 2 minutes

- ► Show **Slide 67/1 – Session 67 – objectives** and read out the objectives:

67/1

Session 67: Gathering information and counselling on complementary feeding practices and growth: role-plays – objectives

After completing this session, participants will be able to gather information and provide counselling on complementary feeding practices and growth, by:

- demonstrating appropriate use of counselling skills
- investigating causes of growth problems
- providing appropriate counselling on the identified problem
- setting a target for growth, to be reviewed at a follow-up visit
- using the JOB AID: INVESTIGATING CAUSES OF UNDERNUTRITION and the JOB AID: INVESTIGATING CAUSES OF OVERWEIGHT
- using the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS

Practise gathering information using the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS, the JOB AID: INVESTIGATING CAUSES OF UNDERNUTRITION and the JOB AID: INVESTIGATING CAUSES OF OVERWEIGHT — 55 minutes

- ► Divide participants into groups of three for role-plays. Three role-play situations are provided in the module, each of which presents a different scenario. Each small group will do all of the role-plays, with participants taking turns in the roles of health-care provider, mother and observer. The small groups will do their role-plays simultaneously, in separate parts of the room.
- ► When the small groups go to their separate areas, each person will need to take their JOB AID: INVESTIGATING CAUSES OF UNDERNUTRITION, JOB AID: INVESTIGATING CAUSES OF OVERWEIGHT, BOY'S GROWTH RECORD, GIRL'S GROWTH RECORD, JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS, a pen or pencil and a notebook.
- ► Each participant plays a different role in each of the three-role play scenarios. It is important that they take time to study each scenario before acting their role as health-care provider, mother or observer. Detailed instructions for each of these roles are printed in the *Participant's manual*, pages 493–494.
- ► Ask the participants to read these instructions now, and in each group to divide up their roles.
- ► Ask the groups whether they have any questions about what to do, and clarify the instructions as needed. Then send each small group of three to a separate area, or perhaps out in a corridor. They should not go far away, however, as the facilitators need to observe them.

- **Observe as the groups get started, and help them as necessary. Move around to be sure that each group is staying on track. Give instruction and feedback as necessary. Watch and listen for the following during each role-play (refer to the trainer's background information on the role-plays):**
  - the correct growth problem is identified when the health worker interprets the graphs (e.g. trend towards overweight)
  - the health worker uses the correct Job aid to investigate causes (e.g. too much food, lack of physical activity); the health worker remembers to turn to the page to ask about physical activity
  - actions are suggested to address the causes found.
- **After each role-play, the observer in the group should make brief comments, followed by the mother and health worker.**
- **Then encourage the group to quickly switch roles and move on to the next role-play. It is important to keep the role-plays moving along, so that participants do not become bored or frustrated.**

Exercise 67.A Role-plays: Interviewing and counselling mothers

In this exercise, participants will practise interviewing and counselling mothers in role-plays. They will work in groups of three. Three role-play situations are described on the following pages. Each small group will do all three role-plays, with participants taking turns in the roles of health-care provider, mother and observer.

Participants will need the following materials when they go to the small groups:

- Job aid: Investigating causes of undernutrition, Job aid: Investigating causes of overweight
- Job aid: Food intake – 6 up to 24 months
- Boy's growth record and Girl's growth record
- notebook and pen or pencil for taking notes during the interview.

When you are the "health-care provider":

1. Study your "patient's" growth charts thoroughly and determine:
   a. whether the child is growing well or has a growth problem
   b. if they have a growth problem, whether it is undernutrition or overweight
   c. which of the three counselling Job aids you will use.
2. Greet the "mother" and introduce yourself. Ask for her name and her child's name, and use them.
3. Ask one or two open questions to start the conversation and to find out in general how the child is.
4. Explain to the mother the growth status of her child, using the points plotted on the three growth charts.
5. Refer to the relevant Job aid as a guide for conducting the interview and counselling session with the mother.
6. If the child has no growth problem:
   a. explain that you would like to learn about how her child is eating. Ask the mother to tell you about the child's eating on the previous day. Prompt as needed. Fill in the Job aid: Food intake – 6 up to 24 months as you listen
   b. think of suggestions you would make and Key messages to give to the mother.
7. If there is a growth problem:
   a. explain the growth problem to the mother. Then use the Job aid to investigate causes; it is helpful to take notes on the causes
   b. after discussing causes, work out with the mother what actions (2–3) to take. Use the Growth record as a reference for giving feeding advice. Ask checking questions as needed.
8. Try to praise the things the mother is doing right.
9. Agree on a time that the mother and child will return for follow-up.

When you are the "mother":

1. Study the background information presented about you and your child in the role-play situation in which you are the mother.
2. Respond to the "health-care provider's" questions realistically, as if you were the mother described. If necessary, you may make up additional information that is realistic and fits in with the story.
3. Answer the questions, but do not volunteer information unless the health-care provider asks for it. If your health-care provider uses good LISTENING AND LEARNING SKILLS, and makes you feel that they are interested, you can tell more.

When you are observing:

1. Study the background information on the mother and child and the growth charts shown on the following pages for the role-play situation that you will observe.
2. As the "health-care provider" interviews the "mother", follow the relevant Job aid.
3. Notice which counselling skills the health-care provider uses and which they do not use
4. After the role-play, be prepared to praise what the heath-care provider does right, and suggest what they could do better. Comment on whether:
   a. all of the relevant questions were asked
   b. the most important, relevant advice was given in an appropriate manner
   c. checking questions were asked to ensure that the mother understood what to do.
5. Ask the mother and then the health-care provider for their comments on the role-play, for example, what was done well, what was omitted or possible improvements.

When all the small groups have finished with the role-plays, the facilitators will lead a brief discussion of lessons learnt during the role-plays.

Background information for role-plays

Role-play situation 1: Mrs Khan and her son Veebol

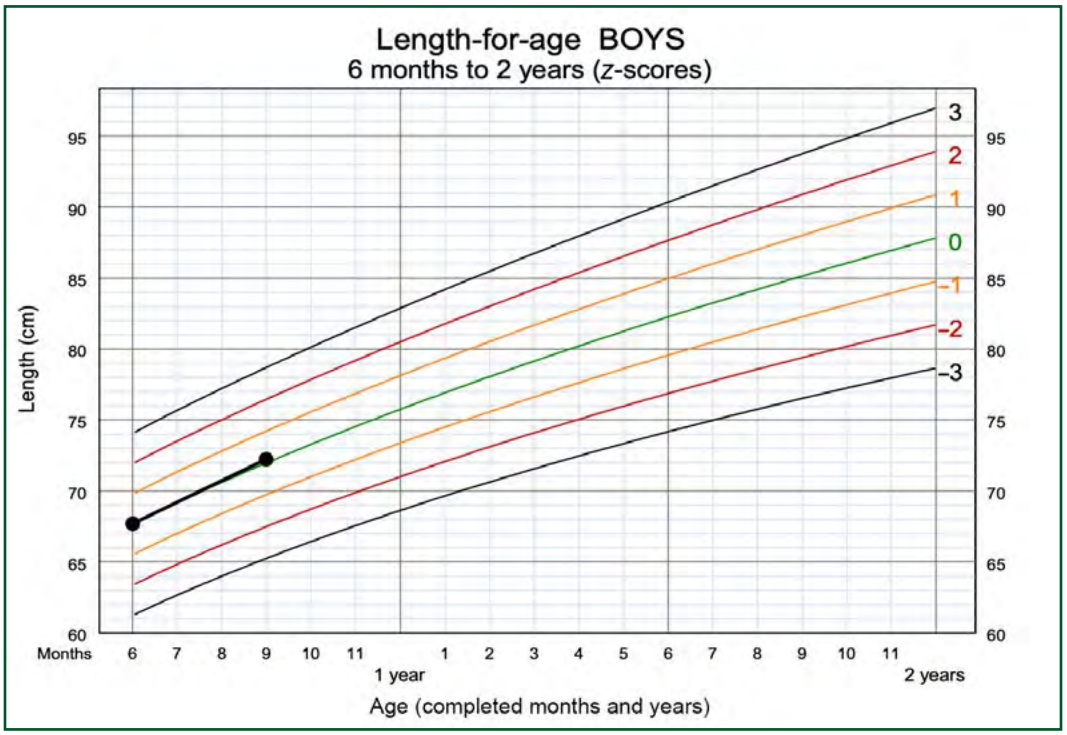
Mrs Khan has a son named Veebol, who is 9 months old. He is still breastfed, but he also takes formula milk in a bottle occasionally. Mrs Khan stays home to care for her son while her husband travels as a bicycle salesman. Their home is comfortable and has many conveniences, including a television. There is plenty of money for food. Veebol takes about a cup of mashed foods (such as porridge or sweet potatoes) three or four times each day. Mrs Khan appears to be overweight, and her son's growth lines show a trend towards overweight, but Mrs Khan does not think that there is any problem. He is beginning to crawl but is carried around much of the time because his mother does not want him to get his hands dirty and put them into his mouth.

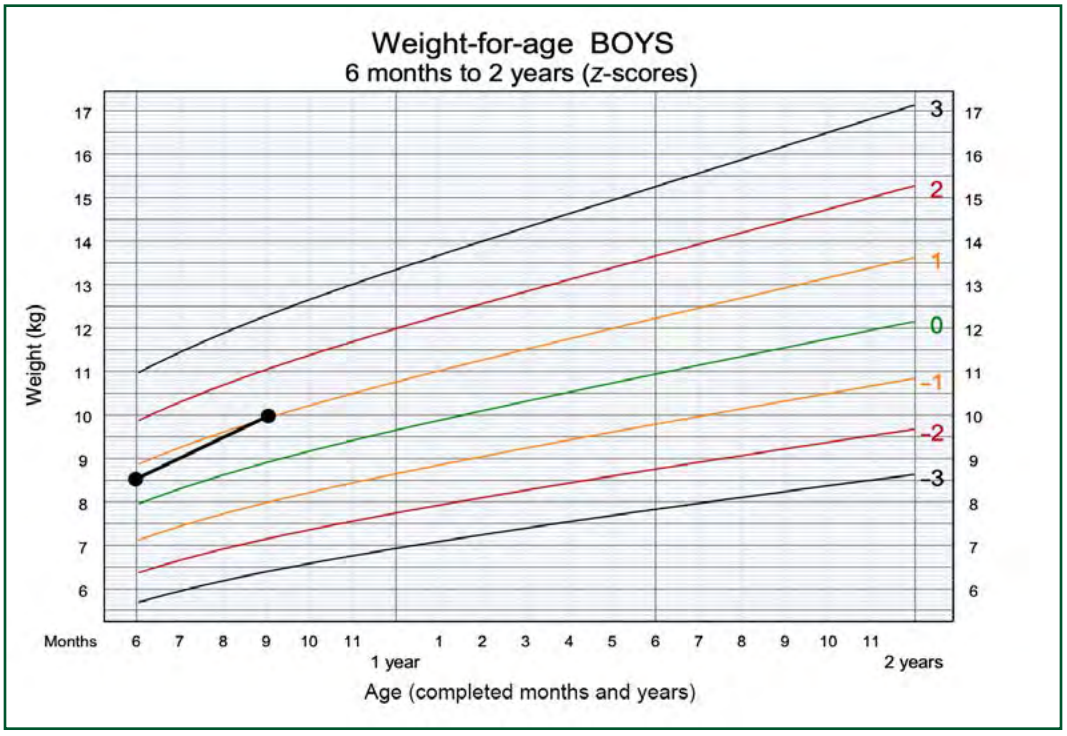
Trainer's background information on Mrs Khan and her son Veebol

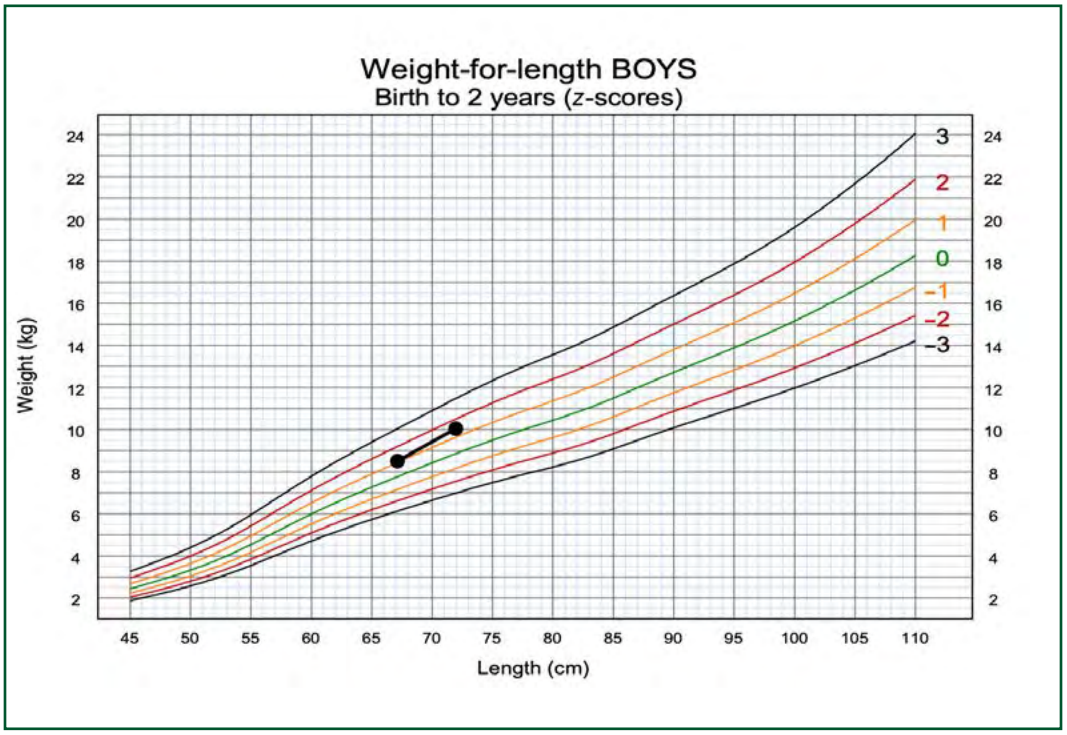
Veebol's growth lines (at age 9 months) show a trend toward overweight. His portions are too large (1 cup instead of the recommended ½ cup per meal). He eats 3–4 meals, instead of the recommended three meals plus one snack. The health worker should explore whether he has sufficient physical activity.

Mrs Khan should be advised about portion size and frequency of meals, and also to provide opportunities for Veebol to move around freely and play in a safe environment.

Growth charts for Veebol






Weight-for-length BOYS
Birth to 2 years (z-scores)
Weight (kg)
Length (cm)
3
2
1
0
-1
-2
-3
24
22
20
18
16
14
12
10
8
6
4
2
45
50
55
60
65
70
75
80
85
90
95
100
105
110

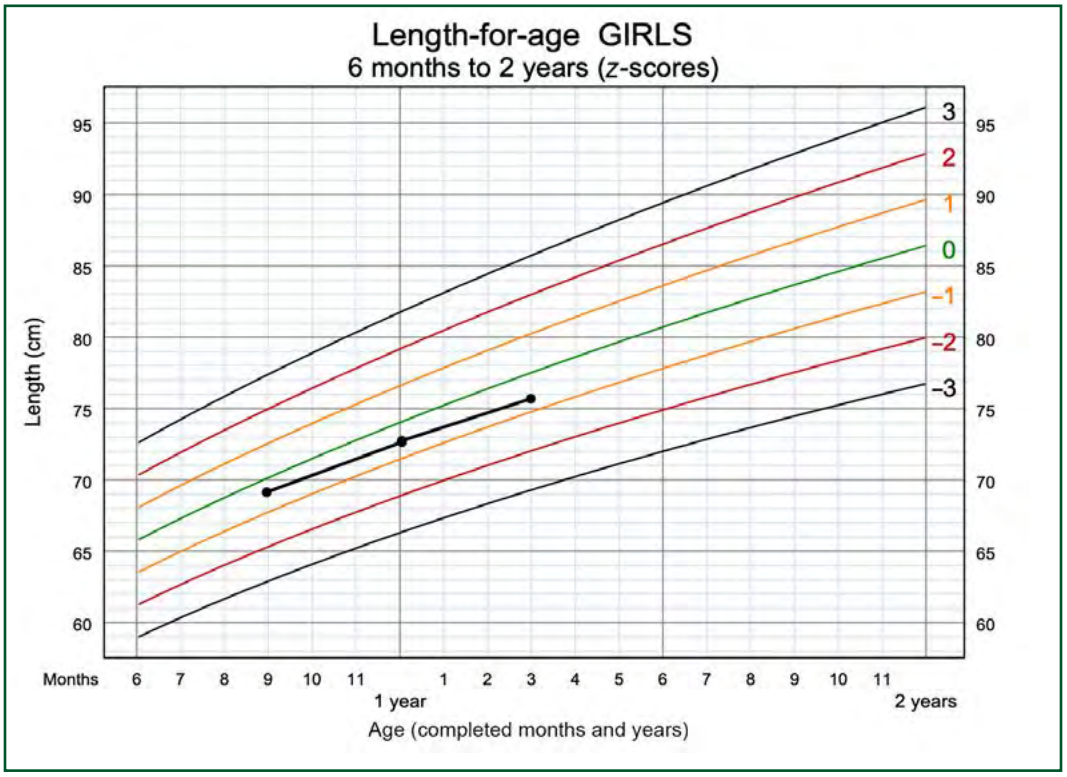
Role-play situation 2: Mrs Smith and her daughter Mary

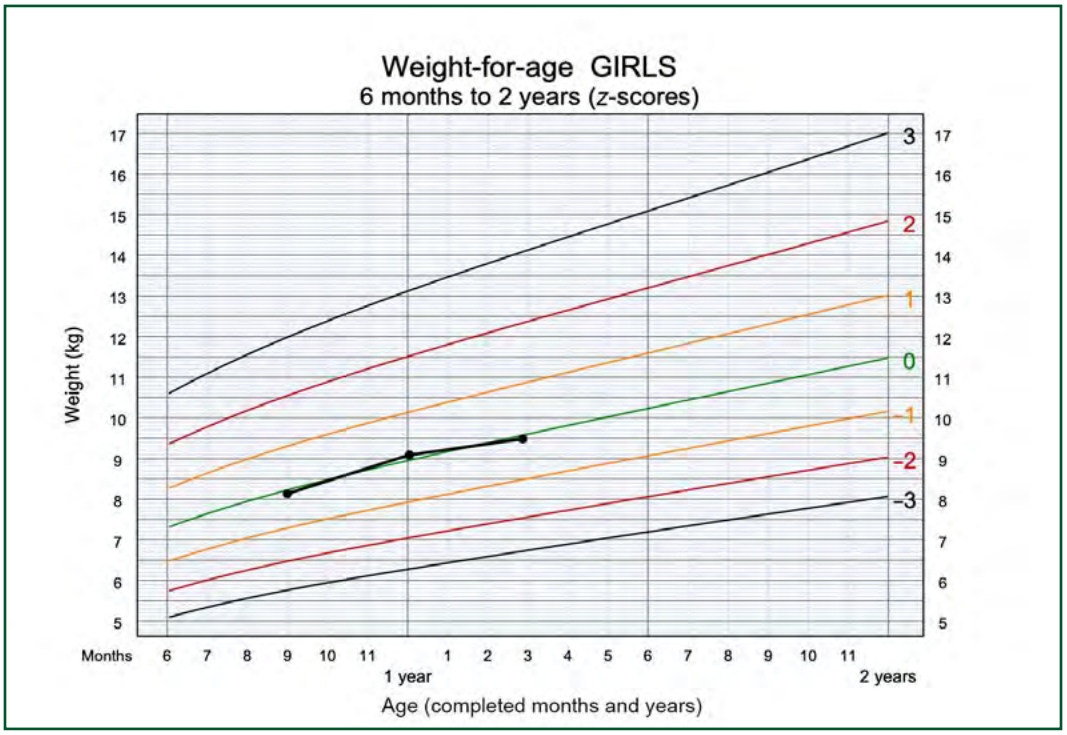
Mrs Smith has a daughter Mary who is 15 months old. Her growth charts indicate that she is growing well. Her mother says that she breastfeeds frequently (she can't keep count of how many times in a day). The heath-care provider asks about Mary's complementary feeding (using the 24-hour recall method). Yesterday Mary had three meals and two snacks. She had ½ cup of mixed-cereal porridge in the morning and some bread and peanut butter at mid-morning. She had bean stew and a little rice for lunch, followed by a slice of mango. She did not have any snack in the afternoon but breastfed several times. For supper she ate steamed fish and greens. The health-care provider has measured Mary and plotted all measurements in her growth charts.

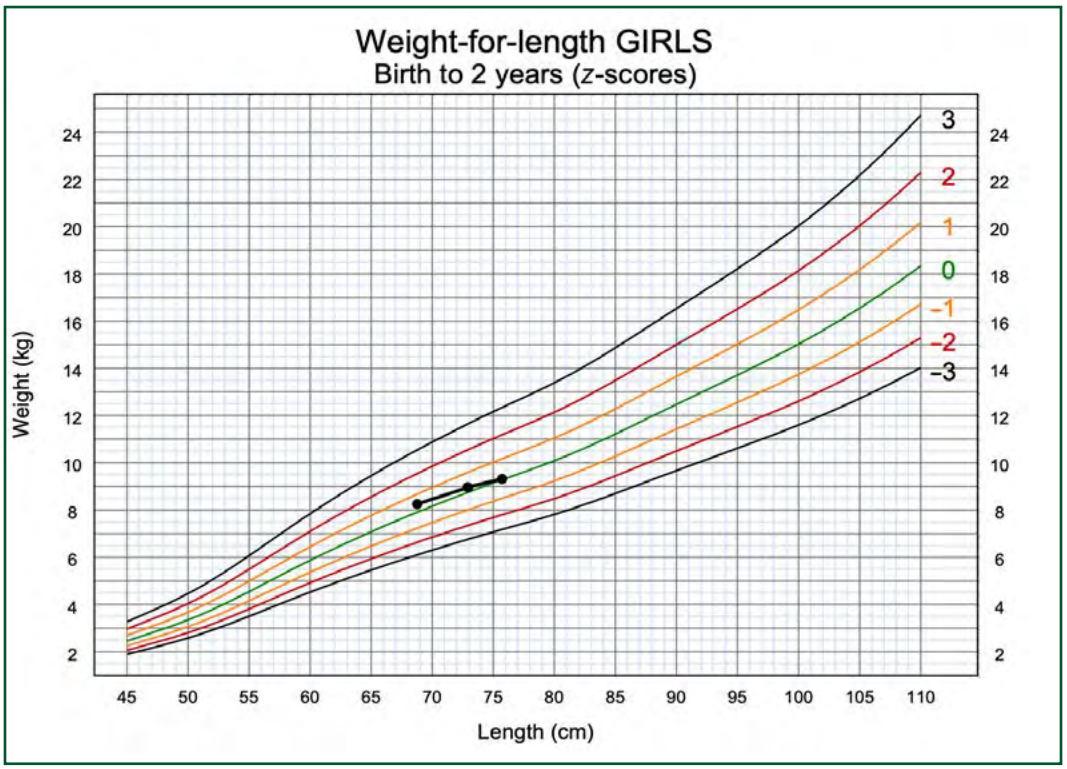
Trainer's background information on Mrs Smith and her daughter Mary

Mary is growing very well in both length and weight. Her weight-for-length shows that she is growing proportionally. The health worker needs to compliment Mrs Smith on her child's growth. Then they should use the 24-hour recall method to ask about her complementary feeding, to encourage the mother to continue the good work.

Growth charts for Mary




Weight-for-age GIRLS
6 months to 2 years (z-scores)
Weight (kg)
Months
1 year
2 years
Age (completed months and years)
3
2
1
0
-1
-2
-3


Weight-for-length GIRLS
Birth to 2 years (z-scores)
Weight (kg)
Length (cm)
3
2
1
0
-1
-2
-3

Role-play situation 3: Mrs Lima and her daughter Anete

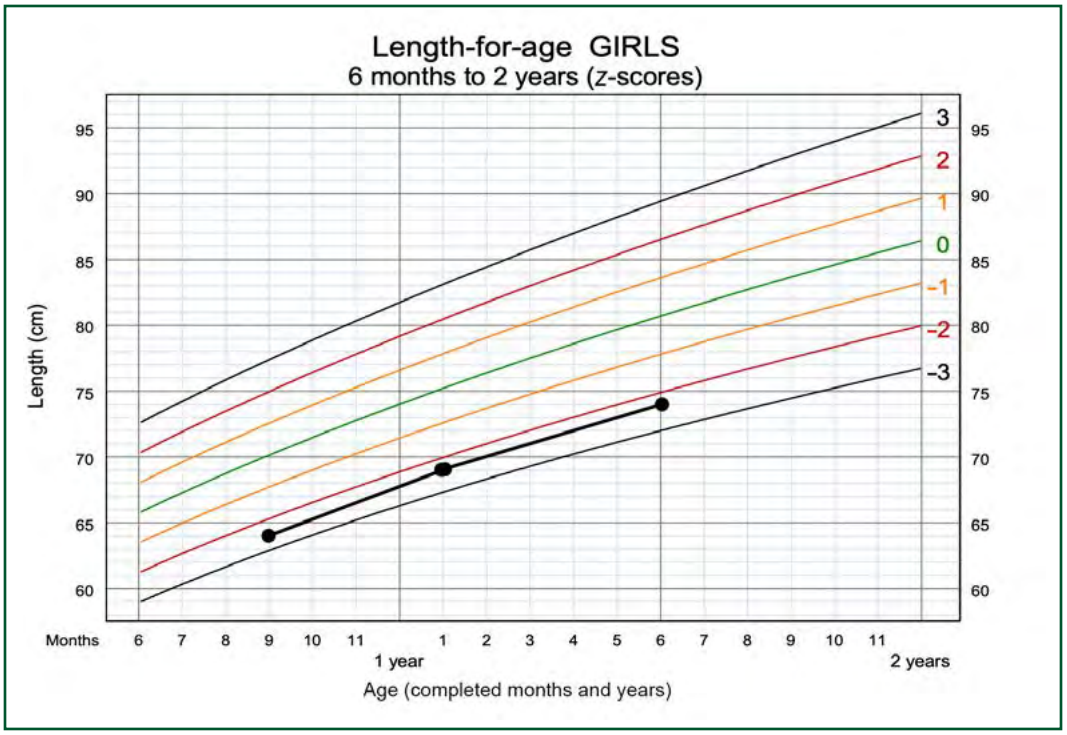
Mrs Lima is the mother of Anete, age 18 months, who seems happy and active. Anete is stunted but looks healthy. She is not breastfed. She does not like to eat and prefers to move around rather than sit still for meals. Although Mrs Lima tries to feed Anete three times each day, sometimes she will only take ¼ cup of food at a time. Anete's growth charts are shown on pages 499–500. Mrs Lima appears to be normal height. She does not have HIV. Her home is simple, but there is enough money for food.

Trainer's background information on Mrs Lima and her daughter Anete

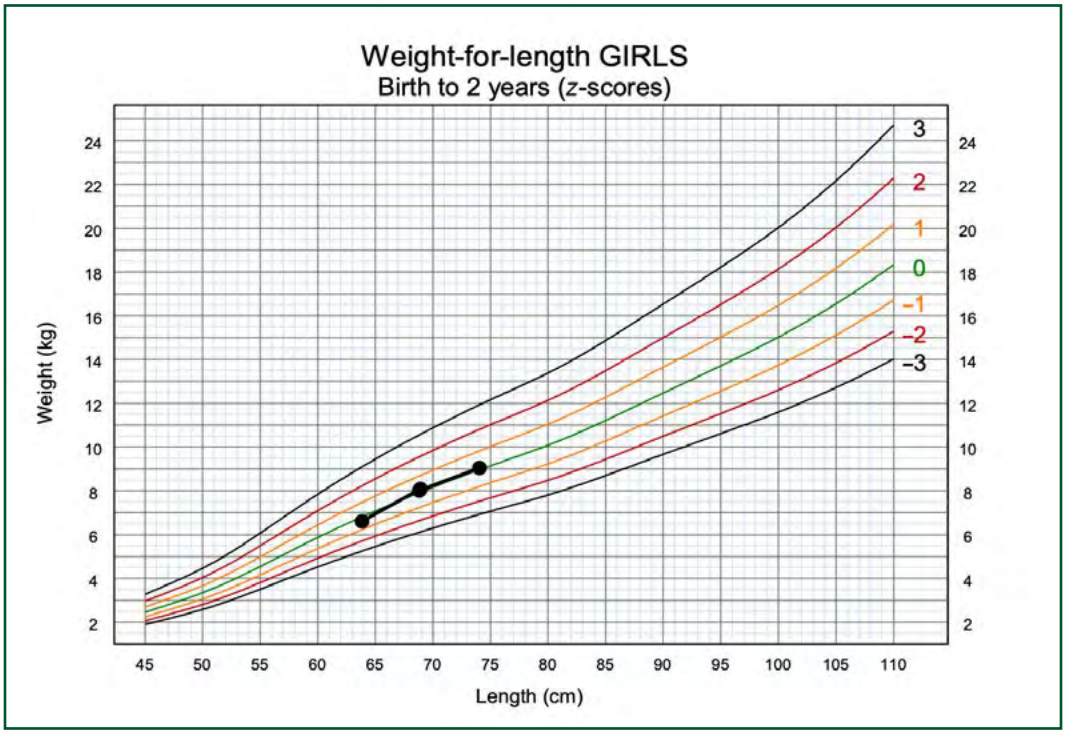
Anete (age 18 months) is stunted, though she seems healthy and active. Inadequate nutrition over a period of time seems to have caused her stunting.

Anete does not have much appetite or interest in eating. She eats only ¼ cup at three meals per day. Mrs Lima should be advised to try to increase her portion to ¾–1 cup and to sit with her to encourage her to eat. Since Anete is stunted, her mother should be given the special advice for a stunted child, that is, to add legumes and animal-source foods to meals to improve the nutrient quality of the diet, so that Anete grows in height while keeping a normal weight-for-height. She could also try to offer Anete a wider variety of good foods, to increase her interest, and offer her two healthy snacks each day in addition to her meals.

Growth charts for Anete




Weight-for-age GIRLS
6 months to 2 years (z-scores)
Weight (kg)
Months
1 year
2 years
Age (completed months and years)
3
2
1
0
-1
-2
-3


Weight-for-length GIRLS
Birth to 2 years (z-scores)
Weight (kg)
Length (cm)
3
2
1
0
-1
-2
-3

Group discussion

- **When all of the small groups have finished with the role-plays, gather the entire group for a brief discussion of lessons learnt during the role-plays.**
- **Summarize the steps that the health-care provider should follow after weighing/measuring the child and plotting the indicators. Suggested steps are as follows:**

1. Show and explain the meaning of the charts to the caregiver.
2. If there is no growth problem, use the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS to collect information on how the child was fed yesterday, and use the occasion to compliment the caregiver and reinforce their good practices, and to counsel on how to feed the child in an approaching age group.
3. If there is a growth problem, determine whether the caregiver recognizes it.
4. Follow the steps in the relevant JOB AID: INVESTIGATING CAUSES OF UNDERNUTRITION or JOB AID: INVESTIGATING CAUSES OF OVERWEIGHT.
5. Ask the caregiver what they think are the most likely causes of the child's growth problem, if there is one.
6. Counsel: two or three actions (only) for the caregiver to take. (Do not forget to praise the caregiver for things they are doing correctly!)
7. Ask checking questions.
8. Set the date of the next clinic visit.
9. Thank the caregiver.

III. Summarize the session 3 minutes

- **Ask participants whether they have any questions, and try to answer them.**
- **Explain that a summary of this session can be found on pages 493–504 of the *Participant's manual*.**
- **Make these points:**
  - The practice scenarios you have acted out gave you a chance to use various ways of gathering information on complementary feeding practices. This included observation, listening, using growth charts and asking questions.
  - In preparation for interacting with mothers in Clincal practice session 7, you have worked with the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS and the Job aids for investigating causes of malnutrition. You will use these when counselling mothers and other caregivers.
  - In Clinical practice session 7, tomorrow, you will meet mothers and children whose growth status may be normal or otherwise, so you will be expected to use the appropriate tools to gather information and the appropriate skills to counsel them.

Enter a ✓ in the Yes column if the practice is in place.

Enter your initials if a message is given (see REFERENCE TOOL: FOOD INTAKE – 6 UP TO 24 MONTHS for the message).

JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS

Child's name:

Date of birth: **Age of child at visit:**

Feeding practice	Yes / number where relevant	Key message given
Growth appropriate?		
Child received breast milk?		
How many meals of a thick consistency did the child eat yesterday? (use FOOD CONSISTENCY PICTURES as needed)		
Child ate an animal-source food yesterday (meat/fish/offal/bird/eggs)?		
Child ate a dairy product yesterday?		
Child ate pulses, nuts or seeds yesterday?		
Child ate a dark-green or yellow vegetable or yellow fruit yesterday?		
Child ate sufficient number of meals and snacks yesterday, for their age?		
Quantity of food eaten at main meal yesterday appropriate for child's age?		
Caregiver assisted the child at mealtimes?		
Child took any vitamin or mineral supplements?		
Child ill or recovering from an illness?		

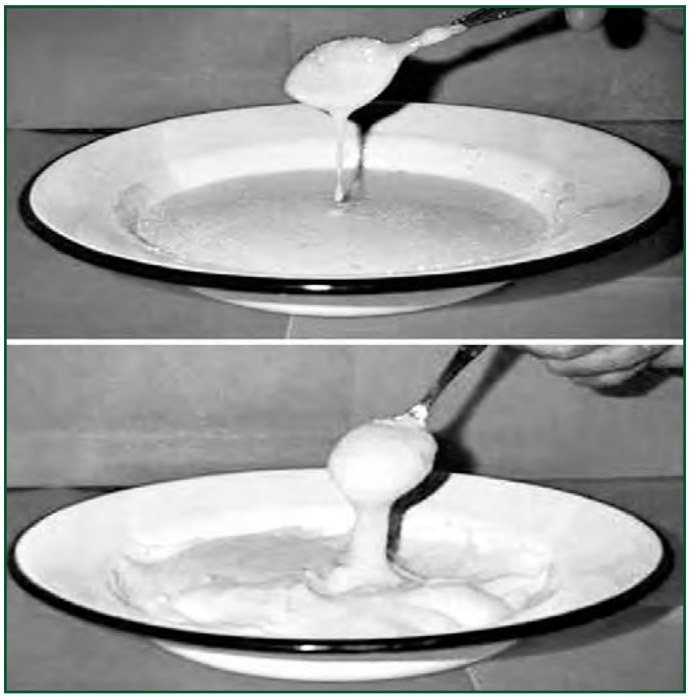
Instructions for completing the Job aid: Food intake – 6 up to 24 months

1. Greet the mother/caregiver. Explain that you want to talk about the child's feeding.
2. Fill out the child's name, birth date, age in completed months or years and today's date.
3. Ask to see the growth chart and observe the pattern of the growth.
4. Start with:
   (Mother/caregiver name), let us talk about what (child's name) ate yesterday.
5. Continue with:
   As we go through yesterday, tell me all (child's name) ate or drank, meals, other foods, water or breastfeeds.
   What was the first thing you gave (child's name) after he woke up yesterday?
   Did (child's name) eat or drink anything else at that time or breastfeed?
6. If the caregiver mentions a preparation, such as a porridge or stew, ask them for the ingredients in the porridge or stew.
7. Then continue with:
   What was the next food or drink or breastfeed (child's name) had yesterday?
   Did (child's name) eat/drink anything else at that time?
8. Remember to "walk" through yesterday's events with the caregiver, to help them remember all the food/drinks/breastfeeds that the child had.
9. Continue to remind the caregiver you are interested in what the child ate and drank yesterday (caregivers may talk about what the child eats/drinks in general).
10. Clarify any points or ask for further information as needed.
11. Mark on the Job aid: Food intake – 6 up to 24 months the practices that are present. If appropriate, show the caregiver the pictures of thin and thick consistency (for porridge and mixed foods). Ask them which drawing is most like the food they gave the child. Was it thick, did it stay on the spoon and hold a shape on the plate, or was it thin and did it flow off the spoon and not hold its shape on the plate?
12. Praise practices you wish to encourage. Offer two or three Key messages as needed and discuss how the caregiver might use this information.
13. If the child is ill on that day and not eating, give the Key message 10: Encourage the child to drink and eat during illness, and provide extra food after illness to help them recover quickly.
14. See the child another day and use the Job aid: Food intake – 6 up to 24 months when they are eating again.

Reference tool: Food intake – 6 up to 24 months

Feeding practice	Ideal feeding practice	Key messages to help counsel mothers
Growth appropriate?		*Look at the shape of the growth curve of the child: is the child growing?*
Child received breast milk?	Yes	Breastfeeding for 2 years or longer helps a child to develop and grow strong and healthy
How many meals of a thick consistency did the child eat yesterday? (use Food consistency pictures as needed)	3 meals	Foods that are thick enough to stay on the spoon give more energy to the child
Child ate an animal-source food yesterday (meat/fish/offal/bird/eggs)?	Animal-source foods should be eaten daily	Animal-source foods are especially good for children, to help them grow strong and lively
Child ate a dairy product yesterday?	Try to give dairy products daily	Animal-source foods are especially good for children, to help them grow strong and lively
Child ate pulses, nuts or seeds yesterday?	If meat is not eaten, pulses or nuts should be eaten daily, with an iron enhancer such as a vitamin-C-rich food	Peas, beans, lentils, nuts and seeds are good for children
Child ate a dark-green or yellow vegetable or yellow fruit yesterday?	A dark-green or yellow vegetable or yellow fruit should be eaten daily	Dark-green leaves and yellow-coloured fruits and vegetables help the child to have healthy eyes and fewer infections
Child ate sufficient number of meals and snacks yesterday, for their age?	Child 6–8 months: 2–3 meals plus 1–2 snacks if hungry Child 9–24 months: 3–4 meals plus 1–2 snacks if hungry	A growing child needs 2–4 meals a day, plus 1–2 snacks if hungry: give a variety of foods
Quantity of food eaten at main meal yesterday appropriate for child's age?	Child 6–8 months: gradually increased to approx. ½ cup at each meal Child 9–11 months: approx. ½ cup at each meal Child 12–24 months: approx. ¾–1 cup at each meal	A growing child needs increasing amounts of food
Caregiver assisted the child at mealtimes?	Yes, assists with learning to eat	A young child needs to learn to eat: encourage and give help … with lots of patience
Child took any vitamin or mineral supplements?	Vitamin and mineral supplements may be needed if child's needs are not met by food intake	*Explain how to use vitamin and mineral supplements if they are needed*
Child ill or recovering from an illness?	Continue to eat and drink during illness and recovery	Encourage the child to drink and eat during illness, and provide extra food after illness to help them recover quickly

Food consistency pictures



Notes

SESSION 68

Clinical practice session 7: Listening and learning – measuring children

Objectives

After completing this session, participants will be able to:

- demonstrate appropriate LISTENING AND LEARNING SKILLS when talking with a mother while measuring her child
- weigh children
- measure length
- measure height

Session outline . . . . . 120 minutes

Participants are together as a class led by one trainer, to prepare for the session, and to discuss it afterwards.

Participants work in small groups of 3–4, each with one trainer for the clinical practice session in a ward or clinic.

I. Prepare the participants . . . . . 20 minutes
II. Conduct the clinical practice . . . . . 95 minutes
III. Summarize the session . . . . . 5 minutes

Preparation

- If you are leading the session:
  - Make sure that you know where the practical session will be held and what times you are expected there. Visit the wards or clinics if you have not done so before. Iintroduce yourself to the staff members in charge, and make sure that they are prepared for the session (see *Director's guide*).
  - Ensure that the equipment is set up properly and conveniently in the room. There should be stations in different areas of the room, each with a scale and a length/height board. Assign pairs of participants to work at each station (or multiple pairs who will take turns).
  - You will also need: paper towels or soft cloth to cover the length/height board; and small toys or fruit to entertain the children and offer as presents to take home (according to availability).
  - Study the instructions on the following pages, so that you can prepare the participants and conduct the clinical practice session.
  - Make sure that each trainer has a copy of the CLINICAL PRACTICE DISCUSSION CHECKLIST.
  - Find out what can be done if participants find that a child has a serious problem; for example, who to refer the child to.

- If you are leading the small group:
  - Study the instructions on the following pages, so that you are clear about how to conduct the clinical practice.
  - Make sure that the equipment for your small group is set up properly and conveniently.
  - Make sure that you have a copy of the CLINICAL PRACTICE DISCUSSION CHECKLIST, to help you to conduct discussions.
  - Make sure that the participants in your group each have a CHILD AGE CALCULATOR, and one copy each of the LISTENING AND LEARNING SKILLS CHECKLIST and the WORKSHEET: MEASURING WEIGHT, LENGTH AND HEIGHT. Have one or two spare copies with you.
  - Find out where to take your group.
  - Take note of the number of children present and their apparent ages. You will try to ensure that each participant measures at least one child who is less than 2 years old and one child who is between 2 and 5 years of age.
  - Assign each pair to weigh and measure a child. When they have finished, you will assign them another child.

As you follow the text, remember:

► **indicates an instruction to you, the trainer.**

¤ indicates what you say to participants.

I. Prepare the participants 20 minutes

- **One trainer leads a preparatory session with all participants and the other trainers together.**
- **If you have to travel to another facility for the clinical practice session, hold the preparatory session in the classroom before you leave. If necessary, this can take place on the evening or the morning before the clinical session.**
- **Explain the following to the participants:**
  - You are going to practise the LISTENING AND LEARNING skills that you learnt in Sessions 6 and 7 and measuring the growth of a child as discussed in Session 57.
  - You will need to take with you one copy each of the LISTENING AND LEARNING SKILLS CHECKLIST and the WORKSHEET: MEASURING WEIGHT, LENGTH AND HEIGHT, and pencil and paper to make notes.
  - You do not need to take anything else – no books, manuals or handbags.
  - You will work in groups of three or four with one trainer; for measuring, you work in pairs.
  - You should follow the steps listed on the JOB AID: WEIGHING AND MEASURING A CHILD.
- **Explain what to do in the clinic:**
  - Take it in turns to talk to a mother and measure her child, while the other member(s) of the group observe.
  - Practise as many of the LISTENING AND LEARNING SKILLS as possible. Try to get the mother to tell you about herself, her situation and her child. You can talk about ordinary life, not only the measuring of her child.
  - The other participant(s) should stand quietly in the background if there is conversation with the mother, and help their colleague when measuring.
  - Make general observations of the conversation between the mother and the participant. Notice for example, who does most of the talking? Does the participant ask open questions? Does the mother talk freely, and seem to enjoy it?
  - Make specific observations of the participant's LISTENING AND LEARNING SKILLS.
  - Mark a ✓ on your LISTENING AND LEARNING SKILLS CHECKLIST, when they use a skill, to help you to remember for the discussion. Notice if they use helpful non-verbal communication.
  - To measure growth, you will start by determining the child's date of birth, then age, etc. You should record the results on the WORKSHEET: MEASURING WEIGHT, LENGTH AND HEIGHT (page 509 of your *Participant's manual*).
  - If you find that the child has a serious problem, you should (add here the information you found in terms of whom to refer the mother to).
  - If a mother is extremely heavy, you may need to ask a lighter adult to hold the child on a taring scale.
  - Note if the participant makes a mistake, for example, if they use a judging word, or if they ask a lot of questions to which the mother says "yes" or "no".
  - For the measurement exercise, check your results by comparing with those of others who measured the same children.
  - Consult with me or another facilitator if there are discrepancies that you cannot resolve.
  - Remember that you are not counselling the mother at this point.
  - When you have finished, thank the mother.

II. Conduct the clinical practice — 95 minutes

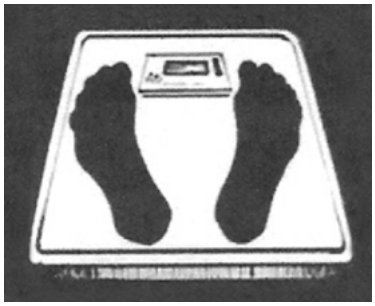
These notes are for the trainers. Trainers should read them to ensure that they know what to do. There is no need to read these notes to the participants.

- Take your group to the ward or clinic.
- Introduce yourself and your group to the staff member in charge.
- Ask which mothers and children it would be appropriate to talk to, and where they are.
- Try to make sure that each participant works with at least one mother.
- Take with you spare copies of the LISTENING AND LEARNING SKILLS CHECKLIST, CLINICAL PRACTICE DISCUSSION CHECKLIST and the WORKSHEET: MEASURING WEIGHT, LENGTH AND HEIGHT.
- Observe participants closely as they work, and correct their technique. There are many details to remember when measuring length and height, and guided practice is required.
- Help participants learn to measure correctly and quickly, by giving them feedback while they work.
  - Ensure that they record weight to the nearest 0.1 kg and length/height to the nearest 0.1 cm.
  - Two participants measuring one child may record different measurements. Retain these for use in the plotting exercise (in Session 59), to illustrate how such differences could lead to very different conclusions about the child's growth status. For the clinical practice exercise on counselling (Session 69), measurements have to be taken accurately, in order to identify problems correctly before counselling caregivers. Allowable differences between two measurers are 0.1 kg for weight and 0.7 cm for length or height.
  - Make note of the names of some children whose measurements would be interesting to plot on growth charts (for example, children who may be underweight, overweight or stunted). There will be a group discussion in Session 59, in which you will demonstrate (using an overhead or PowerPoint projector) plotting the measurements of several children on growth charts, to determine whether they have growth problems.
- In relation to LISTENING AND LEARNING SKILLS, guide the participant who is practising:
  - You do not need to correct every mistake that the participants make in relation to counselling skills immediately. If possible, wait until the discussion afterwards. Then you can both praise what they did correctly and talk about anything they did incorrectly.
  - However, if the participant is making a lot of mistakes, or not making any progress, then you should help them. Try to help in a way that does not make them embarrassed in front of the mother and the group.
  - You need to judge as participants work what will best help them to learn.
  - Use your SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT to correct participants and to help them to develop confidence in their own clinical and counselling skills.
- When each pair of participants has had a chance to weigh and measure at least two children (one less than 2 years and one aged 2–5 years), conclude the exercise and thank the mothers and children.
- For the LISTENING AND LEARNING SKILLS, discuss the participant's performance at the end of the session.
- Use the CLINICAL PRACTICE DISCUSSION CHECKLIST to help you to lead the discussion.
- Ask the GENERAL QUESTIONS, and then ask the specific questions about LISTENING AND LEARNING.
- Go through the LISTENING AND LEARNING SKILLS CHECKLIST, and discuss how the participant practised them. First, ask the participant themself to say how well they think they did. Then ask the other participants. Encourage them to use their counselling skills in the way they give feedback to one another.
- Arrangements should have been made to give each child a small toy and to provide some token of thanks to each mother (whenever appropriate and feasible).

III. Summarize the session — 5 minutes

- Ask participants whether they have any questions, and try to answer them.
- Explain that a summary of this session can be found on pages 507–510 of the *Participant's manual*.

Clinical practice session 7



Worksheet: Measuring weight, length and height

This will be a practical exercise in a clinic setting, or in the classroom if children and measuring equipment can be brought there. The mothers should be present, if possible, to tell the children's dates of birth and to assist with measuring and reassuring them.

Your facilitator will assign you to work in pairs. Each pair should do the following steps for at least two children, one who is less than 2 years old and one who is 2–5 years old.

Review records or ask the mother to determine the child's name, sex and date of birth. Record this information in the inset box below on the left. Use the Child age calculator to determine the child's age today. Make a visual assessment of the child (e.g. does the child appear thin, fat, active, lethargic)?

- Observe the child for signs of marasmus or kwashiorkor. If there is any apparent oedema, test for oedema of both feet.
- Weigh the child.
- Measure the child's length or height. } Each person take a turn
- Record results on the Visit notes page below.

Visit notes

	Date	Age today (completed years/ months or weeks)	Measurements (record below; then plot on charts)		Reason for visit, observations, recommendations
			Weight (kg)	Length/ height (cm)	
Child 1: Sex: DOB:					
Child 2: Sex: DOB:					
Child 3: Sex: DOB					
Child 4: Sex: DOB:					

Clinical practice discussion checklist

Practical skills are best developed by introducing and demonstrating the skills, observing participants as they practise the skills, and giving feedback to participants on how well they performed. Feedback should include praising participants for things done well, and giving gentle suggestions for how to overcome difficulties. Use the checklist below to help guide your feedback discussions.

Questions to ask after each participant completes their turn practising (either in the clinic or using counselling stories)

To the participant who practised:

- What did you do well?
- What difficulties did you have?
- What would you do differently in the future?

To the participants who observed:

- What did the participant do well?
- What difficulties did you observe?

Listening and learning skills (give feedback on the use of these skills in all practical sessions)[1]

- Which listening and learning skills did you use?
- Was the mother willing to talk?
- Did the mother ask any questions? How did you respond?
- Did you empathize with the mother? Give an example.

Skills for building confidence and giving support (give feedback on the use of these skills during clinical practice sessions after Session 10)[1]

- Which Skills for building confidence and giving support were used? (check especially for praise and for two relevant suggestions)
- Which skills were most difficult to use?
- What was the mother's response to your suggestions?

Key messages for complementary feeding (give feedback on the use of these skills in Sessions 53 and 54 [Clinical practice sessions 5 and 6])[2]

- Which messages for complementary feeding did you use? (check especially for "only a few relevant messages")
- What was the mother's response to your suggestions?

General questions to ask at the end of each clinical practice session (in the clinic or using counselling stories)

- What special difficulties or situations helped you to learn?
- What was the most interesting thing that you learnt from this clinical practice session?

[1] See list of skills at the end of the session.
[2] See list of Key messages for complementary feeding on page xiv of the *Participant's manual* and page xvi of the *Trainer's guide*.

Listening and learning skills checklist

Name of counsellor:

Name of observer:

Date of visit:

(✓ for Yes and X for No)

Did the counsellor:

Use Listening and learning skills:

- ☐ Keep the head level with mother/caregiver?
- ☐ Pay attention (eye contact)?
- ☐ Remove physical barriers (tables and notes)?
- ☐ Take time/allow the mother/caregiver time to talk?
- ☐ Use appropriate touch?
- ☐ Ask open questions?
- ☐ Use responses and gestures that showed interest?
- ☐ Reflect back what the mother/caregiver said?
- ☐ Empathize – showing that he or she understood how the mother/caregiver feels?
- ☐ Avoid using words that sound judging?

Counselling skills

Listening and learning skills

1. Use helpful non-verbal communication
2. Ask open questions
3. Use responses and gestures that show interest
4. Reflect back what the mother/caregiver says
5. Empathize – show that you understand how the mother/caregiver feels
6. Avoid using words that sound judging

Skills for building confidence and giving support

1. Accept what a mother/caregiver thinks and feels
2. Recognize and praise what a mother/caregiver and baby are doing right
3. Give practical help
4. Give a little, relevant information
5. Use simple language
6. Make one or two suggestions, not commands

Notes

SESSION 69

Clinical practice session 8: Gathering information and counselling on complementary feeding practices and growth

Objectives

After completing this session, participants will be able to:

- measure a child and correctly determine whether they are growing normally or have a problem
- inform the mother about growth assessment results and identify possible causes of growth problems
- provide counselling to a mother whose child has undernutrition or overweight
- demonstrate how to gather information about complementary feeding using counselling skills and the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS
- provide information about complementary feeding and continuing breastfeeding to a mother of a child aged 6 up to 24 months

Session outline . . . . . 180 minutes

Participants are together as a class led by one trainer, to prepare for the session, and to discuss it afterwards.

Participants work in small groups of 2–4, each with one trainer, or in pairs, for the clinical practice session in a ward or clinic.

I. Prepare the participants . . . . . 15 minutes
II. Conduct the clinical practice . . . . . 150 minutes
III. Discuss the findings as a whole group . . . . . 12 minutes
IV. Summarize the session . . . . . 3 minutes

Preparation

- Make sure that you know where the clinical practice will be held and what times you are expected there. Visit the wards or clinics if you have not done so before. Introduce yourself to the staff members in charge, and make sure that they are prepared for the session (see *Director's guide*).
- Make sure that two copies of the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS and two copies of the COUNSELLING SKILLS CHECKLIST are available for each participant.
- Make sure that each participant has the JOB AID: INVESTIGATING CAUSES OF UNDERNUTRITION and the JOB AID: INVESTIGATING CAUSES OF OVERWEIGHT.
- Make sure that each participant has growth charts for boys and girls, pen or pencil and a notebook
- Make sure there are copies of the CLINICAL PRACTICE DISCUSSION CHECKLIST for each trainer.
- Make sure that one set of the FOOD CONSISTENCY PICTURES is available for each participant.
- Each group needs a typical bowl that a young child would use.
- Have ready COUNSELLING CARD 16: START COMPLEMENTARY FEEDING WHEN THE BABY REACHES 6 MONTHS, COUNSELLING CARD 17: FOOD VARIETY, COUNSELLING CARD 18: COMPLEMENTARY FEEDING FROM 6 UP TO 9 MONTHS, COUNSELLING CARD 19: COMPLEMENTARY FEEDING FROM 9 UP TO 12 MONTHS and COUNSELLING CARD 20: COMPLEMENTARY FEEDING FROM 12 UP TO 24 MONTHS, and the *Guidance on the use of counselling cards*.

- The health facility may keep different types of GROWTH RECORDS for children. If so, the course director will advise you on how to handle the situation

As you follow the text, remember:

► **indicates an instruction to you, the trainer.**

¤ indicates what you say to participants.

I. Prepare the participants 15 minutes

► **One trainer leads a preparatory session with all participants and the other trainers together.**

► **If you have to travel to another facility for the clinical practice session, hold the preparatory session in the classroom before you leave. If necessary, this can take place on the evening or the morning before the clinical session.**

► **Explain to the participants that there will be a visit to a clinic or clinics, so that they can practise measuring children, gathering information on feeding practices and counselling mothers.**

¤ The measurements must be taken and plotted accurately to provide a correct assessment of the child's growth status for the counselling to be appropriate.

► **Explain what the participants should take with them:**

¤ You do not need to bring many items with you. Carrying many things can be a barrier between you and the mother you are talking with. Take with you:

- your CHILD AGE CALCULATOR
- the REFERENCE TOOL: FOOD INTAKE – 6 UP TO 24 MONTHS
- two copies of the COUNSELLING SKILLS CHECKLIST
- two copies of the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS and FOOD CONSISTENCY PICTURES
- the JOB AID: INVESTIGATING CAUSES OF UNDERNUTRITION and the JOB AID: INVESTIGATING CAUSES OF OVERWEIGHT
- one copy of BOY'S GROWTH RECORD and one copy of the GIRL'S GROWTH RECORD
- a common bowl used to feed a young child – one between each pair of participants
- a set of Counselling cards, and the *Guidance on the use of counselling cards*
- pencil and paper.

► **Distribute two blank copies to each person of the COUNSELLING SKILLS CHECKLIST, the JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS and the FOOD CONSISTENCY PICTURES.**

► **Review the steps to follow in counselling mothers (or other caregivers):**

1. After measuring and plotting, show and explain the meaning of the charts to the mother or caregiver.
2. If the child is growing well, let the mother know and congratulate her. Then review the feeding recommendations for the child's present age or the one approaching. Thank the mother and let her go.
3. If there is a growth problem, determine whether the mother recognizes it, as this will influence how the dialogue continues.
4. Follow the steps in the relevant job aid: the JOB AID: INVESTIGATING CAUSES OF UNDERNUTRITION or the JOB AID: INVESTIGATING CAUSES OF OVERWEIGHT.
5. Ask the mother what she thinks are the most common causes of her child's growth problem.

6. Counsel: suggest two or three actions only for the mother to take (do not forget to praise the mother for things she is doing correctly!).
7. Ask checking questions.
8. Speak to a staff member of the facility if you have proposed a return visit for follow-up. Thank the mother and let her go.

▸ Explain how the participants will work:

- You will work in your groups of two to four and each group will have one trainer.
- You will measure the child as you have done during Clinical practice session 7.
- It will not be necessary to start Growth records for the children seen at the clinic. Note each child's age and measurements on a notepad. Plot the child's measurements on the appropriate pages of a Growth record (in pencil, so that you can erase them later). Then use those pages for interpretation and conversation with the mother.
- In the case of children aged 6 up to 24 months with appropriate growth, one participant talks with the mother, filling in the Job aid: Food intake – 6 up to 24 months at the same time.
- The others in the group observe and fill in the Counselling skills checklist.
- If you meet a child who is ill or has a major feeding difficulty, encourage the mother to bring the child to the local health centre.
- Do not offer suggestions for treatment of an ill child.
- In the case of children with a growth problem, use the Job aid: Investigating causes of undernutrition or the Job aid: Investigating causes of overweight, as appropriate.
- For all children aged 2 years or older, use the growth charts and the Job aid: Investigating causes of undernutrition or the Job aid: Investigating causes of overweight, as appropriate.
- Counsel the mother according to your findings.
- **When you talk with a mother:**
- Introduce yourself to the mother and ask permission to talk with her. Introduce the others in your group and explain you are interested in learning about feeding young children in general.
- You may wish to say you are on a course.
- Measure the child, with the mother's help.
- Try to find a chair or stool to sit on, so you are at the same level as the mother.
- Practise as many of the counselling skills as possible as you gather information from the mother using the Job aid: Food intake – 6 up to 24 months, the Job aid: Investigating causes of undernutrition or the Job aid: Investigating causes of overweight, as appropriate.
- Listen to what the mother is saying and try not to ask a question if you have already been told the information.
- Fill out the Job aid: Food intake – 6 up to 24 months as you listen and learn from the mother.
- Use the information you have gathered and then:
  - try to praise things that are going well
  - offer the mother two or three pieces of relevant information
  - offer two or three suggestions that are useful at this time.
- Be careful not to give a lot of advice.
- Answer any questions the mother may ask, as best you can. Ask your trainer for assistance if necessary.
- The participants that are observing can mark a tick on the Counselling skills checklist for every skill that they observe their partner practising. Remember to observe what the "counsellor" is doing rather than thinking about what you would say if you were talking to the mother. The observers do not ask the mother any questions.
- When you have finished talking with a mother, thank her and move away.

- Briefly, discuss with the group and your trainer what you did and what you learnt, and clarify any questions you may have about conducting the exercise.
- Discuss what practices you praised, what feeding problems you noticed, information and suggestions that you offered, and counselling skills used.
- Find another mother and repeat the exercise, with another participant doing the counselling.

- **Each pair of participants should see as many children and mothers as possible. Participants should take turns with the measuring, recording and counselling tasks.**
- **Encourage participants to note feeding practices such as:**
  - whether children are given any food or drinks while waiting
  - whether children are given a bottle or soother/pacifier while waiting
  - general interaction between mothers and children
  - any posters or other information on feeding in the area.
- **Use the CLINICAL PRACTICE DISCUSSION CHECKLIST to guide you as you give feedback to the participants.**

II. Conduct the clinical practice 150 minutes

These notes are for the trainers. Trainers should read them to ensure that they know what to do. There is no need to read these notes to the participants.

- **Take your group to the working area and introduce your group to the person in charge. Listen to any directions that this contact person gives. This may include suitable areas to use, as well as children and mothers that it is best not to talk with.**
- **Remind the participants to try and find mothers of children over 6 months of age.**
  - If you cannot find any more children over 6 months of age, you can take a feeding history from mothers with children under 6 months of age, using the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS.
- **About 10 minutes before the end of the time, remind the groups to start finishing up.**

III. Discuss the findings as a whole group — 12 minutes

- **Return to the whole class group. Discuss what the participants learnt from listening to the mothers and from the completed JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS, as well as from the use of the Job aids for investigating causes of malnutrition.**
  - *Ask: What did you observe in general looking around the health centre?*
- **Wait for a few replies. Prompt if needed – posters, leaflets, food for sale, children with food/bottles/soothers?**
  - Look at the JOB AIDS: FOOD INTAKE – 6 UP TO 24 MONTHS that you filled in.
    - What practices are mothers doing that you could praise and encourage?
    - What areas need improvement?
    - Give some examples of suggestions you made to mothers about complementary feeding practices.
    - Would these suggestions be easy to carry out?
- **Ask participants whether they can implement this process in their own health facilities.**

IV. Summarize the session — 3 minutes

- **Ask participants whether they have any questions, and try to answer them.**
- **Explain that a summary of this session can be found on pages 511–517 of the *Participant's manual*.**

CLINICAL PRACTICE DISCUSSION CHECKLIST

Practical skills are best developed by introducing and demonstrating the skills, observing participants as they practise the skills, and giving feedback to participants on how well they performed. Feedback should include praising participants for things done well, and giving gentle suggestions for how to overcome difficulties. Use the checklist below to help guide your feedback discussions.

Questions to ask after each participant completes their turn practising (either in the clinic or using counselling stories)

To the participant who practised:

- What did you do well?
- What difficulties did you have?
- What would you do differently in the future?

To the participants who observed:

- What did the participant do well?
- What difficulties did you observe?

LISTENING AND LEARNING SKILLS (give feedback on the use of these skills in all practical sessions)[1]

- Which LISTENING AND LEARNING SKILLS did you use?
- Was the mother willing to talk?
- Did the mother ask any questions? How did you respond?
- Did you empathize with the mother? Give an example.

SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT (give feedback on the use of these skills during clinical practice sessions after Session 10)[1]

- Which SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT were used? (check especially for praise and for two relevant suggestions)
- Which skills were most difficult to use?
- What was the mother's response to your suggestions?

KEY MESSAGES FOR COMPLEMENTARY FEEDING (give feedback on the use of these skills in Sessions 53 and 54 [Clinical practice sessions 5 and 6])[2]

- Which messages for complementary feeding did you use? (check especially for "only a few relevant messages")
- What was the mother's response to your suggestions?

General questions to ask at the end of each clinical practice session (in the clinic or using counselling stories)

- What special difficulties or situations helped you to learn?
- What was the most interesting thing that you learnt from this clinical practice session?

[1] See list of skills at the end of the session.
[2] See list of KEY MESSAGES FOR COMPLEMENTARY FEEDING on page xiv of the *Participant's manual* and page xvi of the *Trainer's guide*.

Reference tool: Food intake – 6 up to 24 months

Feeding practice	Ideal feeding practice	Key messages to help counsel mothers
Growth appropriate?		*Look at the shape of the growth curve of the child: is the child growing?*
Child received breast milk?	Yes	Breastfeeding for 2 years or longer helps a child to develop and grow strong and healthy
How many meals of a thick consistency did the child eat yesterday? (use Food consistency pictures as needed)	3 meals	Foods that are thick enough to stay on the spoon give more energy to the child
Child ate an animal-source food yesterday (meat/fish/offal/bird/eggs)?	Animal-source foods should be eaten daily	Animal-source foods are especially good for children, to help them grow strong and lively
Child ate a dairy product yesterday?	Try to give dairy products daily	Animal-source foods are especially good for children, to help them grow strong and lively
Child ate pulses, nuts or seeds yesterday?	If meat is not eaten, pulses or nuts should be eaten daily, with an iron enhancer such as a vitamin-C-rich food	Peas, beans, lentils, nuts and seeds are good for children
Child ate a dark-green or yellow vegetable or yellow fruit yesterday?	A dark-green or yellow vegetable or yellow fruit should be eaten daily	Dark-green leaves and yellow-coloured fruits and vegetables help the child to have healthy eyes and fewer infections
Child ate sufficient number of meals and snacks yesterday, for their age?	Child 6–8 months: 2–3 meals plus 1–2 snacks if hungry Child 9–24 months: 3–4 meals plus 1–2 snacks if hungry	A growing child needs 2–4 meals a day, plus 1–2 snacks if hungry: give a variety of foods
Quantity of food eaten at main meal yesterday appropriate for child's age?	Child 6–8 months: gradually increased to approx. ½ cup at each meal Child 9–11 months: approx. ½ cup at each meal Child 12–24 months: approx. ¾–1 cup at each meal	A growing child needs increasing amounts of food
Caregiver assisted the child at mealtimes?	Yes, assists with learning to eat	A young child needs to learn to eat: encourage and give help … with lots of patience
Child took any vitamin or mineral supplements?	Vitamin and mineral supplements may be needed if child's needs are not met by food intake	*Explain how to use vitamin and mineral supplements if they are needed*
Child ill or recovering from an illness?	Continue to eat and drink during illness and recovery	Encourage the child to drink and eat during illness, and provide extra food after illness to help them recover quickly

Enter a ✓ in the Yes column if the practice is in place.

Enter your initials if a message is given (see REFERENCE TOOL: FOOD INTAKE – 6 UP TO 24 MONTHS for the message).

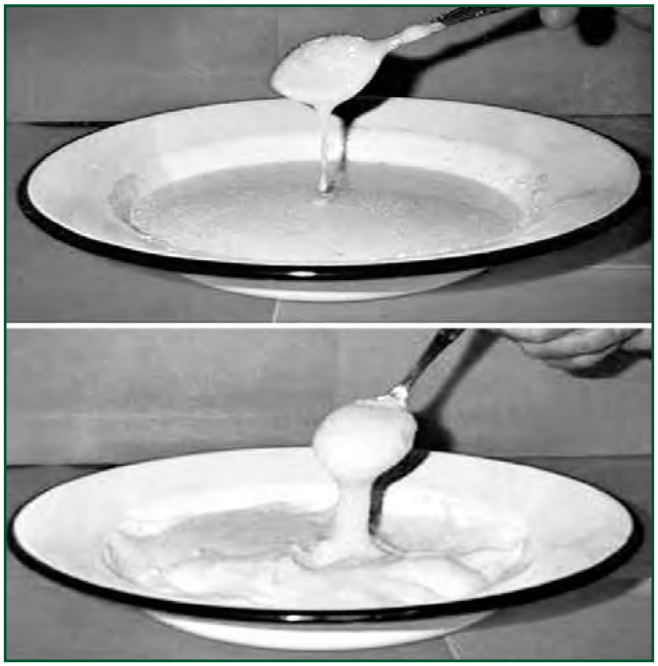
JOB AID: FOOD INTAKE – 6 UP TO 24 MONTHS

Child's name:

Date of birth: **Age of child at visit:**

Feeding practice	Yes / number where relevant	Key message given
Growth appropriate?		
Child received breast milk?		
How many meals of a thick consistency did the child eat yesterday? (use FOOD CONSISTENCY PICTURES as needed)		
Child ate an animal-source food yesterday (meat/fish/offal/bird/eggs)?		
Child ate a dairy product yesterday?		
Child ate pulses, nuts or seeds yesterday?		
Child ate a dark-green or yellow vegetable or yellow fruit yesterday?		
Child ate sufficient number of meals and snacks yesterday, for their age?		
Quantity of food eaten at main meal yesterday appropriate for child's age?		
Caregiver assisted the child at mealtimes?		
Child took any vitamin or mineral supplements?		
Child ill or recovering from an illness?		

Food consistency pictures



COUNSELLING SKILLS CHECKLIST

Name of counsellor:

Name of observer:

Date of visit:

(✓ for Yes and X for No)

Did the counsellor:

Use LISTENING AND LEARNING SKILLS:

☐ Keep the head level with mother/parent/caregiver?

☐ Pay attention (eye contact)?

☐ Remove barriers (tables and notes)?

☐ Take time? Allow the mother/caregiver time to talk?

☐ Use appropriate touch?

☐ Ask open questions?

☐ Use responses and gestures that showed interest?

☐ Reflect back what the mother/caregiver said?

☐ Empathize – showing that he or she understood how the mother/caregiver feels?

☐ Avoid using words that sound judging?

Use SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT:

☐ Accept what the mother/caregiver thinks and feels?

☐ Recognize and praise what the mother/caregiver and baby are doing right?

☐ Give practical help?

☐ Give a little, relevant information?

☐ Use simple language?

☐ Make one or two suggestions, not commands?

Notes

Notes (contd)

SESSION 70

Growth charts

Objectives

After completing this session, participants will be able to:

- explain the meaning of the standard curves
- plot a child's weight and length on a growth chart
- interpret individual growth curves and define whether a child is growing well or has malnutrition

Session outline . . . . . 75 minutes

Participants are all together for a lecture presentation by one trainer.

I.	Introduce the session, present **Slide 70/1**	5 minutes
II.	Explain how to plot a growth chart (**Slides 70/2** and **70/3**)	20 minutes
III.	Discuss how to interpret individual paths (**Slides 70/4** to **70/6**)	40 minutes
IV.	Explain how to classify growth problems	5 minutes
V.	Summarize the session	5 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides.
- Study the **Slides 70/1** to **70/6** and the text that goes with them, so that you are able to present them.
- **Slide 70/2** needs to be copied onto an overhead transparency, as you will demonstrate how to mark the weight and length/height of a child on this overhead. You will need a marker to mark the overhead.
- Make sure that you have one copy of the local growth chart for each participant.
- Make sure that you have enough copies of the growth charts with standard curves for all participants.
- Read the **Further information** sections, so that you are familiar with the ideas that they contain, so that you can answer participants' questions.

As you follow the text, remember:

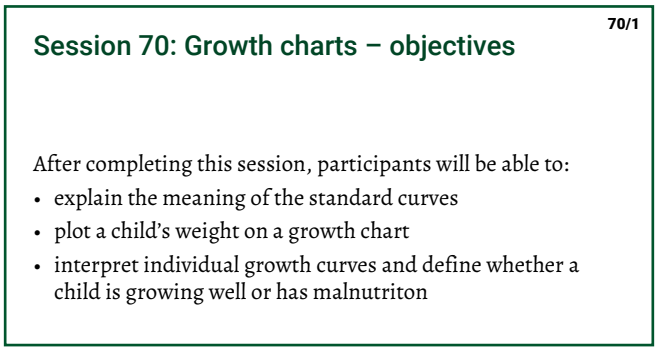
▶ indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the session — 5 minutes

► Show **Slide 70/1 – Session 70** – objectives and read out the objectives:

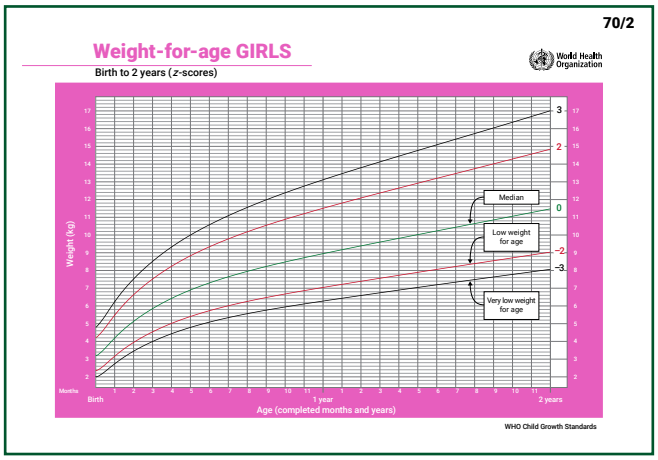


► Make these points:

- When counselling on infant feeding, it is important to understand growth charts.
- If growth charts are not interpreted accurately, incorrect information can be given to a caregiver, leading to worry and loss of confidence.
- Growth charts can reflect past and present conditions, including food intake and health status.
- As well as weight, another measurement you may use is length or height.
- A child who is undernourished for a long time will show slow growth in length or height. This is referred to as stunting or very short height-for-age.
- A shorter child generally weighs less than a taller child of the same age and so they may be on different lines on the growth chart for weight. This is normal.
- What is most important is to see that the curve follows a trend that indicates the child is growing and there is no growth problem.
- Good feeding practices, both before the child is 6 months old and after complementary feeds have been introduced, can help prevent growth faltering in both weight and length, as well as any tendency to overweight.

II. Explain how to plot a growth chart — 20 minutes

► Show **Slide 70/2 – Blank weight chart** and make the points that follow:



- Here is a weight chart for girls.
- *Ask: Where do we find the child's age on the growth chart?*

► Wait for a few replies and then continue.

- The child's age in months is along the bottom of the growth chart (point this out on the overhead).
- *Ask: Where do we find the child's weight on the growth chart?*

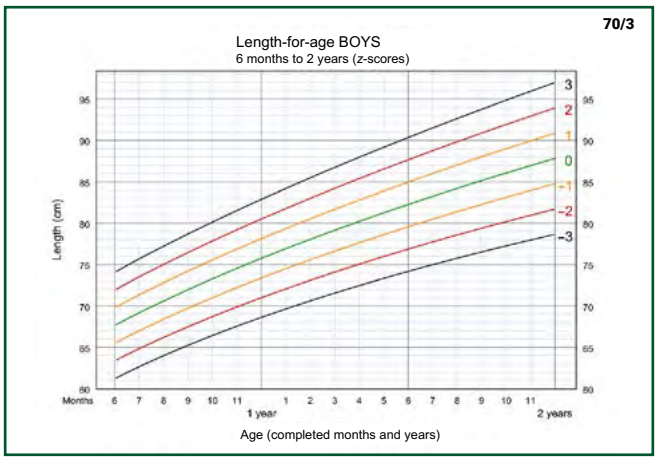
► Wait for a few replies and then continue.

- The child's weight is up the side of the chart (point this out on the overhead).
- There are five curves on this chart. The line labelled 0 is the median, which is, generally speaking, the average. It is also called the 50th percentile because the weights of 50% of healthy children are below it and 50% are above it.
- Most healthy children are near this median curve, either a little above or below it.
- The other lines, called *z*-score lines, indicate distance from the average. A point or trend that is far from the median, such as 3 or –3, usually indicates a growth problem.
- The growth curve of a normally growing child will usually follow a track that is roughly parallel to the median. The track may be above or below the median.
- A child whose weight-for-age is below the –2 *z*-score line (fourth line from the top) is underweight. A genetically or naturally small child may be near this curve but still be growing well.
- The bottom line (–3) indicates very low weight-for-age or severe underweight. A child near this line is probably not healthy, and needs attention (point this out on the overhead).
- In some places, the charts have a different number of lines on them or use colour bands to show the ranges, or sometimes there is one chart for both boys and girls (show local growth charts and point out similar features).
- Now we will plot the weight of Maria who is 15 months (1 year and 3 months) old. When she came today to the health facility with her mother, her weight chart was not available and you do not know Maria. Her weight today is 8 kg.
- Each time the child is weighed, the column for the age is followed up and the line for the weight is followed across to find the place to mark the dot (*show this using a ruler/straight edge, to make it easier to see where the lines cross. Show how you find Maria's age and her weight, and mark at 8 kg*).
- *Ask: What does Maria's weight today tell you?*

► Wait for a few replies and then continue.

- One weight on its own does not give you much information. Maria's weight seems a little low for her age but you do not know whether she is a small child who has grown steadily or a child who has lost weight. You need a pattern of marks before you can judge the tendency of growth.
- You will need to talk to Maria's mother to find out more about her eating and health. You will also observe Maria to see whether she looks wasted or ill, or whether she is active and healthy.
- Document Maria's weight on the growth chart. Assuming Maria is healthy and you are not concerned about her weight or eating, encourage Maria's mother to bring her back in a month for another weight check.
- Connecting the dots for each visit forms the growth line for an individual child. Any quick change in trend (the child's curve veers upward or downward from its normal track) should be investigated, to determine its cause and remedy any problem.
- A flat line indicates that the child is not growing. This is called stagnation and may also need to be investigated.
- A growth curve that crosses a *z*-score line may indicate risk.

► Show **Slide 70/3 – Blank length chart** and make the points that follow:

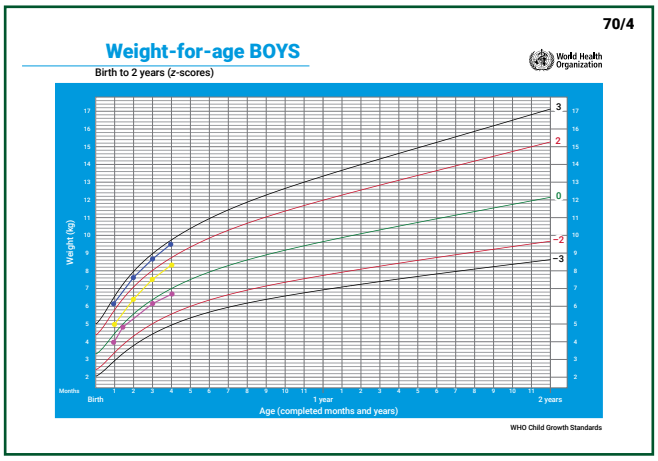


- Length/height-for-age reflects attained growth in length or height at the child's age at a given visit. This indicator can help identify children who are stunted (short) due to prolonged undernutrition or repeated illness. Children who are tall for their age can also be identified, but tallness is rarely a problem unless it is excessive and may reflect uncommon endocrine disorders.
- In the chart, the *x*-axis shows age, and the *y*-axis shows length in centimetres. Age is plotted in completed weeks from birth until age 3 months; in completed months from 3 to 12 months; and then in completed years and months.
- To plot length/height-for-age following the convention of this course, plot completed weeks, months, or years and months on a vertical line (not between vertical lines). For example, if a child is 5½ months old, the point will be plotted on the line for 5 months (not between the lines for 5 and 6 months).
- Plot length on or between the horizontal lines as precisely as possible. For example, if the measurement is 60.5 cm, plot the point midway between the horizontal lines 60 cm and 61 cm.
- To plot weight-for age, use the same convention to plot completed weeks, months, or years and months on a vertical line (not between vertical lines). Plot weight on a horizontal line or in the the space between lines, to show weight measurements to 0.1 kg, e.g. 7.8 kg.plots completed weeks.
- When points are plotted for two or more visits, connect adjacent points with a straight line, to better observe the trend.
- Judge whether a plotted point seems sensible, and if necessary, re-measure or re-weigh the child. For example, a baby's length should not be shorter than at the previous visit. If it is, one of the measurements was wrong.

III. Discuss how to interpret individual paths — 40 minutes

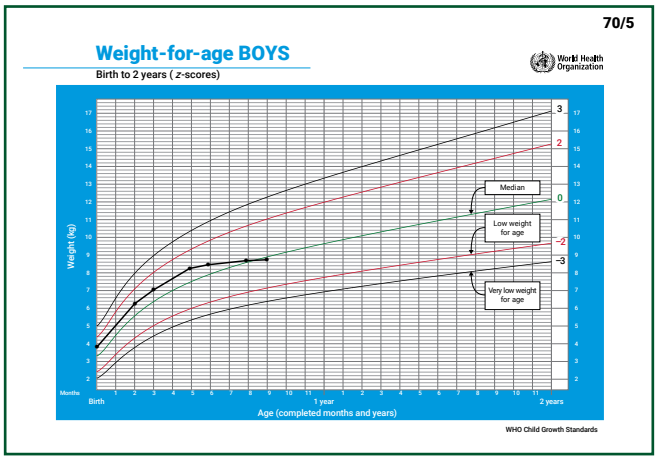
Group work

- **Divide participants into three groups, each group with a trainer/facilitator.**
- **Give each group three growth charts:**
  1. three boys from birth up to 4 months plotted on the same growth chart
  2. 9-month old Manuel
  3. 3-month-old Ana
- **Ask each group to interpret the three charts and give them the following questions:**
  - What can you tell from looking at each chart?
  - What questions would you ask Manuel's mother?
  - What do you think is the reason for Manuel's static weight?
  - What questions would you ask Ana's mother and what would you want to check?
  - What do you think is the cause of Ana's slow weight gain?
  - Do you think Ana should be started on complementary feeds since she is not gaining weight?
- **After about 15 minutes, bring all participants back into the large group.**
- **Show Slide 70/4 – Individual paths and ask one group to report back on the results of their discussion:**



- **Ask other groups to add additional comments.**
- **Make the following points, as needed, and considering the participants' comments:**
  - Here we have a growth chart for boys that shows the curves of three children who were weighed regularly.
  - The growth lines on the chart show a similar shape to the standard curves. However, each child is growing along his individual path. Notice that they all had different weights from the beginning.
  - A child may grow more at one time than another, so there may be small ups and downs in the line. So it is important to look at the general shape or trend.

► Show **Slide 70/5 – Manuel's weight chart** and ask the second group to report back on the results of their discussion:



► Ask other groups to add additional comments.

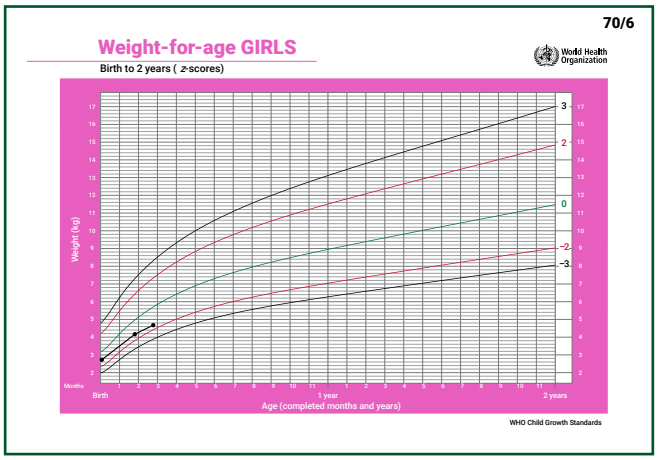
► Make the following points, as needed, and considering the participants' comments:

- Here we have a growth chart for Manuel, aged 9 months, who has been weighed regularly.
- Manuel grew well for the first few months but has not grown at all in the last 3 months.
- Some questions you might ask Manuel's mother are:
  - *How was Manuel fed for the first 6 months of life?*
  - *What milk does Manuel have now?*
  - *What feeds does Manuel receive now? How often does he eat? How much does he eat? What types of food does he eat?*
  - *How has Manuel's health been over the past few months?*
- You find out that Manuel was exclusively breastfed for the first 6 months of life and that his mother is still breastfeeding him frequently by day. He sleeps with his mother at night and breastfeeds during the night. At 6 months, his mother started to give him thin cereal porridge twice a day.
- *Ask: What is Manuel's mother doing that could be praised?*

► Wait for a few replies and then continue. It is helpful to start encouraging participants to look for things to praise.

- Some ways you might praise Manuel's mother are:
  - *You did well to exclusively breastfeed Manuel for the first 6 months of life – look how well he grew just on your breast milk.*
  - *It is good that you are still breastfeeding Manuel now that he is over 6 months of age.*
  - *It is good that you are continuing to feed Manuel at nights and that he is sleeping with you.*
- Manuel's static weight might be due to the fact that he is only receiving two meals of thin porridge twice daily. He needs more frequent, nutrient-rich complementary foods each day, now that he is over 6 months of age. We will talk in more detail about complementary foods in other sessions in the course.

- Show **Slide 70/6 – Ana's weight chart** and ask the third group to report back on the results of their discussion:



- Ask other groups to add additional comments.
- Make the following points, as needed, and considering the participants' comments:
  - Here we have a growth chart for Ana who is 3 months old.
  - She is gaining weight too slowly.
  - Some questions you might ask Ana's mother are:
    - *How is Ana?*
    - *How is Ana feeding?*
    - *How often does Ana feed?*
    - *Where does Ana sleep?*
    - *If the mother says she is breastfeeding – How is breastfeeding going for you and Ana?*
  - You would want to assess a breastfeed, looking at positioning, attachment and the length of the feed.
  - Her mother tells you that Ana is well and a good baby who cries little. She only wants to feed four or five times each day, which her mother finds helpful, as she is busy during the day. Ana sleeps with her mother at night.
  - *Ask: What do you think is the cause of Ana's slow weight gain?*
- Wait for a few replies and then continue.
  - Ana does not breastfeed often enough.
  - Giving complementary feeds should not be necessary. If Ana is breastfed more often during the day and night (at least eight times in each 24 hours), then she should gain weight.

IV. Explain how to classify growth problems — 5 minutes

- Make the following points:
  - Following the growth of a child helps us to prevent growth problems.
  - You can compare the points plotted on the child's growth charts with the *z*-score lines, to determine whether they indicate a growth problem. Measurements in the shaded boxes are in the normal range.

Growth problems

Growth problems chart

Compare the points plotted on the child's growth charts with the *z*-score lines, to determine whether they indicate a growth problem. Measurements in the shaded boxes are in the normal range.

z-score[a]	Growth indicators			
	Length/ height-for-age	Weight-for-age	Weight-for-length/height	BMI-for-age
Above 3	See note 1	See note 2	Obese	Obese
Above 2			Overweight	Overweight
Above 1			Possible risk of overweight (see note 3)	Possible risk of overweight (see note 3)
0 (median)				
Below –1				
Below –2	Stunted (see note 4)	Underweight	Wasted	Wasted
Below –3	Severely stunted (see note 4)	Severely underweight (see note 5)	Severely wasted	Severely wasted

BMI: body mass index.

[a] The *z*-score label in this column refers to a range. For example "above 2" means 2.1 to 3.0; "median" includes –1.1 to 1.0; "below –2" refers to –2.1 to –3.0, etc.

Notes:

1. A child in this range is very tall. Tallness is rarely a problem, unless it is so excessive that it may indicate an endocrine disorder such as a growth-hormone-producing tumour. Refer a child in this range for assessment if you suspect an endocrine disorder (e.g. if parents of normal height have a child who is excessively tall for their age).
2. A child whose weight-for-age falls in this range may have a growth problem, but this is better assessed from weight-for-length/height or BMI-for-age.
3. A plotted point above 1 shows possible risk. A trend towards the 2 *z*-score line shows definite risk.
4. It is possible for a stunted or severely stunted child to become overweight.
5. This is referred to as very low weight in Integrated Management of Childhood Illness training modules; see IMCI in-service training. Geneva: World Health Organization; 1997 (WHO/CHD/97.3.K; https://www.who.int/publications/m/item/WHO-CHD-97.3.K).

V. Summarize the session 5 minutes

- **Ask participants whether they have any questions, and try to answer them.**
- **Make these points:**
  - In this session, we have talked about the use of growth charts.
  - Growth charts are one tool to give us information about how well a child is feeding.
  - We will be using growth charts in other sessions in the course.
  - Explain that a summary of this session can be found on pages 519–523 of the *Participant's manual*.

Further information

The *WHO child growth standards* and infant feeding

The growth charts used in this chapter are part of the World Health Organization (*WHO*) *child growth standards*. Based on an international sample, they demonstrate that children born in different regions of the world have the potential to grow and develop to within the same range of height and weight for age when given the optimum start in life.

The analysis of data from the WHO Multicentre Growth Reference Study (MGRS) documents the strong similarity in linear growth from birth to 5 years in major ethnic groups living under relatively affluent conditions, and provides the message that when health and key environmental needs are met, the world's children grow very similarly wherever they are.

In addition to being truly international, the *WHO child growth standards* differ from existing growth charts in a number of ways: they describe how children should grow, and establish breastfeeding as the biological norm and the breastfed infant as the standard for measuring healthy growth. The shape of the *WHO child growth standards* differs from earlier references, particularly during the first 6 months of life when growth is rapid. They describe the early growth of children who are appropriately fed and protected from morbidities that could affect growth, and whose mothers did not smoke.

The *WHO child growth standards* were derived from the WHO MGRS. A comprehensive review of the uses and interpretation of anthropometric references undertaken by WHO in the early 1990s concluded that new growth curves were needed to replace the National Center for Health Statistics (NCHS)/WHO growth reference, which had been recommended for international use since the late 1970s. The review documented deficiencies of the NCHS/WHO reference and led to a plan for developing new charts to document how children should grow in all countries, rather than merely describing how they grew at a particular time and place. To develop new standards, the MGRS was carried out to collect primary growth data and related information from 8440 healthy breastfed children from diverse ethnic backgrounds and cultural settings (Brazil, Ghana, India, Norway, Oman and the United States of America).

The sample used to create the standards complied with three infant feeding criteria: (1) exclusively or predominantly breastfed for at least 4 months; (2) introduced to complementary foods between 4 and 6 months; and (3) partially breastfed up to at least 12 months. Note that WHO's policy on optimal duration of exclusive breastfeeding changed in 2000 after the initiation of the MGRS in 1997. The recommendation now is that all babies should be exclusively breastfed for 6 months, followed by the addition of complementary feeding while continuing breastfeeding up to 2 years or beyond. The MGRS lactation support teams were successful in enhancing breastfeeding practices and achieving high rates of compliance with the study's feeding criteria. The experience confirmed the observation that community-based breastfeeding counselling is a cost-effective way to increase rates of exclusive breastfeeding.

Countries should decide whether to adopt the standards and, if so, which charts to introduce for general use.

Notes

Notes (contd)

MODULE 7

HIV and infant feeding

SESSION 71

Overview of HIV and infant feeding 1

Objectives

After completing this session, participants will be able to:

- explain the risk of mother-to-child transmission of HIV
- describe factors that influence mother-to-child transmission of HIV
- describe the key principles and recommendations for infant feeding in the context of HIV
- describe the importance of antiretroviral drugs in reducing mother-to-child transmission of HIV and increasing HIV-free survival in infants

Session outline . . . . . 60 minutes

Participants are all together for a lecture presentation by one trainer.

I. Introduce the session, present **Slide 71/1** . . . . . 3 minutes
II. What is HIV and how is it transmitted? (**Slides 71/2** and **71/3**) . . . . . 5 minutes
III. Review the risk of mother-to-child transmission of HIV (**Slide 71/4**) . . . . . 10 minutes
IV. Explain factors that affect mother-to-child transmission of HIV (**Slide 71/5**) . . . . . 10 minutes
V. Explain HIV-free survival (**Slide 71/6**) . . . . . 2 minutes
VI. Review key principles and recommendations for infant feeding in the context of HIV (**Slides 71/7** to **71/10**) . 15 minutes
VII. Antiretroviral therapy and prophylaxis (**Slide 71/11**). . . . . 10 minutes
VIII. Summarize the session . . . . . 5 minutes

Preparation

- **Select Session 71 if the country/region has a high prevalence of HIV**.
- Refer to the Introduction for guidance on giving a presentation with slides.
- Study the **Slides 71/1** to **71/11** and the text that goes with them, so that you are able to present them.
- Find out the local prevalence of HIV infection among women of childbearing age (15–49 years) and among women receiving antenatal care in the area, if known.
- Review recent World Health Organization (WHO), United Nations Children's Fund (UNICEF) and Joint United Nations Programme on HIV/AIDS (UNAIDS) documents, so that you are able to refer participants to them, as needed for further information:
  - WHO, UNICEF, UNAIDS. Guidelines on HIV and infant feeding 2010: principles and recommendations for infant feeding in the context of HIV and a summary of evidence. Geneva: World Health Organization; 2010 (http://apps.who.int/iris/bitstream/10665/44345/1/9789241599535_eng.pdf).
  - WHO, UNICEF. Guideline: updates on HIV and infant feeding: the duration of breastfeeding, and support from health services to improve feeding practices among mothers living with HIV. Geneva: World Health Organization; 2016 (http://apps.who.int/iris/bitstream/10665/246260/1/9789241549707-eng.pdf).
  - Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach, 2nd ed. Geneva: World Health Organization, 2016 (http://apps.who.int/iris/bitstream/10665/208825/1/9789241549684_eng.pdf).

- Familiarize yourself with national policies, strategies and guidelines on infant and young child feeding, if they exist. Check whether they include issues related to HIV/AIDS, and whether there is a specific infant feeding recommendation for HIV-infected mothers in your region or district.
- Read the **Further information** sections, so that you are familiar with the ideas that they contain, so that you can answer participants' questions.

As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the session 3 minutes

► Show **Slide 71/1 – Session 71 – objectives** and read out the objectives:

71/1

Session 71: Overview of HIV and infant feeding 1 – objectives

After completing this session, participants will be able to:
- explain the risk of mother-to-child transmission of HIV
- describe factors that influence mother-to-child transmission of HIV
- describe the key principles and recommendations for infant feeding in the context of HIV
- describe the importance of antiretroviral drugs in reducing mother-to-child transmission of HIV and in increasing HIV-free survival in infants

► Make these points:

¤ HIV is a devastating infection, which touches many aspects of our lives. It affects people of all ages, the rich and the poor, and all sectors of society, and is a major cause of mortality. It is a worldwide challenge, affecting some countries far more than others.

¤ Why do we include HIV in this course? What does it have to do with infant and young child feeding?

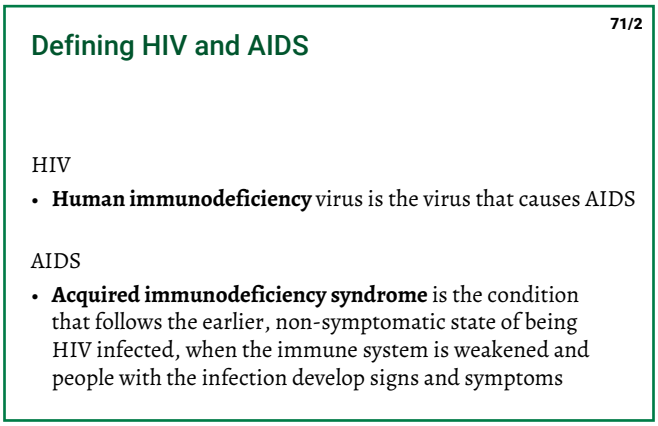
¤ HIV can be passed from a mother to her baby during pregnancy, labour and delivery and during breastfeeding. Antiretroviral (ARV) drugs reduce mother-to-child-transmission of HIV, and increase the HIV-free survival of babies. Breastfeeding prevents babies dying from common causes and is recommended as a principal feeding option, combined with ARV drugs, for mothers living with HIV.

¤ Updated global recommendations on the use of ARV drugs for treating and preventing HIV infection have important implications for infant feeding recommendations. The World Health Organization (WHO) now recommends lifelong antiretroviral therapy (ART) for everyone from the time when any adult (including pregnant and breastfeeding women) or child is first diagnosed with HIV infection. This has affected the role of health workers and infant feeding counsellors in providing information and support to pregnant and breastfeeding women living with HIV, and their babies.

II. What is HIV and how is it transmitted? 5 minutes

- We will start by reminding ourselves what the terms HIV and AIDs stand for and look at why HIV should concern us.

▶ Show **Slide 71/2 – Defining HIV and AIDS** and ask one participant to read out the definitions:



▶ Make these points:

- Individuals who are infected with HIV do not show any signs or symptoms at first and often do not know they are infected. During this time, the body produces antibodies and other specialized immune cells, such as CD4 cells, that fight HIV.
- For several years, CD4 cells are able to keep the virus under control in a person's body and they remain healthy. However, eventually the HIV virus controls and destroys these immune cells.
- When this happens, the body becomes less able to fight other types of infections such as pneumonia, diarrhoea, tuberculosis (TB) and meningitis. When a person can no longer fight these infections, starts getting symptoms and loses weight, we say they are suffering from AIDS. Without any treatment, they usually die.
- To find out whether a person has HIV, a special blood test can be done to see whether there are HIV antibodies in their blood. A positive test means that the person is infected with HIV.
- Once a person has the virus in their body, it can be passed on to another person through:
  - exchange of HIV-infected body fluids such as vaginal fluid, semen or blood, during unprotected sexual intercourse
  - HIV-infected blood transfusions or sharing contaminated needles, for example in the case of drug users sharing needles, or needle injuries in hospitals.
- Children too can be infected in these ways, but they can also be infected by their mothers, during pregnancy, labour, delivery and breastfeeding.

► Show **Slide 71/3 – Mother-to-child transmission of HIV** and read it out:

71/3

Mother-to-child-transmission of HIV

Young children who get HIV are usually infected:
- during pregnancy across the placenta
- at the time of labour and birth, through blood and secretions
- through breastfeeding or breast-milk feeding

This is called mother-to-child transmission of HIV, or MTCT

► Make these points:

- This slide shows how the virus can pass from a mother living with HIV to her baby at different time periods, including during the postnatal period if the mother breastfeeds her baby. It is during the postnatal period that the risk of mother-to-child-transmission is of particular concern to us.

III. Review the risk of mother-to-child transmission of HIV 10 minutes

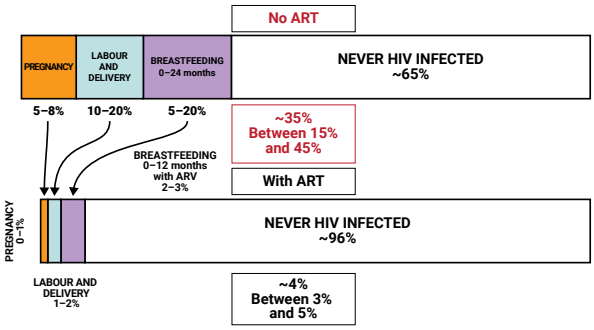
► Make these points:

- Let us now consider when mother-to-child transmission of HIV occurs and how many mothers and babies are likely to be affected.

► Show **Slide 71/4 – Risk of mother-to-child transmission in pregnancy, labour and delivery, and breastfeeding for 2 years: without and with ART** and read out the title of the slide:

71/4

Risk of mother-to-child transmission in pregnancy, labour and delivery, and breastfeeding for 2 years: without and with ART



► Make these points:

- Look at the first bar on this slide; you can see in the first three boxes that a large percentage of babies, about 65%, never become infected and remain free of HIV even when no ARV drugs are available. However, about 35% (range 15–45%) of babies will become HIV infected through mother-to-child transmission if a mother does not receive ART.
- Not all mothers know their HIV status, so it is important when counselling a pregnant woman about HIV testing that she understands the risk to herself and to her baby if she is living with HIV but does not receive ARV drugs.
- Look at the first box. During pregnancy, around 0–1% of babies will be infected when ART is given.
- Now look at the next box. When ART is given to the mother, the risk of transmission during labour and delivery is reduced to 1–2% (from 10–20% without ART), which is a dramatic reduction in comparison.
- Now look at the breastfeeding box. The child is exposed to HIV as long as they are fed breast milk. But look at the percentages when ARV drugs are given to the mother. Only 2–3% of babies become HIV infected.

- The overall mother-to-child-transmission (including intrapartum and postpartum transmission) when mothers receive ART is 3–5%, compared to an average of 35% when treatment is not given. This impressive reduction in rate shows the impact of ART in increasing the number of babies who can be expected to survive free of HIV.
- You may think that even a 3–5% risk of HIV transmission to an HIV-exposed baby is too high to recommend breastfeeding. But statistics show that an HIV-exposed baby who does not breastfeed is at an even greater risk of dying from more common diseases, such as diarrhoea or pneumonia.
- Additionally, the breastfeeding mother receiving ART will be healthier and live longer, thus being able to take care of her infant.

IV. Explain factors that affect mother-to-child transmission of HIV — 10 minutes

▶ **Make these points:**

- The risk of a mother transmitting the virus to her baby depends on a number of factors, such as how ill the mother is, how much virus is in her blood, how long breastfeeding lasts and, most importantly, whether she is taking ART. This explains the numbers we saw in the previous slide and why there are differences in the risk of transmission between individual mothers.
- *Ask: What factors can affect mother-to-child transmission of HIV during pregnancy, labour and delivery?*

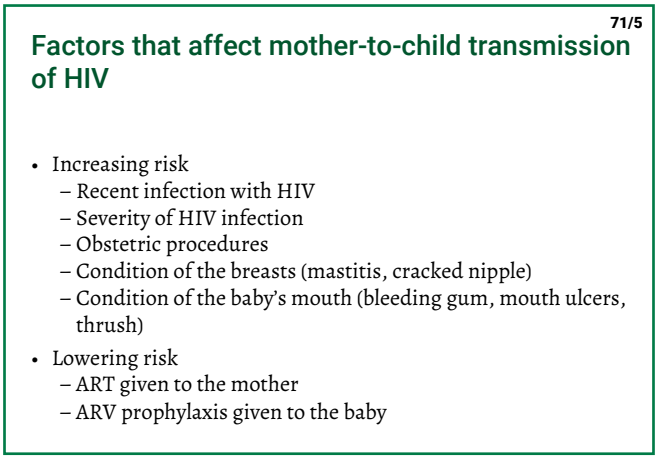
▶ **Write responses on flipchart paper and put on the wall and then continue.**

- *Ask: What factors can affect mother-to-child-transmission during breastfeeding?*

▶ **Write responses on flipchart paper and put next to the first sheet and then continue.**

- Let us compare the factors you suggested and what is on this slide.

▶ Show **Slide 71/5 – Factors that affect mother-to-child transmission of HIV** and read it out:



▶ **Ask participants to turn to page 529 of their *Participant's manual* and find the section FACTORS THAT AFFECT MOTHER-TO-CHILD TRANSMISSION OF HIV.**

▶ **Ask participants to read out each point in turn and then give the following information.**

Factors increasing the risk of transmission

- **Recent infection with HIV**
  If a woman becomes infected with HIV during pregnancy or while breastfeeding, she has higher levels of virus in her blood, and her baby is more likely to be infected. All sexually active men and women need to know that unprotected sexual intercourse exposes them to the risk of infection with HIV. They may infect their partners, and their baby too will be at a higher risk. Using condoms during sexual intercourse is crucial to reducing HIV infections.
- **Severity of HIV infection**
  If the mother is already ill with an HIV-related disease or AIDS and is not receiving ART, she has more virus in her body, and transmission to her baby is more likely.
- **Obstetric procedures**
  During labour and delivery, any interventions that can damage the mother's or the baby's skin or mucous membranes and cause bleeding should be avoided. This means avoiding unnecessary use of instrumentation, episiotomy and premature or artificial rupture of the membranes, unless medically required. Invasive gastric or oral suctioning when the baby is delivered, which can damage the delicate tissues in the baby's nose or mouth, should also be avoided. It also means avoiding procedures that are likely to result in the separation of the mother and baby after delivery, causing a delay in skin-to-skin contact and early initiation of breastfeeding.
- **Conditions of the breast**
  Nipple fissures (particularly if the nipple is bleeding), mastitis or breast abscess may increase the risk of HIV transmission through breastfeeding. Good breastfeeding technique helps to prevent these conditions, and also reduces transmission of HIV.
- **Condition of the baby's mouth**
  Mouth sores or thrush in the baby may make it easier for the virus to get into the baby's body through the damaged skin.

Factors lowering the risk of transmission

- **Antiretroviral therapy given to the mother**
  Mothers living with HIV provided with ART for life, or until after delivery or all breastfeeding stops, have a much lower risk of passing HIV on to their babies.
- **ARV prophylaxis given to the baby**
  ARV prophylaxis given to the baby after birth (for 4–6 weeks) also reduces the risk of mother-to-child transmission of HIV.

Breastfeeding-related factors

- **Mixed feeding**
  In the absence of interventions, the risk of HIV transmission is greater if a baby is given other foods or drinks at the same time as breastfeeding during the first months of life. This is known as mixed feeding. The risk is less if the baby is exclusively breastfed. Other food or drinks may cause diarrhoea and damage the gut, which might make it easier for the virus to enter the baby's blood.
- Note, however, that mothers living with HIV can be reassured that ART reduces the risk of HIV transmission, even in the context of mixed feeding. Although exclusive breastfeeding is recommended, practising mixed feeding is not a reason to stop breastfeeding in the presence of ARV drugs.
- **Duration of breastfeeding**
  The breast milk of a mother living with HIV contains the virus. Therefore, the child is exposed to HIV as long as they are receiving the breast milk. The number of virus particles in the breast milk can be reduced if the mother is correctly and consistently taking ART. It is thus important to support adherence to ART for the full duration of breastfeeding.
- Mothers living with HIV should breastfeed for at least 12 months and may continue breastfeeding for up to 24 months or longer (similar to the general population), while being fully supported for ART adherence.
- Note, however, that mothers living with HIV on ART can be reassured that shorter durations of breastfeeding of less than 12 months are better than never initiating breastfeeding at all.

► **Make these additional points:**

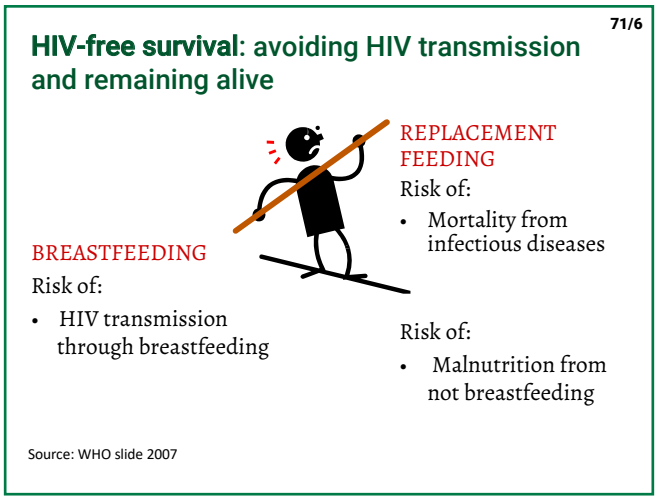
- The following strategies can help women to reduce the risk of these factors causing HIV transmission:
  - practising safe sexual intercourse (with a condom), including during pregnancy and breastfeeding
  - receiving regular antenatal and postnatal care
  - practising good attachment and positioning
  - making HIV testing, care and treatment interventions available to all women during maternal and child health services
  - continuous availability of ART in health centres, and support to people living with HIV for adherence to the treatment
  - giving appropriate public health messages.

V. Explain HIV-free survival — 2 minutes

► **Make these points:**

- The aim of HIV-free survival is for babies of HIV-infected mothers to remain free from HIV and to also remain free of other diseases.

► **Show Slide 71/6 – HIV-free survival and read it out:**

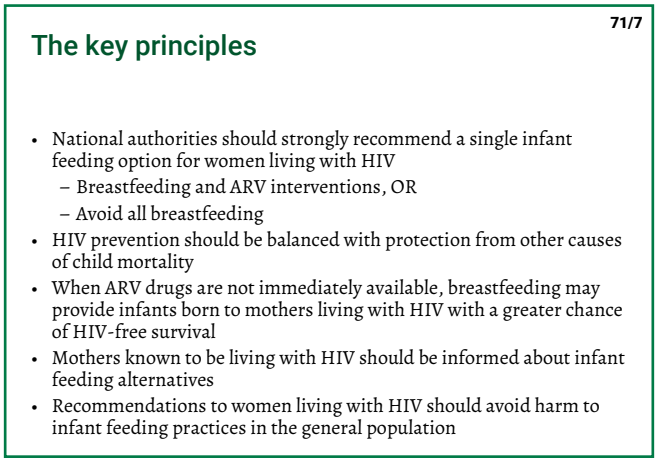


► **Make these points:**

- You can see on this slide, the balance between the risk of an HIV-exposed baby becoming infected with HIV through breastfeeding and the risk of the baby dying from common infectious diseases such as diarrhoea or pneumonia, or from malnutrition if they are not breastfeeding.
- Although giving the baby replacement feeds would reduce the risk of HIV transmission to the baby, it does not necessarily increase the chances of the baby's survival, as the infants are more likely to die from childhood illnesses (when they don't get the antibodies to fight them).
- We know that HIV-exposed babies benefit from breastfeeding for all the reasons we have already discussed in previous sessions, but we also know there is still a very small possibility of the baby becoming infected with HIV, even when the mother is receiving ART (3–5% at 12 months with full adherence).
- For many years, health workers and mothers have been asking the question "which is the safest method of infant feeding for a mother who is living with HIV or who does not know her HIV status, or for a baby who is HIV exposed and still HIV negative?".
- It is clear, from recent publications, that ARV drugs can reduce mother-to-child transmission and more babies who are breastfed can survive their infancy free of HIV. This means that, when deciding how a baby should be fed, health authorities also have to consider which method of feeding poses the lowest risk of illness or of death to a baby.
- In the next slide, we look at ways in which recent guidelines on HIV and infant feeding may help to answer this question.

VI. Review key principles and recommendations for infant feeding in the context of HIV
15 minutes

▸ Show **Slide 71/7 – The key principles**:



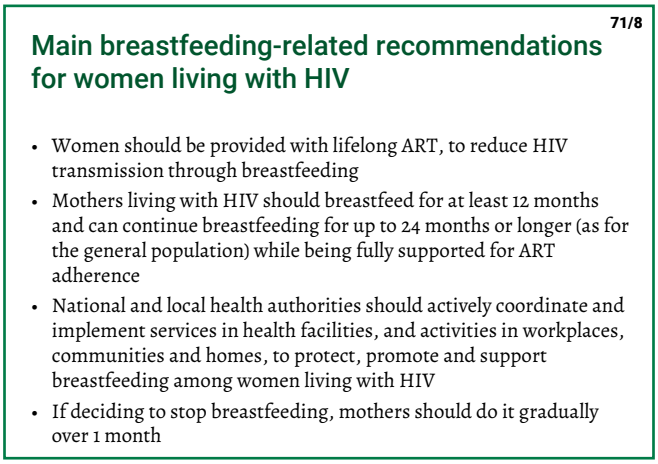
▸ Make these points:

- This slide sets out the current principles of HIV and infant feeding that help national health authorities make policy decisions on infant feeding.
- The first point is that a country's national health authority should make the decision about whether to promote and support breastfeeding with ART for their population of mothers living with HIV, or to advise avoidance of all breastfeeding and recommend the use of replacement feeding. This decision should be based on criteria such as the main causes of infant death and the main causes of maternal and child undernutrition, and whether the conditions needed to safely formula feed are available nationally.
- National health authorities must make sure health workers know which feeding practices are to be promoted and supported in public clinics and hospitals.
- Health workers should then communicate the decision to all pregnant women and mothers. Infant feeding counselling should focus on the practical aspects of feeding and ensure that mothers are fully supported to optimally feed their babies according to national recommendations.
- Some governments may still decide that individual counselling of women living with HIV on various feeding options is best in their particular situation, and may include a new policy on ART and breastfeeding in their own national authority infant feeding recommendations.
- *Ask: Do you know which feeding method is recommended by your national authority for pregnant and breastfeeding women living with HIV?*

▸ Wait for one or two replies and then if participants do not know, tell them the feeding method adopted by the national authority in the country you are in.

- The second point emphasizes the need to have a balanced approach to HIV prevention by protecting the baby from other causes of childhood illness and death.
- The third point continues with this theme. If ARV drugs are not **immediately** available, mothers should be counselled to exclusively breastfeed for the first 6 months of life and then continue breastfeeding alongside complementary feeding. Breastfeeding may still provide the baby with the best chance of HIV-free survival, unless the environmental conditions and support systems are good enough for safe use of replacement feeding. Efforts should be made to accelerate access to ARVs, for both maternal health and prevention of HIV transmission to infants.
- The fourth point states that pregnant women and mothers known to be HIV infected should be informed of the infant feeding practice recommended by the national health authority to improve HIV-free survival of HIV-exposed infants and the health of the mothers living with HIV, and informed that there are alternatives that mothers might wish to adopt.
- The last point emphasizes the need to be careful in delivering counselling and support to mothers living with HIV, so there is no undermining of optimal breastfeeding practices among the general population.
- We will now look at the main infant feeding recommendations from the current guidelines on HIV and infant feeding.

► Show **Slide 71/8 – Main breastfeeding-related recommendations for women living with HIV** and ask participants to read each point in turn.



- The first recommendation highlights the vital importance of ART in preventing mother-to-child-transmission.
- The second recommendation states how long HIV-infected mothers should breastfeed their babies. Additionally, it reinforces the need to start complementary foods at 6 months of age.
- Continuing breastfeeding beyond 12 months may be recommended if a woman is not able to provide a safe replacement for breast milk, or is unsure of her HIV status. In this case, a baby should be exclusively breastfed for 6 months and then breastfed with adequate complementary feeding up to at least 12 months, or up to 24 months or longer if desired (similar to the general population).
- The third recommendation stresses the point that pregnant and breastfeeding women, regardless of their HIV status, should receive skilled counselling and support for their infant feeding practices. Simple, consistent messaging is essential to support breastfeeding in the general population, including for mothers living with HIV. Such messaging should address views and concerns related to previous recommendations.
- The last recommendation is that if an HIV-infected mother decides to stop breastfeeding, she should do it gradually over a period of 1 month.
- *Ask: Are these recommendations different from what you are currently doing?*

► Wait for two or three responses, then continue:

- The recommendations now promote optimal breastfeeding practices – as for the general population – for mothers living with HIV receiving ART.
- Mothers living with HIV should only give commercial infant formula milk as a replacement feed to their HIV-negative babies or to babies who are of unknown status, when specific conditions are met.

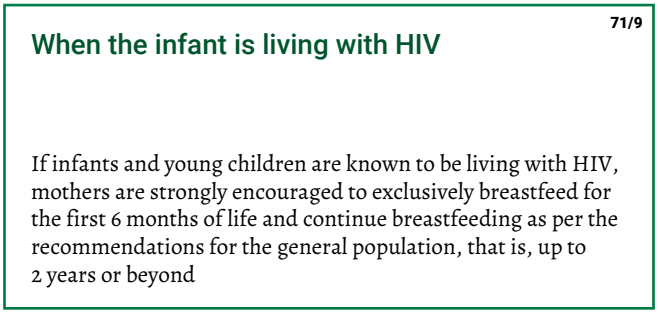
► Ask participants to look at page 533 of their *Participant's manual* and find the box CONDITIONS NEEDED FOR SAFE USE OF REPLACEMENT FEEDING. Ask participants to take it in turns to read out each point.

CONDITIONS NEEDED FOR SAFE USE OF REPLACEMENT FEEDING

1. Safe water and sanitation are assured at household level and in the community.
2. The mother or other caregiver can reliably provide sufficient infant formula milk to support normal growth and development.
3. The mother or caregiver can prepare the infant formula milk cleanly and frequently enough, so that it is safe and carries a low risk of diarrhoea and malnutrition.
4. The mother or caregiver can, in the first 6 months, exclusively give infant formula milk.
5. The family is supportive of this practice.
6. The mother or caregiver can access health care that offers comprehensive child health services.

- The conditions in this box correspond to what was formerly referred as "AFASS" – Acceptable, Feasible, Affordable, Sustainable and Safe. These points are almost the same as previously but have now been expressed more simply to make it easier for you to explain what is needed to mothers.
- These conditions apply where the national authority recommendation is for all mothers who are living with HIV to give replacement feeds. They also apply anywhere women may choose not to breastfeed or may choose to use replacement feeding.
- Additionally, in order to help you address specific challenges, remember that:
  - **When mothers living with HIV do not exclusively breastfeed**, they can be reassured that ART reduces the risk of postnatal HIV transmission in the context of mixed feeding. Although exclusive breastfeeding is recommended, practising mixed feeding is not a reason to stop breastfeeding in the presence of ARV drugs.
  - **When mothers living with HIV do not plan to breastfeed for 12 months**, they can be reassured that shorter durations of breastfeeding of less than 12 months are better than never initiating breastfeeding at all.

▶ Show **Slide 71/9 – When the infant is living with HIV** and read it out:



▶ Make the following points:

- Inevitably, and sadly, some babies will become infected with HIV, and as you can see in this slide, mothers of these babies are strongly encouraged to breastfeed.
- These babies should all be started on lifelong ART, as soon as possible after testing positive for HIV.
- Replacement feeds would increase the likelihood of these babies dying from common infections. If the mother is able to breastfeed it is beneficial because the baby would be receiving the constant source of protective factors provided by breast milk. There are also emotional benefits to breastfeeding, for both the mother and the baby, as well as health benefits to them both, and these should all be considered when making the decision of how to feed the baby.
- The mother and her family will need a lot of support, help and guidance.

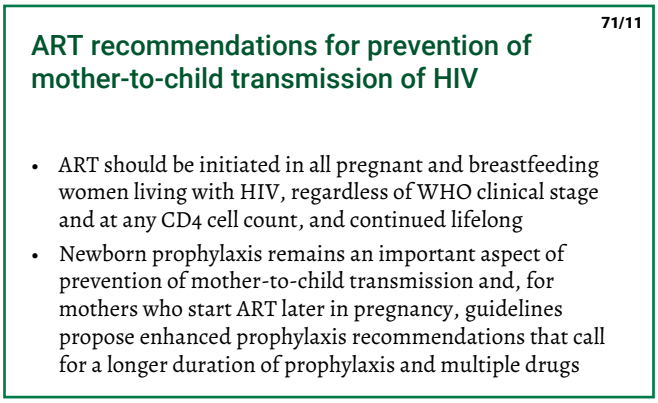
▶ Show **Slide 71/10 – Policy of supporting breastfeeding** and read it out:

▶ Make the following point:

- This policy statement has not changed since 1997; all United Nations organizations continue to strongly support breastfeeding as the main feeding method for the general population of any country.

VII. Antiretroviral therapy and prophylaxis 10 minutes

- **Make these points:**
  - In 2016, global guidelines on the use of ARV drugs for treating and preventing HIV infection were published. Lifelong ART is now recommended for everyone from the time when they are first diagnosed with HIV infection. This has greatly simplified the ARV options recommended for pregnant and breastfeeding women.
  - While looking at the ARV recommendations, it is good to also review the recommendations on HIV testing for infants and young children.
  - It is recommended that all HIV-exposed infants have HIV virological testing at 4–6 weeks of age, or at the earliest opportunity thereafter.
  - It is recommended that all HIV-exposed infants undergo HIV serological testing at around 9 months of age (or at the time of the last immunization visit). Infants who have reactive serological assays at 9 months should have a virological test to identify HIV-infected infants who need ART.
  - It is recommended that children aged 18 months or older with suspected HIV infection or HIV exposure have HIV serological testing performed, according to the validated national testing algorithm used in adults.
  - It is recommended that infants with signs or symptoms suggestive of HIV infection undergo HIV serological testing and, if reactive, should be referred for virological testing
- **Let us now look at the details of the new ARV recommendations.**
- **Show Slide 71/11 – ART recommendations for prevention of mother-to-child transmission of HIV and refer to the slide as you give the information following the slide:**



  - This slide summarizes the current recommendations for antiretroviral therapy to prevent-mother-to-child-transmission of HIV.
  - The first bullet point establishes that ART should be initiated in all women living with HIV as soon as they are diagnosed, regardless of WHO clinical stage and CD4 cell count; and the therapy should continue lifelong.
  - Newborn prophylaxis remains important.
  - **Infants born to mothers with HIV, who are at high risk of acquiring HIV**, should receive dual prophylaxis for the first 6 weeks of life, whether they are breastfed or receiving replacement feeding.
  - **Breastfed infants who are at high risk of acquiring HIV**, including those first identified as exposed to HIV during the postpartum period, should continue prophylaxis for an additional 6 weeks (making a total of 12 weeks).
    - Infants of mothers who are receiving ART and are breastfeeding should receive 6 weeks of infant prophylaxis with nevirapine.
    - Infants receiving replacement feeding and whose mothers are receiving ART should be given 4–6 weeks of infant prophylaxis with nevirapine or azidothymidine.

VIII. Summarize the session 5 minutes

- Ask participants whether they have any questions, and try to answer them.
- Make these points:
  - Our goal is for HIV-exposed babies to remain HIV free and to survive.
  - Breastfeeding is the best way to feed babies who are living with HIV, or of unknown HIV status, in order to improve their long-term survival. Infants living with HIV need to be started on lifelong ART immediately.
  - If they do not breastfeed, they run an increased risk of becoming ill or dying from other common infections.
  - The national recommendations for infant feeding in the context of HIV (to breastfeed and receive ART or to avoid all breastfeeding) has to be made according to socioeconomic, cultural and epidemiologic contexts and the availability and quality of health services.
  - National authorities should aim to provide HIV testing, care and treatment interventions to all. It is a priority to ensure ART is available to all women who test positive to HIV.
  - Health professionals, HIV services and appropriate government departments should be fully aware of the latest guidelines for prevention of mother-to-child transmission of HIV and infant feeding.
  - Breastfeeding should continue to be protected, promoted and supported in all general populations.
  - Women who tested negative for HIV in pregnancy need to prevent HIV infection during breastfeeding, and preferably also have regular HIV testing.
- Explain that a summary of this session can be found on pages 527–535 of the *Participant's manual*.

Further information

Explanation of terms

Breast-milk substitute: any food being marketed or otherwise represented as a partial or total replacement for breast milk, whether or not it is suitable for that purpose.

HIV-free survival: refers to young children who are both alive and HIV uninfected at a given point in time, usually measured at 18 months. This composite measure reflects that the intention of interventions is to both prevent HIV transmission through breastfeeding, while at the same time ensuring that mortality among these children does not increase because of avoidance or modifications of breastfeeding practices.

HIV exposed: refers to the infant or young child of a mother who is living with HIV.

Mixed feeding: means breastfeeding while also receiving water-based drinks, food-based fluid, semi-solid or solid food or non-human milk (also called partial breastfeeding).

Prophylaxis: in the context of mother-to-child transmission of HIV, refers to giving one or more antiretroviral drugs to an HIV-infected mother until all risk of HIV transmission has ended; that is, during pregnancy, labour, delivery, if a mother is giving replacement feeding, and continuing during the breastfeeding period if a mother is breastfeeding, or to an HIV-exposed infant to prevent transmission during the breastfeeding period.

Replacement feeding: the process of feeding an infant or young child, who is not receiving any breast milk, with a diet that provides all the nutrients needed.

Antiretroviral therapy (ART): in the context of mother-to-child transmission of HIV, refers to antiretroviral drugs given to an HIV-infected mother for lifelong treatment in areas where HIV has reached epidemic levels, or where transmission rates are low and ART can be stopped after all risk of mother-to-child-transmission has ceased. It is also given to an infant or young child who is HIV infected.

Effectiveness of prophylaxis of antiretroviral drugs if the mother does not exclusively breastfeed

The research does not give precise information on this question, but antiretroviral drugs are likely to offer protection, even if the mother does not exclusively breastfeed. The research studies all state that they promoted breastfeeding and supported mothers to exclusively breastfeed. In most cases, the research reports do not break the results down according to whether the mothers did in fact exclusively breastfeed for 6 months, or whether they added other foods to their infants' diets. However, looking across many studies where mothers took either lifelong ART or antiretroviral drugs as prophylaxis, the risk of transmission during breastfeeding was still very low. This suggests that, even if mothers do not exclusively breastfeed, antiretroviral drugs still provide infants with very significant protection from HIV transmission through breastfeeding.

Relation of the new recommendations to the *International code of marketing of breast-milk substitutes* and subsequent relevant World Health Assembly resolutions (the Code)

National implementation of the *International code of marketing of breast-milk substitutes* and subsequent relevant World Health Assembly resolutions, and monitoring compliance, is always important. Even in settings where HIV is not highly prevalent, infant feeding is undermined by promotional marketing practices from the food industry and other groups, with the result that some mothers who have every reason to breastfeed choose not to do so, based on misinformation, unfounded fears or lack of confidence in their ability to breastfeed.

The Code provides guidelines on the marketing of breast-milk substitutes, including infant formula milk and other milk products, foods and drinks, and bottle-fed complementary foods, when they are presented as replacements for breast milk. The Code also includes the marketing of feeding bottles and teats. For countries that have chosen to provide breast-milk substitutes to HIV-infected women, the Code aims to ensure that they are used as safely as possible and, if a national authority decides to provide them to some HIV-exposed infants, that they are distributed under strict controls and only to infants that need them.

Conditions should be in place to facilitate safe use, including:

- implementation of the Code at national level, with emphasis on procurement, distribution, and correct labelling and packaging of breast-milk substitutes
- logistic and financial capacity to supply formula milk without interruption, as long as the child needs it
- guidelines for health staff regarding who should receive formula milk, under what conditions, how frequently and for how long, etc.
- trained infant feeding counsellors
- monitoring of the health and nutrition status of infants receiving formula milk.

Where supporting formula feeding is the recommended feeding option, HIV-infected women will need to be helped to properly prepare and give formula milk, whether purchased by families or provided by the health authorities. Such support should be given out of view of other women, as provided for in the Code.

Length of breastfeeding according to the 2016 guidelines

In settings where national authorities recommend breastfeeding and ART, all mothers are recommended to breastfeed their infant, that is, early initiation, exclusive breastfeeding for the first 6 months of life, and continued breastfeeding up to at least 12 months with the option of extending up to 24 months or longer. Adequate amounts of nutritious and safe complementary foods should be added once the infant completes 6 months, while breastfeeding on demand.

Infants of HIV-infected mothers who are taking lifelong ART will be protected against HIV transmission, as long as maternal adherence to treatment remains good. This gives the mother greater flexibility as to when to stop breastfeeding. In some settings, HIV-infected mothers may opt to stop breastfeeding around 12 months of age when there are good options for replacing breastfeeding with animal milks and other household foods.

Notes

SESSION 72

Overview of HIV and infant feeding 2

Objectives

After completing this session, participants will be able to:

- explain the risk of mother-to-child transmission of HIV
- describe factors that influence mother-to-child transmission of HIV
- describe the key principles and recommendations for infant feeding in the context of HIV

Session outline . . . . . 50 minutes

Participants are all together for a lecture presentation by one trainer.

I. Introduce the session, present **Slide 72/1** . . . . . 3 minutes
II. What is HIV and how is it transmitted? (**Slide 72/2** and **72/3**) . . . . . 5 minutes
III. Review the risk of mother-to-child transmission of HIV (**Slide 72/4**) . . . . . 10 minutes
IV. Explain factors that affect mother-to-child transmission of HIV (**Slide 72/5**) . . . . . 10 minutes
V. Explain HIV-free survival (**Slide 72/6**) . . . . . 2 minutes
VI. Review key principles and recommendations for infant feeding in the context of HIV (**Slides 72/7** to **72/10**) 15 minutes
VII. Summarize the session . . . . . 5 minutes

Preparation

- **Select Session 72 if the country/region has a low prevalence of HIV**.
- Refer to the Introduction for guidance on giving a presentation with slides.
- Study the **Slides 72/1** to **72/10** and the text that goes with them, so that you are able to present them.
- Find out the local prevalence of HIV infection among women of childbearing age (15–49 years) and among women receiving antenatal care in the area, if known.
- Review recent World Health Organization (WHO), United Nations Children's Fund (UNICEF) and Joint United Nations Programme on HIV/AIDS (UNAIDS) documents, so that you are able to refer participants to them, as needed for further information:
  - WHO, UNICEF, UNAIDS. Guidelines on HIV and infant feeding 2010: principles and recommendations for infant feeding in the context of HIV and a summary of evidence. Geneva: World Health Organization; 2010 (http://apps.who.int/iris/bitstream/10665/44345/1/9789241599535_eng.pdf).
  - WHO, UNICEF. Guideline: Updates on HIV and infant feeding: the duration of breastfeeding, and support from health services to improve feeding practices among mothers living with HIV. Geneva: World Health Organization; 2016 (http://apps.who.int/iris/bitstream/10665/246260/1/9789241549707-eng.pdf).
  - Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach, 2nd ed. Geneva: World Health Organization, 2016 (http://apps.who.int/iris/bitstream/10665/208825/1/9789241549684_eng.pdf).
- Familiarize yourself with national policies, strategies and guidelines on infant and young child feeding, if they exist. Check whether they include issues related to HIV/AIDS, and whether there is a specific infant feeding recommendation for HIV-infected mothers in your region or district.
- Read the **Further information** sections, so that you are familiar with the ideas that they contain, so that you can answer participants' questions.

As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the session — 3 minutes

► Show **Slide 72/1 – Session 72 – objectives** and read out the objectives:

72/1

Session 72: Overview of HIV and infant feeding 2 – objectives

After completing this session, participants will be able to:
- explain the risk of mother-to-child transmission of HIV
- describe factors that influence mother-to-child transmission of HIV
- describe the key principles and recommendations for infant feeding in the context of HIV

► Make these points:

¤ HIV is a devastating infection, which touches many aspects of our lives. It affects people of all ages, the rich and the poor and all sectors of society, and is a major cause of mortality. It is a worldwide challenge, affecting some countries far more than others.

¤ Why do we include HIV in this course? What does it have to do with infant and young child feeding?

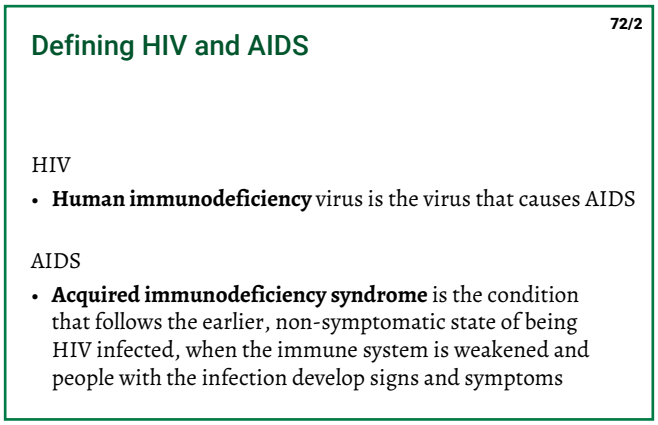
¤ HIV can be passed from a mother to her baby during pregnancy, labour and delivery and during breastfeeding. Antiretroviral (ARV) drugs reduce mother-to-child-transmission of HIV, and increase the HIV-free survival of babies. Breastfeeding prevents babies dying from common causes and is recommended as a principal feeding option, combined with ARV drugs, for mothers living with HIV.

¤ Updated global recommendations on the use of ARV drugs for treating and preventing HIV infection have important implications for infant feeding recommendations. The World Health Organization (WHO) now recommends lifelong antiretroviral therapy (ART) for everyone from the time when any adult (including pregnant and breastfeeding women) or child is first diagnosed with HIV infection. This has affected the role of health workers and infant feeding counsellors in providing information and support to pregnant and breastfeeding women living with HIV, and their babies.

II. What is HIV and how is it transmitted? 5 minutes

- We will start by reminding ourselves what the terms HIV and AIDs stand for and look at why HIV should concern us.

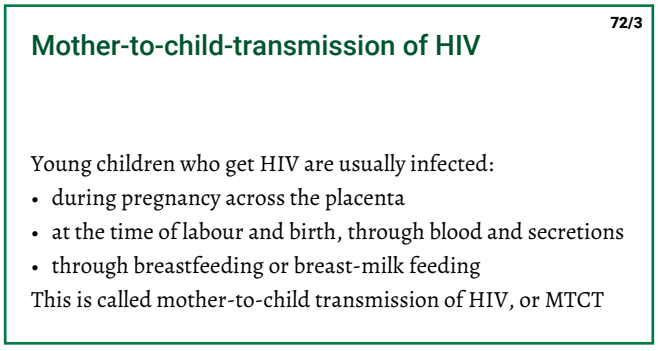
▶ Show **Slide 72/2 – Defining HIV and AIDS** and ask one participant to read out the definitions:



▶ Make these points:

- Individuals who are infected with HIV do not show any signs or symptoms at first and often do not know they are infected. During this time, the body produces antibodies and other specialized immune cells, such as CD4 cells, that fight HIV.
- For several years, CD4 cells are able to keep the virus under control in a person's body and they remain healthy. However, eventually the HIV virus controls and destroys these immune cells.
- When this happens the body becomes less able to fight other types of infections such as pneumonia, diarrhoea, tuberculosis (TB) and meningitis. When a person can no longer fight these infections, starts getting symptoms and loses weight, we say they are suffering from AIDS. Without any treatment, they usually die.
- To find out whether a person has HIV, a special blood test can be done to see whether there are HIV antibodies in their blood. A positive test means that the person is infected with HIV.
- Once a person has the virus in their body, it can be passed on to another person through:
  - exchange of HIV-infected body fluids such as vaginal fluid, semen or blood, during unprotected sexual intercourse
  - HIV-infected blood transfusions or sharing contaminated needles, for example in the case of drug users sharing needles or needle injuries in hospitals.
- Children too can be infected in these ways, but they can also be infected by their mothers, during pregnancy, labour, delivery and breastfeeding.

▶ Show **Slide 72/3 – Mother-to-child transmission of HIV** and read it out:

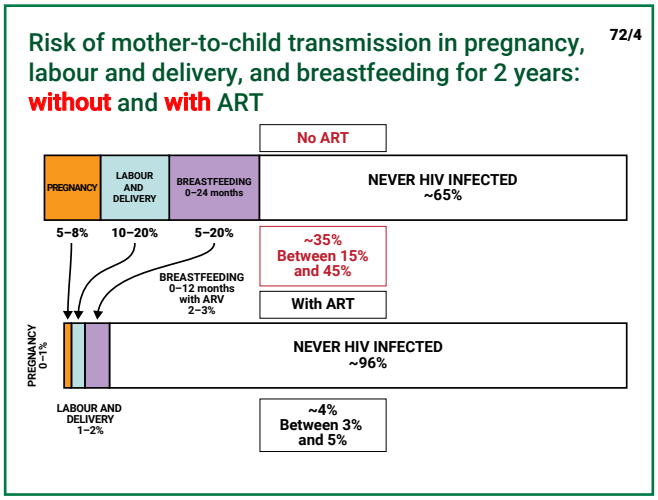


▶ Make these points:

- This slide shows how the virus can pass from a mother living with HIV to her baby at different time periods, including during the postnatal period if the mother breastfeeds her baby. It is during the postnatal period that the risk of mother-to-child-transmission is of particular concern to us.

III. Review the risk of mother-to-child transmission of HIV 10 minutes

- **Make these points:**
  - Let us now consider when mother-to-child transmission of HIV occurs and how many mothers and babies are likely to be affected.
- **Show Slide 72/4 – Risk of mother-to-child transmission in pregnancy, labour and delivery, and breastfeeding for 2 years: without and with ART** and read out the title of the slide:



- **Make these points:**
  - Look at the first bar on this slide; you can see in the first three boxes that a large percentage of babies, about 65%, never become infected and remain free of HIV even when no ARV drugs are available. However, about 35% (range 15–45%) of babies will become HIV infected through mother-to-child transmission if a mother does not receive antiretroviral therapy known as ART for short.
  - Not all mothers know their HIV status, so it is important when counselling a pregnant woman about HIV testing that she understands the risk to herself and to her baby if she is living with HIV but does not receive ARV drugs.
  - Look at the first box. During pregnancy, around 0–1% of babies will be infected when ART is given.
  - Now look at the next box. When ART is given to the mother, the risk of transmission during labour and delivery is reduced to 1–2% (from 10–20% without ART), which is a dramatic reduction in comparison.
  - Now look at the breastfeeding box. The child is exposed to HIV as long as they are fed breast milk. But look at the percentages when ARV drugs are given to the mother. Only 2–3% of babies become HIV infected.
  - The overall mother-to-child-transmission (including intrapartum and postpartum transmission) when mothers receive ART is 3–5%, compared to an average of 35% when treatment is not given. This impressive reduction in rate shows the impact of ART in increasing the number of babies who can be expected to survive free of HIV.
  - You may think that even a 3–5% risk of HIV transmission to an HIV-exposed baby is too high to recommend breastfeeding. But statistics show that an HIV-exposed baby who does not breastfeed is at an even greater risk of dying from more common diseases, such as diarrhoea or pneumonia.
  - Additionally, the breastfeeding mother receiving ART will be healthier and live longer, thus being able to take care of her infant.

IV. Explain factors that affect mother-to-child transmission of HIV 10 minutes

- **Make these points:**
  - The risk of a mother transmitting the virus to her baby depends on a number of factors, such as how ill the mother is, how much virus is in her blood, how long breastfeeding lasts and, most importantly, whether she is taking ART. This explains the numbers we saw in the previous slide and why there are differences in the risk of transmission between individual mothers.
  - *Ask: What factors can affect mother-to-child transmission of HIV during pregnancy, labour and delivery?*
- **Write responses on flipchart paper and put on the wall and then continue.**
  - *Ask: What factors can affect mother-to-child-transmission during breastfeeding?*
- **Write responses on flipchart paper and put next to the first sheet and then continue.**
  - Let us compare the factors you suggested and what is on this slide.
- Show **Slide 72/5 – Factors that affect mother-to-child transmission of HIV** and read it out:

72/5

Factors that affect mother-to-child transmission of HIV

- Increasing risk
  - Recent infection with HIV
  - Severity of HIV infection
  - Obstetric procedures
  - Condition of the breasts (mastitis, cracked nipple)
  - Condition of the baby's mouth (bleeding gum, mouth ulcers, thrush)
- Lowering risk
  - ART given to the mother
  - ARV prophylaxis given to the baby

- **Ask participants to turn to page 539 of their *Participant's manual* and find the section FACTORS THAT AFFECT MOTHER-TO-CHILD TRANSMISSION OF HIV.**
- **Ask participants to read out each point in turn and then give the following information.**
- **Factors increasing the risk of transmission**
  - **Recent infection with HIV**
    If a woman becomes infected with HIV during pregnancy or while breastfeeding, she has higher levels of virus in her blood, and her baby is more likely to be infected. All sexually active men and women need to know that unprotected sexual intercourse exposes them to the risk of infection with HIV. They may infect their partners, and their baby too will be at a higher risk. Using condoms during sexual intercourse is crucial to reducing HIV infections.
  - **Severity of HIV infection**
    If the mother is already ill with an HIV-related disease or AIDS and is not receiving ART, she has more virus in her body, and transmission to her baby is more likely.
  - **Obstetric procedures**
    During labour and delivery, any interventions that can damage the mother's or the baby's skin or mucous membranes and cause bleeding should be avoided. This means avoiding unnecessary use of instrumentation, episiotomy and premature or artificial rupture of the membranes, unless medically required. Invasive gastric or oral suctioning when the baby is delivered, which can damage the delicate tissues in the baby's nose or mouth, should also be avoided. It also means avoiding procedures that are likely to result in the separation of the mother and baby after delivery, causing a delay in skin-to-skin contact and early initiation of breastfeeding.
  - **Conditions of the breast**
    Nipple fissures (particularly if the nipple is bleeding), mastitis or breast abscess may increase the risk of HIV transmission through breastfeeding. Good breastfeeding technique helps to prevent these conditions, and also reduces transmission of HIV.

- **Condition of the baby's mouth**
  Mouth sores or thrush in the baby may make it easier for the virus to get into the baby's body through the damaged skin.

▸ Factors lowering the risk of transmission

- **Antiretroviral therapy given to the mother**
  Mothers living with HIV provided with ART for life, or until after delivery or all breastfeeding stops, have a much lower risk of passing HIV on to their babies.
- **ARV prophylaxis given to the baby**
  ARV prophylaxis given to the baby after birth (for 4–6 weeks) also reduces the risk of mother-to-child transmission of HIV.

▸ Breastfeeding-related factors

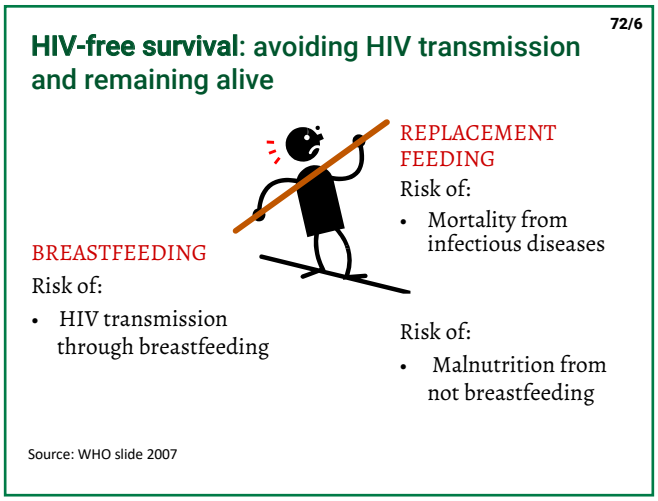
- **Mixed feeding**
  In the absence of interventions, the risk of HIV transmission is greater if a baby is given other foods or drinks at the same time as breastfeeding during the first months of life. This is known as mixed feeding. The risk is less if the baby is exclusively breastfed. Other food or drinks may cause diarrhoea and damage the gut, which might make it easier for the virus to enter the baby's blood.
- Note, however, that mothers living with HIV can be reassured that ART reduces the risk of HIV transmission, even in the context of mixed feeding. Although exclusive breastfeeding is recommended, practising mixed feeding is not a reason to stop breastfeeding in the presence of ARV drugs.
- **Duration of breastfeeding**
  The breast milk of a mother living with HIV contains the virus. Therefore, the child is exposed to HIV as long as they are receiving the breast milk. The number of virus particles in the breast milk can be reduced if the mother is correctly and consistently taking ART. It is thus important to support adherence to ART for the full duration of breastfeeding.
- Mothers living with HIV should breastfeed for at least 12 months and may continue breastfeeding for up to 24 months or longer (similar to the general population), while being fully supported for ART adherence.
- Note, however, that mothers living with HIV on ART can be reassured that shorter durations of breastfeeding of less than 12 months are better than never initiating breastfeeding at all.

▸ Make these additional points:

- The following strategies can help women to reduce the risk of these factors causing HIV transmission:
  - practising safe sexual intercourse (with a condom), including during pregnancy and breastfeeding
  - receiving regular antenatal and postnatal care
  - practising good attachment and positioning
  - making HIV testing, care and treatment interventions available to all women during maternal and child health services
  - continuous availability of ART in health centres, and support to people living with HIV for adherence to the treatment.
  - giving appropriate public health messages.

V. Explain HIV-free survival — 2 minutes

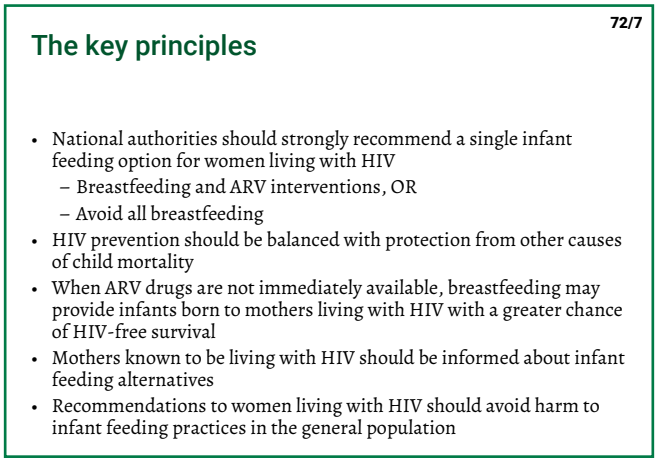
- **Make these points:**
  - The aim of HIV-free survival is for babies of HIV-infected mothers to remain free from HIV and to also remain free of other diseases.
- **Show Slide 72/6 – HIV-free survival and read it out:**



- **Make these points:**
  - You can see on this slide, the balance between the risk of an HIV-exposed baby becoming infected with HIV through breastfeeding and the risk of the baby dying from common infectious diseases such as diarrhoea or pneumonia, or from malnutrition if they are **not** breastfeeding.
  - Although giving the baby replacement feeds would reduce the risk of HIV transmission to the baby, it does not necessarily increase the chances of the baby's survival, as the infants are more likely to die from childhood illnesses (when they don't get the antibodies to fight them).
  - We know that HIV-exposed babies benefit from breastfeeding for all the reasons we have already discussed in previous sessions, but we also know there is still a very small possibility of the baby becoming infected with HIV, even when the mother is receiving ART (3–5% at 24 months with full adherence).
  - For many years, health workers and mothers have been asking the question "which is the safest method of infant feeding for a mother who is living with HIV or who does not know her HIV status, or for a baby who is HIV exposed and still HIV negative?".
  - It is clear, from recent publications, that ARV drugs can reduce mother-to-child transmission and more babies who are breastfed can survive their infancy free of HIV. This means that, when deciding how a baby should be fed, health authorities also have to consider which method of feeding poses the lowest risk of illness or of death to a baby.
  - In the next slide, we look at ways in which recent guidelines on HIV and infant feeding may help to answer this question.

VI. Review key principles and recommendations for infant feeding in the context of HIV
15 minutes

▸ Show **Slide 72/7 – The key principles**:



▸ Make these points:

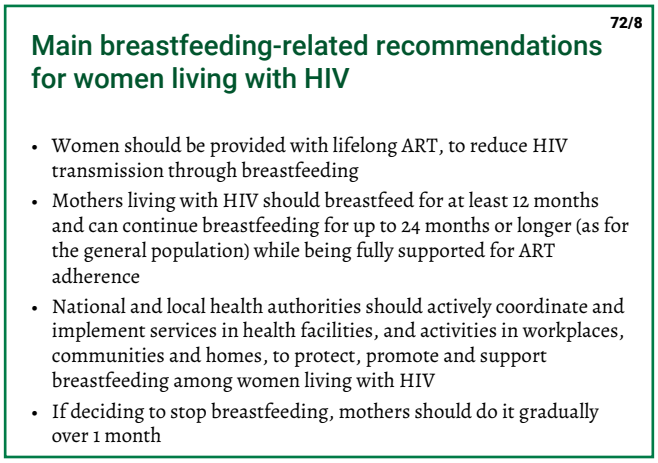
- This slide sets out the current principles of HIV and infant feeding that help national health authorities make policy decisions on infant feeding.
- The first point is that a country's national health authority should make the decision about whether to promote and support breastfeeding with ART for their population of mothers living with HIV, or to advise avoidance of all breastfeeding and recommend the use of replacement feeding. This decision should be based on criteria such as the main causes of infant death and the main causes of maternal and child undernutrition, and whether the conditions needed to safely formula feed are available nationally.
- National health authorities must make sure health workers know which feeding practices are to be promoted and supported in public clinics and hospitals.
- Health workers should then communicate the decision to all pregnant women and mothers. Infant feeding counselling should focus on the practical aspects of feeding and ensure that mothers are fully supported to optimally feed their babies according to national recommendations.
- Some governments may still decide that individual counselling of women living with HIV on various feeding options is best in their particular situation, and may include a new policy on ART and breastfeeding in their own national authority infant feeding recommendations.
- *Ask: Do you know which feeding method is recommended by your national authority for pregnant and breastfeeding women living with HIV?*

▸ **Wait for one or two replies and then if participants do not know, tell them the feeding method adopted by the national authority in the country you are in.**

- The second point emphasizes the need to have a balanced approach to HIV prevention by protecting the baby from other causes of childhood illness and death.
- The third point continues with this theme. If ARV drugs are not immediately available, mothers should be counselled to exclusively breastfeed for the first 6 months of life and then continue breastfeeding alongside complementary feeding. Breastfeeding may still provide the baby with the best chance of HIV-free survival, unless the environmental conditions and support systems are good enough for safe use of replacement feeding. Efforts should be made to accelerate access to ARVs, for both maternal health and prevention of HIV transmission to infants.
- The fourth point states that pregnant women and mothers known to be HIV infected should be informed of the infant feeding practice recommended by the national health authority to improve HIV-free survival of HIV-exposed infants and the health of the mothers living with HIV, and informed that there are alternatives that mothers might wish to adopt.

- The last point emphasizes the need to be careful in delivering counselling and support to mothers living with HIV, so there is no undermining of optimal breastfeeding practices among the general population.
- We will now look at the main infant feeding recommendations from the current guidelines on HIV and infant feeding.

▶ Show **Slide 72/8 – Main breastfeeding-related recommendations for women living with HIV** and ask participants to read each point in turn:



- The first recommendation highlights the vital importance of ART in preventing mother-to-child-transmission.
- The second recommendation states how long HIV-infected mothers should breastfeed their babies. Additionally, it reinforces the need to start complementary foods at 6 months of age.
- Continuing breastfeeding beyond 12 months may be recommended if a woman is not able to provide a safe replacement for breast milk or is unsure of her HIV status. In this case, a baby should be exclusively breastfeed for 6 months and then breastfed with adequate complementary feeding for at least 2 years, the same as for the general population. Mothers in these situations may need reassurance that breastfeeding is the safest option for their babies.
- The third recommendation stresses the point that pregnant and breastfeeding women, regardless of their HIV status, should receive skilled counselling and support for their infant feeding practices. Simple, consistent messaging is essential to support breastfeeding in the general population, including mothers living with HIV. Such messaging should address views and concerns related to previous recommendations.
- The last recommendation is that if an HIV-infected mother decides to stop breastfeeding, she should do it gradually over a period of 1 month.
- *Ask: Are these recommendations different from what you are currently doing?*

▶ Wait for two or three responses, then continue:

- The recommendations now promote optimal breastfeeding practices – as for the general population – for mothers living with HIV receiving ART.
- Mothers living with HIV should only give commercial infant formula milk as a replacement feed to their HIV-negative babies or to babies who are of unknown status, when specific conditions are met.

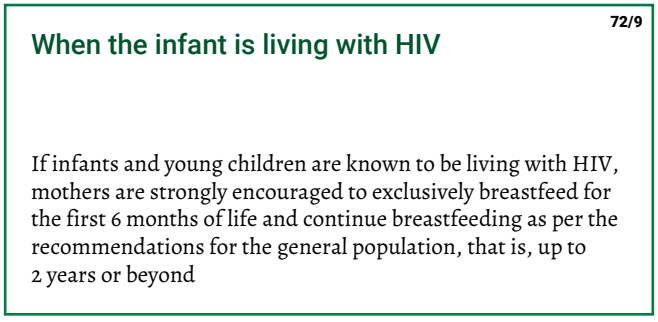
▶ Ask participants to look at page 543 of their *Participant's manual* and find the box CONDITIONS NEEDED FOR SAFE USE OF REPLACEMENT FEEDING. Ask participants to take it in turns to read out each point.

CONDITIONS NEEDED FOR SAFE USE OF REPLACEMENT FEEDING

1. Safe water and sanitation are assured at household level and in the community.
2. The mother or other caregiver can reliably provide sufficient infant formula milk to support normal growth and development.
3. The mother or caregiver can prepare the infant formula milk cleanly and frequently enough, so that it is safe and carries a low risk of diarrhoea and malnutrition.
4. The mother or caregiver can, in the first 6 months, exclusively give infant formula milk.
5. The family is supportive of this practice.
6. The mother or caregiver can access health care that offers comprehensive child health services.

- The conditions in this box correspond to what was formerly referred as "AFASS" – Acceptable, Feasible, Affordable, Sustainable and Safe. These points are almost the same as previously but have now been expressed more simply to make it easier for you to explain what is needed to mothers.
- These conditions apply where the national authority recommendation is for all mothers who are living with HIV to give replacement feeds. They also apply anywhere women may choose not to breastfeed or may choose to give replacement feeds.
- Additionally, in order to help you address specific challenges, remember that::
  - **When mothers living with HIV do not exclusively breastfeed**, they can be reassured that ART reduces the risk of postnatal HIV transmission in the context of mixed feeding. Although exclusive breastfeeding is recommended, practising mixed feeding is not a reason to stop breastfeeding in the presence of ARV drugs.
  - **When mothers living with HIV do not plan to breastfeed for 12 months**, they can be reassured that shorter durations of breastfeeding of less than 12 months are better than never initiating breastfeeding at all.

▶ Show **Slide 72/9 – When the infant is living with HIV** and read it out:



▶ Make the following points:

- Inevitably, and sadly, some babies will become infected with HIV, and as you can see in this slide, mothers of these babies are strongly encouraged to breastfeed.
- These babies should all be started on lifelong ART, as soon as possible after testing positive for HIV.
- Replacement feeds would increase the likelihood of these babies dying from common infections. If the mother is able to breastfeed it is beneficial because the baby would be receiving the constant source of protective factors provided by breast milk. There are also emotional benefits to breastfeeding, for both the mother and the baby, as well as health benefits to them both, and these should all be considered when making the decision of how to feed the baby.
- The mother and her family will need a lot of support, help and guidance.

- Show **Slide 72/10 – Policy of supporting breastfeeding** and read it out:

▶ **Make the following point:**

- This policy statement has not changed since 1997; all United Nations organizations continue to strongly support breastfeeding as the main feeding method for the general population of any country.

VII. Summarize the session 5 minutes

▶ **Ask participants whether they have any questions, and try to answer them.**

▶ **Make these points:**

- Our goal is for HIV-exposed babies to remain HIV free and to survive.
- Breastfeeding is the best way to feed babies who are living with HIV, or of unknown HIV status, in order to improve their long-term survival. Infants living with HIV need to be started on lifelong ART immediately.
- If they do not breastfeed, they run an increased risk of becoming ill or dying from other common infections
- The national recommendations for infant feeding in the context of HIV (to breastfeed and receive ART or to avoid all breastfeeding) has to be made according to socioeconomic, cultural and epidemiologic contexts and the availability and quality of health services.
- National authorities should aim to provide HIV testing, care and treatment interventions to all. It is a priority to ensure ART is available to all women who test positive to HIV.
- Health professionals, HIV services and appropriate government departments should be fully aware of the latest guidelines for prevention of mother-to-child transmission of HIV and infant feeding.
- Breastfeeding should continue to be protected, promoted and supported in all general populations.
- Women who tested negative for HIV in pregnancy need to prevent HIV infection during breastfeeding, and preferably also have regular HIV testing.

▶ **Explain that a summary of this session can be found on pages 537–544 of the *Participant's manual*.**

Further information

Explanation of terms

Breast-milk substitute: any food being marketed or otherwise represented as a partial or total replacement for breast milk, whether or not it is suitable for that purpose.

HIV-free survival: refers to young children who are both alive and HIV uninfected at a given point in time, usually measured at 18 months. This composite measure reflects that the intention of interventions is to both prevent HIV transmission through breastfeeding, while at the same time ensuring that mortality among these children does not increase because of avoidance or modifications of breastfeeding practices.

HIV exposed: refers to the infant or young child of a mother who is living with HIV.

Mixed feeding: means breastfeeding while also receiving water-based drinks, food-based fluid, semi-solid or solid food or non-human milk (also called partial breastfeeding).

Prophylaxis: in the context of mother-to-child transmission of HIV, refers to giving one or more antiretroviral drugs to an HIV-infected mother until all risk of HIV transmission has ended; that is, during pregnancy, labour, delivery, if a mother is giving replacement feeding, and continuing during the breastfeeding period if a mother is breastfeeding, or to an HIV-exposed infant to prevent transmission during the breastfeeding period.

Replacement feeding: the process of feeding an infant or young child, who is not receiving any breast milk, with a diet that provides all the nutrients needed.

Antiretroviral therapy (ART): in the context of mother-to-child transmission of HIV, refers to antiretroviral drugs given to an HIV-infected mother for lifelong treatment in areas where HIV has reached epidemic levels, or where transmission rates are low and ART can be stopped after all risk of mother-to-child-transmission has ceased. It is also given to an infant or young child who is HIV infected.

Effectiveness of prophylaxis of antiretroviral drugs if the mother does not exclusively breastfeed

The research does not give precise information on this question, but antiretroviral drugs are likely to offer protection, even if the mother does not exclusively breastfeed. The research studies all state that they promoted and supported mothers to exclusively breastfeed. In most cases, the research reports do not break the results down according to whether the mothers did in fact exclusively breastfeed for 6 months, or whether they added other foods to their infants' diets. However, looking across many studies where mothers took either lifelong ART or antiretroviral drugs as prophylaxis, the risk of transmission during breastfeeding was still very low. This suggests that, even if mothers do not exclusively breastfeed, antiretroviral drugs still provide infants with very significant protection from HIV transmission through breastfeeding.

Relation of the new recommendations to the *International code of marketing of breast-milk substitutes* and subsequent relevant World Health Assembly resolutions (the Code)

National implementation of the *International code of marketing of breast-milk substitutes* and subsequent relevant World Health Assembly resolutions, and monitoring compliance, is always important. Even in settings where HIV is not highly prevalent, infant feeding is undermined by promotional marketing practices from the food industry and other groups, with the result that some mothers who have every reason to breastfeed choose not to do so, based on misinformation, unfounded fears or lack of confidence in their ability to breastfeed.

The Code provides guidelines on the marketing of breast-milk substitutes, including infant formula milk and other milk products, foods and drinks, and bottle-fed complementary foods, when they are presented as replacements for breast milk. The Code also includes the marketing of feeding bottles and teats. For countries that have chosen to provide breast-milk substitutes to HIV-infected women, the Code aims to ensure that they are used as safely as possible and, if a national authority decides to provide them to some HIV-exposed infants, that they are distributed under strict controls and only to infants that need them.

Conditions should be in place to facilitate safe use, including:

- implementation of the Code at national level, with emphasis on procurement, distribution, and correct labelling and packaging of breast-milk substitutes
- logistic and financial capacity to supply formula milk without interruption, as long as the child needs it
- guidelines for health staff regarding who should receive formula milk, under what conditions, how frequently and for how long, etc.
- trained infant feeding counsellors
- monitoring of the health and nutrition status of infants receiving formula milk.

Where supporting formula feeding is the recommended feeding option, HIV-infected women will need to be helped to properly prepare and give formula milk, whether purchased by families or provided by the health authorities. Such support should be given out of view of other women, as provided for in the Code.

Length of breastfeeding according to the 2016 guidelines

In settings where national authorities recommend breastfeeding and ART, all mothers are recommended to breastfeed their infant, that is, early initiation, exclusive breastfeeding for the first 6 months of life, and continued breastfeeding up to at least 12 months with the option of extending up to 24 months or longer. Adequate amounts of nutritious and safe complementary foods should be added once the infant completes 6 months, while breastfeeding on demand.

Infants of HIV-infected mothers who are taking lifelong ART will be protected against HIV transmission, as long as maternal adherence to treatment remains good. This gives the mother greater flexibility as to when to stop breastfeeding. In some settings, HIV-infected mothers may opt to stop breastfeeding around 12 months of age when there are good options for replacing breastfeeding with animal milks and other household foods.

Notes

Notes (contd)

SESSION 73

Antiretroviral therapy and infant feeding

Objectives

After completing this session, participants will be able to:

- describe the national protocol for antiretroviral therapy (ART) and for use of antiretroviral drugs
- promote appropriate use of nationally recommended ART for mothers living with HIV and their infants
- describe the practical issues of ART implementation

Session outline . . . . . 25 minutes

Participants are all together for a lecture presentation by one trainer.

I. Introduce the session, present **Slide 73/1** . . . . . 2 minutes
II. Explain who should receive antiretroviral therapy . . . . . 10 minutes
III. Outline the main issues involved in implementing antiretroviral therapy (**Slide 73/2**) . . . . . 10 minutes
IV. Summarize the session . . . . . 3 minutes

Preparation

- Refer to the Introduction for guidance on how to give a presentation with slides.
- Study the notes for the session, so that you are clear what to do.
- Study the **Slides 73/1** and **73/2** and the text that goes with them, so that you are able to present them.
- Find out which antiretroviral therapy is used in the country.
- Find out what health and community facilities and what follow-up arrangements exist to support pregnant women and mothers living with HIV in your country/area.
- Decide in advance which sections of the session apply and relate to the national ART protocol; use only those sections and adapt the others to the national programme.

As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

I. Introduce the session — 2 minutes

▸ Show **Slide 73/1 – Session 73 – objectives** and read out the objectives:

73/1

Session 73: Antiretroviral therapy and infant feeding – objectives

After completing this session, participants will be able to:

- describe the national protocol for antiretroviral therapy (ART) and for use of antiretroviral drugs
- promote appropriate use of nationally recommended ART for mothers living with HIV and their infants
- describe the practical issues of ART implementation

▸ Make these points:

- Antiretroviral drugs have a vital role to play in reducing the risk of mother-to-child-transmission of HIV during pregnancy, delivery and, importantly, breastfeeding. In addition, they also keep the mother healthier for longer.
- This is only possible if a woman knows her HIV status. This means one of our main priorities in early pregnancy is to encourage all pregnant women to have an HIV test, if they do not already know whether they are living with HIV.
- In the previous session, we briefly mentioned antiretroviral therapy or ART. We will now examine this in more detail.
- *Ask: Who did we say should be given antiretroviral therapy?*

▸ Wait for a few responses and then continue.

- The latest international recommendation is for all pregnant and breastfeeding women who test positive on an HIV test to be given triple ART (ARV3).
- Let us now look at the details of this recommendation.

II. Explain who should receive lifelong antiretroviral therapy — 10 minutes

▸ Make these points:

- ART should be initiated in all pregnant and breastfeeding women living with HIV, regardless of World Health Organization (WHO) clinical stage and at any CD4 cell count, and continued lifelong.
- Infants born to mothers living with HIV who are at high risk of acquiring HIV-2 should receive dual prophylaxis with azidothymidine (AZT; twice daily) and nevirapine (NVP; once daily) for the first 6 weeks of life, whether they are breastfed or formula fed.
- Breastfed infants who are at high risk of acquiring HIV, including those first identified as exposed to HIV during the postpartum period, should continue infant prophylaxis for an additional 6 weeks (total of 12 weeks of infant prophylaxis), using either AZT (twice daily) and NVP (once daily) or NVP alone.
- Infants of mothers who are receiving ART and are breastfeeding should receive 6 weeks of infant prophylaxis with daily NVP. If infants are receiving replacement feeding, they should be given 4–6 weeks of infant prophylaxis with daily NVP (or twice-daily AZT).
- National or subnational health authorities should decide whether health services will principally counsel and support mothers known to be HIV infected, to either breastfeed and receive ARV3 interventions or avoid all breastfeeding.
- In settings where national authorities have decided that maternal and child health services will principally promote and support breastfeeding and antiretroviral interventions, as the strategy that will most likely give infants born to mothers known to be HIV infected the greatest chance of HIV-free survival, mothers known to be infected with HIV should exclusively breastfeed their infants for the first 6 months of life, introducing appropriate complementary foods thereafter, and continue breastfeeding for the first 12 months of life.

- Breastfeeding should then stop only once a nutritionally adequate and safe diet without breast milk can be provided (strong recommendation, high-quality evidence for the first 6 months; low-quality evidence for the recommendation of 12 months).

► **Make the following points about ART for pregnant or breastfeeding women:**

- The following protocols are recommended for pregnant and breastfeeding women:
  - TDF (tenofovir) + 3TC (lamivudine) (or FTC [emtricitabine]) + EFV (efavirenz)
  - AZT (zidovudine) + 3TC + EFV (or NVP)
  - TDF + 3TC (or FTC) + NVP
- DTG (dolutegravir) has not been sufficiently studied in pregnant women for it to be recommended as an alternative in this population, unless the perceived benefits outweigh the potential risks. In addition, the efficacy of low-dose EFV in pregnancy has not been studied.
- Throughout pregnancy, key principles and practices of safe motherhood should be followed, including reinforcement of recommended antenatal clinic visits and facility-based delivery by skilled birth attendants. Instrumentation should be avoided unless essential, and neonates should be washed of any blood, and cared for using non-invasive techniques as much as possible. Health workers should follow universal precautions for all deliveries, including deliveries by women living with HIV. Special efforts should be made to ensure that delivery care for women living with HIV is provided in a non-stigmatizing and supportive manner.
- Although elective caesarean section has been shown to protect against HIV acquisition, especially in the absence of antiretroviral drugs or in the case of a high viral load, WHO does not recommend it in resource-limited settings specifically for HIV infection; rather, it is recommended for obstetric and other medical indications.
- Neonatal prophylaxis remains an important aspect of prevention of mother-to-child transmission of HIV and, for mothers who start ART later in pregnancy, these guidelines propose enhanced prophylaxis recommendations that call for a longer duration of prophylaxis and multiple drugs.
  - Infants born to mothers with HIV who are at high risk of acquiring HIV should receive dual prophylaxis with AZT (twice daily) and NVP (once daily) for the first 6 weeks of life, whether they are breastfed or formula fed (strong recommendation, moderate-quality evidence).
  - Breastfed infants who are at high risk of acquiring HIV, including those first identified as exposed to HIV during the postpartum period, should continue infant prophylaxis for an additional 6 weeks (total of 12 weeks of infant prophylaxis) using either AZT (twice daily) and NVP (once daily) or NVP alone (conditional recommendation, low-quality evidence).
  - Infants of mothers who are receiving ART and are breastfeeding should receive 6 weeks of infant prophylaxis with daily NVP. If infants are receiving replacement feeding, they should be given 4–6 weeks of infant prophylaxis with daily NVP (or twice-daily AZT) (strong recommendation, moderate-quality evidence for breastfeeding infants; strong recommendation, low-quality evidence for infants receiving only replacement feeding).

III. Outline the main issues involved in implementing antiretroviral therapy 10 minutes

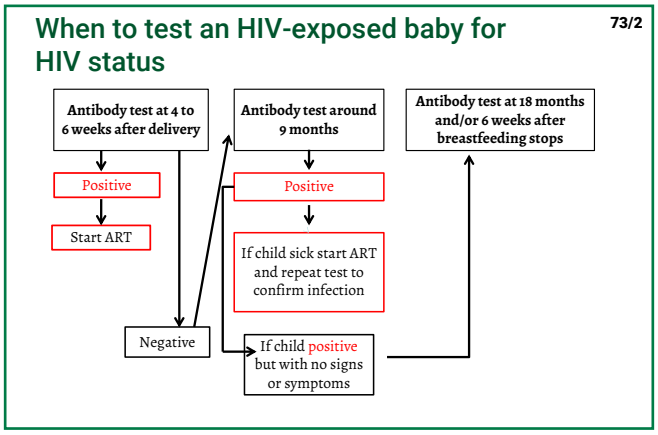
► **Make these points:**

- We will now consider some of the practical issues involved in implementing ART into our health systems and what impact this may have on our communities.
- ART can be initiated without delay, to all pregnant and breastfeeding women who test positive on an HIV test. Initiation does not depend upon a CD4 cell count or clinical stages.
- It is more acceptable for women to have one simple drug regimen throughout pregnancy, childbirth and breastfeeding, and it is much easier to administer for community workers.
- Breastfeeding with ART can increase the chances of a baby surviving HIV free and with a lower risk of other common infections.

- In the community, appropriate services are needed to prevent mother-to-child transmission of HIV; these need to be integrated within the maternal and child health services and programmes for HIV treatment and care. This means there has to be collaboration and regular communication between different services and the people who work in them, to ensure there are no problems for the women having to use them.
- Antenatal and postnatal services should be where treatment, care and support for mothers living with HIV and their children and families can be given; in this way, continuity of care is possible, especially meeting with the same counsellors for HIV and for infant feeding.
- ART has to be available for all pregnant and breastfeeding mothers living with HIV for lifelong use, and adherence to the drug regimen monitored regularly. The health of women and their children must be regularly monitored and maintained.
- Effective support should be provided to include family planning, determining the final infection outcome of the HIV-exposed child and, if necessary, ensuring early treatment for babies who become infected with HIV.
- Infant feeding counsellors have an important role to play in supporting mothers living with HIV for adherence to ART.
- The following slide outlines when a baby 's HIV status should be tested.

▸ **Find out and review the national guidelines to either use what is on the slide or make modifications following these guidelines.**

▸ **Show Slide 73/2 – When to test an HIV-exposed baby for HIV status and read aloud the slide following the arrows; begin on the left-hand side:**



- Record-keeping and confidentiality are crucial at all stages. So too is auditing the impact of ART on the HIV survival of babies and on the health of the mothers.

IV. Summarize the session 3 minutes

▸ **Make these points:**

- In this session, we discussed how current antiretroviral drug regimens can be used to reduce the risk of mother-to-child transmission of HIV during pregnancy, delivery and breastfeeding.
- It is important for people living with HIV, including pregnant and breastfeeding women, to receive lifelong ART.
- Implementing ART requires the integration of many local health services and HIV services to ensure pregnant and breastfeeding women have consistent access to support and to antiretroviral drugs.
- Community-level support is also important for these women.

▸ **Ask participants whether they have any questions, and try to answer them.**

▸ **Explain that a summary of this session can be found on pages 547–549 of the *Participant's manual*.**

▸ **Remind participants that current recommended treatment with antiretroviral drugs may change in the future, as more programmatic experience and research findings are gathered.**

Notes

Notes (contd)

SESSION 74

Supporting women living with HIV to breastfeed

Objectives

After completing this session, participants will be able to:

- counsel a women living with HIV to breastfeed according to national health authority recommendations
- provide practical help in maintaining exclusive breastfeeding
- describe how to heat-treat and store a mother's expressed breast milk
- describe the criteria for using a wet nurse
- explain how to stop breastfeeding gradually
- support a woman living with HIV who decides to breastfeed when the national health authority recommendation is to use replacement feeding

Session outline . . . . . 35 minutes

Participants are all together for a lecture presentation by one trainer, except for Section VIII.

Include Section VI only if replacement feeding is recommended by the national health authority. If it is not, go on to Section VII.

For the group exercise (*optional*), participants work in three groups, each with a facilitator/trainer.

If adding the two optional sections, an additional 35 minutes will be needed.

I. Introduce the session, present **Slide 74/1** . . . . . 2 minutes
II. Discuss exclusive breastfeeding and the importance of adherence to antiretroviral therapy . . . . . 10 minutes
III. Discuss the heat-treatment of expressed breast milk (**Slide 74/2**) . . . . . 10 minutes
IV. Discuss breastfeeding by another woman who is HIV negative . . . . . 5 minutes
V. Explain how to stop breastfeeding gradually (**Slide 74/3**) . . . . . 5 minutes
VI. Support the decision to breastfeed if replacement feeding is the national health authority recommendation (*optional*) . . . . . 5 minutes
VII. Summarize the session . . . . . 3 minutes
VIII. Group exercise (*optional*) . . . . . 30 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides and facilitating group work.
- Study the **Slides 74/1** to **74/3** and the text that goes with them, so that you are able to present them.
- Make sure the 2010 and 2016 guidelines on HIV and infant feeding are available during the session.[1,2]
- Decide before the session whether the group exercise in section VIII will be conducted
  - if yes, decide how to divide the class into the three groups. If teams of health workers attend from one facility, keep them in the same group
- Give each group a flipchart and markers.

[1] WHO, UNICEF, UNAIDS. Guidelines on HIV and infant feeding 2010: principles and recommendations for infant feeding in the context of HIV and a summary of evidence. Geneva: World Health Organization; 2010 (http://apps.who.int/iris/bitstream/10665/44345/1/9789241599535_eng.pdf).
[2] Guideline: updates on HIV and infant feeding. Geneva: World Health Organization; 2016 (http://apps.who.int/iris/bitstream/10665/246260/1/9789241549707-eng.pdf).

- Discuss with trainers/facilitators their role during the group work.
  - Have ready COUNSELLING CARD 3: GOOD ATTACHMENT, COUNSELLING CARD 4: BREASTFEEDING POSITIONS, COUNSELLING CARD 6: HOW TO EXPRESS BREAST MILK AND CUP-FEED, COUNSELLING CARD 7: WHEN YOU ARE SEPARATED FROM YOUR BABY, COUNSELLING CARD 8: SUPPORTING WOMEN LIVING WITH HIV TO BREASTFEED, COUNSELLING CARD 10: HOW TO HEAT-TREAT BREAST MILK, and the *Guidance on the use of counselling cards*.
- Include Section VI only if replacement feeding is recommended by the national health authority.

As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

I. Introduce the session — 2 minutes

► Show **Slide 74/1 – Session 74 – objectives** and read out the objectives:

74/1

Session 74: Supporting women living with HIV to breastfeed – objectives

After completing this session, participants will be able to:

- counsel women living with HIV to breastfeed according to national health authority recommendations
- provide practical help in maintaining exclusive breastfeeding
- describe how to heat-treat and store a mother's expressed breast milk
- describe the criteria for using a wet nurse
- explain how to stop breastfeeding gradually
- support a woman living with HIV who decides to breastfeed when the national recommendation is to use replacement feeding

► Make these points:

¤ All health workers who care for mothers living with HIV should be fully trained to support breastfeeding, particularly exclusive breastfeeding for 6 months, maintaining breastfeeding for at least 12 months while providing complementary foods, and continuing breastfeeding for up to 24 months or beyond while being fully supported for adherence to antiretroviral therapy (ART).

II. Discuss exclusive breastfeeding and the importance of adherence to antiretroviral therapy — 10 minutes

- **Make these points:**
  - Pregnant and breastfeeding women living with HIV should be aware of two important pieces of information: why exclusive breastfeeding is best for their babies in the first 6 months of life and the importance of ART in preventing mother-to-child-transmission) of HIV.
  - Breastfeeding and taking ART will give their babies the best chance of HIV-free survival and the best chance of avoiding common infections and conditions that threaten the lives of babies who are not breastfed.
  - Explain to women that breastfeeding is safe and does protect their babies. It may be difficult for some mothers who were previously advised that replacement feeding was a better option, to now accept that breastfeeding is best.
  - Understanding how the breasts make milk and what can interfere with that process is crucial to a mother's understanding of why giving supplements and mixed feeding can affect their milk supply and put their babies at risk of more common infections. Much of this information was covered in earlier sessions.
  - Take out and review COUNSELLING CARD 8: SUPPORTING WOMEN LIVING WITH HIV TO BREASTFEED and the section in the *Guidance on the use of counselling cards* on KEY PRACTICES AND DISCUSSION POINTS for that Counselling card.
  - *Ask: What practical skills does a mother living with HIV need to exclusively breastfeed her baby?*
- **Write the responses on flipchart paper and continue.**
- **Make these points:**
  - She should know:
    - several different feeding positions
    - how to achieve good attachment and recognize poor attachment
    - how to express her breast milk without damaging her breasts
    - what will happen at the time of birth, and what should happen at the first breastfeed
    - what to do and who to contact if she has any problems with her breasts or with breastfeeding
    - the importance of attending regular follow-up visits, either in the health facility or in a community clinic, to assess breastfeeding
    - that establishing breastfeeding takes time, especially if this is her first baby, and that it gets easier as each day passes
    - where to get regular supplies of ART
    - how to take the ART and have support for adherence (for example through a support group).
  - *Ask: When do you think a woman living with HIV should begin to learn the skills of breastfeeding?*
- **Wait for a few responses then continue.**
  - Women living with HIV, particularly if they are first-time mothers or have had problems with breastfeeding before, should learn the practical skills of breastfeeding in the antenatal period, or as early as possible after delivery.
  - A checklist of what you want a woman to know ensures that you cover the information and practical skills they need.
  - A good way to teach the skills is to let the mother practise with a doll and model breast. For example, the health worker can demonstrate different sitting and lying positions for breastfeeding, and the mother can copy them.

- **Ask participants to look at Counselling card 4: Breastfeeding positions and Counselling card 3: Good attachment and the section in the *Guidance on the use of counselling cards* on Key practices and discussion points for those Counselling cards.**
  - Like all women, a mother living with HIV needs to keep her breasts healthy and she must learn and use good techniques to prevent damaged nipples or breasts.
  - If she has a breast problem, she should know:
    - what immediate action to take
    - where to go for medical help
    - how to continue to give her breast milk safely if she has to stop breastfeeding for a short period of time.
  - Exclusive breastfeeding may be particularly difficult for any mother (whether living with HIV) who works outside the home and cannot take her baby with her. Discussion of how the mother can overcome challenges to exclusive breastfeeding should take place in the antenatal period if possible, so that solutions can be found well in advance.
- **Review Counselling card 6: How to express breast milk and cup-feed, and Counselling card 7: When you are separated from your baby and the section in the *Guidance on the use of counselling cards* on Key practices and discussion points for those Counselling cards.**
  - Regular postnatal follow-up visits in the health facility, or in a community clinic, should be arranged to help and support a woman to breastfeed exclusively for 6 months. These visits should include monitoring that she is taking her ART correctly and breastfeeding is going well, and addressing any other HIV or infant feeding issues she may have. The mother living with HIV and her baby should be followed up until after the baby or young child has had an HIV test to confirm their final HIV status.
  - A woman living with HIV who is taking ART in the first 6 months may occasionally give mixed feeds without increasing the risk of her baby becoming HIV infected. But giving mixed feeds may increase the risk of her baby becoming ill from more common infections because the baby may get fewer breastfeeds.
  - Mixed feeding is more dangerous if a woman is HIV infected and is not being treated with ART, or she does not know her HIV status. In these situations, there is an increased risk of mother-to-child transmission of HIV and of her baby becoming ill. Therefore, any mother who is not exclusively breastfeeding during the first 6 months should be encouraged to start or restart.
  - Counselling on infant feeding needs to take into account the woman's disease progression. Evidence suggests advanced disease may increase the rate of postnatal transmission.

III. Discuss the heat-treatment of expressed breast milk — 10 minutes

- **Make these points:**
  - Although exclusive breastfeeding for 6 months is what we want a mother living with HIV to be able to do, she still needs information about what she can do if she is temporarily unable to breastfeed.
  - *Ask: Could you list some of the reasons why mothers living with HIV may have to temporarily stop breastfeeding?*
- **Wait for a few replies, if the following points have been covered go on to the next question.**
  - The mother or the baby may be unwell, for example the baby may be unable to breastfeed.
  - The mother and baby may be separated for various reasons, for example the mother is working away from her baby.
  - The mother may have a breast condition.
  - The ART or antiretroviral drugs are temporarily unavailable.
  - *Ask: How can we help a mother in these situations to continue to give her baby breast milk?*

- **Wait for a few replies, which should include the following points:**
  - The mother can express her breast milk.
  - The mother's own breast milk can be heat-treated.
  - A wet nurse can breastfeed the baby.
  - If a milk bank is available in the country, donor milk can be used.
  - We will now look at some of these ways of providing breast milk for a baby.
  - If a mother has to stop breastfeeding for a short time, the simplest way she can give her baby her own breast milk is to express her milk and, if necessary, heat-treat it.
  - Heat-treatment of expressed breast milk inactivates HIV, making it safe for a mother to give to her baby.
  - Some anti-infective components in breast milk are reduced by heat-treatment but the breast milk still retains most of its protective value and still remains superior to any breast-milk substitute.
  - The important question is when should expressed breast milk be heat-treated?
  - Expressed breast milk, does not need to be heat-treated if the mother is HIV negative or if she is taking ART when she is breastfeeding, except in a small number of situations, which we will see in the next slide.
- **Show Slide 74/2 – Heat-treated expressed breast milk and ask participants to read out the points on the slide:**

74/2

Heat-treated expressed breast milk

Mothers known to be living with HIV may express and heat-treat their breast milk as an interim feeding strategy, in special circumstances, such as:

- a baby is low birth weight at birth or is otherwise ill in the neonatal period and unable to breastfeed
- the mother is unwell and temporarily unable to breastfeed, or has a temporary breast health problem such as mastitis
- to assist mothers in stopping breastfeeding
- if antiretroviral drugs are temporarily unavailable

- **Make the following points:**
  - There are several ways to heat-treat breast milk. In the practical session (Session 78), we will demonstrate using "flash heating" of breast milk. This method inactivates HIV, making the milk safe to feed to an HIV-exposed baby, and retains more nutrients than some other methods of heat-treatment.
  - If a mother is in a hospital, her milk may be pasteurized using a method called "Holder pasteurization". This is the method used in milk banks for donor milk. The milk is heated using equipment that controls the temperature at 62.5 °C for 30 minutes.
  - *Ask: Have any of you experience of mothers heat-treating their own milk?* (If yes, ask the following question.)
  - *Can you describe the method that was used?*
- **Discuss responses.**
  - To prepare a feed, a mother should express her breast milk about 1 hour before the feed is due. She should express enough milk for that feed into a suitable container, or she can use milk that she may have expressed earlier and refrigerated.
  - A mother may be able to follow her baby's sleeping pattern and prepare feeds ready for when she expects her baby to wake. If necessary, to avoid leaving the milk too long or wasting it, she may sometimes have to wake her baby for a feed.
  - To avoid having to use more fuel to heat the breast milk than necessary, it may be possible to heat-treat the milk while cooking the family's meals.

- **Ask participants to look at COUNSELLING CARD 10: HOW TO HEAT-TREAT BREAST MILK and the section in the *Guidance on the use of counselling cards* on KEY PRACTICES AND DISCUSSION POINTS for that Counselling card. Review the card with them.**
  - *Ask: how will the baby be fed the expressed and heat-treated breast-milk?*
- **Wait for a few replies and then continue**
  - As seen in COUNSELLING CARD 6, it is best to use a small open cup to feed the heat-treated breast milk to a baby, as cups are easy to keep clean. Feeding bottles and teats are more difficult to clean and should be avoided if possible, particularly if the mother intends to continue breastfeeding.
  - A mother can store her expressed breast milk for about 8 hours at room temperature. The milk should be put in the coolest part of the room, in a container with a lid. The container can be stood in cold water. If a mother has a refrigerator, she can store her milk inside it for up to 24 hours.
  - *Ask: where should the milk be put in a refrigerator?*
- **Wait for a few replies and then continue.**
  - Expressed breast milk should be put at the back of the top shelf of the refrigerator, where the temperature is constant. Do not put breast milk in the door of a refrigerator, because each time the door is opened, the temperature rises a little and this can increase the risk of bacterial growth in the milk.
  - Once expressed breast milk is heat-treated, it should be used as soon as possible and should be kept in a covered container in a cool place. Discard any milk left over in the cup or feeding bottle after a feed

IV. Discuss breastfeeding by another woman who is HIV negative — 5 minutes

- **Make these points**
  - We will now look at the option of a baby being fed by another woman who is known to be HIV negative – this is called "wet-nursing".
  - Any breast milk a woman expresses for another baby is called "donor breast milk".
  - *Ask: Is breastfeeding another woman's baby acceptable in your area?*
- **Discuss for a minute or two the cultural acceptability of using milk from another mother.**
  - Where wet-nursing is acceptable, a woman who is breastfeeding another baby will need to have sufficient rest, food and water for herself.
  - The cost of nourishing her is usually less than the cost of providing replacement feeding for a baby.
  - *Ask: How can a mother bond with her baby when her baby is breastfed by another woman?*
- **Wait for a few replies then continue.**
  - The baby's own mother, if she is able, can provide as much of the other care of her baby as possible, cuddling, changing, washing, massaging and later giving other foods. This contact helps to build the bond between the mother and her baby.
  - *Ask: What should a woman living with HIV consider when arranging for another woman to breastfeed her baby?*
- **Wait for a few replies and then continue.**
  - To protect a baby from HIV, the wet nurse must be HIV negative. The only way for the mother to know for sure that the wet nurse is HIV negative is for the wet nurse to be tested at least 3 months after the last time she had unprotected sexual intercourse, or after any other possible exposure to HIV.
  - The wet nurse will need to protect herself from HIV infection for the entire time she is breastfeeding.

- This means:
  - not having sexual intercourse, or
  - using a condom every time she has sexual intercourse, or
  - having sexual intercourse with only one partner, who has tested negative for HIV and who is being faithful to her
  - not sharing any razors, needles or other piercing objects.
- The wet nurse should be available to feed the baby on demand, both night and day.
- She should receive counselling about how to prevent cracked nipples, breast infections and engorgement.
- If a baby is already infected with HIV, there may be a very small chance that HIV can be passed to the wet nurse through breastfeeding. The wet nurse needs to know about this small risk and avoid breastfeeding if she has a cracked nipple or if the baby has oral thrush, or any signs or sore places in their mouth.
- In areas where HIV is prevalent, breastfeeding a close relative's baby is not recommended. For example, an aunt who has a child of her own may care for a baby while their mother is out. The mother may be delayed in returning home and the aunt breastfeeds the baby. But does the mother know the HIV status of her relatives? Both the aunt and the baby may be at increased risk of passing HIV on.

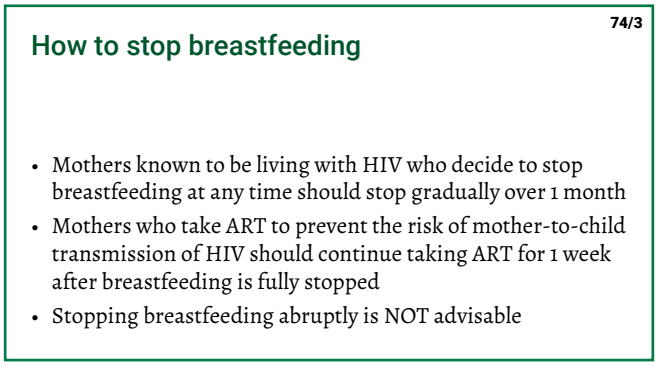
► **Milk banks can be discussed here, as a further option for HIV-infected mothers to use if there is a milk bank available in a nearby hospital or town.**

V. Explain how to stop breastfeeding gradually — 5 minutes

► **Make these points**

- A mother may stop breastfeeding for a variety of reasons. It is how she stops that is important.

► **Show Slide 74/3 – How to stop breastfeeding and ask participants to read the slide:**



- *Ask: Why should mothers gradually stop breastfeeding over a 1-month period?*

► **Wait for a few replies then continue**

- It is clear from the experience of mothers and health workers in different parts of the world that stopping breastfeeding abruptly or stopping over a few days is very difficult.
- Many babies are unhappy about suddenly being denied their mother's breast and often refuse to feed from a bottle, which is distressing for the mother.
- Stopping breastfeeding suddenly can affect the baby's health; for example, the incidence of diarrhoea increases and the baby's growth may slow. Psychologically, it can affect the mother too, making her more stressed and depressed .
- Stopping breastfeeding slowly is a more normal process. The mother's breasts are less likely to become engorged and her milk will gradually diminish over the course of 1 month, giving the baby or young child time to get used to another method of feeding.
- *Ask: Could you suggest ways a mother can stop breastfeeding gradually?*

► **Wait for a few replies then continue.**

- It is a good idea to plan this with a health worker well in advance.
- Begin by expressing some breast milk and replacing one breastfeed with a cup feed of breast milk.
- Gradually increase the number of cup feeds given, until the baby is taking all cup feeds of expressed breast milk.
- Then gradually replace the breast milk with commercial infant formula milk (if the baby is aged under 6 months) or animal milk (e.g. cow's milk; in children aged 6 months or older, boiled for infants under 12 months), depending upon the age of the baby, until the baby is having all replacement feeds.
- *Ask: What can you suggest a mother can do to comfort a baby or young child who is distressed – particularly if it is because breastfeeding has stopped?*

► **Wait for a few replies then continue.**

► **Make these points if the following suggestions are not given. Where possible, demonstrate massaging or rocking the baby.**

- This too, needs advance planning. Cuddling, massaging or rocking the baby may help.
- Offering a finger for the baby to suck on may also help.
- Ask the father to hold and comfort the baby. Babies who are crying often stop when they hear a man's voice.

VI. Support the decision to breastfeed if use of replacement feeding is the national health authority recommendation (*optional*) 5 minutes

► **Make these points:**

- A woman living with HIV who chooses to breastfeed rather than to follow a national health authority recommendation of giving replacement foods needs to be counselled and supported by her infant feeding counsellors and health workers.
- She should be advised to discuss her decision to breastfeed with her family. She needs to think about her personal circumstances and be aware of the implications of her decision.
- It is important for her to know whether the national health authority will provide her with ART if she chooses to breastfeed rather than follow the recommendation of replacement feeding.[1] A national health authority is not obliged to provide more than is covered within the nationally recommended method of infant feeding. This means it is important to know exactly what is written in the national recommendation for HIV and infant feeding.
- It may be helpful for the infant feeding counsellor to discuss with the mother the positive and negative aspects of breastfeeding rather than use of replacement feeding. This may help her decide what to do.
- *Ask: What positive reasons can you think of for breastfeeding rather than replacement feeding?*

► **Wait for a few replies and add the following points if they have not been made.**

- On the positive side:
  - The majority of babies born to mothers living with HIV are not infected with HIV.
  - Exclusive breastfeeding protects babies against many common infections.
  - If the woman is taking lifelong ART, the risk of mother-to-child transmission of HIV is very small.
  - Breastfeeding may be culturally acceptable; replacement feeding may not be so acceptable.
  - If she is not taking ART, the mother can heat-treat her breast milk to feed to her baby, or she could find a wet nurse who is HIV negative.
- *Ask: What negative reasons can you think of for breastfeeding rather than replacement feeding?*

► **Wait for a few replies and add the following points if they have not been made.**

[1] This situation may become less frequent as the current recommendation is for people living with HIV to receive lifelong ART. This will include pregnant women and mothers, regardless how they feed their babies.

- On the negative side:
  - The mother and her family should be aware of the financial implications of not following the national health authority decision to use replacement feeding for her baby. Antiretroviral drugs may not be freely available to her, or she may have difficulty getting a private supply of the drugs, or she may not be eligible for lifelong ART and have to stop taking antiretroviral drugs after delivery.
  - The mother's decision may not be supported by her family.
  - The risk of the baby being infected with HIV is higher if ART is not available to the mother.
  - The mother will have to sustain exclusive breastfeeding for 6 months, which may be very difficult if she has to return to work/school, or be away from home.

VII. Summarize the session 3 minutes

- **Ask participants whether they have any questions, and try to answer them.**
- **Make these points:**
  - We need to ensure that women living with HIV are supported to breastfeed their babies. They must receive appropriate ART, at least until all breastfeeding has stopped, to reduce the risk of mother-to-child transmission of HIV.
  - Exclusive breastfeeding is recommended for 6 months and then breastfeeding alongside complementary foods up to at least 12 months; breastfeeding can continue up to 2 years of age or beyond, provided the woman is receiving ART.
  - When mothers stop breastfeeding, they should do so gradually over a period of 1 month.
  - Mothers need to master the practical skills of breastfeeding, such as attachment and positioning, and expression of breast milk, so that they avoid breast problems. In addition, they should know what to do in the event that they have to temporarily stop breastfeeding. Knowing how to heat-treat their own expressed breast milk or how to choose a wet nurse may be useful in ensuring a baby can continue to have breast milk.
  - Mothers who choose to breastfeed if their national health authority recommends replacement feeding should be fully supported to do so.
- **Explain that a summary of this session can be found on pages 551–555 of the *Participant's manual*.**

VIII. Group exercise (optional) 30 minutes

- **Work in groups, according to either health facility, health worker role or location. Ask participants to consider the following questions:**

1. How will the current recommendations on HIV and breastfeeding change the way you work and support women who are living with HIV women?
2. Your national health authority has decided all women living with HIV should breastfeed their babies. What additional support do you think these women will need compared to women who are HIV negative?

Notes

Notes (contd)

SESSION 75

Supporting women living with HIV to use replacement feeding

Objectives

After completing this session, participants will be able to:

- support women living with HIV to use replacement feeding according to their national health authority's infant feeding recommendations
- describe how to ensure replacement feeding is safely given to babies
- support women living with HIV who decide to use replacement feeding and not follow the national health authority recommendation to breastfeed, with how to ensure replacement feeding is safely given to babies
- support mothers living with HIV who stop breastfeeding and change to replacement feeding

Session outline . . . . . 40 minutes

Participants are all together for a lecture demonstration by one trainer, followed by an optional group exercise.

Include Section VI only if breastfeeding is recommended by the national health authority. If it is not, go on to Section VII. Discuss helping a mother to use replacement feeding when she stops breastfeeding.

For the group exercise (*optional*), participants work in three groups, each with a facilitator/trainer.

If adding the two optional sections, an additional 23 minutes will be needed.

I. Introduce the session, present **Slide 75/1** . . . . . 2 minutes
II. Discuss the meaning of "replacement feeding" (**Slide 75/2**) . . . . . 5 minutes
III. Explain what conditions should be in place for safe replacement feeding . . . . . 5 minutes
IV. Discuss the advantages and disadvantages of replacement feeding . . . . . 10 minutes
V. Information about commercial formula milk (**Slide 75/3**) . . . . . 10 minutes
VI. Supporting a woman living with HIV who decides to replacement feed when the national health authority recommendation is to breastfeed (*optional*) . . . . . 3 minutes
VII. Discuss helping a mother to replacement feed when she stops breastfeeding (**Slide 75/4**) . . . . . 5 minutes
VIII. Summarize the session . . . . . 3 minutes
IX. Group exercise (*optional*) . . . . . 20 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides and facilitating group work.
- Study the **Slides 75/1** to **75/4** and the text that goes with them, so that you are able to present them.
- Make sure the 2010 and 2016 guidelines on HIV and infant feeding are available during the session.[1, 2]
- Check the price of locally available commercial formula milk for newborn babies, and put the correct amount into the text at the end of Section IV on how much it will cost to buy.
- Find out whether the national health authority provides the commercial formula milk, and the procedure for mothers living with HIV to collect it.
- If Section IX will be included, decide before the session how to divide the class into the three groups. If teams of health workers attend from one facility, keep them in the same group.
- Give each group a flipchart and markers.
- Discuss with trainers/facilitators their role during the group work.
- Have ready COUNSELLING CARD 9: CONDITIONS NEEDED FOR SAFE USE OF REPLACEMENT FEEDING, COUNSELLING CARD 11: SUPPORTING WOMEN LIVING WITH HIV WHO USE REPLACEMENT FEEDING, and the *Guidance on the use of counselling cards*.
- You will need:
  - two dolls
  - two cloths for wrapping the dolls
  - Read the **Further information** sections, so that you are familiar with the ideas that they contain, so that you can answer participants' questions.

As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

Do not present the **Further information** sections.
Use them to help you to answer questions.

I. Introduce the session — 2 minutes

► Make these points:

¤ This session examines how to help and support women living with HIV to use replacement feeding.

¤ There are several reasons why replacement feeding may be used instead of breastfeeding. A country's national health authority may recommend replacement feeding for all babies whose mothers are living with HIV; a mother who was breastfeeding may decide to stop breastfeeding; or she may choose replacement feeding rather than breastfeeding.

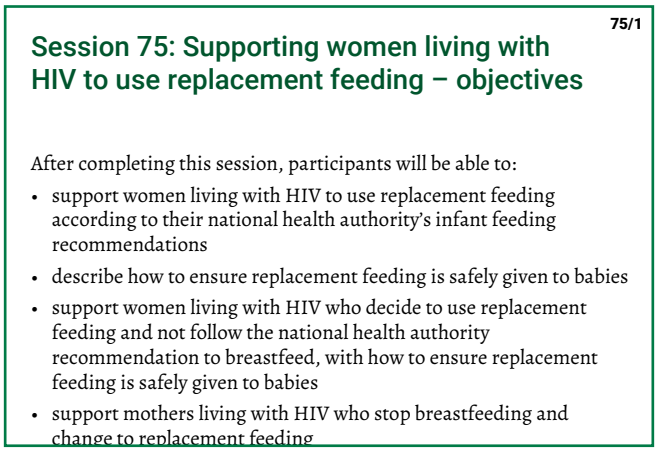
¤ Whatever the reason, mothers need to be supported to give replacement feeds safely, to ensure their babies are not at risk of common infections or malnutrition.

¤ The feeding recommendation in (Country) is to use replacement feeding.

¤ Formula milk is provided free of cost in (Country) (*add this if free distribution is part of the policy*).

[1] WHO, UNICEF, UNAIDS. Guidelines on HIV and infant feeding 2010: principles and recommendations for infant feeding in the context of HIV and a summary of evidence. Geneva: World Health Organization; 2010 (http://apps.who.int/iris/bitstream/10665/44345/1/9789241599535_eng.pdf).
[2] Guideline: Updates on HIV and infant feeding. Geneva: World Health Organization; 2016 (http://apps.who.int/iris/bitstream/10665/246260/1/9789241549707-eng.pdf).

► Show **Slide 75/1 – Session 75 – objectives** and read out the objectives:

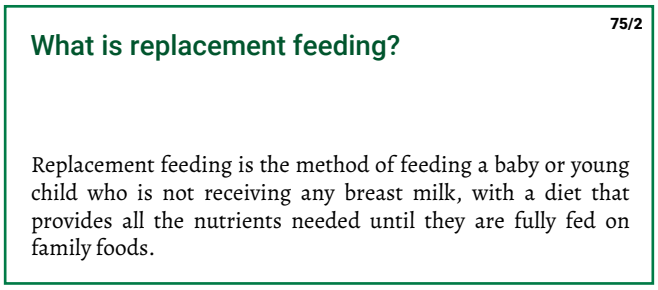


II. Discuss the meaning of "replacement feeding" 5 minutes

- *Ask: What do you understand by 'replacement feeding'?*

► Wait for a few replies and then continue.

► Show **Slide 75/2 – What is replacement feeding?** and read out the definition:



► Make these points:

- Milk is an important part of a baby's diet for at least the first 2 years of life.
- A baby who is being given replacement feeds from birth, or at any time during the first 6 months of life, and who is not breastfeeding or receiving expressed breast milk, should be given a commercial infant formula milk, suitable for newborn babies.
- After the first 6 months, until the baby is 12 months old, the baby can continue with the same commercial infant formula milk or can be given boiled cow's milk alongside suitable complementary foods. The cow's milk should be boiled to make the protein more digestible for babies in this age group, but you do not need to dilute the cow's milk with water.
- Babies aged over 12 months can safely be given cow's milk as a primary source of milk.
- Home-modified animal milks are **NOT** recommended for babies under 6 months and may result in stunting or undernutrition of the baby.

III. Explain what conditions should be in place for safe replacement feeding 5 minutes

- **Make these points:**
  - Commercial infant formula milk is modified milk. It is usually cow's milk, containing added ingredients that provide an appropriate balance of nutrients and micronutrients to support satisfactory early growth and development for the first 12 months of life. Commercial infant formula has to meet strict international standards in accordance with the *Codex Alimentaris*, which makes it acceptable for use as a replacement if breastfeeding is not possible.
  - It is important to remember that formula milk can never be the same quality as a mother's breast milk. It does not contain the immune or growth factors that are found in breast milk and these cannot be added artificially.
  - Formula milk must be hygienically and correctly prepared using formula powder added to clean water, or given as a ready-made formula milk.
  - To be safe, formula milk should only be used as a replacement feed if certain conditions are met.
  - *Ask: We looked at the conditions in the Overview session (Session 71 or 72). There are six conditions; do you remember what they are?*
- **Wait for a few replies and then continue.**
- **Ask participants to look at page 558 of their *Participant's manual* and find the box CONDITIONS NEEDED FOR SAFE USE OF REPLACEMENT FEEDING. Ask participants to take it in turns to read out each point.**

CONDITIONS NEEDED FOR SAFE USE OF REPLACEMENT FEEDING

1. Safe water and sanitation are assured at household level and in the community.
2. The mother or other caregiver can reliably provide sufficient infant formula milk to support normal growth and development.
3. The mother or caregiver can prepare the formula milk cleanly and frequently enough, so that it is safe and carries a low risk of diarrhoea and malnutrition.
4. The mother or caregiver can, in the first 6 months, exclusively give infant formula milk.
5. The family is supportive of this practice.
6. The mother or caregiver can access health care that offers comprehensive child health services.

- **Ask participants to look at COUNSELLING CARD 9: CONDITIONS NEEDED FOR SAFE USE OF REPLACEMENT FEEDING and the section in the *Guidance on the use of counselling cards* on KEY PRACTICES AND DISCUSSION POINTS for that Counselling card.**
- **Make these points:**
  - These conditions should apply to any woman who, for whatever reason, will be giving replacement feeds to her baby, irrespective of her HIV status.
  - Mothers should be told what the specific conditions are, why they are important and how they can be met in their own homes.
  - Where replacement feeding is the national HIV infant feeding recommendation, these conditions should be achievable by all mothers living with HIV using this method of feeding.
  - *Ask: Do you think these conditions can be easily met by all mothers in your area?*
- **Wait for a few replies and then continue.**
  - We will discuss this further in the group exercise.

IV. Discuss the advantages and disadvantages of replacement feeding 10 minutes

- *Ask: What questions do you think mothers will ask you about replacement feeding?*

▶ **As you are given the "questions", write them on flipchart paper or on the board. Put a tick by the question as it is answered during the session.**

- Let us see whether we can answer these questions by the end of this session.

▶ **Make these points:**

- Supporting replacement feeding as the country's choice of feeding method for all women living with HIV means helping them to accept that this is necessary and safe for their babies. It may be a difficult choice for women to accept when the majority of mothers are not infected with HIV, and are breastfeeding.
- We need to reassure a mother who is giving replacement feeding because it is a national choice, that she can have a close bond with her baby. Whether a mother is breastfeeding or replacement feeding, she should still have skin-to-skin contact with her baby after delivery. When the baby shows signs of wanting to feed, the mother should give formula milk, while holding her baby very close to her.
- *Ask: What suggestions can you give to a woman who worries that she will not bond to her baby if she decides to use replacement feeding?*

▶ **Wait for a few replies and then continue.**

- Mothers living with HIV who are not taking antiretroviral therapy (ART) after delivery need to understand that, after delivery, any breastfeeding they do will put their baby at increased risk of being infected with HIV. If a mother has stopped taking ART, the risk will be present each time she breastfeeds. This should be considered if a mother living with HIV is likely to breastfeed at home due to social pressure, such as when friends or relatives are present who do not know her HIV status.
- It is important in the antenatal period to help a woman to think about the positive aspects of replacement feeding, and to think about the challenges she may face, such as the challenge we have just discussed, so that, with the help of an infant feeding counsellor, solutions can be found that may help overcome potentially difficult situations in the future.
- *Ask: First let us consider, what is positive about replacement feeding.*

▶ **Wait for a few replies and add the following points if they have not been made.**

- There is no risk of transmitting HIV if exclusive replacement feeding is given.
- Other family members can help feed the baby.
- Feeding the baby may be easier for the mother if she has to work.
- Formula milk contains an appropriate balance of nutrients for the baby's growth and development.
- You know how much milk a baby is getting.
- Formula milk is provided free of charge (depending upon the national health authority's HIV infant feeding policy; give information on how the formula milk is provided in the specific country).
- *Ask: Now let us consider what is negative about giving replacement feeds.*

▶ **Wait for a few replies and add the following points if they have not been made.**

- Neither formula milk nor cow's milk contains immune factors that help protect a baby from common infections.
- A baby is more at risk of becoming seriously ill from diarrhoea, chest infections and malnutrition, especially if formula milk is not prepared correctly.
- The mother needs clean water and fuel to heat the water sufficiently to prepare formula milk, and if she is using cow's milk from 6 up to 12 months, she must remember to boil it first.
- Formula milk takes time to prepare and must be made freshly at each feed.
- Formula milk is expensive and there must be a reliable source to obtain it. A baby needs approximately 40 500 g tins for the first 6 months. This can cost ….. per month and …… for the first 6 months.
- A mother may feel isolated if all her friends are breastfeeding.

- The mother may feel she has to breastfeed in front of her family or friends.
- If the mother decides to bottle feed, this may not be the normal way to feed a baby, which will make people think the mother has HIV.
- A mother may get pregnant again very quickly, because only breastfeeding will suppress ovulation.
- *Ask: What can we tell a mother to help her overcome these negative points if she is going to use replacement feeding or is already replacement feeding?*

▸ **Wait for a few replies and add any points from the following points that have not already been given.**

- Women need support. They need it from health workers, both in health facilities and in the community, and from their family and friends. It may be very difficult for some women not to breastfeed.
- There is a great deal of work that still has to be done to educate communities about HIV; any support that comes from community groups for the mother giving replacement feeding is particularly important, especially in areas where breastfeeding is the main method of feeding among the general population. This will help mothers feel less isolated.
- Encourage women and their husbands or partners to use appropriate family planning methods, to avoid having another baby too quickly.
- We should tell a woman who will be using replacement feeding to make sure all equipment used in making up feeds or giving them is kept scrupulously clean. This will help to reduce the risk of her baby becoming ill.

V. Information about commercial formula milk — 10 minutes

▸ **Ask participants to form pairs.**

- Each pair has to observe COUNSELLING CARD 11: SUPPORTING WOMEN LIVING WITH HIV WHO USE REPLACEMENT FEEDING. One of the members of the pair will use the Counselling card to counsel their partner-participant on replacement feeding for a woman living with HIV.

▸ **Ask for feedback from *one* of the pairs; the other pairs can add anything missing.**

▸ **Make the following points, avoiding repetitions and covering only the gaps left by the participants.**

- Formula milk has to be made up correctly. The consequences of not doing so can be very serious and lead to the baby becoming ill or dying.
- Any woman giving formula milk to her baby should be individually shown how to make it up. She should then demonstrate back to the health worker, to show that she can make up formula milk safely. It is useful for a woman to do this before the birth of her baby, or very soon after the birth, or before she stops breastfeeding.
- Infant formula powder is not a sterile product. Even if a tin is sealed, it can still contain bacteria. If the feed is not prepared according to the manufacturer's instructions, these bacteria can cause infection in the baby.
- To prevent infection, the water must be boiled so that it is more than 70 °C when used to prepare the formula powder.
- Emphasize to the mother, that she must add the formula powder to the water, **NEVER** add the water to the formula powder.
- The mother needs to regularly check the instructions on the tin, or with a health worker, to see how much formula powder to use as the baby gets older and puts on more weight.

► Show **Slide 75/3 – Approximate amounts of milk needed to feed a baby each day** and read out the title of the slide before continuing with the points below:

75/3

Approximate amount of milk needed to feed a baby each day

Baby's age	Number of feeds per day	Amount of milk or formula per feed	Total milk or formula per day
Birth up to 1 month	8	60 mL	480 mL
1 up to 2 months	7	90 mL	630 mL
2 up to 4 months	6	120 mL	720 mL
4 up to 6 months	6	150 mL	900 mL

- This chart shows you approximately how much milk a baby needs at each feed over a 24-hour period from birth until 6 months of age.
- You can see that a newborn baby needs to be fed small amounts of milk at least eight times in 24 hours. The amount gradually increases as the baby grows and gets older, and the baby usually needs to be fed less often in 24 hours.
- On the first 2 days after birth, you should give the baby smaller feeds more often, because the baby's stomach is very small at birth and gradually stretches over the first few days.
- The amount a baby takes at each feed will vary, so, if a baby takes a very small feed, offer extra at the next feed or give the next feed earlier, especially if the baby shows signs of hunger.
- Remember that if a baby is not gaining weight, they may need to be fed more often or given larger amounts of milk at each feed, or they may be ill. If a mother is worried, she should take her baby to a clinic or health facility, where she can get her baby examined.
- We should tell a mother who is using replacement feeding to make sure all equipment used in making up feeds or giving them is kept scrupulously clean. This will help reduce the risk of her baby becoming ill.

► Using a doll, demonstrate how to position a baby for cup-feeding (refer to SESSION 18: CUP-FEEDING).

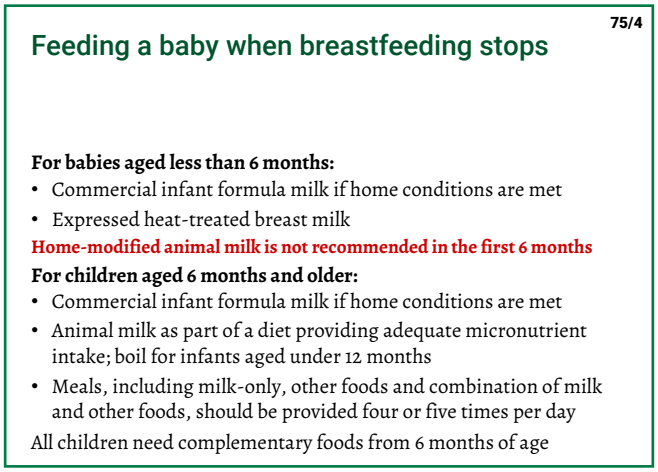
► Give different participants a doll and ask them to copy what you are doing.

VI. Supporting a woman living with HIV who decides to use replacement feeding when the national health authority recommendation is to breastfeed (*optional*) 3 minutes

- A woman living with HIV who chooses to use replacement feeding rather than to follow the national recommendation of breastfeeding, needs skilled counselling and support to safely replacement feed. She needs to consider her particular circumstances and be aware of the positive and the negative aspects of her decision.
- There may be no obligation on the national infant feeding authority to provide a mother with formula milk for her baby. This may mean making the mother and her family aware of the financial implications of not following the national authority decision.

VII. Discuss helping a mother to use replacement feeding when she stops breastfeeding
5 minutes

- **Make these points:**
  - We discussed in detail how to stop breastfeeding in SESSION 74: SUPPORTING WOMEN LIVING WITH HIV TO BREASTFEED. But there are some points we need to re-emphasize if replacement feeds are to be given.
  - A mother living with HIV who is breastfeeding, and stops before her baby is 12 months of age, will need to give replacement feeds.
  - The following slide outlines recommendations from the *Guidelines on HIV and infant feeding 2010*.[1]
  - When mothers living with HIV stop breastfeeding, they must provide their babies with safe, adequate replacement feeds to enable normal growth and development.
- **Show Slide 75/4 – Feeding a baby when breastfeeding stops and ask different participants to read out the points on the slide:**



  - *Ask: Are there any questions about the information on this slide?*
- **Answer any questions and then continue.**
  - As we discussed earlier, the conditions that should be in place before commercial infant formula milk is given to a baby also apply to mothers who stop breastfeeding and then give replacement feeding.
  - The mother should stop breastfeeding gradually over a period of one month, and gradually introduce replacement feeding, as we discussed in SESSION 74: SUPPORTING WOMEN LIVING WITH HIV TO BREASTFEED.
  - If possible, this should be planned well in advance.
  - When stopping breastfeeding, begin by expressing some breast milk and replacing one breastfeed with a cup feed of breast milk.
  - Gradually increase the number of cup feeds given, until the baby is taking all cup feeds of expressed breast milk.
  - Then replace the breast milk with formula milk or cow's milk, depending upon the age of the baby.
  - Skilled counselling and support, to safely give replacement feeding, should be available to all mothers who stop breastfeeding early. The mother should be shown how to make up formula milk and should have the opportunity to demonstrate back to a health worker, to be certain she is making it up correctly.
  - A mother needs to know whether a national health authority will provide commercial infant formula milk if she stops breastfeeding for any reason. If not, she needs to be aware of the financial implications of having to provide it herself.
- **Briefly discuss any questions that are unanswered on the flipchart sheet.**

[1] WHO, UNICEF, UNAIDS. Guidelines on HIV and infant feeding 2010: principles and recommendations for infant feeding in the context of HIV and a summary of evidence. Geneva: World Health Organization; 2010 (http://apps.who.int/iris/bitstream/10665/44345/1/9789241599535_eng.pdf).

VIII. Summarize the session — 3 minutes

- **Make the following points:**
  - In this session, we discussed helping and supporting women living with HIV to give replacement feeds to their babies when it is recommended by the national health authority for all HIV mothers and babies; or for women who have stopped breastfeeding or have chosen to use replacement feeding.
  - For the first 6 months of life, a commercial infant formula milk should be used because it provides appropriate nutrients for the baby's growth and development. After that, boiled cow's milk or commercial infant formula milk can be given until 12 months, and thereafter unboiled cow's milk can be given.
  - We listed the positive and negative aspects of replacement feeding. Many of the negative aspects concerning the higher risk of infection or malnutrition could be reduced by ensuring the recommended conditions to safely formula feed are fully met.
  - We again emphasized the importance of a mother who stops breastfeeding stopping gradually while introducing her baby to replacement feeding.
- **Ask participants whether they have any questions, and try to answer them.**
- **Explain that a summary of this session can be found on pages 557–561 of the *Participant's manual*.**

IX. Group exercise (*optional*) — 20 minutes

- **Ask participants to do the following exercise:**
  - Amy is a young single mother who is living with HIV. Her baby is due to be born in 6 weeks. She lives in very poor housing, with only one tap providing running water, which serves three households. At present, she does not meet the conditions to make up formula milk safely.
  - Make a plan outlining how you can support her and her new baby to use replacement feeding safely.

Further information

If there are questions about how to hold a baby for bottle feeding:

- Most mothers will hold their babies as if they are breastfeeding, but a baby who is bottle feeding should be held and fed in a semi-sitting position. This reduces the risk of the baby getting ear infections from milk going into the tubes connecting the throat and their ear.
- Tell mothers to hold their baby close to them and to look at them during bottle feeding. Eye contact is important in helping a mother to bond with her baby.
- They should then let their baby take as much milk as they want; they should not shake the bottle to encourage the baby to feed. A baby does not have to take all the milk in the bottle. They may want different amounts at each feed.

Notes

Notes (contd)

SESSION 76

Communication and support of infant feeding in the context of HIV

Objectives

After completing this session, participants will be able to:

- describe the role of the infant feeding counsellor (in the health facility and in the community) in relation to HIV
- describe a logical sequence for supporting women living with HIV
- use appropriate communication skills to provide information

Session outline . . . . . 75 minutes

Participants are all together for a lecture presentation by one trainer followed by a demonstration. For Section IV, participants are organized in three groups, each with a facilitator.

I. Introduce the session, present **Slide 76/1** . . . . . 2 minutes
II. The role of the infant feeding counsellor in the health centre and in the community in relation to HIV (**Slides 76/2** and **76/3**) . . . . . 20 minutes
III. Communicating information to a group (DEMONSTRATION 76.A) . . . . . 15 minutes
IV. Group exercise (EXERCISE 76.A) . . . . . 20 minutes
V. Plenary discussion (**Slides 76/4** to **76/6**) . . . . . 15 minutes
VI. Summarize the session . . . . . 3 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides, giving a demonstration and facilitating working group discussion.
- Study the **Slides 76/1** to **76/6** and the text that goes with them, so that you are able to present them.
- Prepare three areas each with a table and chair, for Section IV. Each group should have a facilitator. Give each facilitator one question paper. Each question paper is different, so make sure one participant writes down the main points of the discussion from each question.

As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

I. Introduce the session — 2 minutes

- Make these introductory points:
  - This session is about how to communicate with pregnant women and mothers, in order to give them information about all aspects of infant feeding, including HIV and the special role of the health workers, particularly the infant feeding counsellor, in providing appropriate support to women living with HIV.
- Show **Slide 76/1 – Session 76 – objectives** and read out the objectives:

> 76/1
>
> **Session 76: Communication and support of infant feeding in the context of HIV – objectives**
>
> After completing this session, participants will be able to:
> - describe the role of the infant feeding counsellor (in the health facility and in the community) in relation to HIV
> - describe a logical sequence for supporting women living with HIV
> - use appropriate communication skills to provide information

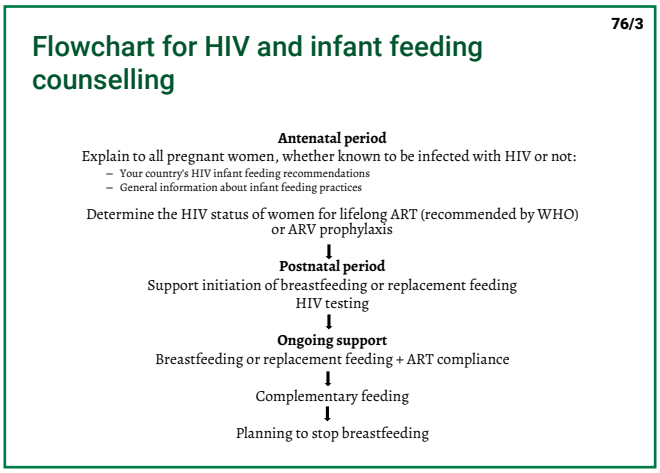
II. The role of the infant feeding counsellor in the health centre and in the community in relation to HIV — 20 minutes

- Make these points:
  - The role of the infant feeding counsellor in relation to HIV has changed in recent years, particularly during the antenatal and postnatal periods.
  - To carry out this new role requires specific knowledge and a different use of existing communication skills.
- Show **Slide 76/2 – Knowledge required to support women living with HIV in infant feeding** and ask participants to read out the points on the slide:

> 76/2
>
> **Knowledge required to support women living with HIV in infant feeding**
>
> - Current national health authority infant feeding recommendation (based on the WHO/UNICEF/UNAIDS *Guidelines on HIV and infant feeding 2010* with updates in 2016 and the WHO *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection* in 2016)
> - The skills and knowledge to counsel and support feeding practices of **ALL** women whether they are HIV positive or negative
> - The feeding options related to the national health authority infant feeding recommendation and feeding alternatives for women who choose not to follow the recommendations
> - The knowledge of the national protocol for antiretroviral therapy for pregnant women, infants and young children

  - Infant feeding counsellors are no longer expected to help individual women living with HIV to make the choice between breastfeeding and replacement feeding for their babies.
  - They are now expected to concentrate on supporting women living with HIV to use the one method of infant feeding recommended by the national health authority to improve the HIV-free survival of infants exposed to HIV and the health of mothers living with HIV. All mothers living with HIV should be provided with skilled counselling and support for infant feeding, whether or not they opt to follow the national health authority recommendations on infant feeding.

▸ Show **Slide 76/3 – Flowchart for HIV and infant feeding counselling**:



▸ **Make these points by referring to the slide:**

- How should infant feeding counsellors carry out this role? This simple flowchart will help. It guides you through a sequence of key events throughout the antenatal and postnatal periods when women, who may or may not be HIV infected, need information and support.
- The flowchart starts in the antenatal period and continues until a mother plans to stop breastfeeding or no longer needs support for replacement feeding.

▸ **Ask participants to take it in turns to read out the steps on the slide.**

- Let us follow the sequence of activities on this slide.
- Communicating information about HIV and infant feeding should begin early in the antenatal period. This is an ideal time to give up-to-date information about infant feeding to **all** pregnant women.
- Therefore, in the context of HIV, the infant feeding information should also include:
  - the national health authority recommendation on infant feeding for women living with HIV, that is, whether in (Country) women living with HIV should breastfeed with antiretroviral intervention or avoid all breastfeeding and give replacement feeds
  - specific reference to infant feeding practices that differ for women who are known to be infected with HIV, for example, how long it is recommended that a woman living with HIV should breastfeed her baby, or what kind of replacement feeding is suitable for a baby for the first 6 months
  - encouraging women to be tested for HIV if they do not know their HIV status
  - reassurance that all women will be fully supported, however they feed their babies.
- *Ask: how can we communicate this information to all women in the antenatal period?*

▸ **Wait for a few replies and then continue.**

- A group talk, while pregnant women attend the antenatal clinic, provides an ideal opportunity to give information on infant feeding to a large group. If any woman needs further information or help, she can discuss this individually with her health worker.
- The next activity on the flowchart is to encourage pregnant women to be tested for HIV, if they do not already know their status. This can be mentioned in a group talk but the personal nature of HIV testing means it is best discussed in detail individually with a health worker.
- Make sure women are told the advantages of knowing their HIV status and being tested.
- *Ask: what are the advantages of a woman knowing her HIV status?*

▸ **Wait for a few answers, then add any points from the list below if they are not mentioned by the participants.**

- If a women tests positive for HIV:
  - she and her baby can be given appropriate antiretroviral therapy (ART)
  - with ART intervention, her baby has a much lower risk of being infected with HIV during pregnancy, childbirth or breastfeeding
  - the mother is likely to be healthier and survive for longer
  - she will receive counselling and support on appropriate infant feeding practices.
- If she tests negative for HIV:
  - she will be counselled to remain negative
  - she will receive counselling and support on appropriate infant feeding practices.
- Testing and counselling may take place in the facility where you work, but HIV testing is not available everywhere. You should know where the nearest HIV testing and counselling centre is and be able to refer a woman to it, if she agrees or wants to be tested.
- A woman may be very anxious when waiting for her test results, so find out whether she has any concerns you can help her with.
- A baby born to a woman who is unsure of her HIV status should be exclusively breastfed for 6 months and then breastfed with adequate complementary feeding for at least 2 years, as for the general population. She may need reassurance that breastfeeding is the safest option for her baby. She should be strongly encouraged to be tested for HIV.
- A woman may believe she is HIV infected even though she has a negative test result. She needs counselling to discuss her worries and should be encouraged to breastfeed.
- For women who have been tested and who are HIV negative, they too should continue to feed their babies in the same way as the rest of the general population. Suggest that they have a repeat test, if they think they have been exposed to HIV since the last test. Talk to them about the risks of becoming infected during pregnancy or while breastfeeding.
- The next activity is supporting the initiation of breastfeeding or replacement feeding. For the woman who is going to breastfeed, this means ensuring the following topics have been discussed or demonstrated:
  - skin to-skin contact
  - starting breastfeeding within the first hour after birth
  - the importance of colostrum
  - the importance of exclusive breastfeeding
  - good attachment and positioning
  - the expression of breast milk.
- For the woman who will be replacement feeding, discuss:
  - skin-to-skin contact
  - how to make up feeds correctly.
- Supporting initiation will also include :
  - making sure that, at birth, babies are well dried, given to their mothers to hold skin-to-skin, and covered, whether or not the mother has decided to breastfeed
  - ensuring that, at birth, babies are given appropriate antiretroviral drugs if their mothers are living with HIV.
- Ongoing support means:
  - helping mothers to maintain breastfeeding (exclusive in the first 6 months and continued after that, with complementary feeding) while taking ART regularly, or to maintain replacement feeding
  - for the breastfeeding mother, this will include discussing and showing the mother what to do if the she has to stop breastfeeding temporarily and heat-treat her expressed breast milk or find a wet nurse, as discussed in Sessions 74 and 78

- if the mother is replacement feeding, she will need support to feed in public or overcome prejudice if she is in a culture where breastfeeding is the normal practice
- ensuring babies start complementary foods from 6 months alongside breastfeeding or replacement feeding; and, for mothers who are breastfeeding, planning for when they will stop, and supporting them to stop gradually.

¤ Mothers living with HIV should also plan to have their babies tested according to the national early infant diagnosis programme or national testing protocol for HIV, regardless of the infant feeding method used. This may include virological testing using nucleic acid testing (DNA-PCR NAT) at 4–6 weeks (or at birth, if feasible); rapid diagnostic tests (RDTs) at 9 months of age if not breastfeeding; or RDTs or serological assays at 18 months of age (or when age appropriate, such as 1 month after breastfeeding stops).

¤ It is recommended for breastfeeding women who believe they are infected to have HIV testing.

¤ It is important to emphasize that whatever infant feeding decision is made by a national health authority for mothers who are living with HIV and their babies, it should not influence the infant feeding practices of mothers who are not HIV positive or who do not know their HIV status. They should all be encouraged and supported to breastfeed.

III. Communicating information to a group 15 minutes

► **Make the following points:**

¤ Group talks, one-to-one discussions, posters on the walls, leaflets and videos are all ways we can use to communicate information antenatally and postnatally. We should also take the opportunities that exist in the wider community to share information, for example, at women's groups, religious groups, and on the radio or television.

¤ Each of these ways uses different communication skills.

¤ We mentioned group talks earlier because they are effective ways to give specific information to large groups. To give a group talk requires careful planning.

¤ We know that when we teach or give a talk, people do not remember everything they are told, so what we include in our talks is really important.

¤ We now have a demonstration of a group talk for pregnant women at an antenatal clinic. Take particular notice of the information the presenter gives and put a tick beside any items of information you hear mentioned that you have in your list.

► **Ask another facilitator/trainer to give the talk.**

► **They should give the talk 1 or 2, according to your national health authority infant feeding recommendations**

- Talk 1: Breastfeeding is recommended by the national health authority
- Talk 2: Replacement feeding is recommended by the national health authority

► **Ask participants to write down – before the talk – five recommendations that they will give to women/mothers attending their service for antenatal care.**

DEMONSTRATION 76.A GROUP TALK FOR WOMEN AT AN ANTENATAL CLINIC

Talk 1: Breastfeeding is recommended by the national health authority

Counsellor:

- My name is Lisa, and I would like to welcome you to this talk on feeding your new baby.
- It is never too early to think about how you will feed your baby and I expect some of you have already decided what you want to do, so I hope you find the information I am going to give you is useful.
- We recommend that you all breastfeed your babies, including mothers who are living with HIV. Our national health authority recommends that all mothers living with HIV should breastfeed. We know that HIV can be passed from a mother to her baby during breastfeeding, as well as in pregnancy and during birth. We now give mothers who test positive to HIV lifelong antiretroviral therapy, starting early in pregnancy (if the country does not have lifelong treatment add: until after the mother stops breastfeeding), this makes the chance of her baby being infected with HIV very low. By taking the drugs for longer now, more babies survive without being infected with HIV and they remain healthier because they are breastfeeding, and do not get ill and die from diarrhoea, or chest infections or other common illnesses. We would urge you to be tested for HIV if you do not know whether you are infected or not.
- So what I am going to say to you about breastfeeding applies to all women.
- In the first 6 months of your baby's life, we recommend that you exclusively breastfeed your baby. Your baby needs no other foods or drinks, not even water or honey after birth, just your breast milk. After 6 months, you should continue to breastfeed, but your baby will need to start other foods at this time as well. We recommend that you breastfeed for at least 12 months and may continue to breastfeed until your baby is at least 2 years old, and longer if you want to, because this will help keep your baby as healthy as possible, while you are being fully supported for adherence to antiretroviral therapy.
- Your breast milk is unique to you and your baby. Many of the substances found in your breast milk cannot be found in other milks. For example, your first milk, colostrum, which is already in your breasts at the time of birth, is very precious for your baby. Colostrum is only produced in small amounts in the first few days, maybe only a teaspoonful at each feed. This is all your baby needs at this time. Colostrum is precious, because it protects your baby from being ill, and helps your baby to develop properly, not only in the first few months but as your baby grows up as well. Babies who do not breastfeed are more likely to become ill, because other milks do not protect your baby.
- Has anyone any questions so far?
- Your baby is born with very little protection against infection, so I want to go back to what I was saying earlier about the importance of your first milk, the colostrum. Many women think they do not have any milk in the first few days, because they do not see it on their nipples when the baby finishes breastfeeding. But it is there, and to be certain that your baby receives colostrum immediately after birth, we give you your baby to hold close to your breasts, so that your baby's skin and your skin are in contact. This keeps your baby warm. We try not to separate you and your baby for at least 1 hour. After a few minutes, your baby will start moving to your nipple and breast and will begin feeding by themself. We will be there to help you both when the time comes.
- Before you leave hospital, we will make sure you can correctly attach and position your baby at the breast, and we teach you how to look after your breasts, so that you have no problems in the future. We will also teach you to recognize when your baby wants to feed.
- In the early days and weeks of your baby's life, this will mean breastfeeding whenever your baby wants, during the day and during the night.
- We also teach you to express your breast milk, so that in the event that you have to be away from your baby, for example, if you go back to work, your baby can have your own expressed breast milk.
- Breastfeeding, whenever your baby wants to feed, means you will make enough milk for your baby. But if you miss feeds or give your baby a bottle of formula milk, your breasts may make less milk.
- It is not only your baby who will be healthy as a result of breastfeeding. You, too, will benefit. Your bones will be stronger, cancer of the breast is less likely while you are young, and breastfeeding soon after birth helps to prevent you bleeding heavily at this time.
- Are there any questions?

- Cleanliness is very important, whichever way you feed. Always make sure you wash your hands before breastfeeding or expressing your breast milk.
- If you intend to give your baby formula milk or cow's milk, please tell your infant feeding counsellor or health worker, so that they can help you feed your baby safely.
- Remember, however you feed your babies, we are here to help and support you. When you see the midwife, you can talk more about feeding your baby and particularly any personal questions that you may have about your own situation.
- Does anyone have any questions?
- Thank you for your attention.

Talk 2: Replacement feeding is recommended by the national health authority

Counsellor:

- My name is Lisa and I would like to welcome you to this talk on feeding your new baby.
- It is never too early to think about how you will feed your baby and I expect some of you have already decided what you want to do, so I hope you will find the information I give you, is useful.
- Before we talk about breastfeeding, I want to tell you about recent international changes to our advice on infant feeding for women who test positive to HIV. Our national health authority has decided that women who are living with HIV should give their babies replacement feeds, so that there is no risk of the babies being infected with HIV through breast milk. To protect the baby from being infected with HIV during pregnancy and while the baby is being born, and to improve women's health, women living with HIV will be given lifelong antiretroviral therapy (recommended) or prophylactic antiretroviral drugs.
- The decision to use replacement feeding has been made because mothers can safely make up the formula feeds in their homes. I want to reassure any mothers who are living with HIV or test positive in the future that we will fully support you to feed your baby safely, for as long as you need our support. We will discuss with you individually any questions you may have about how this decision could affect how you feed your baby. We strongly advise you to be tested for HIV if you do not know whether you are infected or not.
- For all other women, we recommend that you exclusively breastfeed your baby for the first 6 months of your baby's life. Your baby needs no other foods or drinks, not even water or honey after birth, just your breast milk. After 6 months, you should continue to breastfeed, but your baby will need to start other foods at this time as well. We recommend that you continue to breastfeed and give other foods until your baby is at least 2 years old, and longer if you want to, because this will help keep your baby as healthy as possible. A mother who is living with HIV and decides to breastfeed is recommended to breastfeed for at least 1 year and continue breastfeeding for up to 24 months or longer (similar to mothers who are not HIV positive), while receiving antiretroviral therapy.
- Your breast milk is unique to you and your baby. Many of the substances found in your breast milk cannot be found in other milks. For example, your first milk, colostrum, which is already in your breasts at the time of birth, is very precious for your baby. it is only produced in small amounts in the first few days, maybe only a teaspoonful at each feed. This is all your baby needs at this time. Colostrum is precious, because it protects you baby from being ill, and helps your baby to develop properly, not only in the first few months but as your baby grows up as well. Babies who do not breastfeed are more likely to become ill because other milks do not protect your baby.
- Has anyone any questions so far?
- Your baby is born with very little protection against infection, so I want to go back to what I was saying earlier about the importance of your first milk, the colostrum. Many women think they do not have any milk in the first few days, because they do not see it on their nipples when the baby finishes breastfeeding. But it is there, and to be certain that your baby receives colostrum immediately after birth, we give you your baby to hold close to your breasts, so that your baby's skin and your skin are in contact. This keeps your baby warm. We try not to separate you and your baby for at least 1 hour. After a few minutes, your baby will start moving to your nipple and breast and will begin feeding by themself. We will be there to help you both when the time comes.

- Before you leave hospital, we will make sure you can correctly attach and position your baby at the breast, and teach you how to look after your breasts, so that you have no problems in the future. We will also teach you to recognize when your baby wants to feed.
- In the early days and weeks of your baby's life, this will mean breastfeeding whenever your baby wants, during the day and during the night.
- We also teach you to express your breast milk, so that if you have to be away from your baby for example if go back to work, you can still give them your own breast milk. Breastfeeding, whenever your baby wants to feed, means you will make enough milk for your baby.
- It is not only your baby who will be healthy as a result of breastfeeding. You too will benefit. Your bones will be stronger, cancer of the breast is less likely while you are young, and breastfeeding soon after birth helps to prevent you bleeding heavily at this time.
- Are there any questions?
- Cleanliness is very important, however you feed. Always make sure you wash your hands before breastfeeding or expressing your breast milk. If you intend to give your baby formula or cow's milk, please tell your infant feeding counsellor or health worker, so that they can help you feed your baby safely.
- Remember, however you feed your babies, we are here to help and support you. When you see the midwife, you can discuss more about feeding your baby and particularly any personal questions that you may have about your own situation.
- Does anyone have any questions?
- Thank you for your attention.

► **Thank the counsellor and restart the session.**

IV. Group exercise — 20 minutes

Exercise 76.A Reflection on Group talk for women at an antenatal clinic

► **Divide the class into three groups; each group will work with a facilitator/trainer.**

► **Each group will have six question to discuss about the talk they have just heard.**

► **Ask them to choose one of the participants to report back in the plenary discussion.**

Questions for Group 1

1. Was this talk easy or difficult to understand? Why?
2. What did you think about the length of the talk?
3. What about the language used in the talk?
4. What did you learn about HIV and infant feeding and the use of antiretroviral therapy or drugs?
5. What "key points" do you remember from this talk?
6. What might affect what you remember about the talk?

Questions for Group 2

1. Do you think the counsellor was an effective communicator?
2. Which communication skills, learnt about in previous sessions, were used?
3. Can you give any examples?
4. What did you think about the balance of information given to mothers?
5. Was there anything missing in the talk?
6. What could you do to make the talk more lively?

Questions for Group 3

1. This was a group talk; how involved in it did you feel?
2. Do any of you have group talks similar to this in your clinics?
3. Would talks like this be possible in your clinics?
4. If not, why?
5. If you were giving the talk, what would you have done differently?
6. How could you make sure pregnant women remember what you have told them in this talk?

V. Plenary discussion 15 minutes

- **Bring all groups back into the classroom for the plenary discussion.**
- **Put on the screen a slide of the questions given to Group 1 (Slide 76/4).**
- **Ask a participant to feed back the responses to the questions.**
- **Ask the class for their comments.**
- **Repeat this procedure for Group 2 and for Group 3 (Slides 76/5 and 76/6).**
  - *Ask: Before the talk, you chose five items of information that you thought should be in a group talk on breastfeeding. Do any of you have any pieces of information still unticked?*
- **If the answer is "yes", ask what the pieces of information are and discuss whether they should have been included in the talk you heard.**
  - *Ask: Some of you will have experience of counselling women living with HIV. What do you think are the main differences between the group talk and the one-to-one counselling situation?*
- **Wait for some replies and then continue.**
  - What a group talk cannot do is take into consideration a woman's individual circumstances. This can only be done in a one-to-one situation, where a woman can talk about any personal issues, such as discussion about how a positive HIV result affects her life and her relationship with her baby, and with her family and friends, as well as how she feeds her baby.

VI. Summarize the session 3 minutes

- **Ask participants whether they have any questions, and try to answer them.**
- **Make the following points:**
  - All women who are living with HIV need to be supported by infant feeding counsellors to follow the national health authority decision to either breastfeed with antiretroviral intervention to reduce HIV transmission, or avoid all breastfeeding and give replacement feeding. Women who choose not to follow the national decision should also be fully supported in their choice of infant feeding.
  - Information about all aspects of infant feeding, including HIV, should be given to all pregnant women in the antenatal period. A group talk, while pregnant women attend the antenatal clinic, provides an ideal setting.
- **Explain that a summary of this session can be found on pages 563–565 of the *Participant's manual*.**

Notes

SESSION 77

Supporting national health authority infant feeding recommendations for women living with HIV

Objectives

After completing this session, participants will be able to:

- list ways to ensure implementation of their national health authority infant feeding recommendations
- list ways to support implementation of the recommendations in their settings

Session outline . . . . . 45 minutes

Participants are all together for a lecture presentation by one trainer.

I. Introduce the session, present **Slide 77/1** . . . . . 3 minutes
II. Brief overview of the national health authority infant feeding recommendations (**Slides 77/2** and **77/3**) . . . 10 minutes
III. Working group discussion on ways to implement the recommendations (**Slides 77/4** and **77/5**, EXERCISE 77.A) . 15 minutes
IV. Plenary discussion . . . . . 15 minutes
V. Summarize the session . . . . . 2 minutes

Preparation

- Refer to the Introduction for guidance on giving a presentation with slides and facilitating group discussion.
- Study the **Slides 77/1** to **77/5** and the text that goes with them, so that you are able to present them.
- Prepare an overview slide or slides of the national health authority infant feeding recommendations using the suggested topics included on **Slides 77/2** and **77/3**.
- You will need three flipcharts and markers for the working group discussions.
- Prepare cards to be given to the working groups. The cards are also included in the slides for this session (**Slides 77/4** and **77/5**).

As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

I. Introduce the session 3 minutes

- Make the following points:
  - As health workers, we should help to implement our national health authority infant feeding recommendations.
  - The national recommendations have been developed considering the epidemiology of HIV in (Country) and the possibilities of support to the infant feeding recommendations selected.
- Show **Slide 77/1 – Session 77 – objectives** and read out the objectives:

77/1

Session 77: Supporting national health authority infant feeding recommendations for mothers living with HIV – objectives

At the end of this session, participants will be able to:

- list ways to ensure implementation of their national health authority infant feeding recommendations
- list ways to support implementation of the recommendations in their settings

II. Brief overview of the national health authority infant feeding recommendations 10 minutes

- Make the following points:
  - Now we are going to briefly review the national health authorirty infant feeding recommendations for (Country).
  - We will also compare the national recommendations with the 2010 and 2016 HIV and infant feeding guidelines and the recommendations on antiretroviral therapy (ART).

If the national recommendations include breastfeeding:

- Show **Slide 77/2 – Overview of (Country) National Health Authority infant feeding recommendations for mothers living with HIV: breastfeeding** and make the points that follow:

77/2

Overview of (Country) National Health Authority infant feeding recommendations for mothers living with HIV: breastfeeding

- Key points of national infant feeding recommendations
- National provision of ART for women living with HIV
- National conditions relating to ART, e.g. length of time available
- What support is available for mothers living with HIV
- Provision of follow-up for mothers living with HIV and their babies
- What support is available for mothers who choose not to follow national recommendations, e.g. free commercial infant formula milk
- Other

  - The infant feeding recommendations here for mothers living with HIV include breastfeeding.
  - The key points included in the recommendation are the following:
- List the key points and write them down on a flipchart of show them on slides you prepared before the session.
- Go over the key points, and make clarifications as needed.
- Compare each point with the global recommendations on infant feeding and ART.

If the national recommendations include the use of replacement feeding:

- Show **Slide 77/3 – Overview of (Country) National Health Authority infant feeding recommendations for mothers living with HIV: replacement feeding** and make the points that follow:

  - The infant feeding recommendations here for mothers living with HIV include the use of replacement feeding.
  - The key points included in the recommendation are the following:
- List the key points and write them down on a flipchart or show them on slides you prepared before the session.
- Go over the key points, make clarifications as needed.
- Compare each point with the global recommendations on infant feeding and ART.

III. Working group discussion on ways to support implementation of the recommendations 15 minutes

EXERCISE 77.A PUTTING INFANT FEEDING RECOMMENDATIONS FOR WOMEN LIVING WITH HIV INTO PRACTICE

- Divide participants into three groups of 8–12 participants, each with a trainer/facilitator.
- Each group will discuss how they can implement the national health authority infant feeding recommendations in their own places of work.
- Give each group the question card (**Slides 77/4** and **77/5**).
- Ask each group to write their key points on the flipchart paper provided.

Question card

How can you help to put the national health authority infant feeding recommendations into practice?

1. Discuss what needs to happen in your facility or area to implement the national health authority infant feeding recommendations.
2. Discuss what you can do to implement the recommendations in your place of work.
3. If applicable, include some of the following questions in your discussion:
   - What needs to be done at district level?
   - What needs to be done at community/clinical level?
     - Obtaining antiretroviral drugs/providing replacement milk
   - How to engage with local communities:
     - Community workers/dealing with prejudice/fears/etc.
     - Grandparents/religious groups
   - How to provide opportunities for linking with other services e.g. family planning.
   - What information to collect for local clinical use at monthly/other meetings with mothers.
   - What questions do you think mothers may have about breastfeeding/replacement feeding?

IV. Plenary discussion 15 minutes

- Ask the first group to present the results of the discussion in relation to what needs to happen in their facility or area. Ask other groups to add any additional points they may have.
- Ask the second group to present the results of the discussion in relation to how they can implement the recommendations in their place of work. Ask other groups to add any additional points they may have.
- Ask the third group to present results of the discussion of the additional questions. Ask other groups to add any additional point they may have.
- Make any clarification needed.

V. Summarize the session 2 minutes

- Ask participants whether they have any questions, and try to answer them.
- Explain that a summary of this session can be found on page 567 of the *Participant's manual*.

Notes

Notes (contd)

SESSION 78

Practical session: Preparation of milk feeds for babies who require expressed breast milk or replacement feeding

Objectives

After completing this session, participants will be able to:

- demonstrate how to prepare commercial infant formula milk
- demonstrate how to heat-treat expressed breast milk
- calculate the amount of commercial infant formula milk needed for an infant who is not breastfed
- translate measures into a mother's home utensils

Session outline . . . . . 110 minutes

Participants are together as a class led by one trainer to prepare for the session. Participants work in small groups of 3–4, each with one trainer for the practical session.
If adding the optional section, an additional 10 minutes will be needed.

I. Introduce the session (one trainer), present **Slide 78/1** . . . . . 2 minutes
II. Preparing commercial infant formula milk (DEMONSTRATION 78.A) . . . . . 15 minutes
III. Heat-treating expressed breast milk (DEMONSTRATION 78.B) . . . . . 15 minutes
IV. Practical preparation of commercial infant formula milk feeds . . . . . 30 minutes
V. Practical preparation of heat-treated expressed breast milk . . . . . 25 minutes
VI. Discuss the practical exercise (one trainer) . . . . . 20 minutes
VII. Calculate the amounts of commercial infant formula needed for an infant who is not breastfed; translate measures into a mother's home utensils (DEMONSTRATION 78.C) (*optional*) . . . . . 10 minutes
VIII. Summarize the session . . . . . 3 minutes

Preparation

- This session requires advance preparation. Commercial infant formula milk that is available and commonly used in your area should be obtained. The types of fuel you use should be appropriate to your area and cover what is locally available.
- The entire session can take place at the cooking place if it is suitable. The introduction, the first demonstrations and later the discussion, are for the whole group together. For the rest of the time, the participants work in their small groups.
- Prepare a place where one trainer can demonstrate to the whole group.
- Prepare a place where the groups can work.
- Each group should use a different type of fuel if this is appropriate, such as electricity, paraffin, wood or charcoal.
- Arrange for a fireplace, or obtain enough stoves of a commonly used type for each group.
- Obtain firewood, charcoal, paraffin and/or other locally used fuels. Put wood where it will keep dry or dry out.
- Provide matches and any other necessary equipment – prickers for the stove, paper or kindling to start fires, etc.
- Ensure that the stoves will work, and that they have wicks and are filled with fuel.
- Identify a source of water near to the cooking/demonstration site.
- Mark each group's area, and try to allow enough space for their mats, utensils and cookers.

- Discuss with the trainers their role during the session.
- You will follow the appropriate direction sheets to prepare the commercial infant formula milk and to heat-treat expressed breast milk (using formula milk, not breast milk, for the practical session).
- Have ready COUNSELLING CARD 9: CONDITIONS NEEDED FOR SAFE USE OF REPLACEMENT FEEDING, COUNSELLING CARD 10: HOW TO HEAT-TREAT BREAST MILK, and the *Guidance on the use of counselling cards*.
- Make sure you have **Slide 78/1** ready. Alternatively, as there is only one slide in this session, you might prefer to read aloud the objectives on **Slide 78/1** without projecting them onto the screen.

You will need the following utensils for the trainer-demonstrator and each group:

For preparing commercial formula milk:

- Soap and disinfectant
- Bowl of hot water
- Towel/paper napkins
- Clean container with an amount of clean water in it
- Small pan
- Heat source (stove or kettle)
- Tin of formula milk powder with scoop
- One dinner knife
- Bottle and/or feeding cup

For the heat-treatment of expressed breast milk:

- Bowl of hot water
- Soap and towel/paper napkins
- Pan of clean water large enough to boil all utensils
- Cup with 80 mL of "expressed breast milk" for one feed (use the formula milk previously made)
- Small heatproof jar for the breast milk
- Small pan with cool water in it
- Container of cool water
- Small cup for feeding the baby
- Device for heating the pan of water and milk

As you follow the text, remember:

► indicates an instruction to you, the trainer.

¤ indicates what you say to participants.

I. Introduce the session — 2 minutes

78/1

Session 78: Practical session: Preparation of milk feeds for babies who require expressed breast milk or replacement feeding – objectives

After completing this session, participants will be able to:

- demonstrate how to prepare commercial infant formula milk
- demonstrate how to heat-treat expressed breast milk
- calculate the amount of commercial infant formula milk needed for an infant who is not breastfed
- translate measures into a mother's home utensils

▸ **Make these points:**

- Helping a mother to prepare feeds or heat-treat expressed breast milk is easier if you have done it yourself, using equipment similar to that which the mother has at home or can easily purchase in a market.
- Knowing what is needed and how long it takes to prepare milk feeds is part of the information that you will need to give to mothers.
- In this session, we are going to practise preparing commercial infant formula milk and heat-treating expressed breast milk.
- We will begin with a demonstration of how to prepare formula milk and how to heat-treat expressed breast milk; this will be followed by a practical session where you will work in small groups.

II. Preparing commercial infant formula milk — 15 minutes

- We will first see a demonstration of how to make up commercial infant formula milk.
- In Session 75: Supporting women living with HIV to use replacement feeding, we mentioned the importance of preparing formula milk correctly. The consequences of not doing so can be very serious and lead to the baby becoming ill or dying.
- Any woman who is going to give her baby formula milk should be individually shown how to safely make it up. She should then demonstrate back to the health worker, to show that she can make up formula milk safely. It is useful for a woman to do this before the birth of her baby or very soon after the birth.
- *Ask: What equipment does the mother need to prepare infant formula milk?*

▸ **Wait for a few replies and then uncover and name the equipment you have on your table.**

- Soap and disinfectant
- Bowl of hot water
- Towel/paper napkins
- Clean container with an amount of clean water in it
- Small pan
- Heat source (stove or kettle)
- Tin of formula milk powder with scoop
- One dinner knife
- Bottle and/or feeding cup

Demonstration 78.A Preparing commercial infant formula milk

- Ask a participant to slowly read out the instructions from page 570 of the *Participant's manual*. Ask the participant to wait until you have completed each step before continuing to the next step.
- Demonstrate preparing the feed following the participant's directions.

How to prepare commercial infant formula milk*

1. Before you begin to prepare a commercial infant formula milk, clean and disinfect the surface you are going to use.
2. Wash your hands with soap and water and dry them using a clean and dry cloth or a single-use paper napkin.
3. Only make enough commercial infant formula milk for one feed at a time.
4. Make …… mL for each feed. Feed the baby …… times every 24 hours.
5. Boil a sufficient volume of safe clean water:
   - if using an automatic kettle, wait until the kettle switches itself off
   - if using a pan of water, make sure the water is bubbling well before you turn the heat off
   - **never use a microwave to boil the water because the heat may be unevenly distributed**.
6. Allow the water to cool. Do not leave it longer than 30 minutes. The water should be at least 70 °C when it is used, not cooler. As mothers are not likely to have thermometers to measure the water temperature, tell them to use the waer within 30 minutes of it boiling.
7. Be careful not to scald yourself. Pour the appropriate amount of boiled water into a clean and sterilized feeding cup (or bottle). Always check to see that the water level is correct.
8. Loosely fill the spoon or measure (provided with the tin) with the milk powder and level it off, using the flat dry edge of a knife or level provided. Do not squash the powder down in the spoon.
9. Add the exact amount of formula powder to the water, as instructed on the label of the tin. Adding more or less formula powder than insructed can make the baby ill.
   - If using a bottle, gently shake the contents until they are thoroughly mixed.
   - If using a feeding cup, mix thoroughly with a sterlized spoon.
10. Immediately after preparation, quickly cool the feeds to a feeding temperature, by holding the bottle or feeding cup under a cold running tap.
11. Dry the outside of the feeding cup or bottle.
12. Check the feeding temperature of the feed.
13. Feed the baby using a cup (or bottle).
14. Discard any feed not used within 2 hours.
15. Wash the utensils.

*These instructions are in the *Guidance on the use of counselling cards*, Counselling card 11.

- *Ask: Does anyone have any questions?*

- Make these points:
  - When using infant formula powder, you must remember that it is not a sterile product. Even if a tin is sealed, it can still contain bacteria. If the feed is not prepared according to the manufacturer's instructions, these bacteria can cause infection in the baby, which can be life threatening.
  - This is why the water must be more than 70 °C when it is used to prepare the formula powder.
  - Emphasize again to the mother, that she must add the formula powder to the water, NEVER add the water to the formula powder.
  - When you make up the formula feed, follow exactly the measurements of water and formula powder that are written on the label of the tin or package.

- The mother needs to regularly check the instructions on the tin, to see how much formula powder to use as the baby gets older and puts on more weight.
- When the baby is 6 months old, a mother can continue to use commercial formula milk or she can use boiled cow's milk. Once the baby reaches 12 months, cow's milk can be used, without being boiled.
- *Ask: Does anyone have any questions or comments about making up formula milk?*
- You will have the chance to practise what you have just seen; you will work in a small group, where you will:
  - prepare a single feed using formula milk powder that is available locally
  - use the fuel that is the most widely used locally
  - give a clear demonstration to others in the group of what you are doing, as if you are demonstrating to a "mother" and checking that the "mother" understands, by helping her to practise making the feeds.
- You will also observe others preparing feeds, noticing what they do correctly (and praising them). If they do anything incorrectly, help them to improve their technique, using your counselling skills.
- Consider the following as you observe others preparing feeds:
  - are they preparing the feed in a clean and safe manner?
  - are they mixing the correct amounts?
  - are they heating and mixing the feeds correctly?
  - are they explaining what they are doing in a clear way?
  - You will follow the instruction sheet to prepare the formula milk feeds.

► **Decide whether there is a need to discuss the amounts of commercial infant formula milk to be given to the infant according to age, as well as translating measurements into a mother's home utensils. If appropriate, follow the instructions included on page 963 of this session (Section VII) and on page 571 of the *Participant's manual*.**

► **Review COUNSELLING CARD 9: CONDITIONS NEEDED FOR SAFE USE OF REPLACEMENT FEEDING.**

III. Heat-treating expressed breast milk — 15 minutes

- We will now see a demonstration of how to heat-treat expressed breast milk.
- Expressed breast milk can be heat-treated in different ways; the method we use in the demonstration is a quick and effective way called "flash heating", which a mother can use at home.
- *Ask: What equipment does a mother need to heat-treat her milk?*

► **Wait for a few replies and then uncover and name the equipment you have on your table.**

► **Items needed:**

- Bowl of hot water
- Soap and towel/paper napkins
- Pan of clean water large enough to boil all utensils
- Cup with 80 mL expressed breast milk for one feed (use the formula milk previously made)
- Small heatproof jar for the breast milk
- Small pan with cool water in it
- Container of cool water
- Small cup for feeding the baby
- Device for heating the pan of water and milk

DEMONSTRATION 78.B HEAT-TREATING EXPRESSED BREAST MILK

- **Ask a participant to slowly read out the instructions from page 572 of the *Participant's manual*. Ask the participant to wait until you have completed each step before continuing to the next step.**
- **Demonstrate heat-treating "expressed breast milk" following the participant's directions.**

HOW TO HEAT-TREAT EXPRESSED BREAST MILK*

1. Before you begin to express or heat-treat your expressed breast milk, clean and disinfect the surface you are going to use.
2. Wash your hands with soap and water and dry them using a clean and dry cloth or a single-use paper napkin.
3. Before you begin to heat-treat the breast milk, wash the utensils you will use to express and heat-treat the milk. Use clean warm water and soap.
4. Boil these utensils after washing them.
5. Express enough milk for that individual feed, into a suitable container.
6. Put your expressed breast milk, between 50 mL and 150 mL, into a small heatproof jar. If you have more than 150 mL, use two jars. Do not overfill the jar.
7. Place the jar of milk into the pan of water; the water should be about two fingers' width above the level of the milk, so that all the milk is heated.
8. Heat the water in the pan until it reaches a "rolling" boil; this is when the water has large bubbles. This takes a very short time.
9. Remove the jar from the boiling water immediately after the water comes to the boil (taking care not to burn yourself).
10. Put the jar in the container of cool water, or let it stand free to cool until it reaches room temperature.
11. Put a lid on the jar, to protect the milk.
12. Use the milk within 1 hour.

*These instructions are in the *Guidance on the use of counselling cards*, COUNSELLING CARD 10.

- **Review COUNSELLING CARD 10: HOW TO HEAT-TREAT BREAST MILK.**
  - You will now have the chance to practise what you have just seen.
- **Remind participants that they will work in the same groups and should follow the instruction sheet.**
  - Each participant in a small group will:
    - heat-treat a specific volume of milk
    - use the fuel that is the most widely used locally
    - give a clear demonstration to others in the group of what they do, as if they are demonstrating to a "mother" and checking the "mother" understands, by helping her heat-treat her "expressed breast milk".
  - Participants should observe others heat-treating milk, noticing what they do correctly (and praising them). If they do anything incorrectly, help them to improve their technique, using your counselling skills.
  - Consider the following as you observe others heat-treating milk
    - are they preparing the equipment and milk in a clean and safe manner?
    - are they using a sufficient volume of milk for the baby's needs?
    - are they heating the milk correctly?
    - are they explaining what they are doing in a clear way?
  - *Ask: Does anyone have any questions?*

IV. Practical preparation of commercial infant formula milk feeds 30 minutes

- Show each group where they will work. Before they begin, decide who should be the health worker, the mother and the observer. Make sure each participant has the opportunity to make up formula milk.
- As soon as they are in their place, they can start to follow the instruction sheet. Encourage the group to take note of how long it takes to prepare each feed. If participants are preparing a fire and collecting water from a river, then the preparation time should start from this point.
- The trainers will work with their small groups to check that they:
  - have all their equipment and ingredients
  - are doing the exercise correctly
  - are working in a safe manner
  - are observing and giving feedback to the others, as appropriate.

V. Practical preparation of heat-treated expressed breast milk 25 minutes

- Show each group where they will work. Before they begin, decide who should be the health worker, the mother and the observer. Make sure each participant has the opportunity to heat-treat the milk.
- As soon as they are in their place, they can start to follow the instruction sheet. Encourage the group to take note of how long it takes to heat-treat the milk. If participants are preparing a fire and collecting water from a river, then the preparation time should start from this point.
- Remind participants that when heat-treating expressed breast milk, they need to prepare at least 1 hour before the feed is due.
- The trainers will work with their small groups to check that they:
  - have all their equipment and ingredients
  - are doing the exercise correctly
  - are working in a safe manner
  - are observing and giving feedback to the others, as appropriate.

VI. Discuss the practical exercise — 20 minutes

Preparation of commercial formula milk

- **Ask participants to discuss what they learnt about preparing the feeds, and how easy or difficult it would be for mothers.**
- **Use the following questions to start the discussion.**
  - Which fuel was the easiest to use?
  - How easy was it to prepare the formula milk?
  - What are the things that a mother is most likely to have difficulty with, and perhaps make mistakes over?
  - Would a mother be able to prepare these feeds many times a day?
  - How could she manage at night?
  - What special instructions would help her to prepare feeds both as safely and as easily as possible?

Preparation of heat-treated breast milk

- **Ask participants to discuss what they learnt about heat-treating "expressed breast milk", and how easy or difficult it would be for the mother.**
- **Use the following questions to start the discussion.**
  - Which fuel was the easiest to use?
  - How easy was it to heat-treat the breast milk?
  - What are the things that a mother is most likely to have difficulty with, and perhaps make mistakes over?
  - Would a mother be able to heat-treat her milk many times a day?
  - How could she manage at night?
  - What special instructions would help her to heat-treat her breast milk as safely and as easily as possible?

VII. Calculate the amounts of commercial infant formula needed for an infant who is not breastfed; translate measures into a mother's home utensils (*optional*) 10 minutes

► Ask participants to turn to the table on page 571 of their *Participant's manual*.

- This table shows approximately how much commercial infant formula milk a baby needs in the first 6 months. The numbers are rounded rather than exact. An individual baby may need more or less than the amount listed.

APPROXIMATE AMOUNTS OF COMMERCIAL INFANT FORMULA MILK NEEDED BY MONTH

Month	Number of 500 g tins needed per month	Number of 450 g tins needed per month	Number of 400 g tins needed per month
First month	4	5	5
Second month	6	6	8
Third month	7	8	9
Fourth month	7	8	9
Fifth month	8	8	10
Sixth month	8	9	10
Total for 6 months (approximately)	40 × 500 g (20 kg)	44 × 450 g (approx 20 kg)	51 × 400 g (approx 20 kg)

► Ask participants to answer the following questions from the table.

- *Ask: How much commercial infant formula milk would you need to feed an infant for the first month? Choose the size of tin most commonly used in your area.*

► Wait for a few replies and then continue.

- From the table, you can see that you need about 2 kg or four 500 g tins of formula milk.
- *Ask: How much commercial infant formula milk would you need to feed an infant for the first 6 months?*

► Wait for a few replies and then continue.

- If you add up all these months, you will find that a baby needs about 20 kg (40 × 500 g tins; see the row at the bottom of the table).
- A baby who is not breastfed needs a regular supply of milk. A child continues to need milk after complementary foods are introduced, up to at least 1 year of age, and if possible 2 years. So, the mother needs to consider how she can provide milk for all this time.

DEMONSTRATION 78.C MEASURING THE WATER AND MARKING THE MOTHER'S CONTAINER

- **Using the measure that you have decided is most suitable, continue with these points to demonstrate measuring the water, and marking the mother's container (see Fig. 78.1). It does not matter what volumes you demonstrate to the participants – it is the principle of making a measure for a mother that is important.**
  - Decide what volume you are going to measure. For this example, we will use 60 mL for a commercial infant formula feed for a baby from birth to 1 month.

1. Put water into your measure, to reach the 60 mL mark.
2. Pour the 60 mL of water from your measure into the mother's container.
3. Help the mother to mark the level that the water reaches. For the measure to be accurate, the line should be thin and straight, not thick or sloped.

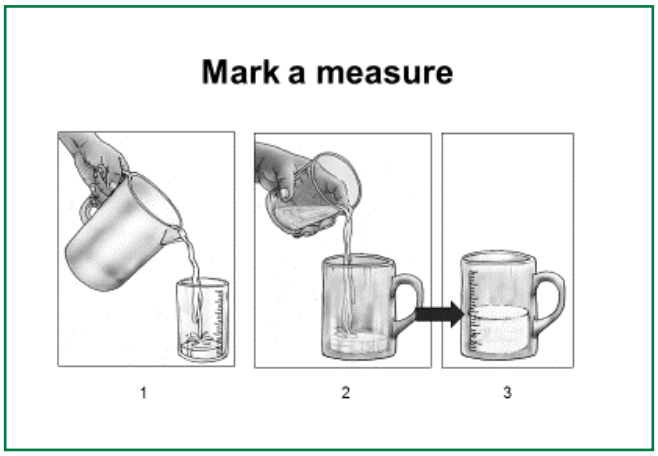


Fig. 78.1 Translating a measure into a mother's utensils

VIII. Summarize the session 3 minutes

- **Ask participants whether they have any questions, and try to answer them.**
- **Explain that a summary of this session can be found on pages 569–572 of the *Participant's manual*.**

Notes

MODULE 8

Follow-up after training

SESSION 79

Follow-up after training

Objectives

After completing this session, participants will be able to:

- describe the contents and arrangement of the table of competencies they are expected to acquire
- describe the components of the follow-up session
- list the tasks that they should complete for the follow-up session
- describe the linkages between the follow-up session and ongoing supportive supervision/mentoring

Session outline . . . . . 55 minutes

Participants are all together for a lecture presentation by one trainer followed by a demonstration. For Section IV, participants are organized in three groups, each with a facilitator.

I. Introduce the session, present **Slide 87/1** . . . . . 5 minutes
II. Discuss the competencies expected of participants . . . . . 20 minutes
III. Discuss the follow-up session and linkage to ongoing supportive supervision/mentoring . . . . . 5 minutes
IV. Discuss the preparation for the follow-up session . . . . . 10 minutes
V. Linking follow-up after training with ongoing supportive supervision/ mentoring . . . . . 10 minutes
VI. Summarize the session . . . . . 5 minutes

Preparation

- Review the *Guidelines for follow-up after training* (**Web Annex A**) and refer to the Introduction for guidance on how to give a lecture presentation. Study the notes for the session, so that you are clear about what to do.
- Make sure you have **Slide 79/1** ready. Alternatively, as there is only one slide in this session, you might prefer to read aloud the objectives on **Slide 79/1** without projecting them onto the screen.
- Prepare a flipchart with two columns. Write CONFIDENT at the top of one column and NOT YET CONFIDENT at the top of the other column.
- Ask participants to look at the table of competencies starting on page 579 of their *Participant's manual* the night before this session. Ask them to tick the knowledge and skills that they feel confident about and put a cross by those that they feel they need more practice at.
- Have ready the documents *Supportive supervision/mentoring and monitoring:* (**Web Annex B**) and accompanying *Toolkit for supportive supervision/mentoring and monitoring* (**Web Annex C**).

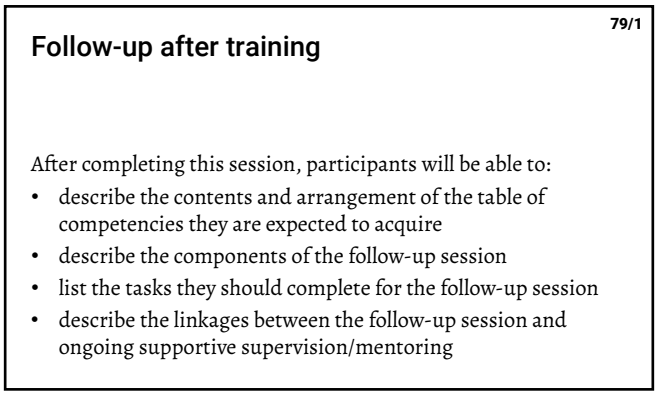
As you follow the text, remember:

► **indicates an instruction to you, the trainer.**

¤ indicates what you say to participants.

I. Introduce the session — 5 minutes

► **Show Slide 79/1 – Session 79 – objectives and read out the objectives:**



► **Make these introductory points:**

- In this session, we will discuss the follow-up you will all receive after this training course.
- This follow-up is not an exam or a test. It is designed to help you to continue to practise the competencies expected of participants, and to help you with any difficulties you may have come across in infant feeding when you return to your facilities.
- The trainer who comes to conduct this follow-up session might be one of the trainers who has facilitated on this course, or another trainer whom you may not have met. However, it will be someone who is experienced in infant feeding counselling and who is a trainer on this course.

II. Discuss the competencies expected of participants — 20 minutes

► **The previous day, review the list of competencies to make sure you refer to those that were covered in the training; this will depend on the modules included in the agenda.**

► **Ask participants to turn to page 579 of their *Participant's manual* and find the table of competencies they are expected to learn. (These competencies are in your *Trainer's gu*ide on pages 4–9 in the Introduction.) They should have looked at this the previous evening, following the list of competencies you told them to review, as covered during the training.**

► **Make these points:**

- You will see a table of competencies. To become competent at something, you need to have the relevant knowledge and also the relevant skills.
- You will see that the table has three columns – a column for the competency, a column for the knowledge required and a column for the skills required.
- Most people find that they obtain the "knowledge" part of the competency more quickly than the "skills" part.
- The first competencies in the table are essential for managing many situations.
- Further down the table, you will see a list of situations where you have to correctly apply these competencies.
- Looking down the table, you may feel that you have already acquired much of the knowledge from attending this course.
- However, you may feel that you need much more practice to develop the skills listed – for example the skill to cup-feed a low-birth-weight baby or the skill to gather information on complementary feeding using the Job aid: Food intake – 6 up to 24 months.
- When you go back to your facility, you will have the opportunity to practise many of these skills. The more you practise the more skilled you will become.

- **Ask participants to take 5 minutes to look at the table. (The previous evening they should have put a tick by the knowledge and skills that they already feel confident about and put a cross by the knowledge and skills that they feel they need more practice at.)**
- **After 5 minutes, ask participants to list the knowledge and skills they feel confident about and the knowledge and skills they do not feel confident about yet. Write these on a flipchart under two headings: CONFIDENT and NOT YET CONFIDENT. Do not take too long over this.**
- **Make this point about competencies:**
  - You can see, from your table and where you have placed your ticks, which skills you may need to practise more. Try to make time when you return to your facility to practise these skills. All the knowledge you need for these competencies is in your *Participant's manual*.

III. Discuss the follow-up session and linkage to ongoing supportive supervision/mentoring — 5 minutes

- **Make these points:**
  - The follow-up session will take place between 1 and 3 months after this training course.
  - The follow-up session will take one full day. The trainer who is coming to assess you will make arrangements with your facility for this follow-up to occur.
  - The morning will be practical sessions and the afternoon will be used to go over written exercises and to discuss positive experiences and any difficulties you have had. This is the time to discuss any difficult cases you may have seen.
  - If there are a few of you at one facility, the afternoon discussion can take place together, but the practical assessments and written exercises will be individual.
  - The competencies that you will be assessed on in the morning are all in the table you have in your *Participant's manual*. You may be taken to the postnatal ward and asked to help a mother with a newborn baby to position and attach her baby. Or you may be asked to counsel a mother living with HIV on infant feeding options. Or you may be asked to plot and interpret a child's growth chart.

IV. Discuss the preparation for the follow-up session — 10 minutes

- **Make these points:**
  - There are some things you need to prepare for the follow-up session.
  - Firstly there is a list of exercises for you that start on page 591 of your *Participant's manual*. These are all exercises on breastfeeding difficulties, so that you can practise applying the knowledge and counselling skills that you have learnt. Complete the answers in your *Participant's manual* in pencil, as you have been doing during this course.
  - During your follow-up session, the trainer will go over these exercises individually with you.
  - On page 585 of your *Participant's manual*, you will find a LOG OF SKILLS PRACTISED to be completed. This log has three columns. There is one column for the date, one column for skills practised, and one column for any comments. When you practise a skill at your facility, you should list the skill and write the date next to it and any comments. Remember the skills that you are expected to learn are on pages 579–584 of your *Participant's manual*.
  - So, for example, on 1 July 2020 you practise the skill of assessing a breastfeed using the JOB AID: BREASTFEED OBSERVATION. You would write the date in the first column and the skill in the second column.
  - Perhaps you found that the mother was not holding her breast in the recommended way, but was using the scissor grip. You might have suggested to her that she tries to hold her breast in a different way. Note this down in the third column.
  - Make particular notes of any difficult cases you have had to deal with, using the LOG OF DIFFICULTIES EXPERIENCED on pages 587–588 of your *Participant's manual*, so that you can discuss these with your trainer when they come for follow-up.
  - Finally, you can use the LOG OF DIFFICULTIES EXPERIENCED to note down any other difficulties you have experienced in trying to implement what you have learnt during the course.

- For example, you may have had difficulty counselling mothers about complementary feeding practices because the clinic in which you work is too crowded and there are too few staff.
- You may have had difficulties trying to help mothers who have had a caesarean section to give the first breastfeed because their babies are kept in the nursery after delivery. These difficulties can be discussed with your trainer at the follow-up session.
- During the afternoon of the follow-up session, the trainer will look at your log of skills with you and see which skills you have been able to practise.
- So, you have three tasks to complete before the follow-up session:
  - complete the exercises on pages 591–602 of your *Participant's manual*
  - complete the log of skills you practise over the next few months
  - complete the table of any difficulties you have come across in organization of your work and implementing the things you have learnt on this course.

V. Linking follow-up after training with ongoing supportive supervision/mentoring 10 minutes

► **Briefly link the follow-up after training with ongoing supportive supervision/mentoring, making the following points:**

- The follow-up session is not the end of learning. You will need to continue applying the knowledge and practising the skills even after you have completed the follow-up session.
- There are different ways in which this may happen in your facility and your supervision system. You may use several of these:
  - You can monitor your own progress using the SELF-ASSESSMENT IN INFANT AND YOUNG CHILD FEEDING: COMPETENCY PRACTICE AND PROGRESS TRACKING FORM on pages 589–591 of your *Participant's manual*.
  - You may partner with a peer (a fellow health-worker counsellor), to observe each other's counselling sessions and provide feedback to each other.
  - Your supervisor may organize group meetings of counsellors, so that you can discuss what is going well and where you are having challenges, and discuss special cases.
  - Your supervisor may work with you individually on an ongoing basis, acting as a mentor to help you monitor your progress in providing support to individual mothers/caregivers, or to groups of women; responding to requests you may have for special assistance; and occasionally observing your work with a mother/caregiver and providing feedback.
  - Your mentor/supervisor may also provide on-the-spot refresher training to individual health workers, and to groups for issues that a larger number of health workers find challenging.
- The way in which this ongoing mentoring is provided will vary from facility to facility, depending on the nature of the supervision/mentoring system. The follow-up after training is the first step in ongoing support, to help you become increasingly skilled in the competencies you will use in your everyday work with mothers/caregivers and their infants and young children.

VI. Summarize the session 5 minutes

- **Ask participants whether they have any questions, and try to answer them.**
- **Make sure that everyone is clear about what is expected of them and that they understand the table of competencies. This concept will be new to many participants.**
- **Make these points:**
  - You have now completed this course in infant feeding.
  - We have covered aspects of infant feeding from birth to 2 years of age, including special situations, such as mothers who are living with HIV.
  - It is important that you now continue revising the knowledge and practising the skills you have learnt, when you return to your facility.
  - You will be contacted about the date of the follow-up session at a time that suits both you and the facility.
- **Explain that a summary of this session can be found on pages 577–602 of the *Participant's manual*.**

LOG OF SKILLS PRACTISED		
Date	**Skill practised**	**Comments**

DIFFICULTIES EXPERIENCED		
Date	**Difficulty experienced**	**Comments**

SELF-ASSESSMENT IN INFANT AND YOUNG CHILD FEEDING: COMPETENCY PRACTICE AND PROGRESS TRACKING FORM

Instructions:

- Track your practice by putting a ✓ in the first box (column) for each skill you have practised.
- In the second box (column), enter a ✓ for competency where a peer has observed you and provided feedback.
- In the third box (column), enter a ✓ for competency observed by a mentor-supervisor who provided feedback.

Competencies	Practised	Peer observed and feedback	Mentor-supervisor observed and feedback
Core competencies			
1. Use the six LISTENING AND LEARNING SKILLS to counsel a mother or caregiver			
2. Use the six SKILLS FOR BUILDING CONFIDENCE AND GIVING SUPPORT to counsel a mother or caregiver			
3. Assess a breastfeed using the JOB AID: BREASTFEED OBSERVATION			
4. Help a mother to position herself and her baby for breastfeeding • THE FOUR KEY SIGNS OF GOOD POSITIONING • Demonstrate different positions: – Cradle – Cross-cradle – Side-lying – Underarm – Cross-position for twins			
5. Help a mother to attach her baby at the breast • THE FOUR KEY SIGNS OF GOOD ATTACHMENT • How to hold the breast • Signs of effective suckling			
6. Explain how the breast makes milk			
7. Explain to a mother about the optimal pattern of breastfeeding • Unrestricted or demand feeding • Day and night • Let baby finish first breast; offer the second one			
8. Help a mother to express her breast milk by hand			
9. Help a mother to cup-feed her baby			
10. Plot and interpret a child's growth chart			
11. Take a feeding history for an infant aged from 0 up to 6 months using the JOB AID: FEEDING HISTORY – 0 UP TO 6 MONTHS			

Competencies	Practised	Peer observed and feedback	Mentor-supervisor observed and feedback
12. Counsel a pregnant woman about breastfeeding (importance and management)			
13. Inform a woman about optimal infant feeding (early skin-to-skin contact, early initiation of breastfeeding, exclusive breastfeeding for 6 months, and continued breastfeeding to 2 years)			
Compound competencies			
1. Help a mother to initiate breastfeeding within an hour after delivery			
2. Support exclusive breastfeeding for the first 6 months of life			
3. Help a mother to continue breastfeeding up to 2 years of age or beyond			
4. Help a mother with "not enough milk"			
5. Help a mother with a baby who cries frequently			
6. Help a mother whose baby is refusing to breastfeed			
7. Help a mother who has flat or inverted nipples			
8. Help a mother with engorged breasts			
9. Help a mother with sore or cracked nipples			
10. Help a mother with mastitis			
11. Help a mother to breastfeed • a low birth-weight-baby • a sick baby • twins			
12. Help a mother to increase her breast milk or to start breastfeeding again (relactate)			
13. Help mothers who are in employment to breastfeed			
14. Explain the importance of continued breastfeeding			
15. Explain why there is an optimal age for children to start complementary feeding			
16. List the local foods that can help fill the energy gap			
17. Explain the reason for recommending using foods of a thick consistency			
18. Describe ways to enrich foods			
19. List the local foods that can fill the nutrient gaps for iron and vitamin A			
20. Explain the importance of animal-source foods			
21. Explain the importance of legumes			

Competencies	Practised	Peer observed and feedback	Mentor-supervisor observed and feedback
22. Describe age-appropriate frequency, amount, thickness, and variety of foods for an infant aged 6–9 months			
23. Describe age-appropriate frequency, amount, thickness, and variety of foods for an infant aged 9–12 months			
24. Describe age-appropriate frequency, amount, thickness, and variety of foods for an infant aged 12–24 months			
25. Describe the importance of responsive feeding			
26. Describe hygiene practices for the mother/caregiver/baby			
27. List the recommendations for feeding a non-breastfed child aged over 6 months			
28. Use the Job aid: Food intake – 6 up to 24 months or IYCF health-worker Job aid 1: IYCF assessment			
29. Explain why children need to continue to eat during illness			
30. Describe appropriate feeding during illness and recovery			
31. Conduct a food demonstration with a mother/caregiver to help feed her child aged 6–24 months			

Notes

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